

Tackling anxiety and depression in older people in primary care

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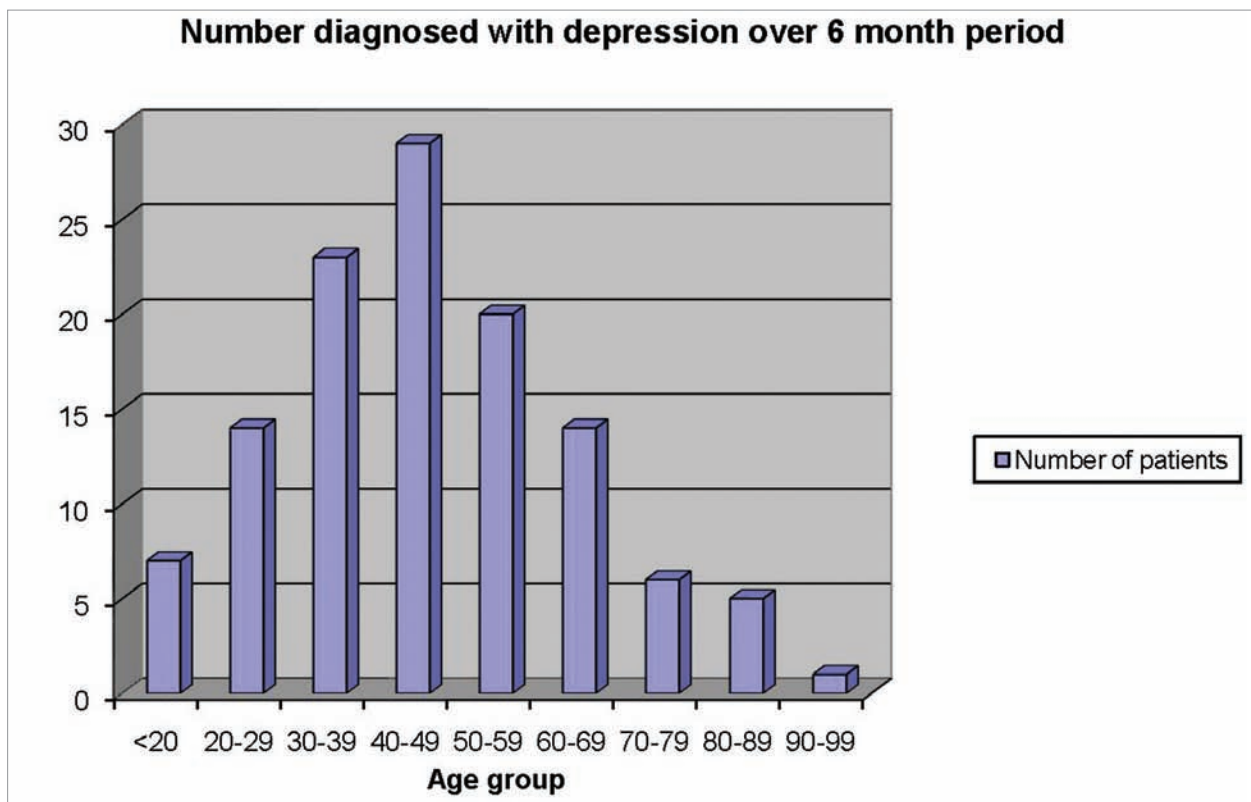


FIGURE 1
Results of a practice
audit on patients
with depression
showing age
distribution

How do older patients present?

What are the risk factors?

What are the treatments?



EPIDEMIOLOGICAL STUDIES SUGGEST THAT ANXIETY AND DEPRESSION, AS DEFINED BY ICD-10 AND

DSM-IV criteria, are less common in older than younger adults.¹² However, this does not mean that they are less important:

- One in ten people aged ≥ 65 fulfil the diagnostic criteria for at least one common mental disorder (see table 1, p18).¹
- Patients with common mental disorders are twice as likely to develop functional impairment.³
- Older depressed patients have an increased risk of both cardiac and all-cause mortality, and there is some evidence that this risk extends to those with subthreshold depressive symptoms.⁴ (The evidence of a possible association between anxiety and increased mortality is limited and conflicting).⁵

- Both anxiety and depression in older patients are often unrecognised and untreated, and have a poor prognosis.^{6,7}

Subthreshold depression is defined by DSM IV as two to four depressive symptoms, one of which must be depressed mood or loss of interest, which have been present for most of the time for at least two weeks, and are associated with some impairment of functioning.

ICD-10 mixed anxiety-depressive disorder is less well defined and comprises those with clinically significant anxiety or depressive symptoms (CIS-R score ≥ 12) who do not meet the diagnostic criteria for a specific disorder (see table 1, p18).¹

PREVALENCE PARADOX

Old age is often a time of loss: of physical health, sensory capacity, cognitive

function, independence, work, income and social support. So it is surprising that there is a progressive decline in the prevalence of common mental disorders after age 55,¹ and that, worldwide, major depression is relatively rare among older people (average prevalence 1.8%).²

There are four possible explanations:

- Older people have a lower lifetime prevalence of anxiety and depression than those from more recent generations.⁸
- Depressed patients have a reduced life expectancy,⁴ creating a healthy survivor effect.²
- Older people are more likely to regard depression as a sign of weakness and conceal their symptoms.⁹
- Diagnostic criteria were generated to reflect symptoms in young people and underestimate prevalence among older people.¹⁰

SYMPOSIUM CARE OF THE ELDERLY

ANXIETY AND DEPRESSION IN OLDER PEOPLE

Table 1
Point prevalence of common mental disorders in older people

Common mental disorder	Age 65-74 (%)	Age 75+ (%)
Mixed anxiety and depressive disorder*	6.4	5.9
Generalised anxiety disorder	3.3	2.6
Depressive episode	1.0	1.5
All phobias	0.3	0.1
Obsessive compulsive disorder	0.3	0.4
Panic disorder	0.5	0.5
Any CMD	10.6	9.9

* Subthreshold anxiety and depressive symptoms

Adapted from McManus S et al. Adult Psychiatric morbidity in England 2007: results of a household survey. NHS Information Centre for Health and Social Care 2009

RISK FACTORS

Anxiety and depression often occur together, and they share many risk factors. However, evidence from longitudinal studies suggests that anxiety tends to follow threats or traumatic events, whereas depression follows loss events.¹¹

Biological

Chronic diseases, cognitive impairment, pain and functional disability are risk factors for the onset of depression, but not anxiety.¹¹

Depression is between two and three times more common among those with a chronic physical health problem, such as diabetes, coronary heart disease and chronic obstructive pulmonary disease.¹²

One in six dementia patients have clinically significant depressive symptoms.¹³ Depression is more prevalent in vascular dementia than in

Alzheimer's disease,¹⁴ and cerebrovascular disease is thought to disrupt prefrontal-striatal circuits, resulting in treatment-resistant vascular depression.¹⁵ Most patients with Parkinson's disease have some degree of cognitive impairment, and nearly half have depression.¹⁶

Psychological

Personality traits (e.g. neuroticism), poor coping skills and previous psychiatric history are risk factors for the onset of both anxiety and depression.¹¹

Generalised anxiety disorder is a chronic condition, which typically waxes and wanes over many years.⁷

Social

Social isolation and bereavement are risk factors for the onset of depression, whereas anxiety follows traumatic events (e.g. serious accidents or life-threatening illness).¹¹

DIAGNOSTIC CHALLENGE

An audit in our practice of patients commenced on antidepressants for depression found that the peak prevalence occurred among those aged 40-49 and that only 18/119 patients (15%) were aged 65 years and over (see figure 1, p17). If our intention was to limit the diagnosis of depression to those with DSM IV major depression, and avoid the prescription of antidepressants to those with subthreshold depression, these results are comparable with our predicted point prevalence of 22 patients aged ≥ 65 . However, if we adopt the broader definition of clinically significant depression, our predicted point prevalence was 172 patients aged ≥ 65 , suggesting a substantial problem of underdiagnosis.

Even those with major depression often remain unrecognised and untreated. A Dutch study found that only 40% of older depressed patients were receiving treatment at baseline. The proportion receiving treatment declined over time and at one year follow-up only 35% had recovered.⁶

Generalised anxiety disorder (GAD) is by far the most common anxiety disorder in older people.¹ Most GAD patients are not recognised in primary care and only a third of them receive any form of treatment;¹ this proportion is likely to be substantially less in older patients.

There are a number of reasons why anxiety and depression in older patients may not be recognised:

- Patients often deny feeling anxious or depressed and are more likely to present with insomnia, irritability, agitation and multiple somatic complaints.^{9,17}
- Depression is harder to recognise among those with chronic conditions e.g. patients may present indirectly with a worsening of their physical illness.
- Most older patients will have subthreshold symptoms, and will not be recognised if we rigidly apply DSM IV diagnostic criteria.
- GPs may wrongly believe that depression is a normal reaction to the losses of old age, and may be reluctant to initiate treatment because of concerns about antidepressant side effects or a belief that older patients cannot change their thinking or behaviour.¹⁷

Cognitive impairment is commonly associated with anxiety and depression, and it can be difficult to determine the direction of causality. Overall 40% of older depressed patients complain of memory problems and in some the cognitive impairment may be sufficiently serious to be considered

Box 1

15-Item Geriatric Depression Scale (GDS-15)

Choose the best answer for how you have felt over the past week:

1 Are you basically satisfied with your life?	YES/NO
2 Have you dropped many of your activities and interests?	YES/NO
3 Do you feel that your life is empty?	YES/NO
4 Do you often get bored?	YES/NO
5 Are you in good spirits most of the time?	YES/NO
6 Are you afraid that something bad is going to happen to you?	YES/NO
7 Do you feel happy most of the time?	YES/NO
8 Do you often feel helpless?	YES/NO
9 Do you prefer to stay at home, rather than going out and doing new things?	YES/NO
10 Do you feel you have more problems with memory than most?	YES/NO
11 Do you think it is wonderful to be alive now?	YES/NO
12 Do you feel pretty worthless the way you are now?	YES/NO
13 Do you feel full of energy?	YES/NO
14 Do you feel that your situation is hopeless?	YES/NO
15 Do you think that most people are better off than you are?	YES/NO

Count 1 for answers in **red**

Scoring intervals: 0-4 no depression; 5-8 mild depression; 9-11 moderate depression; 12+ severe depression

www.stanford.edu/~yesavage/GDS.html

Table 2**Simplified treatment recommendations for depression**

Severity	NICE		British Association for Psychopharmacology ³¹
	Without chronic condition ²⁷	With chronic condition ¹²	
Persistent subthreshold symptoms (>2-3 months)			Consider antidepressants [†]
Mild	Low intensity psychosocial intervention*		Antidepressants are an option + should be considered if persistent (>2-3 months) or previous moderate to severe depression‡
Moderate	Antidepressants + individual CBT or interpersonal therapy	High intensity psychological intervention, preferably group CBT	Antidepressants are first-line treatment.‡ Psychological treatments (CBT, behavioural activation or IPT) are an alternative in mild to moderate depression
Severe		Antidepressants + individual CBT	Antidepressants + CBT or behavioural activation

* Consider antidepressants if previous moderate to severe depression, dysthymia or mild depression + complicates management of chronic condition.

† First line if ≥ 2 years (dysthymia)

‡ CCBT and guided self-help not routinely recommended but could be considered for self-motivated individuals. Supervised exercise could be considered but only as an adjunct to other treatments

pseudodementia.¹⁸ At the same time, depression, apathy and irritability are common in the early stages of dementia.¹³ In patients with pseudodementia, acute onset, prominent memory loss, variable cognitive impairment and frequent 'don't know' answers may suggest the diagnosis.¹⁹

Behavioural disturbance e.g. aggression can be a sign of depression in older people, especially in association with dementia.⁹

ASSESSMENT: ARE RATING SCALES HELPFUL?

DSM IV criteria were generated to reflect symptoms in young people,¹⁰ and they are difficult to apply to older patients, whose somatic symptoms may be caused by depression, physical health problems or aging itself.

An alternative is provided by AGE-CAT which is a computerised diagnostic system designed for use with the Geriatric Mental State (GMS, a 157-item standardised semi-structured psychiatric interview which places a greater emphasis on psychological symptoms. AGE-CAT categorises depression as subclinical (severity level 1-2) or case level (severity level 3-5). The prevalence of case level depression (8.7%)²⁰ is much greater than that of DSM IV depression but, unfortunately, the diagnostic criteria have not been published.

The PHQ-9 is based on the DSM IV criteria for major depression and is subject to the same limitations. A good case can be made for replacing it with the 15-item version of the Geriatric Depression Scale which almost entirely avoids somatic questions. This is a

screening, not a diagnostic tool and does not evaluate symptom severity; nevertheless, it is thought to be a reliable measure of depression severity (see box 1, p18).²¹

Almost half of older patients with major depression also meet the diagnostic criteria for an anxiety disorder.²² Comorbid generalised anxiety disorder should not be diagnosed as a separate disorder if it is experienced only during the course of a depressive illness but is nevertheless a marker of depression severity. The GAD-7 questionnaire is a useful screening tool with a threshold score of ≥ 10 .

Physical illness

When making a diagnosis of depression in older patients, it is important to consider whether it is associated with an underlying physical condition. We should screen for endocrine disorders (thyroid and parathyroid conditions are most common), occult malignancy (especially pancreatic cancer) and nutritional deficiencies (vitamin B₁₂, folate or vitamin D deficiency), see box 2, above.^{19,23}

GENERALISED ANXIETY DISORDER MANAGEMENT

NICE recommends a stepped care approach to the management of generalised anxiety disorder (GAD). If patients have marked functional impairment or if low intensity interventions are ineffective, we are advised to offer either individual CBT or an SSRI.²⁴ Unfortunately, there is very limited evidence from studies in older patients to support this guidance. A recent RCT of CBT for primary care

Box 2

Recommended investigations for apparently depressed older patients with somatic symptoms

- Full blood count
- Erythrocyte sedimentation rate
- Urea and electrolytes
- Liver function tests
- Fasting glucose
- Bone profile
- Thyroid function tests
- Vitamin B₁₂ and folic acid

Further tests may be indicated by symptoms or results of baseline tests

patients aged ≥ 60 reported a significant improvement in worry severity and depressive symptoms, but no effect on GAD severity.²⁵ The only published RCT of SSRIs in older GAD patients suggested that citalopram was effective, but the study was very small.²⁶

DEPRESSION MANAGEMENT

NICE recommends that those with mild or persistent subthreshold depression should be offered low intensity psychosocial interventions, whereas those with moderate to severe depression should be offered a combination of antidepressants and CBT (see table 2, above).²⁷

Low intensity treatment

There is some evidence of short-term benefit from physical exercise programmes, but these probably need to be continued long-term for the improvement to be maintained.²⁸ Guided self-help provides only limited short-term benefit;²⁹ life review group therapy is a promising alternative which attempts to change patients' negative evaluations of their past lives.³⁰

High intensity treatment

Antidepressants are effective in older patients but the antidepressant-placebo difference is smaller than in young adults with an NNT of 7-8.³¹ At the same time, there is a greater risk of clinically significant side effects among older patients and all classes of antidepressants are associated with increased mortality.³²

There is evidence that SSRIs are slightly better tolerated³¹ and NICE recommends their use.²⁷ However, a recent cohort study found that tricyclics were the safest class of antidepressants in older patients and that SSRIs were associated with the highest risk of falls and hyponatraemia.³² SSRIs are also associated with an increased risk of

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key points

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Epidemiological studies suggest that anxiety and

depression are less common in older than younger adults. One in ten people aged ≥ 65 fulfils the diagnostic criteria for at least one common mental disorder. Older depressed patients have an increased risk of both cardiac and all-cause mortality. Both anxiety and depression in older patients are often unrecognised and untreated, and have a poor prognosis. There is a progressive decline in the prevalence of common mental disorders above the age of 55.

Anxiety and depression often occur together, and

share many risk factors. However, evidence from longitudinal studies suggests that anxiety tends to follow threats or traumatic events, whereas depression follows loss events. Chronic diseases, cognitive impairment, pain and functional disability are risk factors for the onset of depression, but not anxiety. Depression is between two and three times more common among those with a chronic physical health problem. One in six dementia patients has clinically significant depressive symptoms and nearly half of Parkinson's sufferers are affected by depression. Even patients with major depression often remain unrecognised and untreated.

Generalised anxiety disorder (GAD) is by far the most

common anxiety disorder in the elderly but most GAD patients are not recognised in primary care and only a third of them receive any form of treatment. Older patients often deny feeling anxious or depressed and are more likely to present with insomnia, irritability, agitation and multiple somatic complaints. GPs may erroneously believe that depression is a normal reaction to the losses of old age, and may be reluctant to initiate treatment.

Cognitive impairment is commonly associated with anxiety

and depression, and it can be difficult to determine the direction of causality. Overall 40% of older depressed patients complain of memory problems and in some the cognitive impairment may be sufficiently serious to be considered pseudodementia. Behavioural disturbance e.g. aggression can be a sign of depression in older people, especially in association with dementia.

A good case can be made for replacing the PHQ-9 with the

15-item version of the Geriatric Depression Scale which almost entirely avoids somatic questions. This is a screening not a diagnostic tool and does not evaluate symptom severity. Almost half of older patients with major depression also meet the diagnostic criteria for an anxiety disorder.

NICE recommends a stepped care approach to the

management of GAD. If patients have marked functional impairment or if low-intensity interventions are ineffective, we are advised to offer either individual CBT or an SSRI. NICE recommends that those with mild or persistent subthreshold depression should be offered low intensity psychosocial interventions, whereas those with moderate to severe depression should be offered a combination of antidepressants and CBT.

upper GI bleeding, fractures³² and cataracts,³³ and a case can be made for using lofepramine as first-line treatment in older patients.

Psychological treatments are as effective in older people as they are in younger adults. There is a medium to large effect size ($d = 0.72$) and there is no evidence to support one type of therapy over another.³⁴

CONCLUSION

The diagnosis of anxiety and depression in older patients is difficult. There is a complex relationship between depression and physical illness, there is uncertainty regarding diagnostic criteria and the PHQ-9 should probably not be used.

We are more likely to recognise late life anxiety and depression if we are aware of the risk factors and the less obvious ways in which patients can present.

Antidepressants are potentially hazardous in older patients and their use should be restricted to those with more severe depression or those who have not responded to psychological treatments.

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Useful information

The Royal College of Psychiatrists:
Depression in Older Adults
www.rcpsych.ac.uk

NICE
NICE has published versions of its guidance on depression (CG90 and CG91) for patients
www.nice.org.uk

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