Depression and Anxiety
Implications and Management

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APRIL 3, 2018 - CRITICAL ISSUES AND PROMISING PRACTICES IN BEHAVIORAL HEALTH: SUPPORTING OLDER ADULTS & PEOPLE WITH DISABILITIES, CORVALLIS, OR

Objectives

1. At the end of this workshop, participants will be able to describe at least three risk factors for co-occurring depression and anxiety.

2. At the end of this workshop, participants will be able to describe at least three non-pharmacological approaches for addressing co-occurring depression and anxiety.

Epidemiology

CO- OCCURRING DEPRESSION AND ANXIETY

Imaged accessed at: https://www.nia.nih.gov/sites/default/files/inline-images/depression-and-older-adults-inline.jpg

Epidemiology

Population-based samples – ***lifetime prevalence rates***

- Major depression in US = 16.6%
  - 75% with depression met criteria for anxiety
- Anxiety disorders in US = 28.8%
  - 79% with anxiety met criteria for depression

Older Adult samples –age 55-104

- Community sample (Netherlands): MDD and any Anxiety Disorder = 47.5%
- Clinical Sample (U.S.): MDD and Anxiety = 38.6%
- Clinical Sample (Europe): Anxiety with subthreshold depression = 67% and anxiety with MDD = 87%

Kessler et al. (2007); Braam et al. (2014).

Epidemiology

‘Healthy Ageing and Intellectual Disability’ (HA-ID) study (n=1050)

Older Adult with ID – ***Point prevalence***

- MDD was 7.6% (subthreshold prevalence 17%)
- anxiety disorders 4.4% (subthreshold prevalence 16%)

Rates of Identification of Depression and Anxiety

- MDD identified in 37.5%
- anxiety disorder identified in 26.3%.

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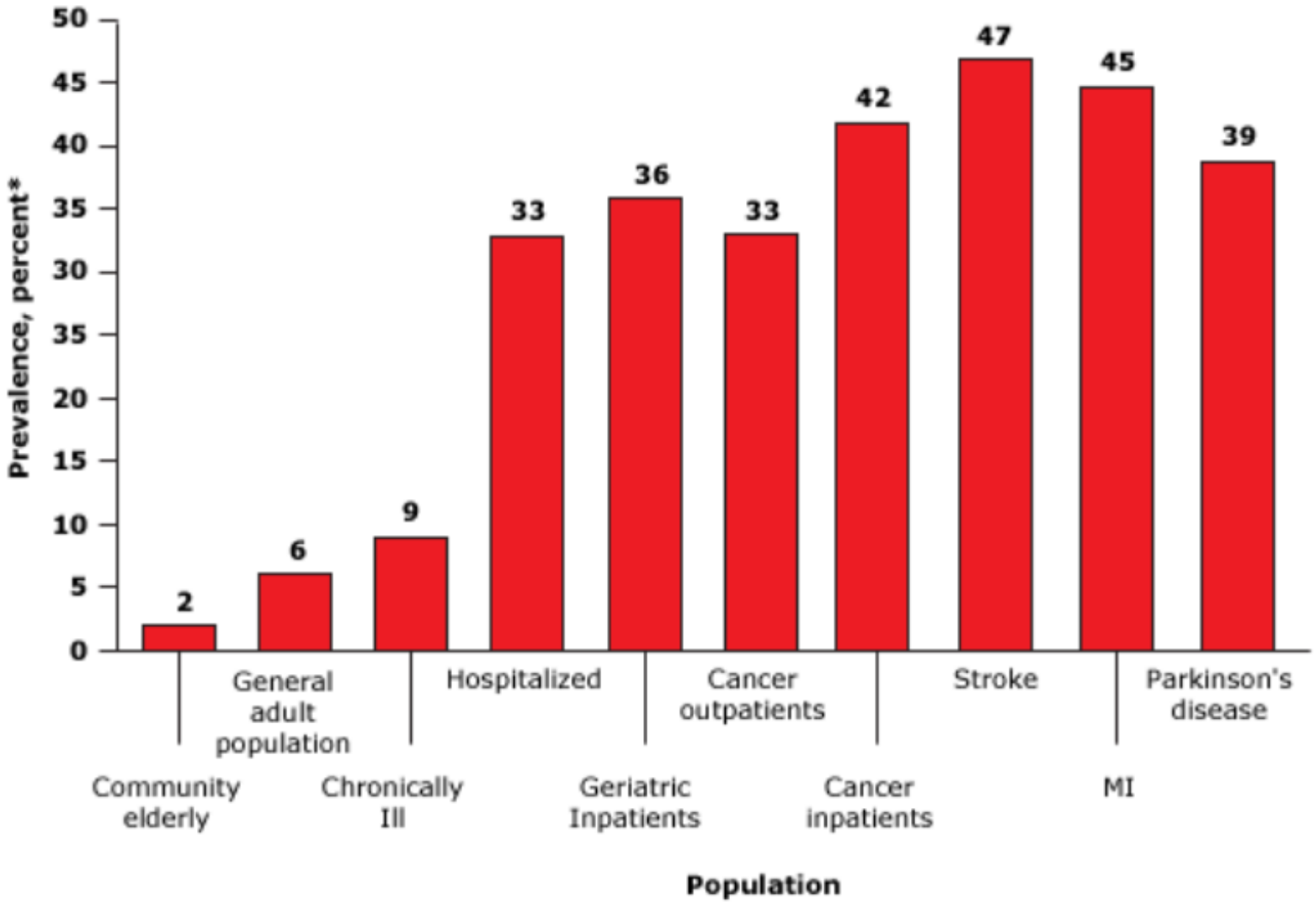
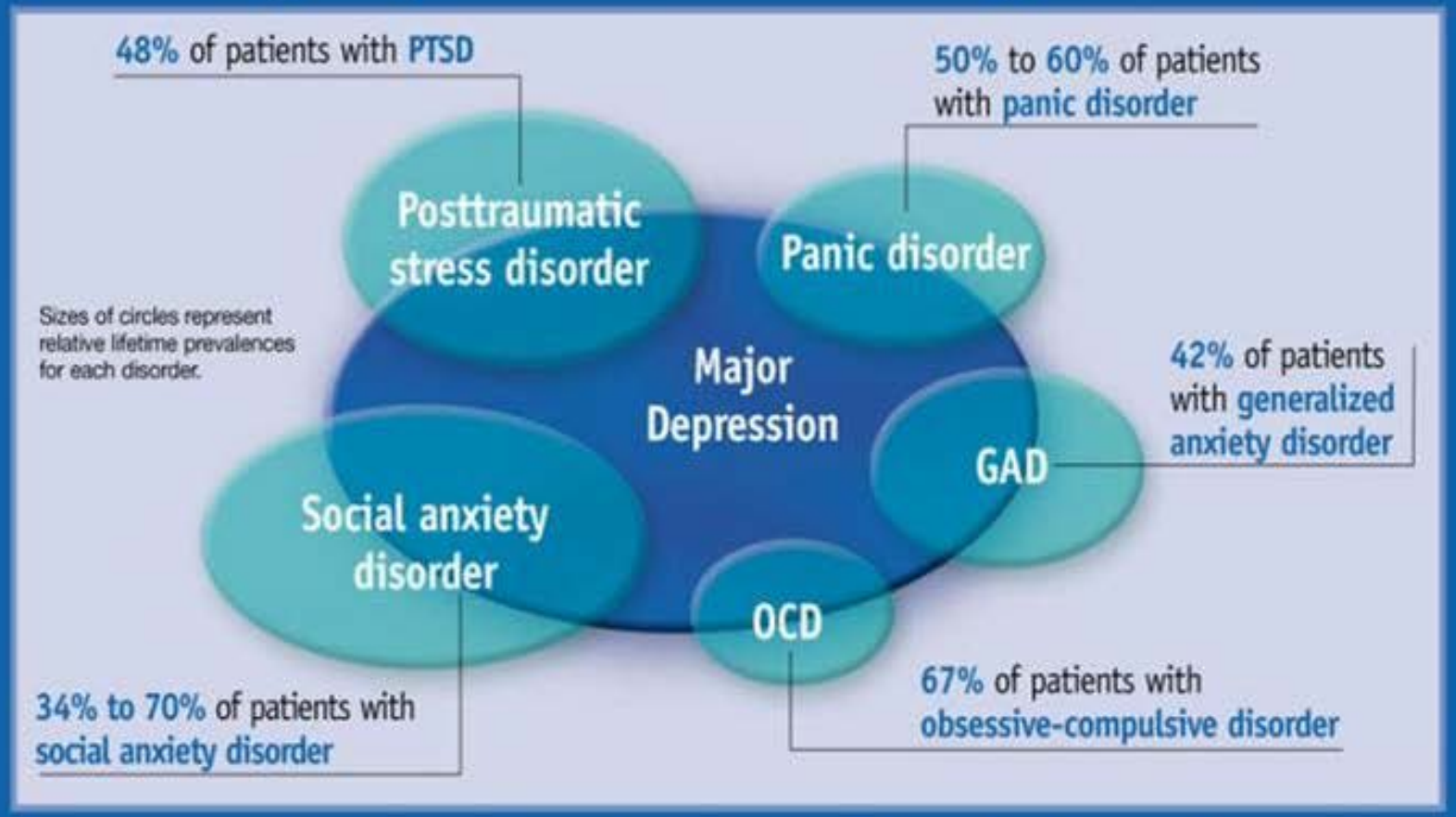
Prevalence of depressive disorders in various patient populations



Many patients with anxiety disorders may have major depression at some time during their lives



- In a 12-month period, 50% of patients with major depression will have a comorbid anxiety disorder

Kessler 1995; American Psychiatric Association 2000; Brawman-Mintzer 1993; Rasmussen and Eisen 1992; Stein 2000; Van Ameringen 1991; Wittchen 1999.

http://slideplayer.com/slide/6408240/

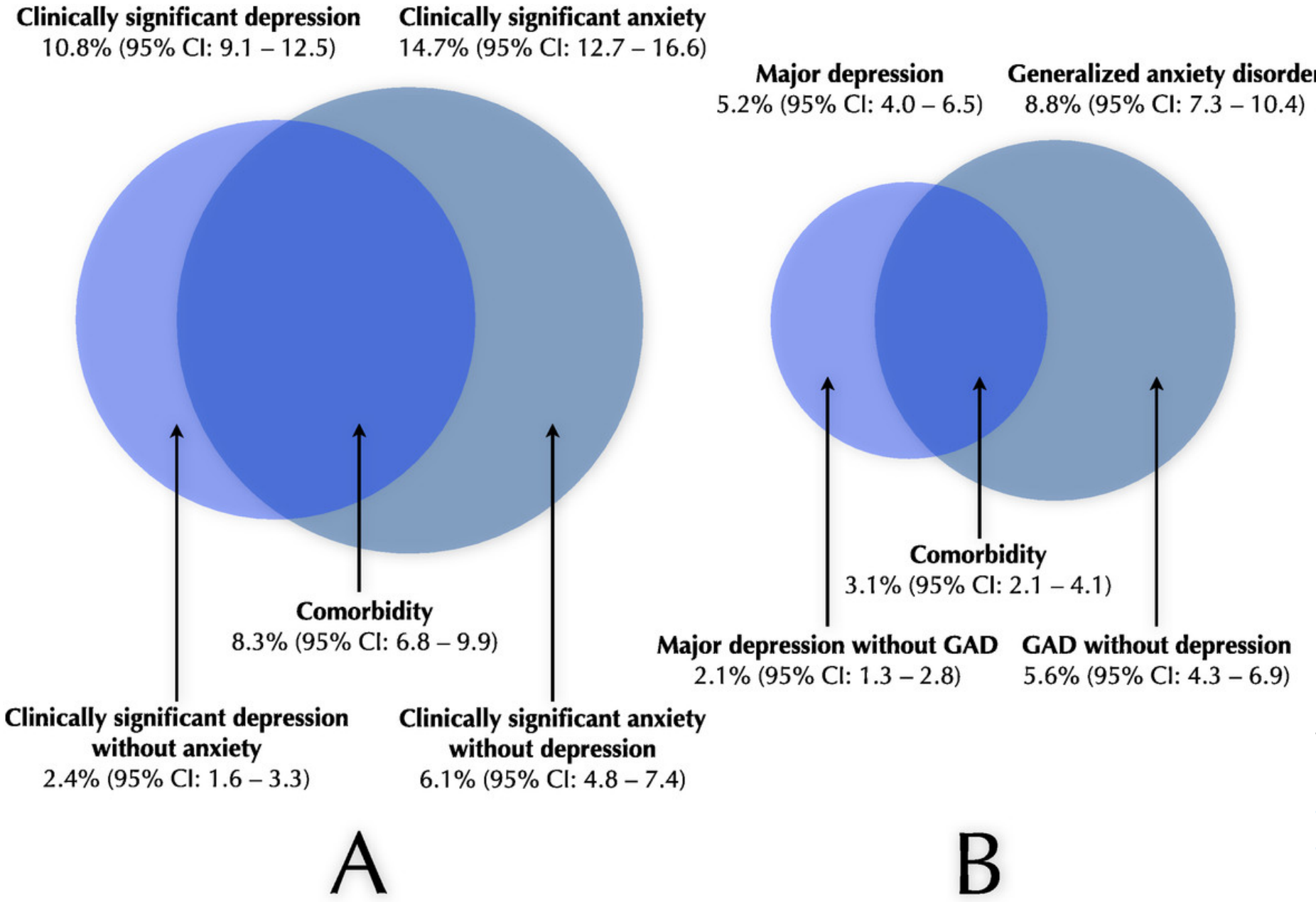


Illustration of prevalence of depression, anxiety and comorbidity

Sweden general population
N=1266

Johansson, R et al. 2013
Figure accessed from:
https://dfzljdn9uc3pi.cloudfront.net/2013/98/1/fig-1-2x.jpg

Risk factors in late-life

Comorbid anxiety and depression (>60yo)

- female sex
- less education
- higher depression severity
- early traumatization
- personality characteristics (neuroticism, extraversion, conscientiousness)
- socioeconomic stressors
- less social support
- poor sleep quality
- chronic disease (HF, CAD, DM, COPD, pain)

Risk factors in older adults with ID

- number of life events during the past year*
- chronic diseases (HF, CVA, COPD, CAD, DM and cancer)
- impairments in instrumental activities of daily living (IADL)-abilities

*72% exposed to 1 or > negative life events (significantly higher for > 65 years)
  - problems with a fellow resident (27.8%),
  - change of staff (26.8%),
  - mild physical illness (23.8%),
  - decline or loss of mobility (15.6%) and
  - severe illness of relative, carer or friend (13.2%)

Life events: Association with Depression and Anxiety

- problems with a fellow resident (27.8%)
- change of staff (26.8%)
- mild physical illness (23.8%)
- decline/loss of mobility (15.6%)
- severe illness of relative/caregiver (13.2%)

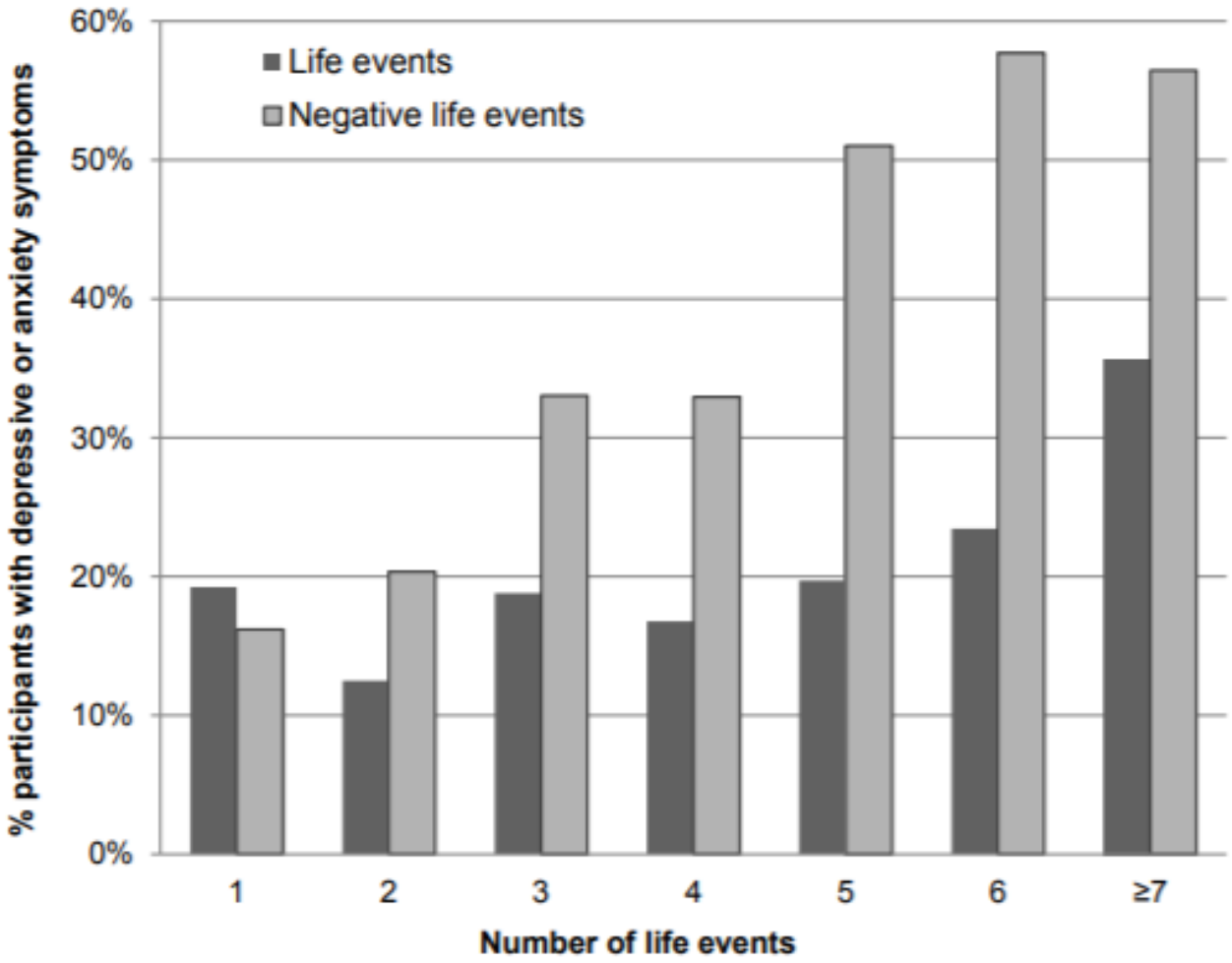


Figure 1: Association of multiple life events and depressive and anxiety symptoms

Causes

CO-OCCURRING ANXIETY AND DEPRESSION

Image accessed at: http://senior-care-central.com/wp-content/uploads/2017/03/pic2-400x267.jpg

Causes of Co-occurrence

Neurobiology
- limbic system disruptions
- hyperactive amygdala
- neurotransmitter imbalance
- decreased Omega-3 polyunsaturated fatty acids

Genetics
- Similarities in genetic structure

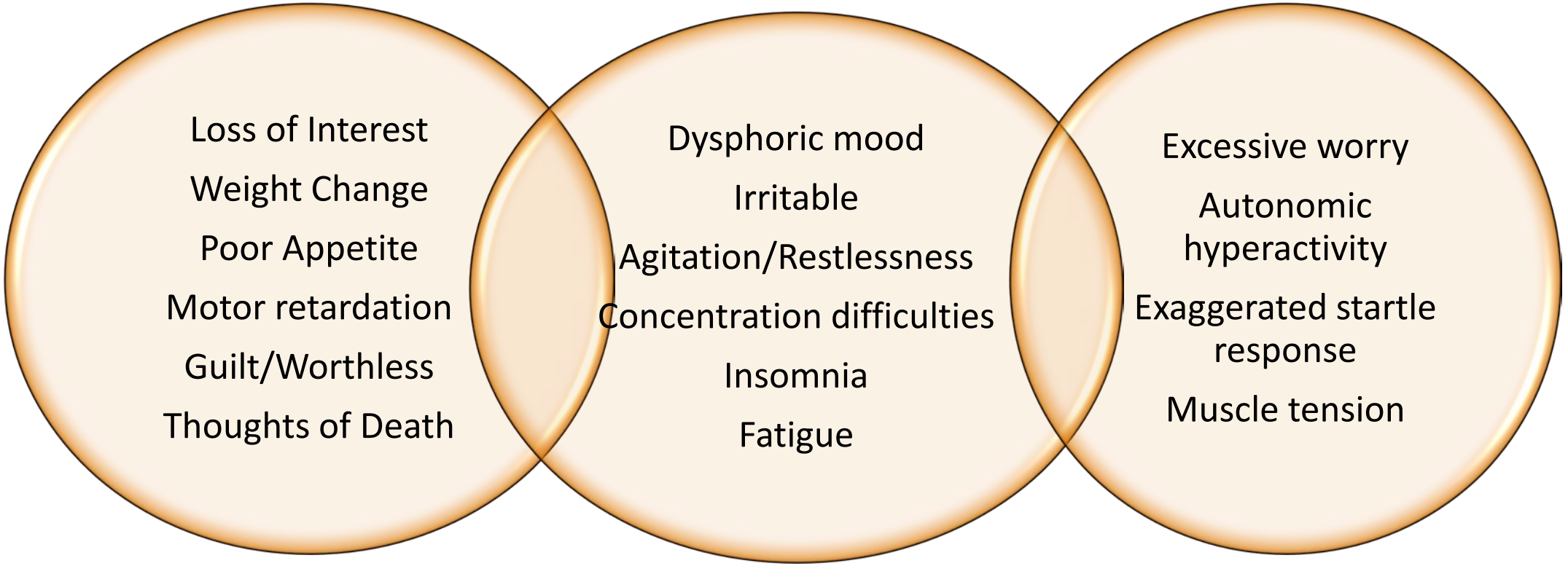
Neuropsychological –
- personality traits (neuroticism)
- greater impairments in working memory and attention
- severity of role impairment (home management, ability to work, social life, and close relationships)

Clinical Implications

CO-OCCURRING ANXIETY AND DEPRESSION

Image accessed at: https://encrypted-tbn0.gstatic.com/images?q=tbn:ANd9GcSbof-lehyoGbovRkOVCYhh_4WsIgBjXujHHgNP5QrIBQV35IXS

Symptoms characteristic of both MDD and GAD



Developed based on UptoDate (2018) evidence review: Comorbid anxiety and depression in adults: Epidemiology, clinical manifestations, and diagnosis

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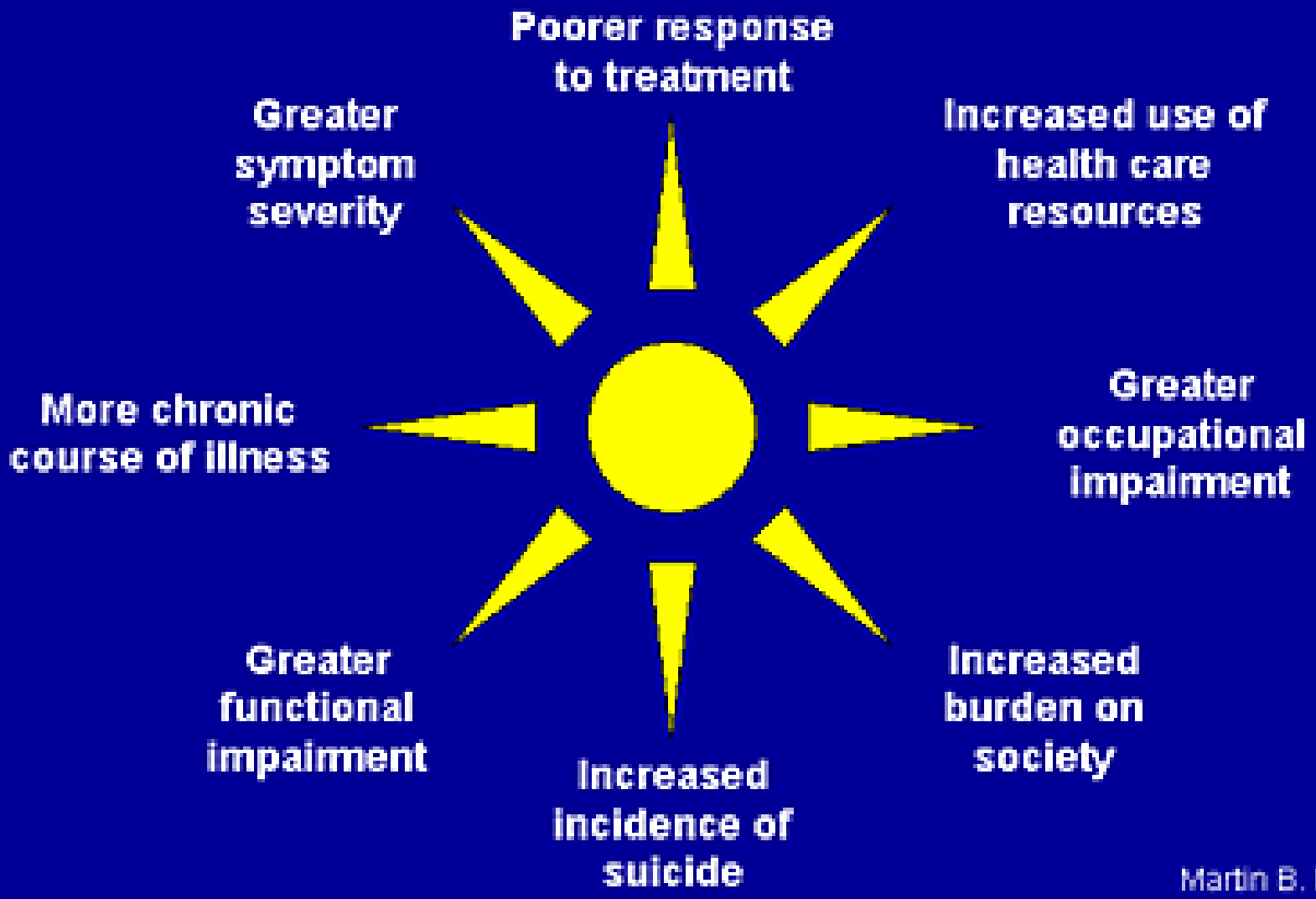
Implications of Comorbid Depression and Anxiety

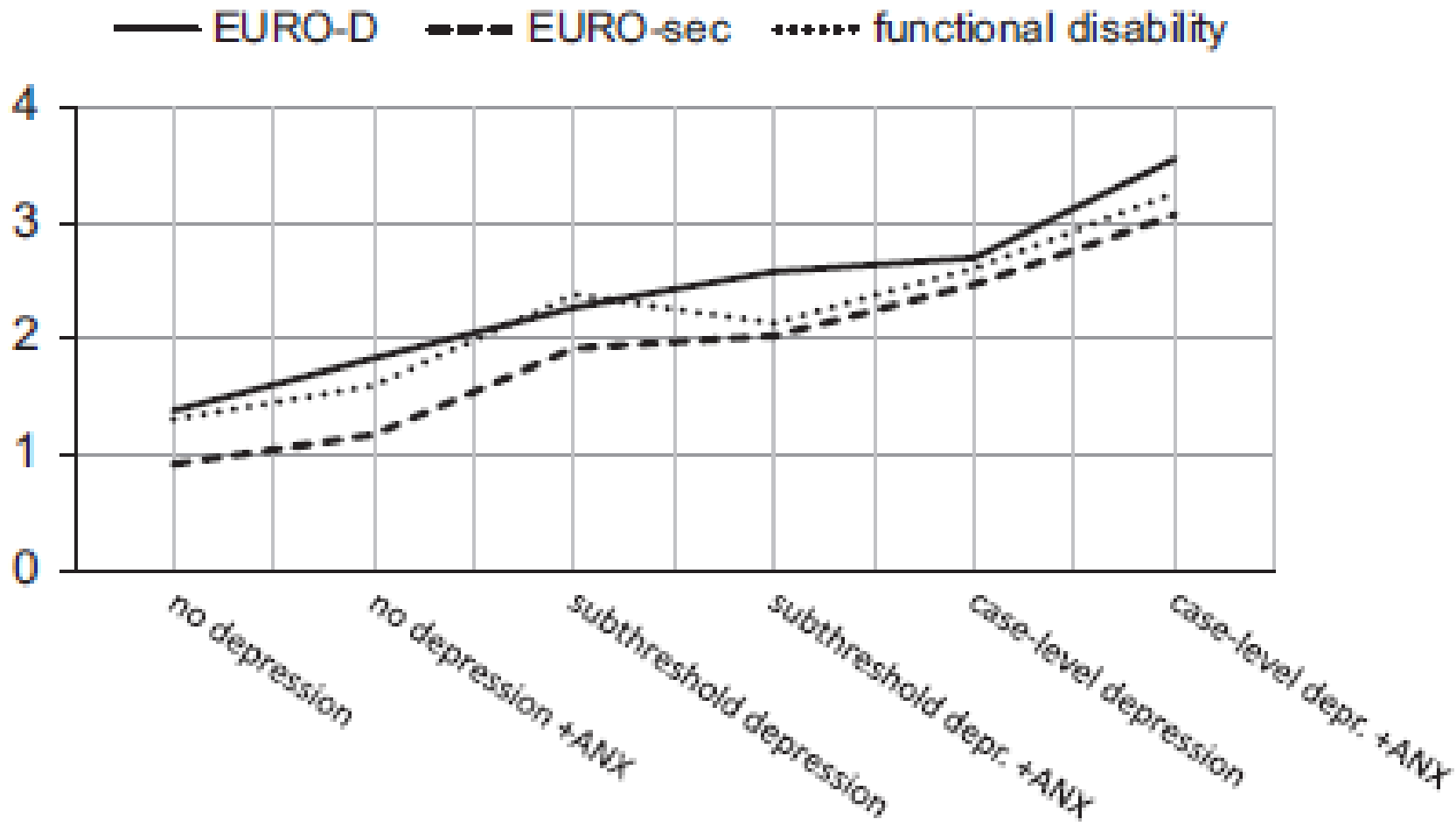


Martin B. Keller, MD
October 2004

Increased Disability

Older adults in community, age 65–104 (*N*=14,200)

Braam et al. (2014). Journal of affective disorders



ASSESSMENT

CO-OCCURRING ANXIETY AND DEPRESSION

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Assessment

Patient History

Physical Examination

- Medical illness (including level of pain)
- Medication side effects (steroids, narcotics, benzodiazepines, beta-blockers. cytotoxic agents)
- Substance use or withdrawal

Appropriate Lab studies

Psychosocial history

- Stressful life events
- Family history of anxiety and/or depression
- Current social history (support)
- Trauma history
- Suicide risk/history

DSM-5 Disorders

DSM-5 diagnostic criteria for depression and anxiety disorders

- Major depressive disorder (MDD)
- Dysthymia
- Generalized anxiety disorder (GAD)
- Obsessive-compulsive disorder (OCD)
- Panic disorder
- Social anxiety disorder
- Specific phobia
- Agoraphobia

MDD with anxious distress

Anxious distress was included as a specifier of major depression in DSM-5

Two or more of the following symptoms during most days of the depressive episode

- Feeling keyed-up or tense
- Feeling unusually restless
- Difficulty concentrating because of worry
- Fear that something awful will happen
- Feeling that the individual might lose control of him or herself

Screening - examples

The Depression and Anxiety Stress Scale (DASS)

- co-occurring depression and GAD symptoms
- Reliable and accurate in assessment of global anxiety, and able to separate anxiety and depressive symptoms

Hospital Anxiety and Depression Scale (HADS-A)

- co-occurring depression and general anxiety symptoms - 7 items on each subscale – self-report
- valid with late life depression/anxiety

Patient Health Questionnaire Depression Scale (PHQ-2/PHQ-9)

- 2 and 9-item
- demonstrated validity in the primary care setting

Generalized Anxiety Disorder Scale (GAD-7)

- 7 items
- general screening – valid with older adults

Implications for Treatment

Symptoms overlap with each other and with physical illnesses (COPD, CAD, DB, pain)

- Under-treated (less than 1/3 of COPD patients with comorbid depression and anxiety receiving appropriate treatment)
- Polypharmacy is common

Cognition impacted by anxiety and depression

Sensory deficits need to be accommodated (hearing, vision)

Coordination of treatment with community services (awareness of resources)

Family relationships and changes in social support

Living environment impact on individual and on interventions

Management

CO-OCCURRING ANXIETY AND DEPRESSION

Image accessed at: https://blog.aarp.org/wp-content/uploads/2014/11/depressedolderadult-300x199.jpg

Recommendations for clinical practice

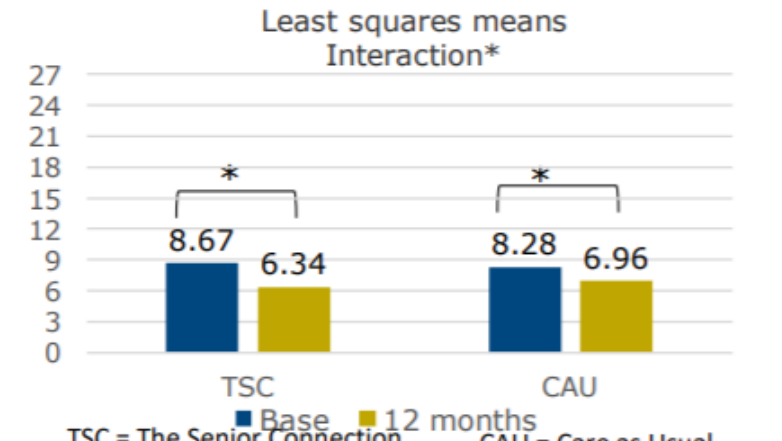
Primary prevention

- social and physical activities
- enhance social support
- sleep management techniques
- pro-active support after major changes or events (e.g. loss of relatives, retirement, decreased mobility, myocardial infarction)

The Senior Connection
A Randomized Trial of Companionship

"The Senior Connection" U01 CE001942 from CDC (Conwell PI)

PHQ-9 Depressive Symptoms (0-27)



TSC = The Senior Connection (peer companionship)

CAU = Care as Usual (control)

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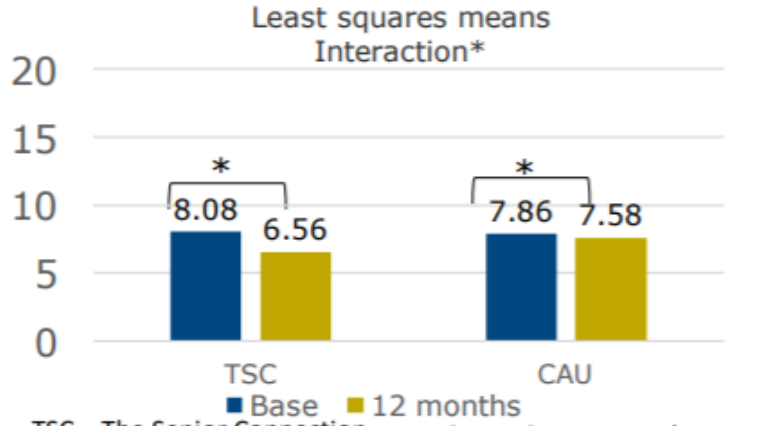
GAD-7 Anxiety Symptoms (0-21)



TSC = The Senior Connection (peer companionship)

CAU = Care as Usual (control)

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Recommendations for clinical practice

Secondary prevention

- Early detection of depression and anxiety symptoms
  - Detection strategies
    - population level screening or ‘at risk’ groups
    - staff/provider education (for increasing detection)
    - inclusion in guidelines/standard practice
    - multidisciplinary collaboration

Outreach Programs (An example)

- Psychogeriatric Assessment and Treatment in City Housing (PATCH) program.
  - Serving Older Persons in Baltimore Public Housing
- 3 elements
  - Train indigenous building workers (i.e.,managers, janitors,) to identify those at risk
  - Identification and referral to a psychiatric nurse
  - Psychiatric evaluation/treatment in the residents home
- Effective in reducing psychiatric symptoms
  - Rabins, et al., 2000

Depression Anxiety and Suicide Prevention Webinar Recording

https://www.youtube.com/watch?v=4HBZgXWtiew

Recommendations for clinical practice

Secondary prevention

Treatment of depression and anxiety symptoms

- Cognitive Behavioral Therapy (CBT)
  - effective for MDD, GAD, PAD and SAD
- Combined treatment (psychotherapy and antidepressant medication)
  - effective for MDD, panic disorder, and OCD

Evidence-based Prevention and Early Intervention: Anxiety

- Anxiety
  - Psychotherapy
    - Relaxation training, CBT, supportive therapy, and cognitive therapy
  - Pharmacotherapy
  - Service-delivery models (i.e., Peaceful Living)

- Protocols should address the specific issues and/or limitations that may be present among older adults.

Wolitzky-Taylor, KB; Castriotta, N; Lenze, EJ; Stanley, MA; Craske, MG. (2010). Anxiety Disorders in Older Adults: A Comprehensive Review. Depression and Anxiety, 27: 190-211.

https://www.youtube.com/watch?v=4HBZgXW

Recommendations for clinical practice

Secondary prevention

Management of depression and anxiety symptoms

- Relaxation Interventions in Older Adults
  - Depression
    - progressive muscle relaxation training
    - music intervention
    - yoga
  - Anxiety
    - music intervention
    - yoga
    - combined relaxation training

Recommendations for clinical practice

Secondary prevention

Treatment of depression and anxiety symptoms

- Enhanced Collaborative Care
  - weekly symptom assessment, medication management, care coordination, education, and goal setting
- Physical Activity (Behavioral Activation)
  - reduced depression
  - reduced anxiety

The IMPACT Treatment Model

aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment

→ **Collaborative care model includes:**

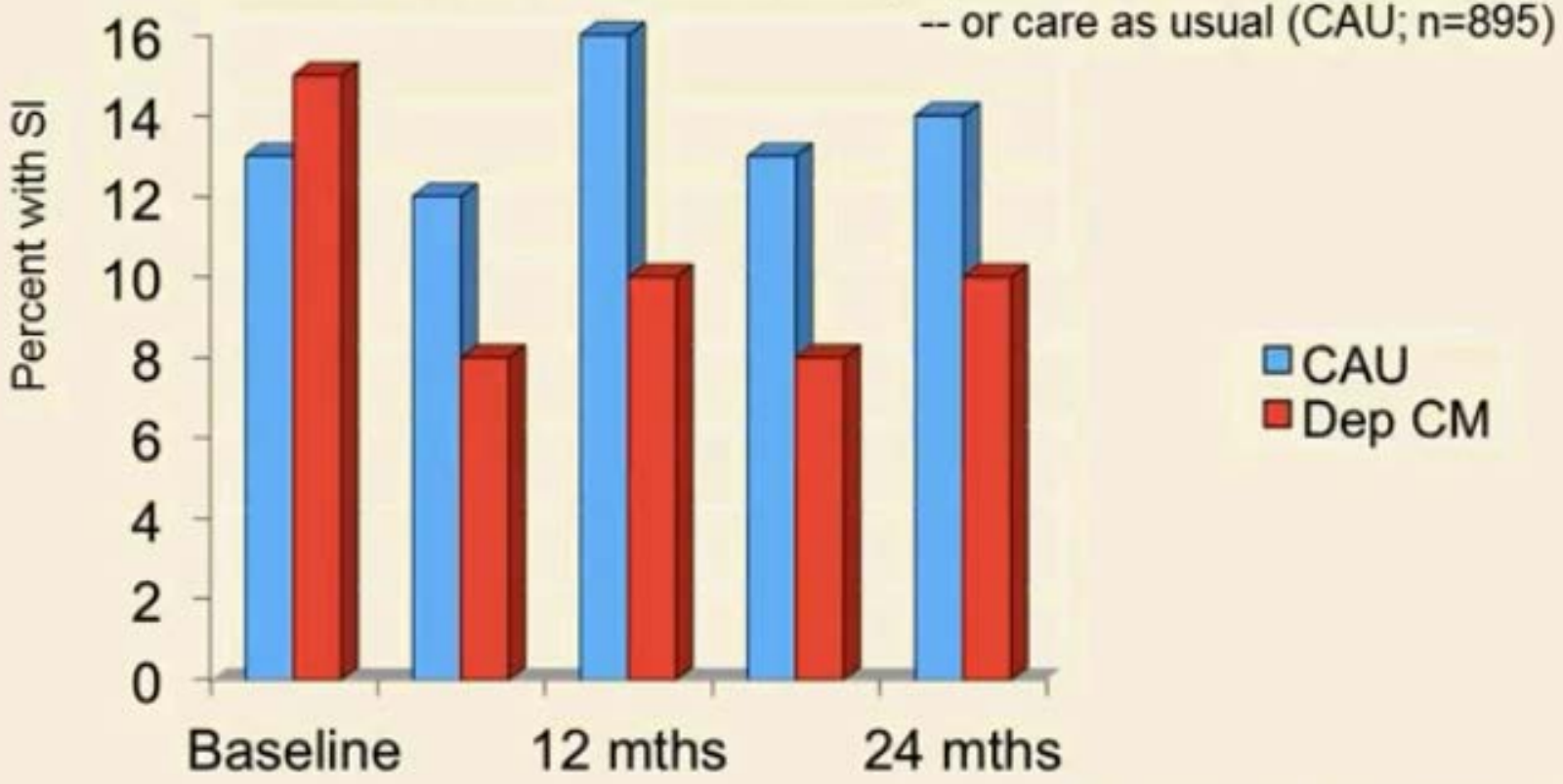
- **Care manager: Depression Clinical Specialist**
  - **Patient education**
  - **Symptom and Side effect tracking**
  - **Brief, structured psychotherapy: PST-PC**
- **Consultation / weekly supervision meetings with**
  - **Primary care physician**
  - **Team psychiatrist**

→ **Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)**

Depression Anxiety and Suicide Prevention Webinar Recording (2017) https://www.youtube.com/watch?v=4HBZgXWtiew

The IMPACT Study

N=1801 subjects >60 yrs with major depression or dysthymia
Randomized to -- collaborative care (depression care manager; n=906)
-- or care as usual (CAU; n=895)



Unutzer et al., JAGS 54:1150-6, 2006

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Depression Anxiety and Suicide Prevention Webinar Recording (2017) https://www.youtube.com/watch?v=4HBZgXWtiew

PEARLS

Together, we help create active and rewarding lives

HOME | OUR PROGRAM | TRAINING | GETTING STARTED | CONDUCTING PEARLS | CREATING A PEARLS INFRASTRUCTURE | STORIES | CONTACT US

Our Program

The PEARLS Program is a highly effective method designed to reduce depressive symptoms and improve quality of life in older adults and in all-age adults with epilepsy. During six to eight in-home sessions that take place in the client's home and focus on brief behavioral techniques, PEARLS Program counselors empower individuals to take action and to make lasting changes so that they can lead more active and rewarding lives.

The PEARLS Program is a highly effective method designed to reduce depressive symptoms and improve adults and in all-age adults with epilepsy.

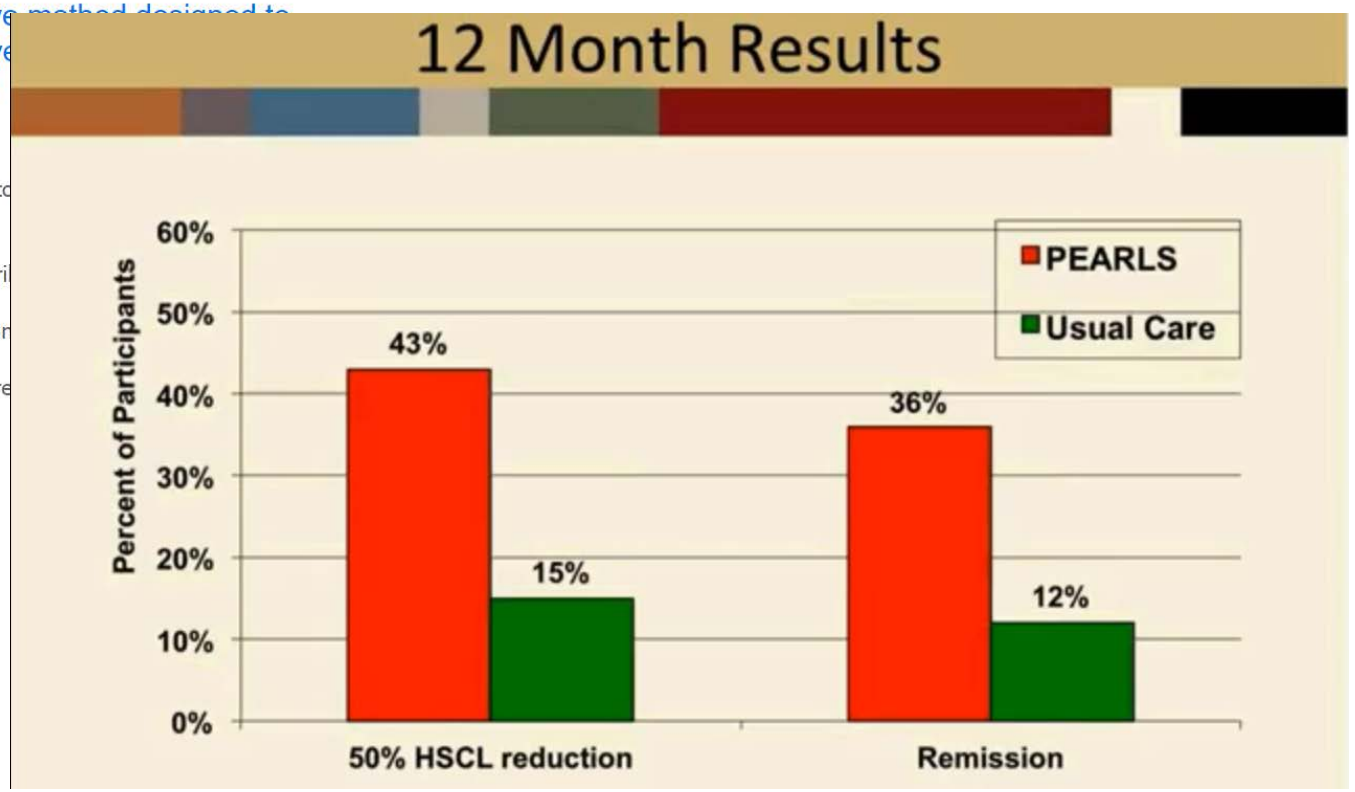
The PEARLS Program

- Focuses on teaching each client the skills necessary to life changes
- Is delivered in the client's home
- Is designed to be delivered in the community, primari provision programs
- Takes a team-based approach, involving PEARLS cour and medical providers
- Aims to improve quality of life as well as reduce depre
- Is well-suited for individuals with chronic illness

Our Program

- WHO WE ARE
- PEARLS FOR OLDER ADULTS
- PEARLS FOR ADULTS WITH EPILEPSY
- ABOUT DEPRESSION

www.pearlsprogram.org



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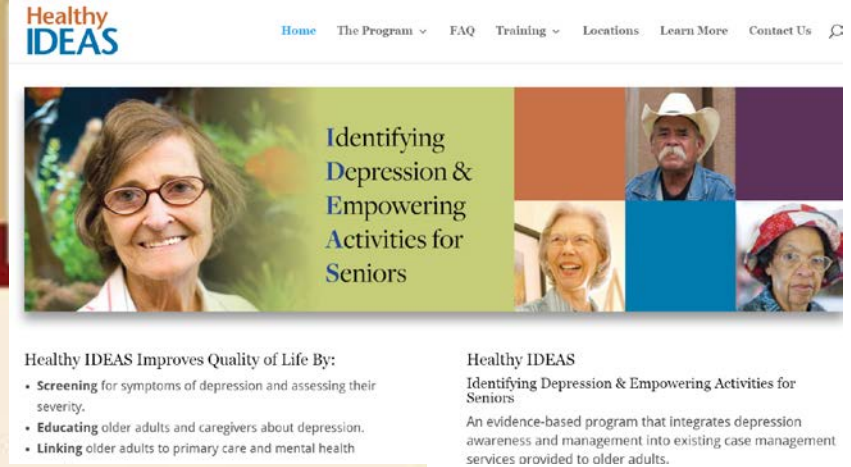
Healthy IDEAS

- Embedded in case management programs
  - Uses existing staff with established relationships.
- Conducted in the client's home on a one-to-one basis by case managers over a 3-6 month period.
- Four components:
  - Screening for depression & assessing severity
  - Educating about depression & effective treatment: including self-care & medication.
  - Referral, linkage & follow-up for older adults with untreated depression to health or mental health providers.
  - Behavioral Activation empowering older adults to manage their depressive symptoms by engaging in meaningful, positive activities.

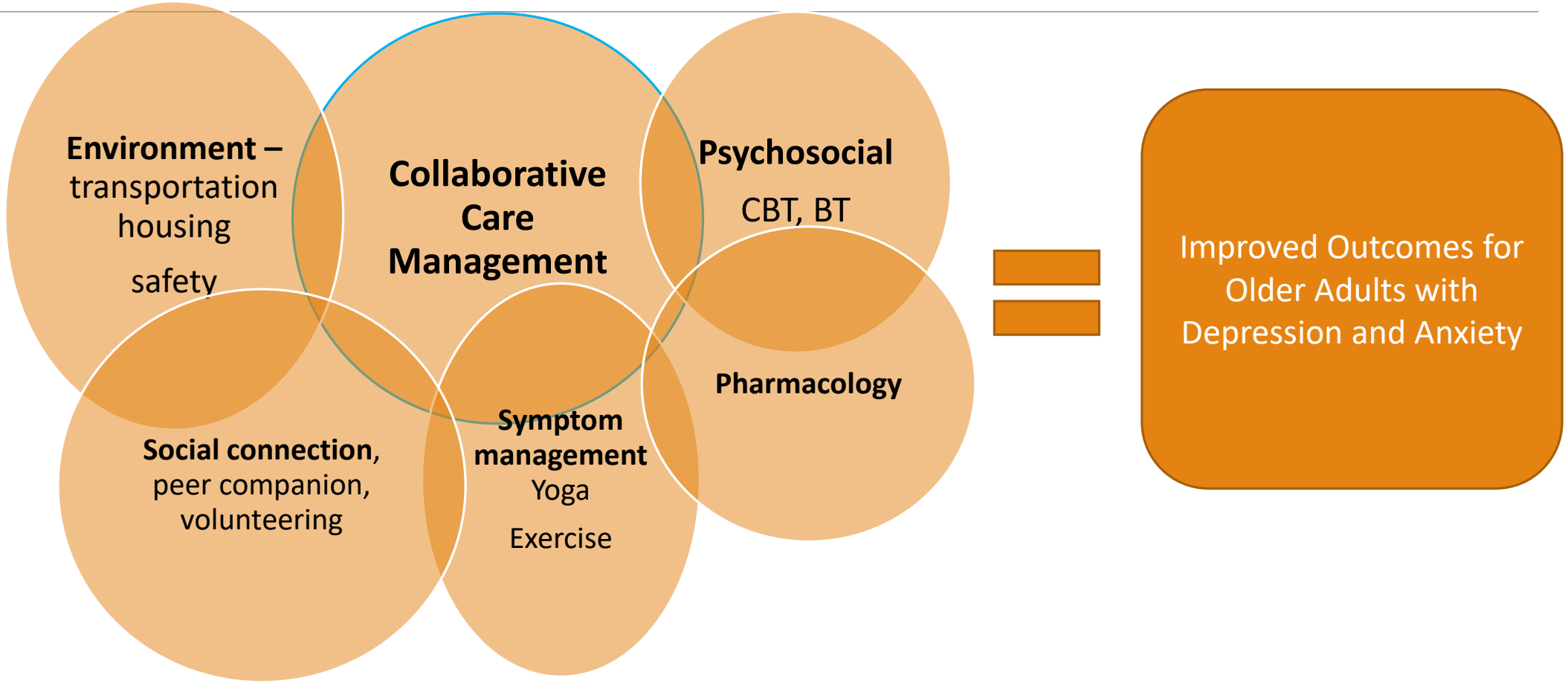
www.careforelders.org/healthyideas



Depression Anxiety and Suicide Prevention Webinar Recording (2017) https://www.youtube.com/watch?v=4HBZgXWtiew

https://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD

Putting it all together….



Collaboration

Activity - Pair and Share with colleague from another agency/area.

Identify current strengths and opportunities related to the development of a plan of care in collaboration with other service providers to address health needs service needs of older adults with anxiety and depression (Conference Goal #3)

- Current strengths
- Opportunities(gaps)

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Questions?

THANK YOU FOR ALL YOU DO!

Image accessed at: https://www.sonashomehealth.com/wp-content/uploads/2017/07/Anxiety-and-Depression-in-Older-Adults.jpg