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Short Communication

Anxiety Disorders and Depression in Older Adults -

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ANXIETY AND ANXIETY DISORDERS IN OLDER ADULTS

Anxiety disorder is not the same as everyday anxiety, stress, and worry, they are persistent conditions that may interfere with daily life and lead to serious physical and mental discomfort [1]. Anxiety in late life was frequently neglected and unrecognized. Anxiety disorders are prevalent in later life and are associated with increased risk for disability, increased use of health services, decreased cognitive and social functioning, and poor quality of life [2].

Anxiety in older adults has been reported with lower rates than in younger adults, but data has shown that it may be underestimated [3]. Accurately assessing anxiety disorders is very challenging in all age groups. In the elderly, differences in presentation, content, and severity of anxiety symptoms, make it more difficult to assess than in younger adults. In community samples, recent evidence reveals that anxiety in older adults is more common than depression, often preceding depressive disorders, and when co-occurring, they provide a worst outcome than either condition alone [4].

Fear of falling, possibly because of changes in gait and balance, is the most common specific phobia in older people. Other factors may also inflence this fear of falling such visual disturbances, cognitive impairment, loss of coordinationand delayed reactions to external stimuli. It can be marked by excessive fear and avoidance; in more severe presentations, the consequences of this fear may be very complex, including avoiding everyday activities. One or more previous falls is the main risk factor for fear of falling. However, fear of falling is found in up to 50% of elderly who have had no previous falls [5].

A particular frequent expression of anxiety in older adults is the health anxiety. In this case patients may present with any physical symptom and symptoms that may change over time. The main problem is not the symptom itself but persistent worry about potential health problems. This health preoccupation is a disorder of the awareness of one's body with a high degree of illness worry. The required symptoms include one (or more) of the following three phenomena:

- The patient may have obsessive rumination with intrusive thoughts, ideas or fears of harbouring illness that cannot be stopped or can only be stopped with great difficulty.
- Either worrying about or preoccupation with fears of harbouring a severe physical disease or the idea that disease will be contracted one in the future or preoccupation with other health concerns or
- Attention and intense awareness on bodily functions, physical sensations, physiological reactions or minor bodily problems that is misinterpreted as serious disease.

van Hout et als [6] have suggested that anxiety is associated with an increased mortality rate in older men. Recent investigations have shown that neither Generalized Anxiety Disorder (GAD) nor both anxiety and depression are associated with excess mortality [7]. For Holwerda et als [7], GAD may even predict less mortality in depressive elderly people. The relation between GAD and its possibly protective effect on mortality merits further exploration.

Anxiety disorders are frequently comorbid with other psychiatric and physical diseases, complicating its management in the elderly [8]. Similar to the general population, anxiety disorders in the late-life frequently co-occur with depression [9]. The rate of comorbidity with depression is higher for GAD compared to other anxiety disorders. The diagnosis of mixed anxiety/depression may be particularly relevant for older adults, whose symptoms may not meet strict diagnostic criteria for either disorder or may demonstrate a fluctuating symptom pattern [10]. Mixed anxiety and depression is a syndrome with a poorer prognosis, compared with anxiety or depression alone [11]. Also, anxiety disorders have consistently been found to have an adverse impact on cognitive functioning in older individuals, increasing the risk of cognitive decline [12].

Regarding physical comorbidity, a variety of medical conditions frequently co-exist with anxiety disorders in older adults [13]. Cardiovascular disease, hyperthyroidism, diabetes, chronic pain, lung disease, and gastrointestinal problems have all been found to be significantly associated with anxiety disorders [14]. Diagnosing anxiety in the context of physical illness is a significant challenge in older adult. Given the deleterious consequences of mental disorders on the outcome of medical illnesses, detecting clinically significant anxiety in this context is crucial.

A growing body of research has focused on cardiac problems due to mutually adverse effect of cardiac problems and anxiety disorders. However, acute coronary syndrome patients meeting GAD criteria had a superior 5-year cardiac outcome. Possibly, they worry constructively, and are more likely to seek help and be more adherent to cardiac rehabilitation programs [15].

DEPRESSION IN OLDER ADULTS

Diagnosing depression in the older adult can be challenging. The differential diagnosis of the classic symptoms of a major mood disorder, including altered sleep; appetite; energy levels; sad mood; hopelessness; poor concentration; and suicidal ideation, may result from life events. However, major life events such as the death of a friend or spouse, new disabilities, and financial instability are more frequent in old age. Primary depression must also be distinguished from organic causes secondary to comorbid medical conditions or medications [16].

Depression is approached differently in adolescents and middle-aged adults. Logically, late-life depression also requires its own detection and management strategies. With increased knowledge of its unique symptoms, geriatric depression becomes less insidious. While late-life depression treatment may create challenges when attempting pharmacologic management, psychosocial interventions hold great potential as primary and adjunctive treatment strategies. Behavioral and lifestyle changes, especially enjoyable exercise, can make a significant and lasting impact on clinical management of depression.

Exercise or physical activity may have several positive effects, which outweigh largely the risks. Exercise and physical activity can prevent or at least delay the onset of some mental disorders; they have therapeutic effects, either as the sole intervention or as an adjunct treatment for mental disorders. Patients are more likely to recover from a mental illness if they are regularly physically active. It is recommended for older adults to be physically active for at least 150 min per week at moderate intensity or for at least 75 min at vigorous intensity.

Other activities may also contribute to the management of anxiety and depression. Meaningful occupations and spiritual needs

should be taken into account. The ability to participate in and enjoy the leisure activities chosen by the individual, regardless of his or her environment, is an often forgotten dimension of global care. Access to appropriate, freely chosen activities is a prerequisite for activities with a positive impact on health. Opportunities to express their spiritual needs must be offered to the sick older adults. They must be able to freely practice the rites related to their convictions in this field [17].

The presentation of depression in the geriatric population may differ significantly from depression seen in middle-aged adults and young people. Relying on the classic adult presentation of depression when diagnosing geriatric patients is problematic. Misidentifying depression among the older adult is especially dangerous because it is associated with an increased suicide risk. Additionally, late-life depression has a high association with increased healthcare costs, family stress, and an impaired quality of life that hinders enjoyment of one's golden years.

Other obstacles that complicate late-life depression are the cultural infantilization of older patients and ageist beliefs about their diminished abilities, and they are only some features of stigma and discrimantion that older adults may suffer. The reduction of stigma and discrimination against older adults with mental disorders, anxiety and depression in particular, is mandatory. Stigma is the result of a process, whereby some individuals are unwarranted to feel ashamed, excluded, and discriminated. Discrimination includes all forms of distinction, exclusion, or preference that result in the abolition or reduction of equitable rights. Discrimination can manifest itself in terms of poor quality of care, marginalization within health systems, poor housing conditions for the people concerned, but also devaluation of professionals and services providing care, difficulties with financing, unfairness in the reimbursement of health costs, negative impact on families, abuse, preventable institutionalization, social exclusion, poor quality of life, discriminatory legislation, negligence on the part of authorities. The reduction of stigma involves complex educational actions to change beliefs and attitudes, while the reduction of discrimination mainly involves a legislative and judicial approach. The main goals of a strategy to reduce stigma and discrimination in the context of mental disorders in older adults are to[17]:

- Ensure the existence and the effectiveness of social and health services for these people and their caregivers.
- Ensure that the mental health of older adults receives the same attention that of other age groups.
- Promote a better understanding and acceptance of these people.
- Create more supportive environments for them.
- Encourage the search for effective and non- stigmatizing treatments, care, and access to sufficient occupational activities.

One confusing feature of geriatric depression is cognitive impairment [18]. Executive dysfunction is often the initial complaint that brings older adult patients in for evaluation [19]. While "slow thinking" or "brain fog" is a common experience of younger people with depression, it may be especially pronounced in depressed older adult patients who are already concerned about developing dementia. At the same time, depressive symptoms confound the work-up of neurodegenerative diseases and age-related memory impairment. A sense of apathy is more prominent in geriatric depression and often translates into features such as reduced short-term recall, poor concentration, and disorganization. Depressed, non-demented patients are not necessarily experiencing memory impairment; they just may not care anymore as a result of being depressed [20].

In addition to apathy, the interview with a depressed patient may express different key phrases regarding mood. Sad mood may present in older patients as disinterested behavior and statements of hopelessness, helplessness, being a burden, or worthlessness. Other signs of depression manifest as subtle behavior changes. Sleeping difficulties are commonly reported. A depressed older adult patient may report poor sleep but is not aware he or she is napping excessively during the day or falling asleep while watching television in the early evening. Another important confounding variable is the lack of any exercise or activity during the day [21]. These symptoms are often overlooked in depressed older adult patients because popular culture tends to portray these behaviors as typical of old age.

Finally, it is important to remind geriatric patients that just because they are old, it does not mean they should be depressed. Rather, they should enjoy life and all it has to offer.

REFERENCES

1. Blay SL, Marinho V. Anxiety disorders in old age. Curr Opin Psychiatry. 2012 Nov;25(6):462-467. doi: 10.1097/YCO.0b013e3283578cdd. PMID: 22914619.
2. Porensky EK, Dew MA, Karp JF, Skidmore E, Rollman BL, Shear MK, Lenze EJ. The burden of late-life generalized anxiety disorder: effects on disability, health-related quality of life, and healthcare utilization. Am J Geriatr Psychiatry. 2009 Jun;17(6):473-482. doi: 10.1097/jgp.0b013e31819b87b2. PMID: 19472438; PMCID: PMC3408215.
3. Gum AM, King-Kallimanis B, Kohn R. Prevalence of mood, anxiety, and substance-abuse disorders for older Americans in the national comorbidity survey-replication. Am J Geriatr Psychiatry. 2009 Sep;17(9):769-781. doi: 10.1097/JGP.0b013e3181ad4f5a. PMID: 19700949.
4. King-Kallimanis B, Gum AM, Kohn R. Comorbidity of depressive and anxiety disorders for older Americans in the national comorbidity survey-replication. Am J Geriatr Psychiatry. 2009 Sep;17(9):782-792. doi: 10.1097/JGP.0b013e3181ad4d17. PMID: 19700950.
5. Scheffer AC, Schuurmans MJ, van Dijk N, van der Hooft T, de Rooij SE. Fear of falling: measurement strategy, prevalence, risk factors and consequences among older persons. Age Ageing. 2008 Jan;37(1):19-24. doi: 10.1093/ageing/afm169. PMID: 18194967.
6. van Hout HP, Beekman AT, de Beurs E, Comijs H, van Marwijk H, de Haan M, van Tilburg W, Deeg DJ. Anxiety and the risk of death in older men and women. Br J Psychiatry. 2004 Nov;185:399-404. doi: 10.1192/bjp.185.5.399. PMID: 15516548.
7. Holwerda TJ, Schoevers RA, Dekker J, Deeg DJ, Jonker C, Beekman AT. The relationship between generalized anxiety disorder, depression and mortality in old age. Int J Geriatr Psychiatry. 2007 Mar;22(3):241-9. doi: 10.1002/gps.1669. PMID: 16998780.
8. Bower ES, Wetherell JL, Mon T, Lenze EJ. Treating Anxiety Disorders in Older Adults: Current Treatments and Future Directions. Harv Rev Psychiatry. 2015 Sep-Oct;23(5):329-342. doi: 10.1097/HRP.0000000000000064. PMID: 26332216.
9. King-Kallimanis B, Gum AM, Kohn R. Comorbidity of depressive and anxiety disorders for older Americans in the national comorbidity survey-replication. Am J Geriatr Psychiatry. 2009 Sep;17(9):782-792. doi: 10.1097/JGP.0b013e3181ad4d17. PMID: 19700950.
10. Jeste DV, Blazer DG, First M. Aging-related diagnostic variations: need for diagnostic criteria appropriate for elderly psychiatric patients. Biol Psychiatry. 2005 Aug 15;58(4):265-71. doi: 10.1016/j.biopsych.2005.02.004. PMID: 16102544.

11. Almeida OP, Draper B, Pirkis J, Snowdon J, Lautenschlager NT, Byrne G, Sim M, Stocks N, Kerse N, Flicker L, Pfaff JJ. Anxiety, depression, and comorbid anxiety and depression: risk factors and outcome over two years. Int Psychogeriatr. 2012 Oct;24(10):1622-1632. doi: 10.1017/S104161021200107X. Epub 2012 Jun 12. PMID: 22687290.

12. Lenze EJ, Butters MA. Consequences of Anxiety in Aging and Cognitive Decline. Am J Geriatr Psychiatry. 2016 Oct;24(10):843-845. doi: 10.1016/j.jagp.2016.07.006. Epub 2016 Jul 12. PMID: 27591156.

13. El-Gabalawy R, Mackenzie CS, Shooshtari S, Sareen J. Comorbid physical health conditions and anxiety disorders: a population-based exploration of prevalence and health outcomes among older adults. Gen Hosp Psychiatry. 2011 Nov-Dec;33(6):556-64. doi: 10.1016/j.genhosppsych.2011.07.005. Epub 2011 Sep 9. Erratum in: Gen Hosp Psychiatry. 2013 May-Jun;35(3):325. PMID: 21908055.

14. Garfield LD, Scherrer JF, Hauptman PJ, Freedland KE, Chrusciel T, Balasubramanian S, Carney RM, Newcomer JW, Owen R, Bucholz KK, Lustman PJ. Association of anxiety disorders and depression with incident heart failure. Psychosom Med. 2014 Feb;76(2):128-136. doi: 10.1097/PSY.0000000000000027. Epub 2014 Jan PMID: 24434950; PMCID: PMC3946309.

15. Parker G, Hyett M, Hadzi-Pavlovic D, Brotchie H, Walsh W. GAD is good? Generalized anxiety disorder predicts a superior five-year outcome following an acute coronary syndrome. Psychiatry Res. 2011 Aug 15;188(3):383-389. doi: 10.1016/j.psychres.2011.05.018. Epub 2011 Jun 8. PMID: 21652086.

16. Hilfiker R. Exercice for older adults with mental health problems. In: de Mendonça Lima CA, Ivbijaro G. Prmary Care Mental Health in older people. Springer 2019. Pp.: 127-143.

17. de Mendonça Lima CA, Kuhne N. Psychosocial Rehabilitation in Mental Health Care for Older Adults. In: de Mendonça Lima CA, Ivbijaro G. Prmary Care Mental Health in older people. Springer 2019. Pp.: 321-362

18. Kwak YT, Song SH, Yang Y. The Relationship between Geriatric Depression Scale Structure and Cognitive-Behavioral Aspects in Patients with Alzheimer›s Disease. Dementia and Neurocognitive Disorders. 2015;14(1):24-30. https://www.dnd.or.kr/Synapse/Data/PDFData/0196DND/dnd-14-24.pdf

19. Lockwood KA, Alexopoulos GS, van Gorp WG. Executive dysfunction in geriatric depression. Am J Psychiatry. 2002 Jul;159(7):1119-1126. doi: 10.1176/appi.ajp.159.7.1119. PMID: 12091189.

20. Morimoto SS, Kanellopoulos D, Manning KJ, Alexopoulos GS. Diagnosis and treatment of depression and cognitive impairment in late life. Ann N Y Acad Sci. 2015 May;1345(1):36-46. doi: 10.1111/nyas.12669. Epub 2015 Feb 5. PMID: 25655026; PMCID: PMC4447532.

21. Poelke G, Ventura MI, Byers AL, Yaffe K, Sudore R, Barnes DE. Leisure activities and depressive symptoms in older adults with cognitive complaints. Int Psychogeriatr. 2016 Jan;28(1):63-69. doi: 10.1017/S1041610215001246. Epub 2015 Aug 24. PMID: 26299193; PMCID: PMC5760211.