Seniors' anxiety: Underdiagnosed and undertreated

Although complaints about anxiety are common among older persons, late-life anxiety disorders have been underestimated. Older persons tend to emphasize their physical complaints and are less likely to report psychiatric symptoms.[1] This article focuses on generalized anxiety disorder, which is characterized by chronic uncontrollable worry that interferes with functioning and is accompanied by restlessness and disturbed sleep.[2] However, it's important to also consider conditions such as social anxiety disorder, specific phobias (e.g., fear of falling), panic disorders, and posttraumatic stress disorder.[3]

Prevalence of anxiety disorders in later life varies significantly based on different methodologies and may not fully capture the nature of anxiety in older people, especially among ethnic and racial minority groups. Overall, anxiety disorders are more common in later life than depression, with estimated rates ranging from 1.2% to 7.3% for 6- and 12-month prevalence respectively, and up to 11% for lifetime prevalence.[4] Using MSP billing data, anxiety codes account for only 0.6% of family practice and 1.5% of psychiatry billings for individuals 60 years of age and older, signaling that anxiety is not usually billed as a primary diagnosis for physician visits, possibly reflecting underdiagnosis or a secondary diagnosis.[5]

Physicians, especially frontline primary care providers, need to recognize the prevalence of anxiety, as many people go their entire lives normalizing it without seeking help. Treating anxiety can be life-changing, making it crucial for overall well-being. Physicians should be aware of red flags such as new panic attacks in older adults, which are less common later in life, and should rule out other medical causes that can cause or mimic anxiety (e.g., paroxysmal atrial fibrillation, hyperthyroidism, tumor).[6]

Anxiety disorders in older adults are associated with increased physical disability, poorer quality of life, higher use of health services, greater risk of depression, cognitive impairment, and dementia.[4] Older adult worries usually relate to later-life issues such as health care costs, loss of loved ones, retirement, caregiving responsibilities, and end-of-life planning.[4]

When nonmedication options are ineffective or not feasible, the first-selected pharmacotherapy is selective serotonin reuptake inhibitors or serotonin-norepinephrine reuptake inhibitors. Despite the specific risks, which are higher in the elderly, like syndrome of inappropriate antidiuretic hormone secretion, falls, and bleeds, use of these medications, as well as pregabalin, can be beneficial in certain cases to improve quality of life and function. As per the classic geriatric adage, start low and go slow, but "go" is key, as medications need to be titrated to useful doses to be effective.[6] The risk-benefit ratio of benzodiazepine pharmacotherapy in elderly patients is not favorable.[7] Also, reduce dosage of or discontinue potentially anxiety-inducing medications while monitoring for suicidal ideation and symptom change.[7]

COVID-19 has disrupted the lives of many BC seniors with increased social isolation, contributing to anxiety. However, relying on social prescribing alone is insufficient to address this issue. Creating genuine social connections in the community is crucial to combat anxiety in seniors, but this falls beyond the scope of this article. The first step is recognizing and treating anxiety in seniors to help them thrive. National Seniors Day is 1 October! I encourage readers to share their strategies to combat seniors' anxiety. ■

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Resources for seniors' anxiety:

- Anxiety Canada's website (www.anxietycanada.com) and free MindShift CBT app (www.anxietycanada.com/resources/mindshift-cbt)
- CBT Skills Groups program for BC patients (https://cbtskills.ca/physicians)
- Mindful:
  - "How to shift direction when you feel stuck" (www.mindful.org/how-to-shift-direction-when-you-feel-stuck)
  - "Stressing Out? S.T.O.P." (stop, take, observe, proceed), creating space in the day to come down from a worried mind (www.mindful.org/stressing-out-stop) and video (www.youtube.com/watch?v=EiuTpeu5xQc)
- *Australian Family Physician*, "Acceptance and commitment therapy: Pathways for general practitioners" (www.racgp.org.au/afp/2012/september/acceptance-and-commitment-therapy)
- *Gerontologist*, "Self-compassionate aging: A systematic review" (https://self-compassion.org/wp-content/uploads/2019/09/Brown2018.pdf)
- American Association for Geriatric Psychiatry, "Anxiety and older adults: Overcoming worry and fear" (www.aagponline.org/patient-article/anxiety-and-older-adults-overcoming-worry-and-fear)
- Canadian Coalition for Seniors' Mental Health, "Anxiety in older adults" (https://ccsmh.ca/projects/anxiety)

sake of everyone's broader education; the children's formal schooling continued by correspondence.

As a person, Daniel was steady, gentle, kind, generous, humble, faithful, attentive, empathetic, and considerate. He was also detailed, patient, caring, understanding, knowledgeable, and thorough, and he had a fine sense of humor. The sum of these characteristics, though, added up to sometimes being unaware of the clock or the passage of time.

As a family doctor, Daniel was adored by both adults and children. His reassuring attentiveness and kindliness, and his maturity in handling ill, worried people, are now often missing from the busy profession of medicine. The fact that he took time to deal with people meant that others would be waiting, but just the same, he was a favorite.

Daniel was a natural educator. Teaching, personal contact, communicating, and educating are a necessary part of a good physician's life and work. Daniel was awarded and accelerated in his career to associate clinical professor in the UBC Department of Family Practice. He mentored many students and family medicine residents and used his skills and experience to explain, demonstrate, and satisfy his patients' questions and concerns. He used these same skills in dealing with family, friends, and foes—if he had any.

To illustrate how thorough he could be, included is a line drawing of an injection procedure **[Figure 1]**. Over the years he built a catalogue of such drawings that he used to teach patients and students, accompanied by a session on anatomy, indications, and expected results. His art went further afield when he submitted a drawing **[Figure 2]**, that he thought would be a perfect symbol engraved on the Canadian loonie to symbolize the Canadian West.

Daniel Froese—BSc, MD, FRCFP, associate professor—was one terrific person, family man, teacher, exemplary physician, and model family doctor/geriatrician. He worked hard, played hard, and lived life to the fullest. To say he will be missed is almost trite. We need more like him in our health care system. ■

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functional goals so they can participate in the activities that give life meaning, including work. You can make a difference by starting the conversation about clinical and vocational recovery early, underscoring the importance of them staying in touch with their workplace, and discussing what they are able to do.

If you have questions about how WorkSafeBC can support a patient's vocational recovery, contact us using the RACE service (phone or app) or request a callback on the Physician's Report (Form 8/11). ■

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