

Factsheet

Anxiety disorders and depression in older people

Contents

<u>Definition</u>	2
<u>Prevalence and incidence</u>	2
<u>Signs and symptoms</u>	2
<u>Causes/risk factors</u>	3
<u>Pathophysiology (mechanism of disease)</u>	3
<u>Prognosis and complications</u>	4
<u>Diagnosis/detection</u>	4
<u>Pharmacological treatment</u>	5
<u>Non-pharmacological treatment</u>	7
<u>Patient support</u>	8
<u>Further resources</u>	8
<u>External websites</u>	9
<u>References</u>	9

Definition

Depression is characterised by persistent low mood and/or loss of pleasure in most activities, and a range of associated emotional, cognitive, physical and behavioural symptoms. 'Subthreshold depressive symptoms' is a term used to describe a situation where someone has some of the symptoms of depression but they do not meet the full criteria to diagnose depression. If subthreshold depressive symptoms last for more than two years, this is described as 'persistent subthreshold depressive symptoms'.¹

Anxiety is a symptom that is associated with a range of disorders, such as generalised anxiety disorder (GAD), post-traumatic stress disorder (PTSD) and social anxiety disorder.² Anxiety, although experienced by most people, does not usually develop into an anxiety disorder. Transient anxiety is normal. However, when anxiety starts to affect daily life, this indicates a problem.

Anxiety disorders are commonly unrecognised or undiagnosed. When anxiety disorders coexist with depression, the depressive episode may be recognised but the underlying anxiety disorder may be overlooked.³

Depression and anxiety or anxiety disorders are commonly experienced together in some form, but can also be experienced separately.⁴ There are several terms used to describe the combination of depression and anxiety, including mixed anxiety and depressive disorder and depressive anxiety.

[Return to contents](#)

Prevalence and incidence

Around 1 in 20 adults will experience depression, and the prevalence of depression increases with age.⁵

Depression is recognised as the most common mental health condition in the elderly; in England, depression affects 22 percent of men and 28 percent of women aged 65 or over.⁶

Although underdiagnosed, it has been reported that anxiety disorders are the most prevalent psychiatric disorder,⁷ with GAD being the most prevalent.³ For this reason, we will focus on GAD when considering anxiety for the remainder of this fact sheet. For more information about other anxiety disorders, access the National Institute for Health and Care Excellence (NICE) quality standard **Anxiety disorders [QS53]**. The *Introduction* section links to a topic overview which references relevant NICE guidance.

[Return to contents](#)

Signs and symptoms

Signs and symptoms of depression include:

- feeling down, depressed or hopeless
- lack of enjoyment
- reluctance to engage in usual activities or to leave the house
- tiredness and loss of energy
- difficulty concentrating
- insomnia or hypersomnia
- changes in weight and appetite
- loss of confidence
- inappropriate guilt
- feelings of worthlessness

Factsheet

Anxiety disorders and depression in older people

- agitation
- suicidal thoughts or actions.^{8,9}

To hear from a patient about his experience of clinical depression and its symptoms, visit the NHS page ***Clinical depression*** and scroll down to watch the video *Lawrence's story*.

Symptoms of acute anxiety include:

- restlessness
- irritability
- tachycardia
- dry mouth
- nausea
- sweating.⁹

The symptoms of acute anxiety may be experienced by people with GAD, but for prolonged periods; emotional symptoms are also likely to be present.

To learn more about anxiety, visit the NHS page ***Generalised anxiety disorder in adults*** and watch the video to hear a psychiatrist discuss the symptoms and treatments of anxiety.

[Return to contents](#)

Causes/risk factors

Risk factors for anxiety include psychosocial issues (eg, unemployment), genetic factors, personality, previous head injury, chronic pain syndromes, cardiovascular disease and chronic comorbidities, such as ***Type 2 diabetes*** and ***Chronic obstructive pulmonary disease (COPD)***.¹⁰

Factors that may increase the risk of depression include history of depression, recent childbirth, adverse childhood experiences and medicines.¹¹

Depression is two to three times more common in patients with a chronic physical health problem than in those with good physical health, occurring in about 20 percent of people with a chronic physical health problem.¹² It has also been reported that anxiety and depressive disorders are highly prevalent in the elderly, and this often relates to other health conditions.¹²

[Return to contents](#)

Pathophysiology (mechanism of disease)

The pathophysiological mechanisms of depression and anxiety disorders are not well understood. It is recognised that monoamines (serotonin, noradrenaline and dopamine) play a role in depression and its treatment, but it has become clear that there are other factors which likely also contribute. Similarly, for anxiety disorders, monoamines are thought to play a role, in addition to the inhibitory neurotransmitter gamma-aminobutyric acid (GABA).

For more information on the pathophysiology of depression, read the *Dialogues in Clinical Neuroscience* article ***Pathophysiology of depression and mechanisms of treatment***.

For more information on the pathophysiology of anxiety disorders, read the *International Journal of Pharmacy and Pharmaceutical Research* article ***Understanding the pathophysiology and management of the anxiety disorders***.

[Return to contents](#)

Prognosis and complications

Depression

Depression can exacerbate the pain, disability and distress associated with a range of physical diseases. It can also increase mortality in a range of comorbid conditions, including coronary artery disease, and is associated with an increased risk of substance misuse.

The risk of suicide in people who are depressed is higher compared with the general population. Depression also impairs normal functioning, which can lead to employment problems, neglect of dependants, family problems and relationship break-ups.¹²

With treatment, episodes of depression last about three to six months and most people recover within 12 months.¹³

The risk of recurrence is high and increases with every episode. Approximately 80 percent of people who receive psychiatric care for an episode of major depression will have at least one more episode and a median of four more in their lifetime. The prognosis is worse for those with psychotic features, prominent anxiety, personality disorders and severe symptoms.¹¹

GAD

Complications include serious disability and impaired quality of life, impaired social and occupational functioning, increased risk of major depression, social anxiety disorder, and alcohol and drug misuse.

Physical health problems are more common in people with GAD. These include chronic pain syndromes, asthma or chronic obstructive pulmonary disease, and inflammatory bowel disease.

Suicidal ideation and attempts are also more prevalent in people with GAD compared with the general population, and this risk increases further in those who also suffer from major depression.¹⁵

[Return to contents](#)

Diagnosis/detection

There are multiple different criteria which can be used to detect and diagnose both depression and anxiety disorders. These criteria explore a person's feelings, assess whether there are any other symptoms present and determine how long they have been experiencing these symptoms.

For both depression and anxiety disorders, there are multiple differential diagnoses. For GAD, these include other types of anxiety disorders, long-term health conditions such as cardiac and pulmonary disease, and medicine-induced anxiety and depression.¹⁶ For depression, these include grief, dementia, bipolar disorder, premenstrual dysphoric disorder, hypothyroidism, obstructive sleep apnoea syndrome and adverse reactions to substances (eg, carbon monoxide, medicines and illicit substances).¹⁷

Depression

Current NICE guidance recommends the following, for more detail see the International classification of diseases-11 (ICD-11) or the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) for depression.

Factsheet

Anxiety disorders and depression in older people

For more on the diagnosis of depression and the DSM-5 criteria, visit NICE clinical knowledge summary ***Depression – Diagnosis*** and NICE clinical guideline ***NICE guideline on depression in adults: treatment and management [NG222]***.

NICE also offers clinical guideline ***Depression in adults with a chronic physical health problem: recognition and management [CG91]***.

Anxiety disorders

NICE guidance recommends using the DSM-IV to assess GAD,¹⁸ but this has now been superseded by the DSM-5. The GAD questionnaires GAD-2 and GAD-7 can be used to assess a person's symptoms and determine the severity of GAD.

For more on the diagnosis of GAD and its assessment using GAD-2 and GAD-7, visit NICE clinical knowledge summary ***Generalized anxiety disorder – Diagnosis***.

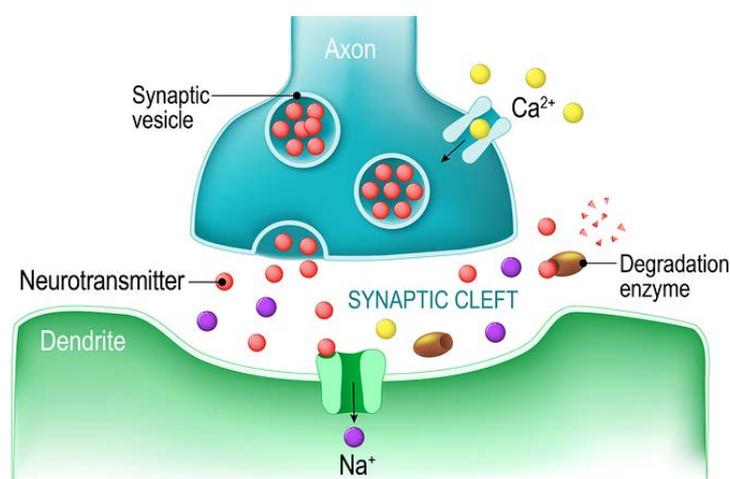
[Return to contents](#)

Pharmacological treatment

One of the key aims of pharmacological treatment for both depression and GAD is to increase levels of the monoamine neurotransmitters in the brain's neuronal synapses – the junctions between nerve cells (neurons). Additionally, in GAD, the inhibitory GABA neurotransmitter plays a role in and is a target of pharmacological treatment.

To understand how this effect is achieved, we need to understand the way neurotransmitters act at a neuronal synapse.

The image below shows a synapse.



In very simple terms, electrical signals travel down the axon of the presynaptic nerve towards the synaptic cleft. When they reach the synaptic cleft, they cause synaptic vesicles, which contain neurotransmitters, to merge with the cell wall and release the neurotransmitters into the synaptic cleft. These neurotransmitters bind to receptors on the dendrite, which is part of the postsynaptic nerve, and cause another electrical signal to travel down the postsynaptic neuron, passing the message along the nervous system.

The neurotransmitters are then left in the synaptic cleft. At this point, they may diffuse away; be taken back into the presynaptic nerve by transporter proteins, in a process called reuptake; or be degraded by enzymes.

Antidepressant medicines work to increase the number of neurotransmitters that are left in the synaptic cleft.

There are three main classes of antidepressants:

Selective-serotonin reuptake inhibitors (SSRIs)

The primary action of the SSRIs is to inhibit the serotonin reuptake transporter, and therefore inhibit the reuptake of serotonin into the presynaptic neuron, increasing the amount available to bind to the receptors of the postsynaptic neuron.

Medicines in this group include citalopram, escitalopram, fluoxetine, paroxetine and sertraline.¹⁹

Serotonin and noradrenaline reuptake inhibitors (SNRIs)

The primary action of the SNRIs is to inhibit the serotonin and noradrenaline reuptake transporters, and therefore inhibit the reuptake of serotonin and noradrenaline into the presynaptic neuron, increasing the amount available to bind to the receptors of the postsynaptic neuron.

The most commonly used medicines in this group are duloxetine and venlafaxine, which are also recommended for the treatment of GAD.¹⁹

Tricyclic and related antidepressants

The primary action of the tricyclic and related antidepressants is similar to that of the SNRIs, ie, inhibiting serotonin and noradrenaline reuptake.

This group of antidepressants is now less commonly seen in practice. They have a high anticholinergic burden and can cause a decrease in cognition. They also have a high incidence of side effects, particularly in the elderly. The group includes amitriptyline, clomipramine, dosulepin, doxepin, trazodone, imipramine, lofepramine and nortriptyline.¹⁹

Doses of both SSRIs and tricyclic and related antidepressants are reduced in elderly patients, particularly at initiation. Refer to individual summary of product characteristics (SPCs) for starting doses, titration and maximum doses in the elderly.

Monoamine oxidase inhibitors (MAOIs)

The primary action of MAOIs is to inhibit the activity of the monoamine oxidase enzyme, which breaks down the monoamine oxidases, increasing the amount available to bind to the receptors of the postsynaptic neuron.

Again less commonly seen in practice, this group includes tranylcypromine, phenelzine, isocarboxazid and moclobemide.¹⁹

Antidepressants all have different risks and benefits. This is summarised in the *British National Formulary (BNF)* under the **Antidepressant drugs** treatment summary.

It should be noted that the use of antidepressants has been linked with suicidal thoughts and behaviour; children, young adults and patients with a history of suicidal behaviour are particularly at risk.¹⁹

GAD and GABA

To learn more about the action of GABA and its role in GAD, access the following *Neuropsychiatric Disease and Treatment* article **Anxiety disorders and GABA neurotransmission: a disturbance of modulation**.

Medicines used in GAD that affect GABA include:

- pregabalin, which is a structural analogue of GABA
- benzodiazepines, which increase the action of GABA at the GABA receptors, although these should **not** be offered for the treatment of GAD in primary care, except as a short-term measure during crises.²⁰

More information about choice of treatments for depression and GAD can also be found in the following NICE guidelines and summaries:

- NICE clinical guideline **NICE guideline on depression in adults: treatment and management [NG222]**
- NICE clinical guideline **Generalised anxiety disorder and panic disorder in adults: management [CG113]**
- NICE clinical knowledge summary Depression – Management
- NICE clinical knowledge summary **Generalized anxiety disorder – Scenario: management**
- NICE clinical guideline **Implanted vagus nerve stimulation for treatment-resistant depression [IPG679]**
- NICE Interventional procedures guidance **Transcranial magnetic stimulation for obsessive-compulsive disorder [IPG676]**

[Return to contents](#)

Non-pharmacological treatment

The non-pharmacological treatment of depression is complex. It involves:

- managing comorbidities, such as alcohol and substance misuse, anxiety, psychotic symptoms, eating disorders and dementia
- the provision of information about depression and active monitoring with planned follow-up
- offering appropriate psychological intervention such as individual guided self-help, computerised cognitive behavioural therapy (CCBT) or group-based peer support, or the more intensive group-based or individual cognitive behavioural therapy (CBT).²¹

The management of GAD is similar, with a stepwise approach being recommended.

More information about the non-pharmacological management of depression and GAD can be found in NICE guidelines and summaries, which are linked to above.

To hear older people talking about psychological interventions, watch the following video by Age UK:

Factsheet

Anxiety disorders and depression in older people

Older people explain how talking treatments have helped them



For those who are suffering from a mental health crisis and are at risk of suicide, the crisis resolution and home treatment (CRHT) team may need to be contacted for an urgent assessment. More information about mental health crises and the CRHT team can be found on Mind's website:

- **How to get help in a crisis**
- **Crisis services and planning for a crisis**

[Return to contents](#)

Patient support

For general support, the following websites offer information about depression and anxiety:

- **Mind**, the mental health charity
- NHS, **Generalised anxiety disorder in adults**
- NHS, **Clinical depression**
- NHS, **Mental health** and **Support groups – clinical depression**

Support for older people can be found on the following websites:

- Royal College of Psychiatrists, **Depression in older adults**
- Age UK, **Depression and anxiety**

[Return to contents](#)

Further resources

NICE quality standard **Mental wellbeing of older people in care homes [QS50]** 'covers the mental wellbeing of older people (aged 65 and over) receiving care in care homes (including residential and nursing accommodation, day care and respite care). It focuses on support for people to improve their mental wellbeing so that they can stay as well and independent as possible. It describes high-quality care in priority areas for improvement'.²²

The following video from the NICE news article **New video to support mental wellbeing of older people in care homes quality standard** supports this quality standard:

Factsheet

Anxiety disorders and depression in older people



Visit CPPE's **Mental health** gateway page for further learning on mental health in general.

An overview of all NICE products on depression, including any guidance, advice, NICE pathways and quality standards, can be found on the NICE **Depression** page.

An overview of all NICE products on anxiety, including any guidance, advice, NICE pathways and quality standards, can be found on the NICE **Anxiety** page.

[Return to contents](#)

External websites

CPPE is not responsible for the content of any non-CPPE websites mentioned in this fact sheet, or for the accuracy of any information found therein.

All web links were accessed on 1 February 2023.

[Return to contents](#)

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Factsheet

Anxiety disorders and depression in older people

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[Return to contents](#)

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