Treating Late-Life Anxiety & Depression

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Outline

• background on late-life depression and anxiety
• clinical presentation of late-life depression and anxiety
• suicide
• assessment of the depressed or anxious elder
• treatment approach

Emotional changes associated with aging

• aging is not associated with increased rates of depression or anxiety (despite multiple stressors)
• resilience to adversity is the norm
• continued capacity for relationships, productivity and creativity

Lifetime prevalence of mood & anxiety disorders

Long-term course

The many faces of anxiety

- worry that is persistent and difficult to control
- discrete episodes of panic
- fear of falling (specific phobia)
- intrusive thoughts, accompanied by repetitive behaviors
- re-experiencing of prior traumas
- unexplained medical symptoms

Comorbidity of depression & medical conditions

Medical causes of depression

- stroke
- coronary artery disease
- thyroid disease
- chronic pain, including osteoarthritis
- sleep apnea
- nutritional deficiencies (vitamin B-12)
- medications
- Parkinson’s or Alzheimer’s

Medical causes of anxiety

- cardiac: congestive heart failure, arrhythmia, coronary artery disease
- neurologic: transient ischemic attack, stroke, epilepsy, Parkinson’s, Alzheimer’s
- pulmonary: COPD, pneumonia, asthma, pulmonary embolus, sleep apnea
- endocrine: hyperthyroidism, hypoglycemia, hypo- or hypercalcemia

Types of late-life depression

- major depression with or without psychotic features
- dysthyemic disorder (persistent depressive disorder)
- bipolar depression
- depression due to another medical condition
  - vascular depression
  - depression of Alzheimer’s disease
- substance/medication-induced depressive disorder
- minor (subsyndromal) depression
Suicide across the life span

Rate of suicide by age in 2012 (per 100,000 per year)

Elder suicide risk factors

- gender: men > women
- marital status: widowed/divorced/separated > married
- ethnic: white > African-American & Asian > Hispanic
- prior suicide attempts
- depression, anxiety, suicidal ideation, hopelessness
- alcohol use

Suicidal ideation

<table>
<thead>
<tr>
<th>of older adults who committed suicide ...</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>expressed SI to a health professional in the last year</td>
<td>40</td>
</tr>
<tr>
<td>expressed SI to a family member in the last year</td>
<td>75</td>
</tr>
<tr>
<td>had a prior suicide attempt</td>
<td>20</td>
</tr>
<tr>
<td>denied SI when directly asked</td>
<td>8</td>
</tr>
</tbody>
</table>

Suicide among older adults

- older adults make up 13% of the population, but 18% of suicides
- older adults are less likely to have suicidal ideation (SI) or attempt suicide but more likely to complete suicide
- depression is present among 80% of elders who suicide & is the strongest risk factor for suicide
- most elder suicides visit their PCP in the months prior to suicide

Assessment of the depressed or anxious elder

- history from patient and caregivers
- assess for:
  - depression (PHQ-9 or GDS)
  - anxiety disorders (GAD-7)
  - psychosis
  - mania
  - cognitive impairment (SLUMS)
  - alcohol use (AUDIT-C)
- suicide risk assessment
- underrecognized (& misdiagnosed) in ethnic minority elders
Medical evaluation

- review medication list
- physical exam
- laboratory evaluation
- cognitive evaluation

Treatment approach

- address medical issues
- SSRIs
- TCAs
- ECT
- address psychosocial issues
- cognitive-behavioral therapy
- interpersonal psychotherapy
- problem-solving therapy
- monitor and address suicidal ideation

Geriatric psychopharmacology

- start low
- go slow
- but go

Pharmacologic options

- specific serotonin reuptake inhibitors (SSRIs): sertraline, citalopram, escitalopram
- serotonin-norepinephrine reuptake inhibitors (SNRIs): duloxetine, venlafaxine, levomilnacipram
- other antidepressants: mirtazapine, bupropion, vilazodone, vortioxetine
- tricyclic antidepressants: nortriptyline
- anxiolytics: buspirone, benzodiazepines
- augmentation: lithium, thyroid hormone (T3), buspirone, stimulants, atypical antipsychotics

Factors affecting medication treatment in older adults

- altered kidney, liver & brain function
- drug-drug interactions
- drug-disease interactions
- cognitive barriers to comprehension & adherence
- financial barriers

Antidepressants & suicide

Odds of suicidality (ideation or worse) for active drug relative to placebo by age in adults with psychiatric disorders

<table>
<thead>
<tr>
<th>Age range</th>
<th>Odds ratio (95% CI)</th>
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<tr>
<td>&lt;25</td>
<td>1.42 (0.97 to 2.12)</td>
</tr>
<tr>
<td>25-34</td>
<td>0.74 (0.53 to 1.08)</td>
</tr>
<tr>
<td>35-44</td>
<td>0.78 (0.57 to 1.04)</td>
</tr>
<tr>
<td>45-54</td>
<td>0.84 (0.63 to 1.14)</td>
</tr>
<tr>
<td>55-64</td>
<td>0.62 (0.40 to 1.02)</td>
</tr>
<tr>
<td>65-74</td>
<td>0.52 (0.33 to 0.83)</td>
</tr>
<tr>
<td>75-84</td>
<td>0.22 (0.05 to 0.94)</td>
</tr>
<tr>
<td>25-64</td>
<td>0.76 (0.45 to 1.29)</td>
</tr>
<tr>
<td>25-75</td>
<td>0.74 (0.43 to 1.30)</td>
</tr>
<tr>
<td>25-84</td>
<td>0.72 (0.44 to 1.19)</td>
</tr>
<tr>
<td>25-90</td>
<td>0.79 (0.49 to 1.30)</td>
</tr>
<tr>
<td>All ages, overall</td>
<td>0.83 (0.69 to 1.00)</td>
</tr>
</tbody>
</table>

Source: Stone et al. BMJ 2009;339:b2880
Antidepressants & weight

- Bupropion
- Duloxetine
- SSRIs
- MAOIs
- Venlafaxine
- TCAs
- Mirtazapine

Reasons for non-adherence
- Side effects
- Cost
- Perceived to no longer be necessary
- Lack of understanding (e.g., not an as needed medication; don’t stop after one prescription)

Phototherapy

Neuromodulation
- Electroconvulsive therapy (ECT)
- Repetitive transcranial magnetic stimulation (rTMS)

Psychotherapy
- Cognitive behavioral therapy
- Interpersonal psychotherapy
- Problem-solving therapy (especially when cognitive impairment is present)
- Behavioral activation
- Mindfulness-based relaxation therapy
- Sleep hygiene
- Life review (reminiscence) therapy

Behavioral model of late-life depression

Cognitive-behavioral model of late-life anxiety

- Stressful events, cues or triggers → negative affect → dysfunctional performance → avoidance → hyperarousal & hypervigilance

Meta-analysis of depression treatment studies

<table>
<thead>
<tr>
<th>Modality*</th>
<th>Number of Studies</th>
<th>Effect Size</th>
<th>Response Rate**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>62</td>
<td>0.69</td>
<td>66% vs 31%</td>
</tr>
<tr>
<td>Therapy</td>
<td>32</td>
<td>1.09</td>
<td>72% vs 31%</td>
</tr>
</tbody>
</table>

* 5 of these studies included both therapy and medications
** Clinician-rated measures of depression: intervention versus control

Factors affecting psychosocial interventions

- Stigma as a barrier to seeking and continuing treatment
- Decreased cognitive flexibility & memory
- Transportation & access to care
- Financial barriers
- Lack of trained professionals

Depression care management in older adults

- Active screening for depression
- Trained depression care manager
- Proactive outcome measurement and tracking
- Team approach, stepped care
- Follow-up

Depression care management: examples

- PROSPECT: prevention of suicide in primary care
- IMPACT: collaborative care model of treating depression in primary care
- PEARLS: community-based treatment of depression

Questions?

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