Anxiety, Depression, and Suicide in Later Life

David Mays, MD, PhD
dvmays@wisc.edu

Disclosure

• Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
• No off label uses of medications will be discussed unless mentioned in the handout and by the presenter.
• No funny business.

Depression

• Depression is a commonly experienced mood and a syndrome. A clinical depression is distinguished from a depressed mood by the intensity and pervasiveness of its symptoms. Depressed people are usually not able to relate to others and may be able to express only a limited range of emotions. They are frequently obsessively focused on themselves and how they are feeling moment to moment. In a primary care setting the following complaints may identify depression: sleep disturbance, fatigue, somatic complaints.
Symptoms

- **Affective**
  - Depressed mood
- **Vegetative**
  - Weight loss or gain
  - Insomnia or hypersomnia (insomnia has a bidirectional relationship to depression – a cause and an effect)
  - Decreased sex drive
- **Behavioral**
  - Psychomotor retardation or agitation
  - Fatigue
  - Diminished interest or pleasure in most activities

Symptoms

- **Cognitive**
  - Feelings of worthlessness or guilt
  - Diminished ability to think and concentrate
  - Poor frustration tolerance
  - Negative distortions
  - Affective agnosia and apraxia
- **Impulse Control**
  - Recurrent thoughts of suicide, homicide, or death
- **Somatic**
  - Headaches, stomach aches, muscle tension
- **Chronic Painful Physical Conditions**

Chronic, Painful Physical Condition

- 43% of clients with depression have at least one Chronic Painful Physical Condition, 4x the rate of the general population. They also rate their pain as severe to unbearable more frequently. In 61% of the time, the pain appears before the depression. 28% develop the pain after the depression.
- The overlap of anxiety, depression and pain is evident in syndromes such as fibromyalgia, irritable bowel syndrome, low back pain, headaches, and nerve pain.
- This is not just “psychological.”
Symptoms

- Clients with depression have difficulties with interpersonal relationships, largely related to problems with emotional perception and executive function. They misidentify happy facial expressions as sad, for instance.
- There is evidence of mood state dependent learning - clients don’t remember ever feeling good, increasing the risk of suicide. These memories can be retrieved with proper prompting and cueing.

Comorbidities

- Social anxiety disorder is a major risk factor
- Comorbid personality disorder confers worse prognosis and treatment response
- Obesity and metabolic syndrome – bidirectional
- Coronary artery disease
- 65% increase in risk for diabetes
- Secretion and production of proinflammatory enzymes

Depression and Substance Abuse

- Among those with a history of depression, 40.3% have alcohol abuse, 17.2% have drug abuse, and 30% have nicotine abuse.
- Among those with alcohol abuse disorders, 32.75% have major depression, drug abusers, 44.26%.
- Individuals with substance abuse often present with complaints of anxiety, sleep disturbance and depression. People with late stage alcoholism feel worthless and helpless.
- Treating depression decreases relapse.
Impairment

• 44% of depressed people have some sort of functional work impairment, 11% are unable to work altogether. In 2020, major depression will be second only to heart disease in the amount of disability suffered.
• Cardiac clients have 4x greater risk of depression and depression a month after a heart attack is the best predictor of MI in next year - the risk is the same as being a smoker – 5x more likely to die than healthy peers.

Secondary Causes of Depression

• Medications
  – Antihypertensives, sedatives, hormones, cimetidine, L-dopa
• Drug Abuse
  – Alcohol, sedative/hypnotics, withdrawal
• Neurological Disorders
  – Stroke, subdural hematoma, MS, brain tumors, Parkinson’s, Huntington’s, seizures, dementia
• Metabolic
  – Hypo-hyperthyroidism, Cushing’s hypercalcemia, diabetes, B12 deficiency, pellagra
• Other
  – Pancreatic cancer, viral infections

Geriatrics

• Older people in the community do not higher rates of depression than younger people, but all medical illnesses increase the rate of depression.
Geriatrics

- Older clients do not come to the doctor saying they are depressed. They come with medical complaints - poor sleep, low energy, decreased appetite, somatic complaints (palpitations, shortness of breath, etc.)
- Certain illnesses may mimic depression – hypothyroidism, B vitamin deficiency, blood pressure medication, etc.
- An important stressor is change in medical status of self or spouse.

DSM-IV Based Depression Scale for Older Adults
(not focused on “feeling depressed”)

- Sleep changes
- Interest diminished
- Guilt, low self-esteem
- Energy decrease
- Concentration poor
- Appetite change
- Psychomotor agitation or retardation
- Suicidal ideation
Late Onset Depression

- Depression that first arises after 60 years old may be more serious, less likely to respond to antidepressants, and more associated with cognitive problems.
- It is characterized by greater apathy, greater cardiovascular morbidity, and stronger association with dementia.

Assessment of Older Adults

- Older people with symptoms of depression should always have a good cardiovascular assessment, as well as an assessment of their cognitive status.

Dementia

- Depression is a risk factor for dementia, and dementia frequently presents as depression. In addition, mild cognitive impairment may persist for a year after a depressive episode in 50% of sufferers.
- Distinguishing the cognitive problems of depression from dementia is important. Depression has:
  - Faster onset
  - More problems with concentration
  - Rare impairment of motor, speaking skills
Bereavement

- Bereavement is a universal experience related to the loss of a loved one. It can be thought of as “attachment trauma.”
- The psychological reaction to bereavement is grief. Grief is not a single emotion, but a combination of different emotions, including the negative feelings of sadness, anxiety, guilt, anger and shame; and the positive emotions of happy reminiscence, pride in the deceased, warmth, and relief.

Acute Grief

- Acute grief lasts most of the day, every day for up to six months, then recurs transiently. It is characterized by a sense of disbelief, dominant painful emotions, preoccupation with thoughts of the deceased, and attenuation of interest and engagement with life.
- This painful state normally transitions into “integrated grief,” which can be thought of as a permanent background state, where grief can be triggered, but positive emotions, such as acceptance, forgiveness, and compassion predominate.

Integrated Grief

- Grief occurs intermittently and changes over time
- Comprehension of death
- Mix of emotions with positive predominant
- Thoughts and memories of the deceased are accessible, but not preoccupying
- Interest and engagement in life re-established
Grief Stages?

- There is little evidence that individuals go through a linear five-step process of grieving (Kubler-Ross.) Rather, people have many prolonged, overlapping experiences. There are a number of different conceptualizations of this process.
- Task Model (Worden): the 4 tasks are to accept the loss, experience the pain, put the loss in perspective, and change the relationship to the deceased.
- Coping Model (Stroebe/Schut): loss-oriented coping is followed by restoration-oriented coping

Grief Stages

- Protracted Illness Grief (Okun/Nowinski): Crisis (the diagnosis), Unity (managing medical treatment, finances, wills), Upheaval (stress, fatigue), Resolution (recognition that the end is near, hospice, final conversations), Renewal (funeral, adjustment to loss)
- Every family and individual grieving differently. Some people feel anxious if they are not going through “the right stages.” Grief is not a tidy, orderly process.

Complicated Grief

- Rarely, grief may be “complicated” — great difficulty accepting death, excessively painful memories which may be very difficult to access or very intrusive, overwhelming feelings of guilt or yearning.
- Complicated grief is not limited to just those people who had ambivalent relationships with the deceased. It is seen just as frequently in those with very positive and close relationships.
Complicated Grief

- More than 6 months after loss
- Continued preoccupation with deceased
- Continued longing and yearning
- Disbelief and inability to accept death
- Self-blame, bitterness, anger
- Inability to experience satisfaction or joy
- Avoidance of reminders of loss
- New brain scan results show that in individuals experiencing complicated grief, reminders of the loved one continue to stimulate the “pleasure” centers in the nucleus accumbens, unlike normal controls.

Complicated Grief Predicts:

- At 13 months
  - Cancer diagnosis
  - High blood pressure
  - Suicidal ideation
  - High grief intensity
- At 25 months
  - Heart trouble
  - Suicidal ideation
  - High grief intensity

Complicated Grief Therapy

- Medication is not usually helpful unless depression is present
- Education
- Personal goals (geared toward restoring life)
- Meeting with significant other
- Revisiting activities - exposure
- Imaginal revisiting - prolonged exposure
- Memories and pictures - exposure
- Imaginal conversations with the deceased - exposure
- Interpersonal psychotherapy toward goals
Complicated Grief Therapy

- Goals: reduce symptoms
- Treatment objectives
  - Understand natural grief and complicated grief
  - Accept loss, decrease trauma
  - Decrease excessive guilt
  - Help client get back on track with relationships and daily activities
  - Maintain sense of connectedness to the person who died

Grief vs. Depression

- Grief
  - Yearning
  - Preoccupation
  - Disbelief
  - Sadness is not pervasive but comes in waves
  - Retained ability to experience positive emotions

- Depression
  - Apathy
  - Suicidality
  - Sadness is pervasive
  - Pervasive guilt and self-criticism
  - Psychomotor retardation

Treatment? The Bottom Line

- Most people who are grieving are restored to functioning and integrate their grief within 6 months. Those that show very intense grief reactions, or who show symptoms of depression have a poor outcome.
- Therefore, treat depression during bereavement, but don’t treat normal grieving with antidepressants.
Geriatrics: Morbidity

- Medical comorbidity decreases the speed at which clients respond to antidepressants, especially chronic pulmonary disease (smokers, ex-smokers, clients on clozapine).
- Prostate cancer increases the risk of suicide.
- Depression is associated with poor adherence in diabetics.
- Depression decreases the probability of survival in nursing home patients.

Psychotherapy

- Many kinds of psychotherapy have been proven efficacious for treatment of all levels of depression. The kind of therapy seems less important than other variables such as treatment alliance, skill of the therapist, faith in the therapy.
- A number of different therapies have been studied. CBT is the most studied. It appears as though all bona fide therapies (CBT, cognitive therapy, behavioral activation, supportive, psychodynamic, interpersonal) are equally effective, and may have better long term results than medication.

Nutraceuticals for Depression

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- Omega-3 fatty acids: epidemiologic evidence, modest efficacy data as adjunctive treatment, low risk
- Vitamin D
- SAMe: studies support that more rigorous research is needed – so far we have small samples, different delivery systems, few comparison studies, unstable preparations
- Folate: which forms cross the blood-brain barrier? Low risk as an augmenter
Other Treatments

- Electroconvulsive therapy (ECT)
- Avoid diets high in processed or fried foods and sugar. Obesity is linked to depression.
- Light therapy – may work for depression that worsens in the winter or treatment resistant depression
- Physical activity (30 min aerobic/day). Very persuasive for fibromyalgia.
- Positive psychology/meditation (may relieve the unremitting self-focus)

Group Membership

- There is a growing body of evidence demonstrating that belonging to a group may prevent and/or cure depression in many people. This is not surprising given how commonly depression follows a significant loss.
- The group must be one that the client strongly identifies with and must be important to them.

Placebo Response Rates in Older Adults

- Placebo
- SSRIs
- TCA's
- Atypicals
- Exp Placebo
Best Antidepressant Choices for Older Adults

- Sertraline or citalopram
  - Both have evidence of efficacy
  - Both have once per day dosing
  - Both have few drug-drug interactions
  - Both lack anticholinergic side effects
  - Both are available as a generic
Demographics

- Anxiety disorders are the most common emotional disorders. Lifetime prevalence is 24.9% (women 30.5%, men 19.2%), 25 million people.
- 33% of total mental health bill, average of 37 medical visits/year (vs. average of 5)
- Comorbidity with depression 60-80%.

Anxiety and Substance Abuse

- 18% of substance abusers suffer from an independent anxiety disorder. 70% of alcoholics have anxiety problems, mostly caused by the alcoholism. 15% of anxiety disorder clients have substance abuse problems. The relationship is bidirectional and complex.
- Alcohol relieves anxiety in the short term, but chronic drinking makes agoraphobia and social phobia worse.

Anxiety and Substance Abuse

- It is difficult to detect substance dependence in the presence of an anxiety disorder. 98% will report anxiety while drinking/withdrawing, but only 4% after 3 months of abstinence.
- Anxiety can be precipitated by caffeine, diet pills, androgenic steroids, etc. Clients with anxiety disorders usually stop the use of marijuana and hallucinogens, but increase the abuse of alcohol and benzodiazepines.
Generalized Anxiety Disorder

- GAD is a clinical syndrome characterized by excessive worrying, hypervigilance, and anxiety
- Lifetime prevalence of 5.7% (women 6.6%, men 3.6%)
- Median age of onset is 31 – oldest of any anxiety disorder. It looks like major depression.
- It is unique in that sufferers will present to their primary care physician, where it is the second most frequent mental disorder. The main complaints will be insomnia and somatic problems. Clients will regard themselves as in poor health and will be high utilizers of healthcare resources. No other anxiety disorder has such a high rate of disability.

Generalized Anxiety Disorder and Depression

- The overlap of GAD and depression is substantial and bidirectional. More than 70% of people with lifetime anxiety also have depression and 50% of those with lifetime depression have anxiety.
- The prevailing notion is that anxiety usually precedes depression, but this is not always the case.
- GAD and depression are most likely to occur in the same year.

Generalized Anxiety Disorder and Medical Illnesses

- GAD is frequently found in patients with arthritis, migraine, and back pain. Pain perception differs depending on whether a person approaches pain with anxiety or fear. Those who approach pain with fear expect pain and often have reduced pain sensitivity. Those who approach pain with anxiety feel uncertainty and lack of control, and become hyper-alert and become more sensitive to pain.
- There is more ulcer disease and irritable bowel disease in GAD patients.
Generalized Anxiety Disorder and Medical Illnesses

- GAD is associated with increased risk of coronary artery disease. Anxiety may lead to increased body scanning and awareness of heart variations. Normal physiologic variability is interpreted catastrophically, leading to chronic autonomic arousal.
- Patients have higher rates of hyperthyroidism, diabetes, asthma, and chronic obstructive lung disease.

GAD in Older Adults

- Older adults may seek treatment for weakness, fatigue, restlessness, poor concentration rather than anxiety.
- The literature strongly supports CBT in older adults, with 46% experiencing symptom relief. Their symptom response is lower than younger patients, and they tend to drop out of treatment more.
- SSRI's increase the risk of osteoporosis and fractures, and SSRIs and SNRI's increase the risk of hyponatremia.

Natural History

- Course of illness is chronic, with waxing and waning symptoms.
- Unlike other anxiety disorders, GAD does not decrease with age. Older people tend to worry more and for longer periods of time. Fewer than 33% completely remit. They experience the same degree of disability as major depressive disorder and coronary artery disease.
- People with GAD often report problems with memory and attention.
- There is a strong association with suicidal behavior.
Treatment of GAD

- Short term stabilization with benzodiazepines is appropriate. Long term treatment should focus on lifestyle changes, stress reduction techniques, cognitive therapy, appropriate work situation, management of personal affairs.
- Little is known about long term treatment and the natural course of the disorder.
- A poor prognosis is associated with poor family relationships, comorbid avoidant, dependent, or obsessive compulsive personality, other mental illnesses, or female gender.

Warning Signs vs. Risk Factors

- Risk factors are epidemiologically derived, often distant in time and unchangeable (age, gender, previous attempts, etc...) They may mean nothing.
- Warning signs are behavioral signs of precipitating conditions in an individual. They are observable and current.
- Risk factors make warning signs more ominous.

Simplified Risk Assessment:
5 Risk Factors, 5 Warning Signs, 5 Steps

- **Five Warning Signs**
  1) Suicidal intention (rumination, planning, preparation, access, giving items away)
  2) Sudden change in mood with no known reason
  3) Anxiety, agitation, insomnia, despair, hopelessness
  4) Feeling like a burden to others, disconnected
  5) Poor treatment alliance

- **Five Risk Factors**
  1) Previous attempts or exposure to violence, self-injury, impulsive aggression
  2) Mental illness, substance abuse
  3) Social isolation, stress, loss
  4) Family history or exposure to suicide
  5) Native-American or white male
1) Ask About Suicidal Behavior

- RISK FACTOR
  - Has the client made previous suicide attempts, or shown self-injurious behavior or violence?
- WARNING SIGN
  - Is the client showing the intention to act?

2) Ask About Mental State

- RISK FACTOR:
  - Presence or history of mental illness, substance abuse
- WARNING SIGN:
  - Anxiety, agitation, insomnia, despair, sudden unexplained change in mood, sudden increase in substance use

3) Ask About Social Connection and Stresses

- RISK FACTOR
  - isolation, stress, losses, exposure to suicide or violence
- WARNING SIGN
  - feeling like a burden, disconnected
4) Assess Treatment Alliance

- **RISK FACTOR**
  - No treatment alliance, help negation, unreliability and impulsivity

- **WARNING SIGN**
  - Non-adherence to treatment
  - Client show sudden, unexplained improvement (Most improvement is a slow process. It includes socialization.)
  - Client tells caregivers what they want to hear in order to avoid supervision, or to go on pass from the hospital, etc.

5) The Plan

- What is the plan for reducing suicide risk? Are the client and other participants willing and able to follow the plan?
  - The basic plan should reduce risk factors and enhance protective factors.
  - The client must be kept safe. You need to use sound clinical judgment. Denial and wishful thinking are obstacles that can lead to a bad outcome.
  - Documentation is a must.
  - Consultation is always a good idea. Every consultation brings you into contact with “the standard of care.”

**Epidemiologic Risk Factors**

- Gender, Age, and Race
- Marital Status
- Family History
- Mental Illness History
- Newness in Treatment Program
- Time of Year
- Rural vs. Urban
- Natural/Unnatural Disasters
- The Media
**Gender, Race, and Age**

Natl Center Health Statistics, 2006

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**Risk Related to Mental Illness**

- History of mental illness - 95%
  - Affective disorders 40-60%
  - Alcohol associated 25-50%
  - Comorbid Personality Disorder 50%
- Relative risk by diagnosis
  - Prior attempt 38.4
  - Bipolar disorder 22.1
  - Depression 20.4
  - Mixed AODA 19.2
  - Dysthymia 12.1
  - Ob/comp 11.5
  - Panic disorder 10.0

**Severe Suicide Attempters (Hall 1999)**

- 92% severe anxiety
- 92% partial insomnia
- 84% no plan
- 83% had seen caregiver in previous month
- 80% panic attacks
- 80% depression
- 78% had conflicted relationship with someone close to him
- 69% no or fleeting ideation
- 67% first attempt
- 28% had been asked about suicidal behavior
Suicide in Older Adults

- In the US, suicide rates increase with age, only for men, particularly white men. Worldwide both men and women are at increased risk as they age.
- White males over 50 account for 10% of the US population, but 30% of the suicides. Why? The prevalence of depression declines with age. 66% describe themselves as satisfied.

Older Adult Suicide

- Older adults
  - tend not to go to mental health services
  - have complications in their presentation from comorbid medical conditions and medications
  - are reluctant to talk about emotional problems
  - are usually more isolated (making rescue more unlikely)
  - are more frail. Therefore, although older people have less suicidal ideation and make fewer attempts than younger people, they are more likely to die from suicide (1:4 vs. 1:200 for <65 yrs.) They often use guns (80%) or more lethal means.
Guns and Older Adults

- The presence of a handgun, but not a rifle, in the home significantly increases the risk of suicide in older men. (66% of men >65 have served in the military.) These guns are typically purchased in the week before death. The Brady Handgun Violence Prevention Act, which requires a waiting period before buying a handgun, has been found to prevent suicides among persons 55 or older, although not in younger people.

Suicide in Older Adults

- Older adults who die of suicide usually have a mental illness diagnosis. There is less association with substance abuse than with younger people. Dementia has not been linked to suicide, and may be protective. People with constricted, neurotic personality styles who do not tend to develop strong support networks are also at risk.

Suicide in Older Adults

- Life events associated with suicide in older adults are typically those stressors found with aging: bereavement, financial stresses, family discord, loss of social support, and the impact of physical illness. Physical illness, especially cancer, HIV, Huntington’s disease, MS, renal disease, peptic ulcer, spinal cord injury, and lupus increase the risk of suicide. Terminal illness, especially if depression is controlled for, does not.
Protective Factors
• Having a rich social network with friends and family is associated with lower risk, as is having a sense of meaning or religious connection.
• Other than this, the evidence base for preventive interventions in this age group is lacking.

Suicide in Older Adults
• 75% have seen a health care provider within 30 days of their death, 20% within 24 hours.
• Mood disorders are often missed in the elderly because their depression may be masked by somatic complaints, the presence of pseudo-dementia, refusal of medical care, and the belief that the elderly have good reason to be depressed.

Prevention
• Primary care providers must be involved, since the elderly do not tend to go to mental health care settings, and many older adults are seen by a primary care doctor within a week of their suicide.
• Elderly who are at risk due to physical health changes, symptoms of depression, or increasing isolation should be screened.