

Treatment of Anxiety Disorders in Late Life

Joel Sadavoy, MD, FRCPC¹, J Kenneth LeClair, MD, FRCPC²

Objective: To provide a current review and synthesis of the present state of knowledge of anxiety disorders and symptoms in the elderly.

Methods: Current research derived from a MEDLINE search and references in key textbook articles and other papers were reviewed. These data were combined with the clinical empirical knowledge and experience of the authors.

Results: Anxiety disorders and symptoms are a common presenting problem in the elderly. Current knowledge and research findings are limited. Extrapolation from adult studies are of use, but important limitations are evident because of the nature, uniqueness, and complexity of the geriatric psychiatry patient. Comorbidity, especially with depression, medical conditions, drugs, and dementia, remains an important concept in assessment and approach to management of anxiety in the older person. Comprehensive assessment of anxiety symptoms requires consideration of physical, intellectual, environmental, and social determinants. Major anxiety disorders, as defined by DSM-IV, and anxiety symptoms are significant problems in the older adult population and are responsible for significant morbidity and cost to the health care network.

Conclusions: Anxiety disorders and symptoms in old age, although common, have received little research focus to date. A comprehensive, careful approach by the clinician to assessment and management is required because anxiety is often a comorbid condition in the elderly. Effective treatments are available and should be applied in a flexible, integrated, and specific manner.

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Key Words: review, anxiety disorders, elderly, pharmacotherapy, psychotherapy, assessment, management

The epidemiology of anxiety disorders is not well studied in the elderly, but epidemiological data are important because they highlight for the clinician the need for awareness of significant etiological factors to be addressed in treatment. Studies to date suggest that formal anxiety disorders, as defined by the diagnostic criteria of the DSM-IV (1), seem to be less common in the elderly than in younger adults, although they are still widespread. Of these disorders, generalized anxiety disorder and phobias account for most anxiety in late life while panic and obsessive-compulsive disorders (OCD) are less prominent (2). Agoraphobia may begin in late life (3), shows a lower incidence of associated panic (4), and

is often associated with specific events such as criminal attacks, falls, or illness (5).

Geriatric psychiatry has been defined as the specialty of comorbidity. Anxiety disorders in the elderly characterize this position. Clinicians should bear in mind that new-onset anxiety in the elderly, with the exception of phobia, is routinely comorbid with physical disorder, depression, cognitive dysfunction, or personality disorder (6).

There have been no specific studies of the epidemiology of posttraumatic stress disorder (PTSD) in the general elderly population (2). Data exist for some specific subpopulations, especially war veterans, which are referenced later in the paper.

In a comprehensive review of anxiety symptoms in medically ill older patients, Hocking and Koenig concluded that 10% to 20% of older patients experience clinically significant symptoms of anxiety (7). Anxiety disorder was found in 38% of patients with early dementia and 38% of patients with Parkinson's disease; 8% of patients with chronic obstructive pulmonary disease (COPD) and 27% of patients with atypical chest pain had panic disorder. Anxiety has been found to be a significant factor in determining prognosis, length of illness, and response time to antidepressants in major psychiatric

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¹Psychiatrist-in-Chief, Mount Sinai Hospital; Associate Professor of Psychiatry, University of Toronto, Toronto, Ontario.

²Vice-Chair of Psychiatry, McMaster University; Associate Director, Educational Centre for Aging and Health, McMaster University Medical Centre, Hamilton, Ontario.

Address for correspondence: Dr J Sadavoy, University of Toronto, 600 University Avenue, Room 925, Toronto, ON M5G 1X5

syndromes such as depression (2). Symptoms of anxiety have been associated with suicide, which has its highest prevalence in the elderly. Behavioural problems and psychiatric comorbidity in individuals with dementia, including anxiety, are, in addition, associated with high morbidity in the client and caregiver and have been noted to increase rates of institutionalization (8).

Treatment Strategy

Successful treatment begins with careful diagnosis, especially as we become aware of the value of specific interventions for specific syndromes. Based on our current understanding, there are 4 key areas of diagnostic inquiry.

Medical. The clinician should carefully screen for potential contributors to or causes of anxiety symptoms. Common factors include cardiovascular diseases such as angina, myocardial infarction, atypical chest pain, or arrhythmias; dietary contributors such as excess caffeine intake or vitamin deficiencies; neurological disorders such as early dementia, Parkinson's disease, stroke, delirium, central nervous system infections or masses, toxins, or postconcussion syndromes; endocrinologic causes such as insulinoma, hypoglycemia, hypo- or hyperthyroidism, hypo- or hypercalcemia, pheochromocytoma, carcinoid syndrome, hypothermia, Cushing's disease, and hyperkalemia; sleep disorders (such as sleep apnea); anemia; systemic lupus erythematosus; and pulmonary disorders such as COPD, pneumonia, and other forms of hypoxia.

Psychiatric. Here, the clinician should examine for the presence of affective (especially depressive) disorder, dementia, psychosis, adjustment-induced or reactive anxieties (for example, moving to a new residence or encountering realistic environmental fears such as crime), or long-standing generalized or other anxieties deriving from personality traits or disorders that have taken on a new colouration associated with the stresses of old age.

Pharmacologic. In this area of inquiry, the clinician should determine whether medication or substance abuse factors are contributing to anxiety, for example, neuroleptic-induced akathisia, antidepressant-induced agitation (especially serotonin reuptake inhibitors), anticholinergic toxicity, digitalis toxicity, alcohol or benzodiazepine withdrawal syndromes, theophylline, bronchodilators, corticosteroid side effects, thyroid replacement treatments, and calcium channel blockers.

Formal Anxiety Syndromes. The specific form of anxiety is important because the treatment will vary depending on whether the focus is generalized anxiety, panic disorder, phobia, OCD, PTSD, or anxiety associated with a general medical condition.

The presentation of anxiety within a dementia syndrome deserves special comment. In order to determine the cause of anxiety, the clinician must consider a number of often-interdependent etiological factors. These include physical,

intellectual, emotional, and capacity changes, as well as environmental and social determinants, that is, PIECES (9). New-onset or recurrent physical disease, silent myocardial infarction, undiagnosed pain, or inappropriate use of prescription and over-the-counter drugs or alcohol may be the underlying reasons for the anxiety associated with dementia, and these often go undiagnosed or untreated. Recent deterioration in intellectual function due to a recurrent vascular insult can result in acute anxiety in the demented individual. Family, social, and interactional issues among caregivers and their perceptions of the reasons for the behaviour of the client may contribute to the expression of anxiety symptoms in the older individual with dementia.

Management

Following a careful diagnostic workup, clinicians must first address the underlying causes of anxiety, that is, through treatment of primary psychiatric disorders, especially depression, modification of environmental factors (such as living in a high crime area), medication review, treatment of medical disease states, and pain relief. While this approach is self-evident in the abstract, in practice clinicians often miss comorbid medical and psychiatric disorders in the elderly (10). Needless to say, attempting to treat secondary anxiety symptoms instead of a primary disorder such as depression will usually lead to treatment failure and unnecessary prolongation of the patient's suffering. A thorough workup includes a careful screening interview and appropriate ancillary laboratory, neuroimaging, or psychological tests. As in most geriatric workups, it often is important to obtain collateral information from knowledgeable family or friends. Once a diagnosis is made, treatment should be as specific as possible.

General Issues

Despite the prevalence of anxiety symptoms and syndromes in the elderly, surprisingly sparse empirical data are available to guide clinical practice. In general, because of the potentially dangerous side effects of many anti-anxiety drugs, clinicians should consider nonpharmacologic interventions first, including reassurance, education, therapeutic contact, reduced isolation, relaxation techniques, and formal psychotherapy, including cognitive-behavioural, interpersonal, and dynamic approaches. The efficacy data are still preliminary but indicate that cognitive-behavioural therapy (CBT) can be effective for panic disorder in elderly patients (11), biofeedback may be of some value for the elderly (12), as may systematic desensitization (13), stress inoculation (14), or relaxation training (15). By extrapolation from younger patients, we conclude that phobias and OCD symptoms in the elderly may also respond to exposure techniques (16). One case reports the successful treatment of chronic PTSD with eye movement desensitization (17).

Interpersonal, psychodynamic, and supportive psychotherapy techniques have not been researched, but there is no reason to suppose that these approaches will be any less

effective than in younger patients if applied appropriately. Foci of treatment include relationship therapy using coaching techniques, marital and family therapy, ventilation and reminiscence, internal conflicts (such as dependency, loss, grief, abandonment, and self-esteem issues), ego support (such as case management), and caregiver education. Because anxiety in the elderly often arises from situational sources, environmental intervention may be helpful and includes ensuring appropriate, safe living arrangements, economic support, social interaction, and predictable, stable routines (especially for the cognitively impaired).

Pharmacology as a primary or adjunctive intervention is indicated when anxiety is severe and persistent, when there is a history of prior drug treatment response, or if psychosocial interventions alone have failed. As Young and Meyers (18) suggest, pharmacologic treatment is based on a thorough understanding of the geriatric patient, accurate diagnosis, knowledge of the patient's physical health and physiological functioning, and the effects of aging on the particular patient. Normal physiological changes with aging affect drug metabolism and influence the expression of side effects and the therapeutic effect of medications (18,19).

Unwanted effects of antianxiety medications are much more common in the elderly. Important side effects of benzodiazepines include the potential for abuse, falls, daytime sedation, disinhibition, impaired cognitive function, sleep disorder, cerebellar dysfunction (for example, ataxia, dysarthria, incoordination, and gait disturbance), and slowed reaction time (19). Discontinuation of long-term benzodiazepine use may lead to withdrawal syndromes including exacerbated anxiety, restlessness, flu-like symptoms, unsteadiness, and perceptual distortion (20).

While clinical advice almost always advocates short-term use of benzodiazepines, many elderly patients seeking psychiatric care for anxiety already have been chronic users of antianxiety medications, and one-third to one-half of elderly benzodiazepine-dependant patients are unable to remain drug-free (21,22). Since tapering and discontinuation of benzodiazepines may be difficult or impossible because of patients' psychological dependency (10), clinicians are often placed in the position of maintaining geriatric patients on suboptimal drug regimens, doing their best to minimize the ill effects. Nevertheless, patients should continue to be advised to reduce or eliminate potentially harmful medications. Over time, once therapeutic trust has been established, it may be possible to motivate the patient to discontinue inappropriate drugs. In evaluating the patient's capacity to continue to tolerate a long-standing drug regimen, the clinician also must bear in mind the continuing effects of aging, that is, increasing fat storage and gradually decreasing hepatic metabolism, glomerular filtration rate, renal blood flow, and serum albumin, all of which increase the level and duration of drug action.

While long-term use of benzodiazepines by elderly patients is not uncommon, drug abuse per se does not appear to

be common in this population (23). Patients who become dependent on pharmacologic agents may experience increased anxiety if they do not have regular visits and prescriptions. All changes in treatment should be planned in advance with the patient, and therapists should avoid the temptation to threaten difficult, refractory, or demanding patients with withdrawal of medications or care.

Clinicians should expect only partial response to treatment in many cases and should educate patients accordingly. Patients should be warned about periods of recurrent anxiety and agitation and encouraged to try to ride out time-limited episodes using behavioural techniques such as distraction, relaxation, or cognitive strategies, rather than immediately turning to increased drug dosages. Pharmacotherapy should be optimized and kept to a minimum (while still using therapeutic doses), but intermittent drug regimens may be problematic, sometimes producing rebound effects such as insomnia (24), panic, or phobia (25).

Compliance in the elderly population is often difficult to achieve. It may be compromised by the memory deficits of dementia syndromes, idiosyncratic beliefs about how therapeutic drugs should work, personality-based dependency conflicts, self-medicating (with alcohol, nonprescribed medications, or excessive doses of prescription drugs) to counter sleep disturbance, or caregiver intolerance of symptoms, which sometimes leads to erratic use of medications. Consequently, medication regimens should be closely supervised. A strong therapeutic alliance facilitates compliance.

Concurrent personality disorder and anxiety symptoms pose a special challenge for the clinician. A key element in management is to distinguish personality disorder from depressive or early dementing disorders. Once the diagnosis is confirmed, the clinician should set clear limits on the patient's treatment, including frequency of visits and phone calls, timing of prescriptions, and use of emergency services. The problem of double-doctoring should be addressed directly with the patient. The treatment plan will be most effective if discussed with the patient's family and all other relevant treating physicians and pharmacists.

Choosing a Drug for Use in the Elderly

The benzodiazepines remain the most commonly used antianxiety agents for the elderly. The choice of benzodiazepine for anxiety is best made based on the side effect profile, since no benzodiazepine is more effective in moderating anxiety symptoms than another (7). The shorter-acting drugs that are metabolized by glucuronidation, such as lorazepam or oxazepam (rather than oxidation, such as clonazepam, diazepam, clorazepate, or flurazepam), are probably to be preferred, although clear-cut data are sparse (7). Alprazolam, while useful for panic disorder, may lead to rebound anxiety states and habituation and is therefore not generally preferred for the elderly. Ultrashort-acting benzodiazepines (triazolam) may produce cognitive disruptions,

such as anterograde amnesia, confusion, hallucinations, and agitation, and are contraindicated for the elderly (26).

Occasionally, longer-acting benzodiazepines may be justified, for example, in patients with daytime anxiety as well as insomnia, for whom a constant 24-hour blood level is advantageous for a limited time. The clinician must be wary of the effects of aging on the metabolism of these drugs, however, and of the potential for long-acting metabolites to produce continuing clinical effects following discontinuation.

Azaspirones, of which buspirone is now commonly available, may offer therapeutic advantages for the elderly. They have shown efficacy (27,28) and safety (29) and may be particularly useful in the elderly (30). Buspirone does not seem to potentiate alcohol, produce psychomotor driving skill or cognitive impairment, or lead to dependency (31–34). The delayed onset of action of this drug often makes it unacceptable to geriatric patients, who are accustomed to the more immediate effects of benzodiazepines. Buspirone is usually prescribed in doses of 15 to 30 mg/day and up to 60 mg/day for anxiety associated with depression (20). Steinberg recommends buspirone as the drug of choice for treatment of anxiety (35) in the elderly, but clinical experience still remains sparse, so it is premature to recommend it as the drug of first choice for routine clinical practice.

The utility of β -blockers for treatment of anxiety in the elderly remains somewhat uncertain, and data for the elderly are restricted to clinical case reports. Propranolol in small doses of 10 to 40 mg/day has been proposed for anxiety in the elderly (20) and in high doses of up to 600 mg/day for aggression associated with organic brain disease (36). Caution is necessary with nonselective β -blocker use, such as propranolol in medically ill elderly, and these drugs are contraindicated in COPD, diabetes mellitus, and congestive heart failure (37). Pindolol has been reported to be useful for treatment of behavioural problems and anxiety and agitation in dementia (38). Thymoleptics such as carbamazepine and buspirone, as well as antipsychotics, have been used to treat agitation and anxiety in individuals with dementia. The full description and the efficacy of these medications is beyond the scope of this paper, and the reader is referred to useful reviews and recent studies (39,40).

All of the antidepressants are thought to be equally effective in their impact on anxiety symptoms, especially panic, OCD, or anxiety associated with depression. Of the antidepressant classes of drugs, the selective serotonin reuptake inhibitors (SSRIs) are now the drugs of choice because of their favourable side effect profile. Even so, SSRIs may produce troublesome side effects in the elderly, including gastrointestinal upset, anorexia, weight loss, and agitation that can mimic some anxiety symptoms, insomnia, and headache. Tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs) may also be useful for some in anxiety syndromes. Of these, the secondary amines nortriptyline and desipramine are preferred because they produce fewer

autonomic and cardiotoxic side effects. MAOIs generally have fallen out of favour in the therapeutic armamentarium for the elderly. The reversible MAOI moclobemide is well tolerated by the elderly, but its utility in anxiety disorders for this age group has yet to be demonstrated in controlled trials. Trazodone, a sedative serotonergic antidepressant, may be particularly helpful for agitated states associated with dementia. Its sedative qualities also make it useful as a nighttime sedative for other anxiety syndromes, with due caution for its ability to produce orthostatic hypotension and priapism. Venlafaxine (a non-SSRI) and nefazadone (an SSRI) are newer agents not yet studied for their effect on anxiety disorders in the elderly.

Clinical experience suggests that neuroleptics are sometimes useful for severe anxiety symptoms associated with dementia, delirium, or psychosis (41), but their side effect profile makes them unsuitable for anxiety management in the elderly. Controlled trials of antihistamines as anxiolytics in the elderly have not been conducted, but because of their anticholinergic and sedative (as opposed to anxiolytic) effects, antihistamines are not generally recommended for the elderly (20). Because alcohol often produces rebound anxiety and insomnia, it too should be avoided as an anxiolytic (7). New anti-anxiety agents that are not sedating and are therefore less likely to affect cognitive functioning are in development. These include the serotonin agonists ipsapirone and gepirone and the benzodiazepine agonist suriclone (42).

Treatment of Specific Anxiety Syndromes

Mixed Anxiety and Depression

As noted previously, anxiety is very commonly associated with depression. Accurate diagnosis is crucial because when anxiety appears as a comorbid feature of depression, it is usually effectively treated by addressing the depressive disorder with antidepressant therapies (7). While pharmacologic management primarily targets the depression, because anxiety may be intense, an anxiolytic may be used concurrently and tapered as the symptoms improve. Depressive anxiety may be hard for both patient and caregivers to tolerate, and it may impel therapists to change treatment plans prematurely before adequate trials of medication or psychosocial intervention have been completed. Anxious depressed patients need a lot of support and reassurance, borrowing hope from their therapists when they are overcome by anxious despair. When psychotic features are present, low doses of antipsychotics are often warranted. In this specific circumstance, these agents can decrease anxiety symptoms, and antipsychotics combined with antidepressants are more effective in psychotic depressions than antidepressants alone. Clearly, those antipsychotics with minimal orthostatic hypotension, extrapyramidal, and anticholinergic effects are preferred.

Panic Disorder

While relatively uncommon in old age, panic disorder associated with stresses like depression, medical events, or financial or interpersonal losses may arise late in life.

Symptoms of shortness of breath and chest pain may lead to early diagnostic confusion (43).

Unfortunately, there are no pharmacologic treatment studies specific to the elderly, so we must extrapolate from the general adult data. The SSRIs have shown efficacy in the treatment of panic disorder (44,45), adding to earlier studies demonstrating efficacy for tricyclics, MAOIs, and benzodiazepines. All appear equally effective, so the choice of agent should be based on patient tolerance and side effect profile. Based on these criteria, the SSRIs are currently the drugs of choice for the elderly (37). As noted previously, preliminary data from Swales and coworkers (11) have shown that CBT may also be an effective specific treatment intervention for panic disorder as demonstrated in their study of a white, predominantly female, young-old sample of self-referred patients. The treatment combined breathing, relaxation, and cognitive procedures, and treatment benefits were maintained at 3-month follow-up (11).

General management principles as described earlier should be used to maximize treatment effects, that is, education and life style coaching, avoidance of exacerbating chemicals such as caffeine, alcohol, and other stimulants, family coaching, and development of a therapeutic alliance and trust.

OCD

OCD is less common in the aged than in younger populations, but it is still an important clinical problem, with an estimated prevalence of 0.8% in those over 65. The annual incidence seems to rise in older women, and more OCD symptoms are found in institutionalized elderly (2). OCD is often associated with depression, and symptoms of OCD may persist after resolution of the depressive episode (46). As with other anxiety disorders, the symptom picture of OCD is often mixed with other anxiety disorders such as panic disorder, generalized anxiety disorder, and phobias (47), or with alcohol abuse (48).

Because there are no controlled studies, treatment of OCD in the elderly is generally extrapolated from studies of younger populations. SSRIs are the drugs of first choice for OCD (37,46). Of these, fluvoxamine and fluoxetine have shown greatest efficacy. The appropriate dose of these agents for treating OCD in the elderly has not been established. Younger patients generally require a higher dosage range for OCD. The efficacy of paroxetine, nefazodone, and venlafaxine in treatment of OCD in the elderly has not yet been established, and the evidence for the efficacy of sertraline for OCD in younger patients has been conflicting (46). Clomipramine has not been systematically studied in the elderly. Although effective for OCD in younger patients, its use in the elderly may be more limited by anticholinergic, antihistaminic, sedative, and sexual dysfunction side effects. The hypothesized efficacy of SSRIs for OCD in the elderly is supported by individual case studies demonstrating the efficacy of fluoxetine in combination with lithium (49) and behaviour therapy (50). There is one case report of the

successful treatment of a 66-year-old woman with OCD symptoms using venlafaxine (51).

There are a few case reports of successful treatment of elderly patients with OCD symptoms using psychological interventions. These include psychodynamic psychotherapy (52) and exposure and response prevention either combined with medication (53) or used alone (54). Electroconvulsive therapy may be useful for OCD symptoms associated with depression (55).

In summary, elderly patients may present with OCD symptoms. These conditions are probably responsive to SSRIs and clomipramine, but they require adjustment of dosage and monitoring procedures. Modified CBT interventions may also be effective. The clinical cases that are discussed in the literature often describe mixed clinical pictures of OCD with comorbid depression, psychosis, bipolar disorder, phobia, or hypochondrias. Since mixed symptom pictures appear to be the norm, treatment will be most effective if it is administered flexibly, with due regard for the need to treat more than one set of target symptoms concurrently.

Phobias

Most epidemiological data support the contention that phobias are very common among the elderly and may present for the first time in old age, generally associated with a triggering event such as falling, physical attack, or medical illness (2). While treatment studies in the elderly are lacking, the stress-related onset of these disorders, especially of specific phobias, makes them amenable to psychological interventions. CBT has been recommended as the treatment of choice for phobias in combination with benzodiazepines (for specific phobias) and β -blockers or MAOIs (7,37). A key element in management is a high index of diagnostic suspicion, since these disorders are often hidden and subtle in their presentations (56). Phobic elderly patients often feel shame, isolation, and excessive dependence on caregivers. Psychiatrists should educate front-line practitioners, especially family doctors, about the need for careful inquiry about phobic disorders, since they can be quietly disabling to the geriatric patient.

Generalized Anxiety Disorder

Epidemiological data suggest that most elderly patients with generalized anxiety disorder have had their symptoms for many years (2). Hence management often requires judicious, long-term intermittent or continuous therapy. Generalized anxiety disorder is best managed by a combination of psychosocial measures and pharmacotherapy. At the current state of knowledge, it is not possible to advocate one form of psychotherapy over another, although some clinicians favour CBT (7,37). As noted previously, short-acting benzodiazepines are the drugs of choice. Typical geriatric dosages include: lorazepam 0.5 to 3 mg/day, oxazepam 15 to 30 mg/day, and temazepam 7.5 to 15 mg/day. Buspirone may also be an effective agent in this condition.

PTSD

The literature on PTSD in the elderly focuses almost entirely on survivors of earlier-life trauma, for example, victims of the Holocaust or combat veterans. These studies reveal the enduring nature of chronic PTSD symptoms (57,58), their frequency among subpopulations of the elderly such as war veterans (59), and the potential for serious reactivation of symptoms in late life (60–69). Based on current data, management requires history from collateral sources, physical evaluation, examination of the nature, duration, intensity, and context of the trauma, sleep patterns, and interpersonal functioning. Medication studies have not been done for PTSD in the elderly. In younger populations, however, partial benefits have been demonstrated from tricyclic and MAOI antidepressants, especially in diminishing nightmares and intrusive thoughts (70), and fluoxetine has been effective for avoidant symptoms (71). Other potentially useful drugs include propranolol, valproate, and carbamazepine (72,73). Psychotherapy begins with establishing a climate of trust and safety (74); successful techniques include group therapy with war veterans (75) and family therapy (76). CBT has shown some efficacy in younger patients, as has brief psychotherapy (77). Sadavoy has written a comprehensive review on the late-life psychological effects of earlier trauma (78).

Conclusion

As is true of most other psychiatric illnesses in the elderly, anxiety disorders are often underrecognized and ineffectively treated. While systematic treatment studies are sorely needed for anxiety disorders in the elderly, we can tentatively conclude from current data that the elderly are responsive to a variety of specific interventions for the various forms of anxiety disorder, including shorter-acting benzodiazepines, buspirone, SSRIs, tricyclics, MAOIs, and β -blockers, as well as psychological and behavioural techniques, often in combination. Some anxiety disorders may respond relatively quickly, but late-life anxiety frequently requires longer-term management. Diagnosis is often complex, requiring a multifocal approach, with special care taken to evaluate medical and social conditions and incorporate their effect into the treatment plan. Specific diagnosis is essential. Since depression in the elderly may easily be misdiagnosed as anxiety, there is a tendency for clinicians to treat anxiety when it is the underlying depression that really requires management.

The field is wide open for this critical research, since there are almost no controlled treatment studies of pharmacologic, psychosocial, or psychotherapeutic interventions for anxiety in this age group. The limited data tend to treat anxiety in the elderly as a homogenous disorder, without sufficient regard to the variety of etiologies, symptom pictures, and comorbidities that are the norm in aged patients.

Clinical Implications

- New-onset anxiety disorders in the elderly are routinely comorbid with a physical, other psychiatric, or cognitive disorder. Specific diagnosis is essential.
- Clinicians should consider nonpharmacologic interventions first because of the often dangerous side effects of many antianxiety agents.
- Treatment of late-life anxiety disorders often requires long-term management.

Limitations

- Data on treatments specific for anxiety in the elderly are sparse.
- While formal abuse is not common, elderly chronic users of antianxiety medications very often are unable to relinquish their medications.
- Unwanted side effects of antianxiety medications are much more common in the elderly.

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Résumé

Objectif : Effectuer un examen et une synthèse de l'état actuel des connaissances sur les troubles anxieux et leurs symptômes chez les personnes âgées.

Méthodes : La recherche en cours a été répertoriée au moyen de MEDLINE et de références d'articles extraites de manuels clés et d'autres documents. Ces données s'ajoutent aux connaissances et à l'expérience cliniques et empiriques des auteurs.

Résultats : Les troubles et les symptômes d'anxiété constituent un problème qui se pose fréquemment chez les personnes âgées. Les connaissances et les résultats de recherche actuels sont restreints. L'extrapolation à partir d'études menées chez des adultes est d'une certaine utilité, mais on constate de grandes limites étant donné la nature, la spécificité et la complexité du patient gériatrique en psychiatrie. La comorbidité, surtout quand elle est associée à la dépression, à des pathologies, à des médicaments et à la démence, demeure un aspect important de l'évaluation et de l'approche du traitement de l'anxiété chez la personne âgée. L'évaluation exhaustive des symptômes d'anxiété exige la prise en compte de déterminants physiques, intellectuels, environnementaux et sociaux. Les troubles anxieux majeurs, selon les définitions du DSM-IV, et les symptômes d'anxiété constituent des problèmes de taille dans la population adulte âgée, et ils sont responsables d'une morbidité et de coûts importants pour le réseau des soins de santé.

Conclusions : À ce jour, les chercheurs n'ont pas beaucoup mis l'accent sur les troubles et les symptômes d'anxiété malgré leur fréquence au cours de la vieillesse. Le clinicien doit emprunter une approche exhaustive et prudente parce que l'anxiété est souvent un état comorbide chez les personnes âgées. Il existe des traitements efficaces qui devraient être administrés de façon souple, intégrée et spécifique.