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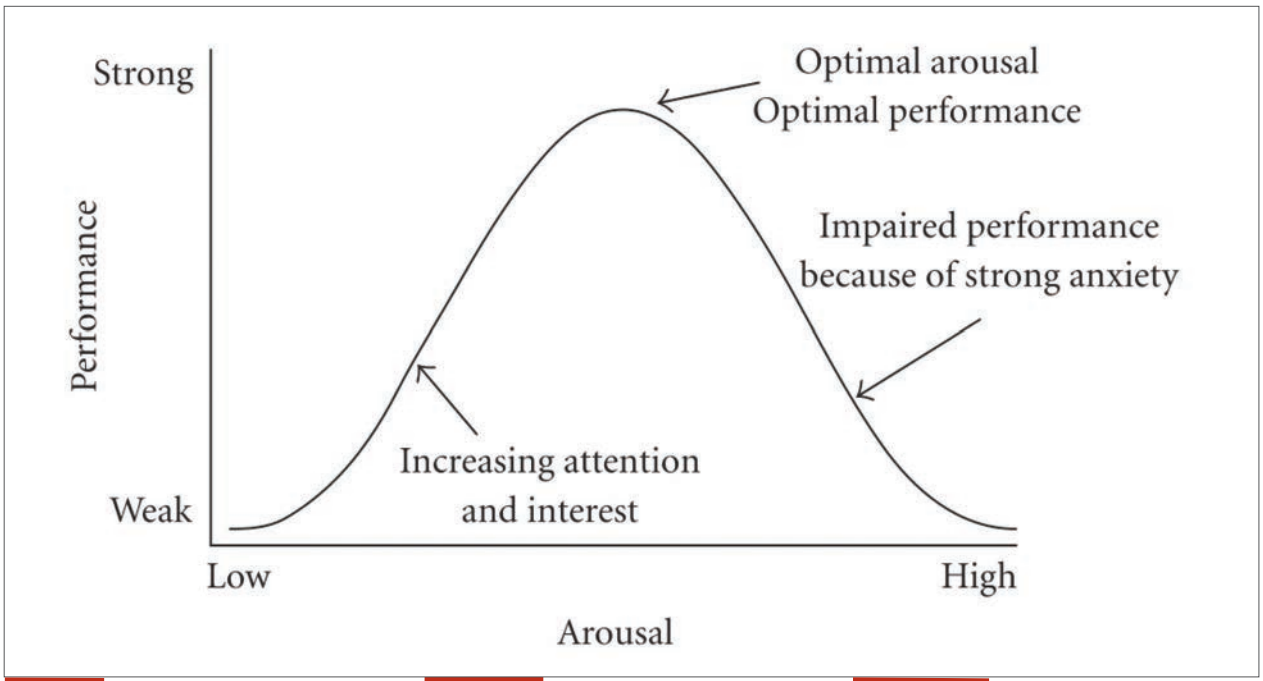

FIGURE 1
Hebbian version of the Yerkes-Dodson Law[1]

How should patients be assessed?

ANXIETY IS A FEELING OF UNEASE, NERVOUSNESS, OR WORRY ABOUT SOMETHING. IT IS A NORMAL PART OF the human condition. It can be argued that anxiety is a form of arousal which is required for action. However, too much anxiety is detrimental to constructive action and is maladaptive.

Determining when anxiety is excessive and constitutes a disorder can be challenging. Markers for intervention are severity/intensity, duration, a trivial stimulus or situation as trigger, and deviation from the previous level of functioning with a detrimental impact on social, occupational or personal life.

Some may find the dysphoria (profound sense of unease or dissatisfaction) associated with anxiety itself sufficiently distressing to consult their doctor.

PRESENTATION

Anxiety disorders are a heterogeneous group of disorders.[2] In the UK, they affect around 4.2% of the population.[3]

What are the management approaches?

Prevalence decreases with age,[4,5] but this may reflect underrecognition.[6] Although anxiety disorders are more prevalent among women, this gender difference may decrease with increasing age.[7] Prevalence varies with settings: with lower rates in the community and higher rates in older adults with other health problems, in hospital and in care settings.[4,8] Generalised anxiety disorder (GAD) is by far the most common anxiety disorder seen in older adults.[4]

Like depression, anxiety disorders have a huge impact on quality of life[9] and cause excess mortality through natural causes and suicide.[10] They are thought to increase the risk of dementia,[11,12] although some of the association may be explained by anxiety and depression preceding onset of dementia.[13]

Diagnostic categories for anxiety disorders are based on symptom clusters. However, it is important to highlight that anxiety and depression often exist on a continuum, with shared risk and vulnerability factors. This is especially true in community dwelling older adults.[14] Coexistence of anxiety often indicates a more severe presentation of depression. This emphasises the importance of screening for depression in those presenting with anxiety.[14]

The core symptom of anxiety is worry, which can be free-floating or specific to a situation or object. However, the breadth of symptoms is vast, see table 1, p18.[6] Older adults may complain of physical or somatic symptoms rather than mental symptoms.

Which patients should be referred?

COMMON COMORBIDITIES

Psychiatric

Between one in three and one in four patients with anxiety meet the criteria for a mood or substance use disorder.[15] A primary depressive disorder should be excluded in an older person presenting for the first time with anxiety symptoms.

Medical

Around four in five patients have a comorbid physical disorder which in itself can predispose an individual to »

an anxiety disorder.[15] These comorbid physical disorders can mimic symptoms of, predispose to, or even directly precipitate an anxiety disorder, and may colour its symptomatology or limit treatment options, see table 2, below.[16]

ASSESSMENT

Although it is desirable to have a specific anxiety disorder diagnosis, in primary care it may be more important to elicit the nature and severity of anxiety symptoms, their impact on day to day functioning, and how they interact with other health conditions.

Questionnaires

There is no single primary care assessment scale for all anxiety disorders, and even anxiety-specific questionnaires show substantial overlap with depression.[17] Nonetheless, the Geriatric Anxiety Inventory (GAI), which has a five-item screening version (short form), and the Geriatric Anxiety Scale (GAS), which has ten items, can be useful screening tools. The Generalised Anxiety Disorder-7 (GAD-7) questionnaire may also be used.

History taking

Ask about worries, preoccupations, ability to relax, and physical symptoms. Enquire about health concerns and activities which are avoided.

Often older adults will not volunteer concerns about their mental state and instead present with physical symptoms. This may reflect misinterpretation of physiological processes as pathological processes, especially if a major health event has occurred. An example of how this can occur, and how a basic cognitive behavioural cross-sectional formulation can assist both patient and clinician in understanding how symptom-perpetuating vicious cycles can develop, is detailed in the case in box 1, below.

It is always important to consider the level of distress, including suicide risk, and functional impairment, rather than solely relying on number, severity or duration of symptoms.

An informant history can clarify the extent of day to day functional impairment and avoidance and identify potential therapeutic allies.

Medical workup

A medical workup is recommended if this is the patient's first presentation of anxiety, or the patient is presenting after an extended symptom-free period.[6] It should include:

- Systematic review including, ideally, cardiovascular and neurological examination

Table 1

Common symptoms of anxiety

Mental symptoms
- Worry
- Ruminations (excessive preoccupations)
- Poor concentration
- Depersonalisation (the person or part of them does not feel real)
- Derealisation (the world does not feel real)
- Memory impairment

Physical symptoms
- Pain/tension
- Tremor
- Dry mouth
- Blurred vision
- Paraesthesia
- Dizziness
- Palpitations
- Nausea/vomiting
- Change in bowel habits
- Sweating/feeling flushed
- Choking sensation
- Swallowing difficulties

Emotional symptoms
- Fear
- Irritability/anger
- Numbness
- Sadness/low mood

Behavioural responses
- Avoidance
- Repeating tasks

Box 1

Cognitive behavioural formulation of an anxiety presentation

A 70-year-old woman had suffered a stroke four months ago and had made a good recovery. She made repeated presentations to A&E with headaches, light headedness and facial tingling expressing concerns about a further stroke. Standard medical workup and imaging and hospital discharge letters attributed her symptoms to anxiety. She had reported frequent episodes beginning with a headache which she believed were a recurrent stroke.

Recurrent presentations to A&E: brief reassurance but reinforces idea of a concerning event
Stops going out alone in case she has a stroke (with loss of distractions/rewarding activities)
Increased symptom vigilance/body scanning/recurrent checking in mirror for facial drooping

Table 2

Examples of interplay between medical conditions and anxiety symptoms

Medical disorders which can be mistaken for anxiety disorders (and vice versa)
- Arrhythmias mistaken for anxiety driven palpitations
- Anxiety driven dizziness mistaken for vertigo

Medical disorders as precipitants for anxiety disorders
- Agoraphobia secondary to fear of stroke recurrence
- PTSD following serious illness and treatment in ICU
- Fear of falling following vasovagal episode and falls

Medical disorders as maintaining factors for anxiety disorders
- Unstable asthma or COPD promoting vigilance re breathing and panic/hyperventilation
- Gait disorders promoting vigilance re falling

Table 3

Pointers to the diagnosis of anxiety disorders[19]

Nature/setting of anxiety	Diagnosis
● Persistent or free-floating	**Generalised anxiety disorder**
● Discrete unpredictable episodes	**Panic disorder**
● Social situations	**Social anxiety disorder**
● Leaving home, being in situations where there are perceived to be few escape options (such as public places)	**Agoraphobia**
● A specific situation or object	**Specific phobia**
● Obsessions (intrusive, repetitive thoughts) and/or compulsions (repetitive actions)	**Obsessive compulsive disorder**
● Nightmares, flashbacks and hypervigilance	**Post traumatic stress disorder**

- Blood tests: FBC; U&Es; LFTs; glucose; TSH
- Urinalysis
- ECG if the patient is starting medication which could impact on cardiac conduction, especially if there is a cardiac history
- Review of known chronic health conditions and their management

Medication review
The use of medications which may contribute to anxiety should be rationalised. Common culprits include: sympathomimetics, antihistamines, corticosteroids, interferon/TNF-alpha, oestrogen and thyroid hormones.

Substance use
Ask patients about their current substance use, including alcohol, nicotine, cannabis, herbal supplements, benzodiazepines, and the oft forgotten caffeine.

Sensory impairment
Hearing and visual impairment can contribute to the severity of anxiety symptoms.[18]

Cognition may be affected by both anxiety and any associated depressive symptoms. There may also be preexisting cognitive impairment or dementia, making history taking more challenging.

Patients may answer negatively to general questions about anxiety but later voice their worries. Careful history taking with both open questions and narrowed questioning (re family, finances, etc.) is essential.

DIAGNOSIS

The nature of anxiety and the setting in which it is experienced can provide pointers to the diagnosis, see table 3, above.

Generalised anxiety disorder
Persistent anxiety which is not restricted to any situation or topic, said to be free-floating, leads to a state of internal tension and inability to relax.

Physical symptoms and catastrophising (fear of dying, 'going mad', or losing control) are often prominent (as in panic disorder), but anxiety is pervasive rather than the discrete episodes of panic disorder.

It is useful to distinguish anxiety state (a current experience) from trait anxiety, a lifelong and habitual tendency to an excessive degree of anxiety which the individual has learned to adapt to.[20]

Panic disorder
Recurrent discrete episodes (panic attacks) of unpredictable severe anxiety, involving physical symptoms of anxiety (though not necessarily recognised as such) and often associated with catastrophising thoughts.

Social anxiety disorder (social phobia)
Fear of social situations, involving fear of criticism, and associated with low self-esteem.

Agoraphobia
A group of phobias involving fear of leaving home or being in public places with perceived poor escape options. If avoidance of such situations is maintained, patients may experience little, if any, anxiety. These are often chronic and embedded through avoidance, making it a challenge to treat.

Specific phobia
Excessive anxiety about a specific situation or object. Despite the fact that specific phobias are common most people do not seek treatment and simply avoid the situations that induce fear and anxiety.

Many phobias can be treated with basic psychotherapy approaches of exposure and desensitisation; others, such as fear of falling with its associated implications for independent mobility (see below), may require more complex formulations and interventions.

Fear of falling
High levels of physiological arousal occur when confronted with walking with subsequent avoidance of walking or confinement to home. It is often difficult to delineate the abnormal nature of fear, as it is commonly seen in people who are frail and may have a history of falling. Assessing the excessiveness of fear relative to the threat posed can help.[21]

As well as formulating the excessiveness of fear with the patient, treatment requires exposure and desensitisation; given there may genuinely be an increased risk of falls, this often requires input from physiotherapy to facilitate physical activity.[22]

Obsessive compulsive disorder
As first-time presentation of obsessive compulsive disorder (OCD) is rare in older adults, be mindful of a primary depressive illness. OCD has two components, either or both of which may be present:
- **Obsessions:** repetitive, intrusive thoughts (can be ideas or images), often distressing and resisted
- **Compulsions:** repetitive actions made to prevent something from happening, usually unpleasant, not useful and resisted

— Associated anxiety related to the above is almost always present
— Not to be confused with obsessive-compulsive personality disorder traits, which include perfectionism, excessive preoccupation with details, and conscientiousness. These are lifelong, not distressing, and do not severely impact function.

Post traumatic stress disorder (PTSD)
Initial potentially threatening event(s), such as hospitalisation in the elderly (especially in the intensive care setting) and delirium, may eventually (after a few weeks to months) give rise to flashbacks (vivid intrusive reliving of events, not just memories), nightmares, avoidance, and hypervigilance. Depressive and anxiety symptoms are also common. »

MANAGEMENT

A stepped care model guided by symptom severity and functional impairment is recommended by NICE (see table 4, below).[23]

Few studies have specifically addressed management of anxiety in older adults. Difficulties with compliance may be more common, because of frailty, mobility problems, sensory or cognitive impairment.

Psychological approaches are generally well received by older adults, once a formulation of the problem is agreed between the patient and GP.[26] However, there may be problems with access to such services.

Involving the multidisciplinary team (MDT) at a primary care level may help facilitate psychological approaches. The MDT may include physiotherapy, occupational therapy, support workers, community-based mental health nurses, district nurses, counsellors, psychologists, and social workers. Family and friends may also be involved.

Psychoeducation

Discuss the diagnosis with the patient, including an explanation about the link between anxiety and physical symptoms if these are present (see box 1, p18). Explaining any medical workup findings, rationalising existing medications, and addressing any substance misuse can also help provide reassurance that potential organic causes for symptoms have been taken into consideration and excluded.

Table 4

Stepped care model guided by symptom severity and functional impairment

Step one: Education and active monitoring
If there is marked functional impairment, go to step three but include step one
- Psychoeducation
- Encourage physical activity
- Sleep hygiene advice
- Review medical workup and rationalise existing medications and substance use

Step two: Low-intensity psychological interventions[19,20]
- Individual self-help (including mindfulness and relaxation training)
- Guided self-help such as online programmes (see Useful information box, p21)
- Psychoeducational groups

Step three: High-intensity psychological intervention and/or medication
- Cognitive behaviour therapy
- Medication: Selective serotonin reuptake inhibitors are first line

Physical activity

Studies have shown that exercise can reduce anxiety.[27,28] Consider referral to physiotherapy and occupational therapy to facilitate this if there are any problems with mobility or function. This may be useful when addressing fear of falling.[22]

Sleep hygiene advice

If the patient has insomnia, prior to considering medication, provide sleep hygiene advice. This should include minimising caffeine intake and avoiding caffeine altogether later in the day; establishing a bedtime routine; ensuring a comfortable environment (temperature, textures, noise level); avoiding stimulating activities before bedtime; associating the bedroom with sleeping rather than activities.

Psychological interventions

It is crucial to remember the distinction between generalised and phobic anxiety disorders.

Relaxation training together with cognitive restructuring and problem solving will be central in the management of the former, whereas exposure and desensitisation is crucial to remission of the latter.

Cognitive behaviour therapy (CBT) provides the structure for delivery of these interventions and can treat anxiety disorders either alone or as an adjunct to medication. Variants include trauma-focused therapy for PTSD and exposure and response prevention for OCD.

Medication [23,29]

For any anxiety disorder, a selective serotonin reuptake inhibitor (SSRI) is recommended first line, up to the maximum dose for a full trial of six weeks.[30] Treatment should continue for at least 6-12 months after resolution of symptoms to prevent relapse.

Commonly used SSRIs are sertraline (50-200 mg) which is the best tolerated; citalopram (10-20 mg); and escitalopram (5-10 mg).

Although fluoxetine (maximum dose 40 mg), which has the longest half-life, has some evidence base in adults of working age, it is not well tolerated in older patients and therefore not commonly used.

Paroxetine should be avoided because of its strong anticholinergic side effect profile and shorter half-life leading to withdrawal symptoms.

The maximum licensed doses of citalopram and escitalopram were restricted due to concerns about cardiac conduction, specifically prolongation of QTc interval.

The prescriber should be mindful that while not all SSRIs are licensed in the UK for all anxiety disorders they are commonly used interchangeably as a class of drugs. This is reflected in the NICE guidelines as well as the British Association of Psychopharmacology guidelines.[23,31]

The second line of treatments can be a switch to a selective noradrenergic reuptake inhibitor (SNRI) such as venlafaxine (75-225 mg) or duloxetine (30-120 mg). These are recommended for generalised anxiety disorder, panic disorder, social phobia, and PTSD.

Mirtazapine with its hypnotic effects is generally well tolerated and often used, commonly in primary care, especially if there is insomnia.

Duloxetine is especially useful if there is concomitant neuropathic pain and has a better tolerance profile than venlafaxine.

There is increased bleeding risk with SSRIs, especially if the patient is on anticoagulation.[32] Prescribing a gastroprotective medication as well should be considered. Mirtazapine is a recommended alternative.

All of the above medications are associated with hyponatraemia (due to SIADH). Older people are prone to this, especially if they have other risk factors. It is advisable to check sodium levels 2-3 weeks after initiation of therapy.

Tricyclic antidepressants are not recommended owing to their strong anticholinergic side effect profile. The exception is in OCD where clomipramine is considered second line.

Antidepressants will take longer to work for anxiety than depressive symptoms. An initial increase in anxiety or insomnia is common. Patients should be warned of this and that it will settle. Sometimes a short course of benzodiazepines, such as diazepam 2 mg BD will help with this.

Benzodiazepines although effective in the short term for anxiety disorders and insomnia, carry a risk of dependence and falls, and are associated with cognitive decline. Their use is therefore strongly discouraged except in exceptional circumstances. Pregabalin has similar long-term risks and is not recommended as first- or second-line treatment.

Propranolol can be helpful when physiological symptoms of anxiety are prominent.

Setting realistic expectations when prescribing is crucial in maintaining a therapeutic relationship and improving medication compliance. Consider a blister pack to minimise risk of overdose.

key points

SELECTED BY

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Anxiety disorders are a heterogeneous group of disorders which affect around 4.2% of the UK population. Prevalence falls with age, but this may reflect underrecognition. Although anxiety disorders are more prevalent among women, this gender difference may decrease with increasing age. The prevalence is higher among older adults with other health problems, and those in hospital and care settings. Generalised anxiety disorder (GAD) is by far the most common anxiety disorder seen in older adults.

Between one in three and one in four patients with an anxiety disorder also meet criteria for a mood or substance use disorder. A primary depressive disorder should be excluded whenever an older person presents with anxiety symptoms for the first time, and comorbid anxiety often indicates a more severe presentation of depression. Around four in five patients have a comorbid physical disorder. Medical conditions can mimic symptoms of, predispose to, or even directly precipitate an anxiety disorder, and may colour its symptomatology or limit treatment options.

Although it is desirable to have a specific anxiety disorder diagnosis, in primary care it may be more important to elicit the nature and severity of anxiety symptoms, their impact on day to day functioning, and how they interact with other health conditions. The history should cover worries, preoccupations, ability to relax, physical symptoms, health concerns, activities which are avoided, and the level of distress, including suicide risk.

A medical workup is recommended if this is the first presentation of anxiety or the patient is presenting after an extended symptom-free period. It should include cardiovascular and neurological examination, blood tests, urinalysis, an ECG and a review of known chronic health conditions. The use of medications which may contribute to anxiety should be reviewed. Patients should be asked about substance use, including alcohol, nicotine, cannabis, herbal supplements, benzodiazepines and caffeine.

NICE recommends a stepped care approach to management guided by symptom severity and functional impairment. Step one comprises education and active monitoring. The link between anxiety and physical symptoms should be explained, exercise should be encouraged, and sleep hygiene advice given. Step two consists of low intensity psychological interventions, such as guided self-help. At step three patients should be offered a high-intensity, CBT-based psychological intervention and/or medication. An SSRI is recommended as first-line. GAD is treated with a combination of relaxation training, cognitive restructuring and problem solving, whereas phobic anxiety disorders are treated with exposure and desensitisation.

Referral is indicated where there is: a high risk to self (suicide, self-neglect) and/or others; poor response to treatments; a need for specialist psychological therapy; diagnostic uncertainty; suspected OCD, PTSD or specific phobias requiring treatment; or suspected dementia.

REFERRAL

Most patients with anxiety disorders are treated in primary care. Referral to specialist mental health services is indicated in the following cases:

- High risk to self (suicide, self-neglect) and/or to others
- Poor response to treatments
- Specialist psychological therapy indicated
- Diagnostic uncertainty
- Suspected diagnosis of OCD, PTSD, or specific phobias requiring treatment
- Suspected dementia

Competing interests: None

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Useful information

Royal College of Psychiatrists Patient information leaflets
www.rcpsych.ac.uk/mental-health/problems-disorders

MIND
www.mind.org.uk/information-support/types-of-mental-health-problems/anxiety-and-panic-attacks/anxiety-treatments/#SelfHelpResources

Online guided self-help programmes
www.moodjuice.scot.nhs.uk/anxiety.asp

www.nhsinform.scot/illnesses-and-conditions/mental-health/mental-health-self-help-guides/anxiety-self-help-guide

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