

ANXIETY AND DEPRESSION

Concurrent depression and anxiety often occur among older people, leading to reduced functional status and quality of life. The presence of depression is strongly related to the presence of anxiety symptoms, and anxiety is a predictor of depression.

Anxiety disorders affect around 14% of Australian adults and range from 3.2% to 20% among older adults in residential care. Rates of depression among people living in residential aged care facilities are believed to be much higher than in the general population. In 2012, over half (52%) of all permanent residential aged care residents had symptoms of depression. Depression is underrecognised and poorly treated among older people living in aged care homes worldwide. Depression and anxiety symptoms in older people are often modifiable without medication.

Depression

Depression is a mood disorder characterised by feelings of sadness, loss of interest or pleasure in nearly all activities, feelings of hopelessness and suicidal thoughts or self-blame. Depression is not a normal part of ageing. Symptoms of depression may be confused with other conditions or with ageing. Symptoms such as sadness, sleep and appetite problems or mood changes may be dismissed as a 'normal' part of getting older. Symptoms such as poor concentration and memory difficulties may also be confused with other conditions such as dementia.

Symptoms present for more than two weeks may indicate depression, including:

- felt sad, down or miserable most of the time, or
- lost interest or pleasure in most of their usual activities, and
- experienced several of the signs and symptoms across at least three of the categories below.

Feelings may include:

- moodiness or irritability, which may present as anger or aggression
- sadness, hopelessness or emptiness

- feeling overwhelmed
- worthlessness
- guilt

Anxiety disorders

Anxiety disorders are not just a matter of being too anxious. Anxiety often fluctuates and it is important to identify precipitants or triggers for anxiety. Anxiety disorders are characterised by specific thoughts and behaviours:

- panic disorder
- social anxiety disorder (SAD)
- generalised anxiety disorder (GAD)

Panic disorder involves sudden attacks of fear or anxiety, concern about the attacks recurring and avoidance of situations in which they might recur. In SAD, people experience fear and avoidance of situations where they might be the centre of attention, and concern about doing or saying something embarrassing. People with GAD tend to worry excessively over everyday things, avoiding or seeking reassurance about situations where the outcome is uncertain, and being overly concerned about things that could go wrong.

Treatment

Simple psychological interventions can have a positive effect on the mood and behaviour of older people. Effective treatments are available, but they take time to work.

Depression

Depression can be successfully treated with lifestyle changes, psychological therapies and medication. Lifestyle interventions include such as diet, physical exercise and social supports. There were many types of psychological therapies that have been found to be effective for depression in older people. These include therapies such as cognitive behaviour therapy (CBT) and interpersonal therapy (IPT). Reminiscence therapy also appears to be an effective approach to treating depression in older people.

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Anxiety

Psychological interventions can be effective in managing anxiety. CBT, problem-solving, relaxation, interpersonal therapy, cognitive bias modification, mindfulness or psychodynamic approaches appear to be of benefit for anxiety. Relaxation and breathing control can be taught to manage increased anxiety levels. CBT can still be effective in people with mild cognitive impairment. A combination of CBT and medication has been shown to be effective.

Antidepressants, especially SSRIs and to a lesser extent SNRIs are first-line medicines for panic disorder, SAD and GAD. Pharmacotherapy for anxiety disorders should always be accompanied by instructions for graded exposure to feared situations. SSRI and SNRI antidepressants can have adverse effects including initial exacerbation of anxiety (particularly where there is a history of panic attacks), nausea, headache, and sleep disruption. SSRIs can cause SIADH increasing the possibility of delirium and seizures secondary to hyponatraemia and are associated with an increased risk of gastrointestinal and other bleeds. Sertraline and venlafaxine appear to be the most effective antidepressants for treatment of GAD.

Tricyclic antidepressants (TCAs) have demonstrated efficacy in the treatment of panic disorder and GAD; however, their use should be limited in older people due to their adverse effects (anticholinergic effects, falls, confusion).

It is recommended to start antidepressants for anxiety at a low dose (half the normal daily dose) and slowly increased according to tolerance and monitor frequently for benefit and harm. Many older people will respond to lower doses than used for depression. It may take up to 6 weeks for benefits to start to be seen. Benzodiazepines have rapid anxiolytic effects, but in general, the risks outweigh any benefits among older frail people. Benzodiazepines are relatively ineffective against cognitive anxiety symptoms and ineffective against depression. Benzodiazepines frequently cause falls, sedation and cognitive impairment, as well as leading to tolerance and dependence. They may be useful for a 2 to 4 week course (not prn) at low doses (for example, 7.5-15mg oxazepam) to control symptoms whilst other treatments take effect. Long-term use of benzodiazepines should be avoided.

When antidepressants and benzodiazepines are to be stopped, tapering over weeks to months reduces the risk of discontinuation symptoms. Withdrawing SSRIs and SNRIs tends to cause flu-like symptoms, nausea, lethargy, dizziness, ataxia, 'electric shock' sensations, anxiety, irritability, insomnia and vivid dreams. Venlafaxine, a SNRI antidepressant, is associated with the most severe withdrawal effects. Withdrawal of tricyclic antidepressants can cause nausea, headache, abdominal pain, diarrhoea, lethargy, anxiety, insomnia and vivid dreams. Benzodiazepine withdrawal symptoms include anxiety, irritability, insomnia, palpitations, hypersensitivity to sensory stimuli, nausea, headache, tremor, and sweating.

Beta-blockers such as atenolol and propranolol should not be used for SAD or GAD. They decrease tremor and heart rate but are not supported by evidence and may cause harm in people with other conditions. Pregabalin has some benefit in GAD and could be considered if SSRIs and SNRIs are not tolerated or are ineffective. Benzodiazepines and atypical antipsychotics (e.g. risperidone, quetiapine, olanzapine) are not recommended in the treatment of GAD due to their adverse safety profile.

Summary

Psychological interventions such as cognitive behavioural therapy alone or combined with antidepressants are effective in the treatment of comorbid anxiety and depression.

References

- Australian Institute of Health and Welfare 2013. Depression in residential aged care 2008–2012.*
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 - International Journal of Geriatric Psychiatry. 2016;31(6):555-66.*
- Further information**
<https://www.nps.org.au/professionals/anxiety>

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