Depression and Anxiety in the Elderly — Treatment Considerations

Depression and anxiety have unique characteristics in the elderly and their treatment might differ from the young adults. The elderly population is defined as those who are 65 years or older. This age group is at an increased risk of atypical depression which can be complicated by the presence of chronic medical conditions. In fact, up to 80% of those older than 65 years is expected to have at least one chronic medical issue which might require medical treatment. This age group is more likely to reside in special facilities and are more likely to have other concerns such as financial or abuse complaints.

Why is the Elderly a Unique Population?

In many cases, the source of information about the symptoms of the patient come from the caregivers rather than the patients themselves. Sometimes the caregivers might have other intentions behind their request for a consultation which might not go hand in hand with what is best for the patient. Additionally, older patients are more likely to have the idea that mental health issues carry a significant taboo and stigmata. Older patients usually present with less typical symptoms of depression or anxiety.

Depression in the elderly might present with cognitive decline which might be mistaken
for vascular dementia or other types of dementia rather than a mood disorder. Additionally, the elderly are more likely to complain of drug side effects when medicated for depression or anxiety, hence are more likely to show poor compliance with medical therapy for mood and anxiety disorders.

Finally, the older patients usually tend to go to their primary care physician to inquire about the available options for their depressive symptoms rather than to a psychiatrist. Therefore, primary care physicians should be aware of the symptoms and signs of depression and anxiety disorders in this unique population.

**Depression in the Elderly**

**Prevalence of Depressive Disorders in the Elderly**

Women are two times more likely to develop major depressive disorder compared to men. The estimated prevalence of the major depressive disorder in the elderly ranges between 1 to 4%.

Minor depression and non-specific depressive symptoms are quite common in the elderly. Approximately, 14% of older adults are expected to complain of depression symptoms. The persistent depressive disorder has an estimated prevalence of 2% in the geriatric population. Depression is also more common in hospitalized patients and those who reside in nursing homes.

**Risk Factors for Depressive Disorders in the Elderly**

The elderly are more likely to complain of depression symptoms or full-blown major depressive disorder because of several risk factors. Substance abuse is a common problem among the elderly that may not be obvious at first. The use of certain drugs such as beta-blockers, carbidopa, and opioids for pain control in the elderly also puts them at an increased risk of a low-mood and possibly depression symptoms that can be clinically relevant.

Patients with chronic medical conditions such as coronary artery disease, multiple sclerosis, chronic obstructive pulmonary disease, cognitive impairment, or cerebrovascular disease can also develop depressive symptoms or major depressive disorder.

**Differences between Young and Old Depressed Patients**

Older patients with major depressive disorder are less likely to complain of a sad or depressed mood. Therefore, the term depression without sadness has been previously used to describe depression in the elderly. Insomnia, somatic symptoms such as pain, loss of appetite and decreased energy are more common in older adults presenting with depression compared to younger adults. Additionally, the elderly who usually show poor recovery after treatment, are more likely to have recurrent major depressive episodes and show poor adherence to treatment compared to younger adults.

The most common presentation of depression in the elderly consists of sleep disturbances, diminished interest in daily activities, feeling of guilt, decreased energy, loss of appetite, impaired concentration and/or cognition, and suicidal ideation.
Impact of Depression

Patients with depression usually have a decreased quality of life, an increased risk of cognitive disturbances, increased disability, and a higher rate of completed suicide. Suicidal attempts are most commonly seen in depressed white men who are over 85 years old. Additionally, the risk of post-myocardial infarction or post-cerebrovascular accident deaths is higher among depressed older patients compared to non-depressed older patients.

Treatment of Depression in the Elderly

The main differences between young and old adults who are depressed in terms of treatment are within the adequate dose, the adequate time for response anticipation, and the choice of maintenance treatment.

Selective serotonin reuptake inhibitors can be used in the elderly and they are usually well tolerated. It is important to understand that medication therapy for depression in the elderly takes longer to work compared to younger adults. Fluoxetine and paroxetine should be avoided in the elderly because of the increased risk of drug-drug interactions. Citalopram, sertraline or escitalopram are common and reasonable choices for the medical therapy of depression and major depressive disorder in the elderly.

Venlafaxine, a serotonin-norepinephrine reuptake inhibitor, is superior to typical selective serotonin-reuptake inhibitors in that it also helps with pain and somatic complaints, which are common in the depressed elderly. Unfortunately, venlafaxine tolerability compared to selective serotonin reuptake inhibitors is lower.

Mirtazapine is not recommended in the elderly because of the increased risk of sedation. Bupropion use in the elderly is also not recommended due to the increased risk of seizures, anxiety disorders and tremors. Tricyclic antidepressants are generally not used in the treatment of depression in the elderly because of the increased risk of hypotension, tachycardia, arrhythmias, and cardiac conduction deficits.

Maintenance therapy for depression in the elderly can be either continued antidepressant therapy alone, psychotherapy alone, or combined antidepressant and psychotherapy. Because the risk of relapse is the same in each approach, we consider psychotherapy alone for maintenance as the safest approach for the depressed elderly.

Anxiety in the Elderly

Prevalence of Anxiety Disorders in the Elderly

Anxiety disorders are less common in the elderly compared to the younger population. This is partly because older people are more likely to express their physical complaints as opposed to psychiatric complaints. However, anxiety is common among the elderly with the estimated prevalence of anxiety disorders in those older than 65 years being around 1 to 15%. The most common anxiety disorder in the elderly is generalized anxiety disorder followed by phobic disorders. The estimated prevalence of generalized anxiety disorder in the elderly is around 10%.
Risk Factors for Anxiety Disorders in the Elderly

Female gender, recent experience of adverse events, the presence of chronic medical conditions or mental illness and previous history of anxiety disorders are the main risk factors for anxiety disorders in the elderly.

Differences between Young and Old Anxious Patients

Older patients who develop an anxiety disorder are more likely to complain of restlessness, fatigue, decreased concentration and muscle tension. Sleep disturbances are also common. The patient's worries are usually about his or her loved ones or their health.

Impact of Anxiety

Anxious older patients usually have reduced physical activity and avoidance behavior, poor perception of their own health, impaired working memory and problems' solving skills, an increased risk of depression and major depressive disorder, and an increased risk of cardiovascular or cerebrovascular disease.

Treatment of Anxiety in the Elderly

Selective serotonin reuptake inhibitors such as escitalopram, citalopram or sertraline are the first-line therapy for anxiety disorders in the elderly. Venlafaxine can be also used but with caution. Tricyclic antidepressants should be avoided if possible in the management of anxiety symptoms in the elderly. Gabapentin has shown an effect in managing the anxiety symptoms of generalized anxiety disorder in the elderly.

In contrast to adults, benzodiazepines use for the treatment of acute exacerbations of an anxiety disorder in the elderly is highly discouraged. This is because of the increased risk of falls, sedation, respiratory depression and cognitive impairment in the elderly.

In contrast to the maintenance therapy for major depressive disorder in the elderly, medication therapy for maintenance in the elderly is superior to psychotherapy alone. Therefore, continued medical therapy with a selective serotonin reuptake inhibitor is recommended whenever possible. Beta-blockers which are used for the management of certain cardiovascular conditions in the elderly can be also used as maintenance therapy for anxiety.

References

Rojas-Fernandez et al. Considerations in the treatment geriatric depression. Research in Gerontological Nursing 2010; 3:3

Wilkinson P and Izmeth Z. Continuation and maintenance treatment for depression in older people. Cochrane Database of Systemic Reviews 2012; 11


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