Identification and Treatment of Depression and Anxiety in the Geriatric Patient

REBECCA SCHLACHET, D.O.

Objectives

- Identification and treatment of depression in older patients

- Identification and treatment of anxiety in older patients

Who are these patients

- The most common definition is those greater than 65 years old
- More likely to live at facilities ie. NH, ALF, ILF
- 80% have at least one chronic medical issue
- Usually present to PCP

Unique population

- Source of information
- Taboo regarding mental health issues
- Different terminology to describe depressed mood and anxiety
- Cognitive decline
- Ability to engage in treatment

Depression

- Depression is not a normal part of aging
- 1-4% of older people have MDD, women 2 times as likely
- Minor depression: 4-14 % older adults
- Dysthymia/PDD: 2%
- Hospital: MDD up to 12%
- Nursing home: MDD 14 %, clinically relevant depression 17-35%

Rojas-Fernandez et al. Considerations in the treatment geriatric depression. Research in Gerontological Nursing 2010; 3:3

Depression

- Symptoms vs. Disorder
- Be on the alert for signs and symptoms of depression
- Screening tools (PHQ9)
- Who treats depression in the elderly – up to 80% treated by primary care
- Often depression is NOT identified or treated

Depression- Risk Factors

- Substance abuse
- Medications (ie. beta blockers, carbidopa, opioids)
- Hearing/vision impairment
- H/O depression
- Stress
- Medical conditions (CAD, COPD, MS, chronic pain, cancer, CVA, PD, cognitive impairment)

Depression-Risk Factors

- Insomnia
- Lower socioeconomic status

- Late onset depression- not more likely to report family history

Depression in the Elderly- Characteristics

- Depressed mood less prevalent
- More likely to complain of decreased energy, anhedonia, poor appetite, insomnia, somatic concerns , pain, anxiety
- Signs of withdrawal, poor interest, low energy, cognitive impairment, weight loss
- Poor recovery after illness, poor adherence to rehab, refusal of treatment
- “Depression without sadness”

Rojas-Fernandez et al. Considerations in the treatment geriatric depression. Research in Gerontological Nursing 2010; 3:3

Considerations

- Medical evaluation as appropriate- labs, medical history, physical exam, brain imaging, medication review
- Psychosocial stressors. ie. Abuse, inadequate support, finances
- Waiting room paperwork- Brief screening tools (PHQ-9, 5-item Geriatric Depression Scale)

Depression

S- Sleep disturbance

I- Interest diminished

G- guilt

E- decreased energy

C- impaired concentration

A- appetite/weight change

P- psychomotor disturbance

S- suicidal ideation

DSM V - Depression

- Major Depressive Disorder-

  -severity

  -with or without psychosis
- Persistent Depressive Disorder
- Depressive disorder unspecified
- Adjustment disorder with depressed mood

Major Depressive Disorder

- At least 5 symptoms for at least 2 weeks that cause clinically significant distress or functional impairment
- 1 symptom must be depressed mood or loss of interest/pleasure
- Depressed mood, diminished interest/pleasure, significant weight loss/gain or appetite change, insomnia/hypersomnia, psychomotor agitation/retardation, fatigue/loss of energy, worthlessness/guilt, poor concentration/indecisive, recurrent thoughts of death/SI

DSM-5

Persistent Depressive Disorder (dysthymia)

- Depressed mood for the majority of the time for at least 2 years
- 2 of the following: poor appetite or overeating, insomnia/hypersomnia, low energy/fatigue, low self-esteem, poor concentration/indecisive, hopelessness

DSM-5

Adjustment Disorder with Depressed Mood

- Emotional or behavioral symptoms that occur in response to a stressor.
- Symptoms within 3 months of stressor onset
- Marked distress that is out of proportion to stressor severity
- Significant impairment in social, occupational or other important areas of functioning

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Unspecified Depressive Disorder

- Symptoms cause clinically significant distress or functional impairment, but do not meet full criteria for the disorders in the depressive disorders diagnostic class

DSM-5

Unspecified Depressive Disorder

- minor depression/subsyndromal depression
- Do not meet criteria for MDD, PDD (duration, # sx)
- Results in increased health care cost, functional impairment, poorer health outcomes
- High risk for MDD

Other Depressive Syndromes

- Vascular Depression-post stroke depression rates 30%

  -apathy, poor insight, decreased agitation, increased cognitive impairment

- Depression-executive dysfunction syndrome

  -front striatal dysfunction.

  -poor insight, lack of interest, PMR, impaired IADLs

  -often poor response to antidepressant

Rojas-Fernandez et al. Considerations in the treatment geriatric depression. Research in Gerontological Nursing 2010; 3:3

Depression Impact

- Decline in life quality
- Associated with increased rates of cognitive disturbance
- Increased disability
- Increased health care costs
- Higher death rates in post-MI patients and post-CVA patients
- Higher rate of completed suicide, white men over 85 years highest suicide rate

Course of Depression

- ¼ of patients become depressed within 2 years of remission/recovery
- Response- decrease of greater than 50% in depression rating scale score
- Remission – depression scale score below a threshold that demonstrates relative absence of symptoms/depressed mood

  -goal of treatment

  -continuation therapy (relapse)
- Remission greater than 6 months= recovery

  -maintenance therapy (recurrence)

Wilkinson P and Izmeth Z. Continuation and maintenance treatment for depression in older people. Cochrane Database of Systemic Reviews 2012; 11

Treatment

- Medications
- ECT, rTMS, Vagus nerve stimulation
- Psychotherapy
- Alternative treatment- bright light, exercise, meditation, supplements

Medication Considerations

- Adequate dose
- Allow adequate time for response; older adults may take longer to respond (8-12 weeks)
- Tolerability
- Cost
- Drug interactions
- Prior medication use/response

Medication Considerations

- Consider biweekly contact (in person or phone)
- Scales to monitor improvement ie. PHQ-9, remission score<5
- Relapse/recurrence are common-
- Continue on effective dose: at least 6-12 months after remission
- Studies show little difference in efficacy between AD classes

Treatment-Psychotropic Medications

- Selective serotonin reuptake inhibitors (SSRI), Serotonin-noradrenaline reuptake inhibitors (SNRI), noradrenergic and specific serotonergic (NAS-SA)
- TCA; MAOIs
- Antipsychotic medications
- Mood stabilizers – lamotrigine, valproic acid, lithium
- Others- thyroid hormone, folic acid
- ECT- for severe depression/refractory to treatment/high risk suicide/poor self-care

Medication

- Selective serotonin reuptake inhibitors (SSRI) usually first line
- Citalopram, sertraline and escitalopram common choices
- Fluoxetine- less so- long ½ life, increased drug interactions, stimulating
- paroxetine- anticholinergic properties, drug interactions
- QTC prolongation, bradycardia, nausea, hyponatremia, weight loss, sexual dysfunction, upper GI bleed, anxiety, falls

Medications

- Serotonin-norepinephrine reuptake inhibitors – venlafaxine, duloxetine, desvenlafaxine
- Useful with pain complaints
- Tolerability may be less than SSRI
- Nausea, agitation, insomnia, hypertension

Medication

- Mirtazepine (NE, $5HT_{2/3}$ antagonist)
- Side effects- increased appetite, sedation, weight gain
- Low incidence of sexual SE

Medication

- Bupropion (↑ activity of dopamine and NE)
- SE: Stimulating, anxiety, tremor
- May lower seizure threshold
- Low incidence sexual SE

Rojas-Fernandez et al. Considerations in the treatment geriatric depression. Research in Gerontological Nursing 2010; 3:3

Stimulants

- Methylphenidate commonly used for depression, particularly with treatment resistant apathy, low energy, desire to have medically ill patient improve quickly
- Monitor for BP and HR changes
- Baseline EKG to rule out arrhythmia or acute ischemic features

Aripiprazole

- Treatment-resistant depression
- Adjunctive therapy
- There is evidence for use of Seroquel in depression as well. Approved as add-on treatment
- Suggest low starting doses

Espinoza ad Unutzer. Diagnosis and management of late-life unipolar depression. Up to date. 2016

Tricyclic Antidepressants

- Infrequent use secondary to potential harm to patient
- May be considered in those refractory to other options or past favorable response
- Anticholinergic, hypotension, tachycardia, cardiac toxicity
- Contraindications include: narrow angle glaucoma, cardiac conduction disturbance, orthostatic, urinary retention
- Nortriptyline and desipramine- less potent anticholinergic

MDD with psychotic features

- Most likely treated by mental health specialist
- Antipsychotic agents- lurasidone, aripiprazole, risperidone, olanzapine, quetiapine
- Mood stabilizers- valproic acid, lithium, lamotrigine
- ECT

Treatment Modalities

- Meta-analyses of 7 RCTs of patients >60 y/o
- Patients successfully treated for depression→randomized to continuation/maintenance treatment with AD, psychological tx or combo
- At 12 month f/u antidepressant group vs placebo: reduced recurrence (NNTB- 5; recurrence decreased from 61% to 42%). 6, 36 months no sig benefit
- No significant difference in recurrence rates between AD and psychological tx or between combination and AD tx alone

Wilkinson P and Izmeth Z. Continuation and maintenance treatment for depression in older people.

Psychological Treatments

- Cognitive behavioral therapy (CBT)
- Supportive counseling
- Mindfulness-based therapy
- Interpersonal therapy
- Psychodynamic therapy

Wilkinson P and Izmeth Z. Continuation and maintenance treatment for depression in older people.

Psychological treatments

- CBT has been shown to be more effective than control group in depression (Wilson and Mottram, 2008)

Other Approaches to Depression

- Exercise programs- increased social engagement

  -evidence suggesting group based exercise programs can reduce depressive symptoms (Sjosten and Kivela, 2006)

- Massage, social interaction, support groups

Anxiety Disorders

- Prevalence 0.9%-15 % on older adults (prevalence higher in younger adults)
- Longitudinal Aging Study Amesterdam- prevalence of anxiety disorders 10.2%: GAD most common, then phobic disorders
- The National Comorbidity Survey Replication: (≥60) Anxiety disorder prevalence 15.3%. Specific phobia most prevalent followed by social phobia, GAD, PTSD, panic disorder, agoraphobia, OCD

Tampi and Tampi. Anxiety disorders in late life: A comprehensive review. Healthy Aging Research; 2014;3:14

Anxiety

- Most anxiety disorder start in earlier life, although GAD (24.6%) and agoraphobia can start in late life
- 2001 study estimated rate of GAD in primary care at 8%, only diagnosed about 0.1% of cases
- Very few RCTs in older patients with anxiety- those available mainly focus on GAD or mixed anxiety disorders.

Andreescu and Varon. New research on anxiety disorders in the elderly and an update on evidence-based treatments. Curr Psychiatry Rep. 2015;17:53

Generalized Anxiety Disorder

- Persistent difficulty controlling worry a majority of the time
- Significant distress/impairment
- Somatic and psychological symptoms
- At least 3 of the following: restless, fatigue, decreased concentration, irritability, muscle tension, sleep disturbance
- In older adults, worry often about loved ones and health

DSM-5

Predictors of late-onset GAD

- Female
- Recent adverse events
- Chronic medical illness
- Chronic mental illness
- History of anxiety disorder

Panic Disorder

- Recurrent panic attacks, some of which are unexpected
- 4 symptoms such as palpitations, sweating, shaking, feeling SOB/smothering, chest pain, dizzy, paresthesias, fear of dying, derealization/depersonalization
- Anxiety about having future panic attacks or implications of panic attacks
- Or change in behavior due to attacks (avoidance)

DSM-5

Obsessive-Compulsive Disorder

- Obsessions (thoughts, urges, images), compulsions or both
- Compulsive hand washing and fears of sin may be more common in elderly
- More common in men
- Yale-Brown Obsessive Compulsive Scale
- SSRI, Clomipramine, SNRI, second generation antipsychotics
- CBT

Hoarding Disorder

- “persistent difficulty discarding or parting with possessions, regardless of their actual value” (DSM-5)
- Symptoms often worsen with age
- Mutidimensional approach to treatment- medication, CBT, organization, time management

Specific Phobia

- Situational fears- avoid situation or object
- Fear of falling common- low risk of fall, but high fear
- Multidimensional therapeutic approach
- Balance training and exercise

Social Anxiety Disorder

- “Marked fear or anxiety about one or more social situations in which individual is exposed to possible scrutiny by others”
- Causes distress of functional impairment

DSM-5

Posttraumatic Stress Disorder

- “Exposure to actual or threatened death, serious injury, or sexual violence”
- “Direct experience/witness/learning about/repeated or extreme exposure to aversive details of traumatic event(s)”
- Intrusion symptoms, avoidance, negative alterations in cognitions and mood, alterations in arousal or reactivity associated with the traumatic event

DSM-5

PTSD

- Subgroup with delayed-onset symptoms
- Increasing avoidance and hyper-arousal
- PTSD checklist- validated in older adults

Sequelae of Anxiety Disorders

- Reduced physical activity
- Decreased functional status
- Poor perception of one's health
- Impaired working memory, attention and problems solving ability
- Greater cost of health care
- Patients often progress to depression if anxiety is untreated
- Association with cognitive decline, cardiovascular disease, and stroke

Wolitzky-Taylor et al. Anxiety disorders in older adults: a comprehensive review. Depression and Anxiety. 2010;27:190-211

Andreescu and Varon. New research on anxiety disorders in the elderly and an update on evidence-based treatments. Curr Psychiatry Rep. 2015;17:53

Evaluation

- Thorough history of the problem, including collateral information
- Medical work up as in depression
- Mental status exam, including dementia screening.
- Both depression and dementia can mask GAD symptoms.
- Consider assessment scales (Beck anxiety inventory, Hamilton anxiety scale, Geriatric Anxiety Scale, PRIME-MD).

Tampi and Tampi

Anxiety

- Examine onset of symptoms in relation to cognitive decline, medical illness, medications, substance use including caffeine and ETOH
- Be sure to screen for suicidal ideation: comorbid depression/anxiety increase suicide risk

Generalized anxiety Disorder

- 3-14% of older patients in primary care settings
- Often see physical symptoms as opposed to complaint of constant worry
- Late onset (above 50's) less common. Often chronic or fluctuating course beginning is earlier life
- Literature review shows that medications are more effective than psychotherapy at reducing symptoms of anxiety in the elderly

Calleo and Stanley. Anxiety disorders in later life. Psychiatric Times. 2008. Harvard Mental Health letter. September 2009

Treatment- medication

- Reduced GFR, reduced hepatic metabolism, decreased cardiac output and changes in density/activity of target receptors increase susceptibility to medication side effects.
- SSRI and SNRI first line
- 2010 randomized, single blind trial found sertraline and buspirone to be efficacious for elderly with GAD

Andreescu and Varon. New research on anxiety disorders in the elderly and an update on evidence-based treatments. Curr Psychiatry Rep. 2015;17:53

GAD- Medications

- SSRI- escitalopram, citalopram, sertraline
- SNRI- venlafaxine, duloxetine
- Bupirone

  -low incidence of SE, low risk problematic interactions

  -can be used to augment other medications

- Can see initial anxiety exacerbation when starting treatment with SSRI/SNRI. Start low and work up.

Medication Treatment- Anxiety

- Tricyclics and MAOi can be efficacious, however limited use secondary to side effect profile
- Mirtazepine- limited evidence
- Pregabalin, gabapentin- shown to be efficacious for GAD. Block release of excitatory neurotransmitters (off label use).
- Quetiapine efficacious for GAD

Clifford et al. Update on managing generalized anxiety disorder in older adult. Journal of Gerontological Nursing 2015; 41:4

Medication Treatment

- Benzodiazepines

  -Frequently used for anxiety

  -best to avoid use unless other medications are not effective, short term use is needed due to high distress

  -concerning safety profile along with physical/psychological dependence and withdrawal can be life threatening

  -SE: cognitive impairment, increased falls, sedation

PTSD- Treatment

- SSRI, SNRI, newer antidepressants
- Antipsychotics
- B-blockers
- Prazosin (alpha 1 blocker)
- psychotherapy

Panic disorder

- Antidepressants (sertraline, citalopram, venlafaxine etc.)
- Buspirone
- Beta- blockers
- Second generation antipsychotics
- Avoid benzodiazepines
- CBT

Treatment of Anxiety

- Screen and assess the disorder, including focus on avoidance behaviors
- Avoid benzodiazepines and anticholinergic medications: unfavorable risk-benefit ratio.

  -reinforces maladaptive behavior-anxiety must be remedied immediately

Bower et al. Treating anxiety disorders in older adults: Current treatments and future directions. Harvard Review of Psychiatry 2015;vol 23:number 5

Treatment Steps

- Psychoeducation: education about the disorder and the importance of treatment
- First-Line Treatment: SSRI, SNRI, CBT, relaxation training
- Frequent follow-up: important for med-compliance, often patients hypervigilant about side effects; point out areas of improvement; gradually uptitrate medication

- Bower et al. Treating anxiety disorders in older adults: Current treatments and future directions. Harvard Review of Psychiatry 2015;vol 23:number 5

Treatment

- Maintenance Treatment: Anxiety is chronic and effective medication dose should be continued. If the patient insists on stopping medication, it should be tapered off over 4-6 weeks.

Bower et al. Treating anxiety disorders in older adults: Current treatments and future directions. Harvard Review of Psychiatry 2015;vol 23:number 5

CBT

- CBT has been shown to be superior to treatment as usual in elderly with anxiety
- Elderly do not benefit from CBT as much as their younger counterparts
- Elderly more likely to drop out of CBT
- Learning new skills, coping mechanisms and adjusting one's thoughts is challenging – consider different CBT approach for older patient

Take Home Points

- Screen for mental health issues in older patients; they probably will not announce their symptoms.
- Most older patients will be untreated if the primary care physician does not recognize their anxiety and depressive disorders
- Use established questionnaires and be aware of general criteria

Take Home Points

- Time is limited, consider using a nurse to help screen for mental health issues
- Collaborative Care Model- nurse can provide screening, brief interventions and be a liaison to MH providers
- Identify mental health specialists – often limited
- Use entry level medications to treat the disorders- generally safe using SSRI, SNRI, bupoprion, buspirone starting at low doses

Take Home Points

- Do not forget to increase medication to effective dose
- Be patient- response may take 8-12 weeks
- Always monitor for medication compliance
- Does the patient need help taking medications?

Take Home Points

- If one medication does not work, try another
- Augment- exercise, structure, socialization, diet, meditation, relaxation
- Refer out when first or second line medications are not effective
- Medication resistance may indicate need for diagnostic clarification ie. Possibility of bipolar disorder, cognitive impairment, subtle psychotic features

GAD-7 anxiety scale

	Not at all	Several days	More than half the days	Nearly every day
Over the last two weeks, how often have you been bothered by the following problems?				
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total score* _____ =	Add Columns	_____ +	_____ +	_____
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Circle one	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

* Score: 5 to 9 = mild anxiety; 10 to 14 = moderate anxiety; 15 to 21 = severe anxiety.

Adapted and reproduced with permission from: Spitzer RL, Kroenke K, Williams JB, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med 2006; 166:1092. *Copyright © 2006 American Medical Association. All rights reserved.*

Short Patient Health Questionnaire (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things?	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
Feeling down, depressed, or hopeless	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
Total point score:	

Score interpretation[1]:

PHQ-2 score	Probability of major depressive disorder (percent)	Probability of any depressive disorder (percent)
1	15.4	36.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

Reference:

1. *Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care 2003; 41:1284.*

PHQ-2 reproduced with the permission of Pfizer Inc.

UpToDate®

PHQ-9 depression questionnaire

Name:	Date:			
Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Total ___ =	___	+ ___	+ ___	+ ___
PHQ-9 score ≥10: Likely major depression				
Depression score ranges:				
5 to 9: mild				
10 to 14: moderate				
15 to 19: moderately severe				
≥20: severe				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ___	Somewhat difficult ___	Very difficult ___	Extremely difficult ___

PHQ: Patient Health Questionnaire.

Developed by Drs. Robert L Spitzer, Janet BW Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.

PTSD checklist for DSM-5

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PTSD: Posttraumatic stress disorder; DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th edition.

Reproduced from: Weathers FW, Litz BT, Keane TM, et al (2013). The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov.

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