Anxiety and Depression in Older People: Diagnostic Challenges

5

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This chapter considers the presentation of anxiety and depression in older people and explores the challenges clinicians face in making a diagnosis in the face of multiple health problems. Depression is a major global public health threat, and by 2030, depressive disorders are predicted to be the second leading cause of disease burden and disability worldwide [1]. Reducing the burden of depressive disorders is recognised as a major public health priority [2]. Anxiety and depression commonly overlap or coexist.

Depression severe enough to warrant intervention is one of the commonest mental health problems facing older people, affecting more than one in ten older people in the community. Demographic changes mean that even if prevalence rates were to remain stable, the growing numbers of older people will translate into large increases in the demand for treatment for these disorders in this population [3]. This is likely to place an increasing burden on health and social care. Untreated anxiety and depression leads to increased use of health and social care services and raised mortality [4]. Depression and anxiety are more prevalent in people with long-term physical conditions: prevalence of depression in people with diabetes may be as high as 30 % [5], and prevalence of anxiety in people with chronic obstructive pulmonary disease (COPD) is up to 25 % [6]. Depression is more than seven times more common in those with two or more chronic physical conditions [5]. Thus, mental and physical health problems tend to become entwined and manifest in complex co-morbidity) [7]. As co-morbidities are common in later life (36 % of people aged 65–74 and 47 % of those aged 75 and over have a limiting chronic illness), they constitute a serious risk factor for developing depression and/or anxiety. Treatment of depression has the potential to improve outcomes of diabetes [8] and to improve mortality from all causes in older adults [9].

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Loneliness and depression are strongly associated in older people [10], and loneliness is an independent risk factor for depression [11].

5.1 Anxiety, Depression and Long-Term Conditions

Depression is associated with disability; increased mortality, including from suicide; poorer outcomes from physical illness; and increased use of primary and secondary and social care resources. Major depression is a recurring disorder, and older people are more at risk of recurrence than the younger population. The aetiology of depression in older people is illustrated in Table 5.1.

There are a number of risk factors for depression, which clinicians need to be aware of (Table 5.2), and some of these are also risk factors for anxiety, particularly chronic physical conditions and loneliness.

Anxiety disorders are also common in older people. 'Anxiety' covers the terms generalised anxiety disorder (GAD) and panic and phobic disorders. GAD is a common disorder, of which the central feature is excessive worry about a number of different events associated with heightened tension. Anxiety and depression often

Table 5.1 Aetiology of depression in older people

Structural brain changes: atrophy
Vascular hypothesis: apathy and retardation, reduced depressive symptoms, reduced insight, more cognitive impairment, poorer recovery
Neurodegenerative disorders: Alzheimer's disease, Parkinson's disease, vascular dementia, multiple sclerosis
Physical illnesses: endocrine abnormalities, anaemia, cancer (lung, pancreas), tuberculosis, neurosyphilis

Table 5.2 Risk factors for depression in older people

Physical factors
Chronic disease: diabetes, ischaemic heart disease, chronic obstructive pulmonary disease, inflammatory arthritis
Organic brain disease: dementia, Parkinson's disease, cerebrovascular disease
Endocrine/metabolic disorders: hypothyroidism, hypercalcaemia
Malignancy
Chronic pain
Psychosocial factors
Social isolation
Loneliness
Being a carer
Loss: bereavement, income, social status
History of depression
Being in institutional care

coexist (or overlap) in older people and may also be co-morbid with physical conditions (leading to poorer outcomes in those conditions).

5.2 Presentation of Anxiety and Depression

Older people with depression may present with a variety of symptoms (Table 5.3).

Other clinical features often found in older people with depression include somatic preoccupation, hypochondriasis and the morbid fear of illness, which are more common presentations than the complaint of low mood or sadness. In addition, physical symptoms, in particular seemingly disproportionate pain, are common, and the primary care clinician may feel they represent organic disease. This can cause problems for the GP, as a depressed patient's hypochondriacal complaints can be quite different from the bodily symptoms one might expect from knowledge of the patient's medical history. Subjective memory disturbance may be a prominent symptom and lead to a differential diagnosis of dementia, but true cognitive disturbance is also common in late-life depression.

People with anxiety disorders may complain of worry, irritability, tension, tiredness or 'nerves', but older people may present, instead, with somatic symptoms that may cause diagnostic difficulty for the GP and (if not identified) may result in unnecessary investigations for the patient – with the resultant worries about the possibility of physical illness aggravating the depression or anxiety symptoms. The GP needs to be aware of the link with alcohol misuse and anxiety and should always explore alcohol consumption in older people who present with symptoms of depression or anxiety.

5.3 Diagnostic Challenges

Depression and anxiety in older people are poorly detected and managed in primary care [12], particularly in people with chronic physical ill health where symptoms may be 'normalised' [13]. Older adults may have beliefs that prevent them from seeking help for mental health problems, such as a fear of stigmatisation or concern that antidepressant medication is addictive. They may not consider themselves candidates for care because of previous experience of help-seeking. In addition, older people may be reluctant to recognise and name 'depression' as a specific condition that legitimises attending their GP, or they may misattribute symptoms of major depression for 'old age', ill health or grief and use normalising attributional styles

Table 5.3 Clinical features of depression

Emotional – sadness, anhedonia, worthlessness
Cognitive – self-blame, self-dislike, guilt
Motivational – low energy, lack of drive
Neurovegetative – change in appetite, sleep
Psychotic – delusions, hallucinations

that see their depression as a normal consequence of ill health, of difficult personal circumstances or even of old age itself.

Depression in older people (particularly when there is no history of depression earlier in the patient's life) is associated with increased risk of subsequently developing a 'true' dementia. Lastly, a persistent complaint of loneliness in an older person (even when that person is known to live with others) should prompt enquiry into mood, feelings and views on the future and a more systematic enquiry about biological symptoms of depression, along with a formal assessment, including a risk assessment.

Clinicians may lack the necessary consultation skills and confidence to correctly diagnose depression in older people, and anxiety is particularly underdiagnosed. Clinicians may also be wary of opening a 'Pandora's box' in time-limited consultations and instead collude with the patient in what has been called 'therapeutic nihilism' [14]. Additionally, a lack of congruence between patients' and professionals' conceptual language about mental health problems, along with deficits in communication skills on the part of both patients and professionals, can lead to uncertainty about the nature of the problem and reduce opportunities to talk about appropriate management strategies [13].

Because of the risk of depression and anxiety in people with long-term conditions, clinicians should consider using case-finding questions in consultations to opportunistically identify depression or anxiety (Tables 5.4a and 5.4b).

Asking the patient 'Is this something you want help with?' is thought to be a useful third question to take the discussion further and enable the patient to explore their problems with the clinician.

Primary care clinicians may have difficulty asking these case-finding questions of patients with long-term conditions due to lack of skill in making full assessment of mood and, at least partly, due to lack of referral options [15].

To make the diagnosis of depression, it is important to ask about the two key symptoms in the DSM 5 (Diagnosis and Statistical Manual), followed by the

Table 5.4a Case-finding questions for depression

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
During the past month, have you often been bothered by having little interest or pleasure in doing things?
A 'yes' to either question is considered a positive test. A 'no' response to both questions makes depression highly unlikely

Table 5.4b Case-finding questions for anxiety

Over the last 2 weeks, have you often been bothered by the following problems?
Feeling nervous, anxious or on edge
Not being able to stop or control worrying
A 'yes' to either question is considered a positive test. A 'no' response to both questions makes GAD highly unlikely

associated symptoms; in addition, the NICE guidelines for depression, and depression in people with chronic physical health problems [16, 17], stress the important of a thorough assessment of duration and severity of symptoms (Table 5.5).

There has been considerable emphasis on encouraging GPs to improve their skills in the diagnosis and management of depression, yet anxiety disorders have been relatively neglected [18]. Anxiety symptoms are more common than those of depression in the community and may be accompanied by significant morbidity.

When an anxiety disorder is suspected, the patient's symptoms should be explored in detail to establish the diagnosis (Table 5.6).

It is important to elicit a history of previous similar problems – this will affect a patient's understanding of their problems and impact on management decisions, particularly previous treatments and response to antidepressants. It is important to take an accurate drug history and ensure that the patient is not taking medication which could be contributing to a mood disorder. Enquiry into alcohol and non-prescribed drug use (particularly St John's wort, over-the-counter analgesics and illicit drugs such as benzodiazepines which can be obtained over the internet) is vital and often forgotten in older people. The clinician should ask about feelings of loneliness, social context and support, and the impact of symptoms on self-care and activities of daily living (e.g. motivation to shop and cook may be affected by low mood or panic attacks).

Where possible and with the patient's consent, a collateral history from a family member or other carer can provide important information, particularly about ability to cope at home (Table 5.7).

Table 5.5 Making the diagnosis of depression

Key symptoms
Persistent sadness or low mood
Marked loss of interest or pleasure
At least one of these, most days, most of the time for at least 2 weeks
If any of above present, ask about associated symptoms
Disturbed sleep (decreased or increased compared to usual)
Decreased or increased appetite and/or weight
Fatigue or loss of energy
Agitation or slowing of movements
Poor concentration or indecisiveness
Feelings of worthvlessness or excessive or inappropriate guilt
Suicidal thoughts or acts
Assess
Symptoms
Duration of episode
Course of illness
Severity of symptoms

Table 5.6 Making the diagnosis of anxiety

The diagnostic criteria for generalised anxiety disorder (GAD) include
Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities
The individual finds it difficult to control the worry
The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not over the past 6 months)
Restlessness or feeling keyed up or on edge
Being easily fatigued
Difficulty concentrating or mind going blank
Irritability
Muscle tension
Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning
The disturbance is not attributable to the physiological effects of a substance (e.g. alcohol drugs or medication) or another medical condition (e.g. hyperthyroidism)
The disturbance is not better explained by another mental disorder

Table 5.7 Holistic assessment of an older person

The following specific information should be obtained during the assessment of an older person with suspected mental health problems
Timing of onset of symptoms and their subsequent course
Any previous similar episodes
A description of behaviour over a typical 24 h (from patient and collateral history if possible)
Previous medical and psychiatric history (including previous intellectual ability and personality characteristics)
Accurate drug history
Family history of mental health problems
Living conditions
Financial position
Ability for self-care, shopping, cooking, laundry
Ability to manage finances and deal with hazards such as fire
Any behaviour that may cause difficulties for carers or neighbours
The ability of family/neighbours/friends to offer support
Other services already involved in the patient's care

The clinician should assess memory using the CG-COG and the Abbreviated Mental Test or asking the patient to name 15 animals (which is an excellent test for cognitive impairment and probably as useful as the Mini Mental State Examination or MMSE).

The NICE guidelines for anxiety (CG 113) [19] and depression (CGs 90 and 91) [16, 17] suggest that severity should be assessed using the GAD-7 [20] and PHQ-9

Table 5.8 Suggested investigations in suspected anxiety and/or depression in older people

FBC, U&E, liver and thyroid function tests, vitamin B_{12} and folate, HbA1C, bone profile, and any further tests dictated by clinical presentation

[21], respectively, in order to guide management (see Appendix 1 and 2 and chapters on managing anxiety and depression, Chaps. 8 and 9).

In older people, it is advisable for the clinician to exclude organic causes for change in mood and to organise for the patient to undergo a number of blood tests (Table 5.8).

5.4 Risk Assessment

Assessment of risk is important in any patient who is depressed, and older men are at particular risk of suicide. Apart from the risk of self-harm and suicide, the clinician should explore the risk of self-neglect, particularly when motivation is affected (Table 5.9).

A *normalising* approach may feel more comfortable to the patient and clinician than the more direct approach '*do you feel you would be better off dead*?' or '*have you been thinking of harming yourself*?' Thus, saying '*some people may feel like harming themselves when they feel down, as you tell me you do – do you ever feel like this*?' may be a useful approach.

It is important for the clinician to enquire about 'protective factors': does the patient have anything that stops them acting on thoughts of self-harm? Such factors might be faith, family, pets or an event to look forward to. If there are no protective factors, the risk of completed suicide is high.

Suicide mitigation is a vital role that primary care clinicians play as only 25 % of those who kill themselves are in contact with specialist mental health services. Contrary to some clinicians' worries, asking about suicide does not increase risk (actually reduces risk of self-harm and suicide). Clinicians should remember that if a patient is distressed, it is important *always* to explore thoughts of self-harm and to always document discussion. Similarly, it is important always to respond with compassion and maintain hope, and after managing the crisis, to ensure that the clinician himself or herself has support and supervision to talk through the consultation.

As well as agreeing a safety plan (developing strategies to remain safe, build up social network and utilise professional help including third sector services) and a crisis plan (agreed actions when suicidal thoughts increase or become persistent, how to access help, particularly out of hours) (http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf).

Risk should always be managed through a team approach, whether this is within the primary care team or shared across the primary care/specialist care interface.

Management of anxiety and depression will be discussed in Chaps. 8 and 9.

Table 5.9 Assessment of risk

The following prompts may be helpful to encourage the patient to talk about self-harm and suicide
How do you see the future
Have there been times when you felt you had wanted to get away from everything
Sometimes when people are low, they feel like harming themselves*….do you ever feel like this? If yes, when? How often? Are these thoughts persistent? How easy is it to resist them
Have you made any plans? What have you considered
What has stopped you from carrying this out? What are the things that you still look forward to
The clinician needs to be alert to the following 'red flags'
Well-formed suicidal plans and preparations: recent worsening in intensity, persistence with distress
Hopelessness: especially if persistently hopeless, and/or only able to see a brief future, no plans beyond the consultation or in the days ahead, 'nothing to live for', expressions of guilt, 'I'm a burden'
Ambivalence
Rigid thinking
Distressing psychotic phenomena: persecutory and nihilistic delusions, command hallucinations perceived as omnipotent
Sense of 'entrapment'
Impulsivity
Pain and/or chronic medical illness
Lack of social support: no confidants, major relationship instability, recently bereaved

5.5 Case Studies

5.5.1 Case Study 1: Hidden Anxiety (Peter C)

Peter, 80, lives with his 78-year-old wife in a terraced house. Their two sons and daughter live in towns more than 40 miles away, all in different directions.

Peter has COPD and is finding that he is increasingly breathless on very minor exertion. His wife is fit and well, apart from some knee pain due to arthritis, and she takes tablets for high blood pressure. Her sister died of breast cancer 4 years ago, and Peter worries all the time that she might get cancer. Sometimes the worry takes over and he can't sleep at night. He then starts to panic, feels breathless and has to get up and walk around. In the night, he worries what will happen when he can no longer manage the stairs.

He has started to drink a small whiskey every night to help him get off to sleep, but his wife grumbles at him, so he now drinks it in secret.

He doesn't feel he can talk to anyone about how he feels and is not sure what might be available to help him.

Peter's problems are suggestive of an anxiety disorder. Anxiety can occur in up to 40 % of people with COPD [22] and increases the risk of health and social care use [23] as well as poorer patient outcomes. Depression is also common in people

with COPD, so anxiety and depression may be co-morbid in a patient like Peter. People with anxiety may use alcohol to manage their anxiety, and the clinician should always explore alcohol use.

Peter is likely to consult his general practice about 12 times a year and is likely to see a practice nurse (PN) or GP for review of his COPD and medication. It is likely that Peter might be unwilling to disclose symptoms of anxiety, but these routine consultations offer an opportunity for opportunistic case-finding for anxiety and depression, using the case-finding questions (Tables 5.4a and 5.4b). If Peter responds positively to any of the case-finding questions, then the clinician can explore symptoms further and assess severity using the GAD-7 or PHQ-9 (see Appendix 1 and 2), in addition to exploring risk and managing appropriately.

Peter may not be happy about a label of anxiety or depression – this may not fit with his model of illness [13], or he may feel stigmatised by the suggestion that he has a mental health problem or that his symptoms are to be expected given his age and COPD [14]. The clinician's role is to find an explanation of Peter's symptoms that is understandable and acceptable, so that a discussion about management may be had. This may need to be over a number of consultations, and the clinician may need to use patient-information leaflets to support their discussion. Peter could be referred to a third sector service, if acceptable to Peter, at this stage, and he should be offered review.

Further management of a patient like Peter, with anxiety, will be described in Chap. 8.

5.5.2 Case Study 2: Diabetes and Depression (Afzal K)

Mr K is 75 years old and lives with his eldest son, who works as an accountant, daughter-in-law and their four children. His wife died suddenly 2 years ago following a subarachnoid haemorrhage. He stopped working in the family shop following his bereavement and gave the business to his second son. He has had diabetes since the age of 50 and tries hard to watch his diet; he usually takes his medication regularly but struggles to know what to do during Ramadan. His son has just been told he, too, has diabetes, and now the family meals are more focused on ensuring that all the family eat plenty of fruit and vegetables. Mr K rarely attends his general practice, except when he is told to make an appointment for an annual review with the practice nurse.

Mr K tries to speak to his grandchildren, who are teenagers, but they all seem so busy, so he spends a lot of time on his own. He goes to the Mosque but, otherwise, rarely leaves the house.

Sometimes he wishes he didn't wake up in a morning, but feels guilty about this.

From the above history, Mr K is likely to have a depressive illness. Depression is common in patients with diabetes and worsens outcomes from both the diabetes and depression [5], whilst Katon et al. (2012) demonstrated that actively managing both depression and diabetes can improve outcomes in both conditions [24]. As Mr K does not attend the general practice very often, when he does attend, the clinician could usefully ask the case-finding questions for depression (see Table 5.4a), followed up by a broader exploration of

symptoms, duration, severity (including use of PHQ-9 – Appendix 2) and impact. An older person with depression is at risk of self-harm and completed suicide, particularly an older male. Thus, the clinician should gently explore risk, with an explanation of why (s) he is asking these questions and what protective factors stop Mr K from acting on thoughts of harming himself. His faith might play an important role in this, and the clinician should be aware of culturally sensitive services that are available locally, which Mr K might be prepared to consider trying out. Such services might also address Mr K's loneliness. This case serves to remind us that people can be lonely even if they do not live alone, and any patient complaining of feeling lonely is at risk of depression.

Further management of a patient like Mr K, with depression, is discussed in Chaps. 8 and 9.

5.6 Suggested Activities

Reflect on:

How recently have you suspected that a patient or client might have anxiety or depression? How do you confirm this? What role do you have in management?

When a patient has multiple physical health problems, how often do you think about their mood? Do you use the depression and/or anxiety case-finding questions?

What support do you need in managing people with anxiety or depression? Do you have regular supervision?

Do you know what third sector services are available in your locality, and what services are provided for older people?

Key Points

- Depression and anxiety are common in older people, particularly where there is physical co-morbidity.
- Clinicians should consider case-finding for depression and anxiety in patients with long-term physical health problems.
- Making a diagnosis of depression or anxiety in older people can be challenging, and a collateral history can be helpful.
- Depression in older people is a risk factor for suicide, and a risk assessment should always be conducted when depression is suspected.

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