Anxiety and Depression in the Elderly: Implications for Diagnosis and Treatment

By David L. Dunner, MD, FACP

Introduction

Approximately 12% of the United States population is ≥65 years of age, and this percentage is expected to double by the year 2030.1 At least 6% to 9% of these elderly individuals suffer from various forms of depression.1 Although the exact age limits of geriatric medicine are not defined, concerns associated with aging in a particular individual generally begin at ≥60 years of age. Mood and anxiety disorders in the elderly can present as a recurrence or continuation of a previous disorder, or as an initial psychiatric disturbance. This supplement to CNS Spectrums features a collection of articles that address anxiety and depression in the geriatric population.

Eric J. Lenze, MD, and colleagues, review studies of anxiety disorders in the elderly and provide treatment recommendations for generalized anxiety disorder, panic disorder, posttraumatic stress disorder, anxious depression, and dementia-associated anxiety. Issues regarding treatment selections for elderly anxious patients are similar to those for elderly depressed patients. Selective serotonin reuptake inhibitors (SSRIs) are the first-line treatments for these conditions and, although research is limited in this area, psychotherapy has shown some efficacy as well.

Next, David L. Dunner, MD, FACP, presents a discussion of depression in the elderly, focusing on issues of drug selection regarding both efficacy and safety. All antidepressants, including SSRIs, monoamine oxidase inhibitors, tricyclic antidepressants, and others outside these drug classes, have been shown to be effective in the treatment of depressed elderly patients; drug selection is therefore primarily based on the safety and possible drug interactions for a particular patient. Alternative treatments and the limited literature on psychotherapy for depression in this population is reviewed as well.

Compared to younger individuals, elderly people with depression or anxiety have similar rates of psychiatric comorbidity but elevated rates of medical comorbidities, which in turn increases the risk for drug-drug interactions. Christos A. Ballas, MD, and Jeffrey P. Staab, MD, discuss diagnosis and treatment of medically unexplained physical symptoms, such as chronic pain, chest pain, and dizziness. As pointed out by the authors, these are often indicators of Axis I pathology, such as depression, panic disorder, and anxiety disorder. While the prevalence of unexplained physical symptoms is higher in the elderly and thus particularly relevant for this age group, the model presented for understanding these conditions has relevance for younger patients as well.

Benoit H. Mulsant, MD, and colleagues, focus on the long-term treatment of anxiety and depression in the elderly. They address reasons for the “gap” between antidepressant treatment efficacy shown in clinical trials and actual effectiveness in real-world situations. Comorbid conditions, patient education, and management of side effects are factors that can affect the success of long-term treatment. Although the challenge is great, as in younger patients, long-term treatment is indicated for depression and anxiety; strategies to enhance adherence to continued treatment are discussed.

As discussed by Mark H. Rapaport, MD, Rachel E. Maddux, BA, and Katia K. Delrahim, BA, the quality of life in elderly patients is greatly reduced by depression and anxiety. Treatment has a positive impact not only on symptoms but in restoring psychosocial functioning. Impact on quality of life, disability, and burden are reviewed in relation to both depression and anxiety in elderly patients. As we move forward, treatment outcome studies need to include measures of quality of life, psychosocial function, and pharmacoeconomics.

While adherence to treatment is a problem in many patients, it is perhaps especially in the depressed and anxious elderly as addressed by Julie Loebach Wetherell, PhD, and Jürgen Unützer, MD, MPH. The authors review this literature, with an emphasis primarily on depression, as little research has been conducted on adherence to anxiety treatment in this population. Cost of medication is an important issue as inability to afford medication is a common reason for nonadherence. Recommendations for improving treatment adherence are presented. Data suggest that an integrative care model combining psychotherapy and pharmacotherapy may be optimal for enhancing overall treatment adherence.

REFERENCE