



## National ECHO Care of the Elderly: Mental Health

### Session 1: Anxiety Disorders in Older Adults

**Disclaimer:** All information is provided by healthcare providers working in Canada in the area of mental health of older adults. All identifying information including names of individuals, organizations, or locations have been removed for privacy.

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**Question 1:** Given that we're in this pandemic, is there any evidence from previous pandemics or health crises that have resulted in PTSD in the elderly population? Is this pandemic going to lead to trauma in the long run in the sense of Post Traumatic Syndromes?

**Answer:** I am not aware of anything specific about PTSD, and people being traumatized but there is emerging work about how older people are dealing with this in terms of their mental health, and what is actually being shown is that older people actually are more resilient than younger people and most of this is survey work that is being done, some of it is better quality than others. But the work that is being done showed that during the first wave of the pandemic last year, there was more of a sense of uncertainty about what was going on. I think some people were rising to the challenge and for some older people there was a sense of resilience in terms of being able to adapt and cope. What is being shown from surveys now towards the end of the year now, is that there are some things developing and one of them is that people are just getting fed up. Especially amongst older people, the sense of detachment now from close family members, especially grandchildren, and not being able to have that degree of social contact is leading to a degree of demoralization. But there is no evidence that older people are actually more anxious or more depressed than younger people, and in fact, probably less so. And partly, obviously, this is a lifestyle issue in that older people's lives may have been less disrupted than younger people because the social changes may not have been as disruptive apart from some of the key things I mentioned. But things like employment, for example, the breadth of their social circles may have been narrower and so on, and maybe it is not so much in terms of financial insecurity as younger people losing their jobs. But I think older people are resilient, and I think many, many surveys have shown this and this is one cycle at what's been called Psychological Immunization, that as people get older, they just become more resilient to stressful things and more wise, and wisdom is certainly part of this to help them cope better. So there is no doubt that people are suffering, but I just do not know that the data would suggest that older people are more at risk than younger people.

**Question 2:** Can you comment on paradoxical increase in anxiety with benzodiazepines? So a paradoxical response?

**Answer:** This is an old term that people used to talk about paradoxical anxiety in response to benzodiazepines and probably what was being described was actually people withdrawing from

benzodiazepines and anxiety mounting, especially with the use of short-acting benzodiazepines, or some of the ultra short-acting ones that are being used at nighttime as sleeping medicines. In the middle of the night or early in the morning people would start getting insomnia and rebound anxiety symptoms and the reason you get rebound anxiety is because if people start taking anxiolytics on an ad-hoc basis. So, rather than sticking to a schedule, for example, if one is talking about Lorazepam and taking half milligram twice a day, they start taking an extra dose of Lorazepam at other times of the day. Then it becomes an erratic adherence and people become tolerant to the effects and they start getting rebound anxiety or exacerbations of the underlying condition. I don't think benzodiazepines themselves paradoxically worsen anxiety. I think what is happening is that it is a poor control of anxiety, especially in people who have become tolerant to the effects. People can become tolerant to the effects of benzodiazepines quite quickly, within a matter of weeks, and then they start wanting to increase the dose to get the same benefit they did when they had first started the drug.

**Question 3:** You said that phobias start early in life, what starts the phobia? Does something have to happen first?

**Answer:** Yes it does. Just to clarify, it depends which phobia. So a specific phobia tends to start early in life and rarely begins later in life. Agoraphobia can certainly start later in life in response to someone who has had like a bad fall, and then they become housebound because they do not want to risk leaving the home for fear of another fall or if someone has had a heart attack and they become fearful of exercising too much or exerting themselves too much out of the home for fear of having another heart attack. With respect to specific phobias, those tend to happen in childhood and they tend to happen in anxious families. There tends to often be an anxious parent who models the phobic behavior and then the child basically becomes conditioned to having phobic behavior as well so that what has been found is that it often is modeling behavior. There is some genetic vulnerability to specific phobias as well but there is certainly a familial aspect to it.

**Question 4:** Is there any evidence regarding oral swabbing for enzymes contributing to drug metabolism?

**Answer:** There's nothing I'm aware of with respect to pharmacogenomics in terms of its use to guide practice with anxiety. But certainly in depression, there have been some studies recently where the cost effectiveness of doing that is very debatable. Those studies have essentially looked at whether just regular care, or basing treatment decisions based on genetic testing in terms of how these drugs are metabolized, leads to improved outcomes. The cost effectiveness I think is very debatable and also just in terms of health outcomes. Although some studies have found a statistically significant difference, the actual clinically significant difference in outcomes is really not that great at all. I think where it can be helpful is when you've been trying treatments, and you've got people who seem to be extremely sensitive to very, very low doses of a variety of drugs, it is then useful to find out whether those people tend to be very poor metabolizers across a range of enzymes. Then there is the other group, the extreme group of people who don't seem to get better with anything, and you've pushed the drug to the limit with the maximum doses and they don't seem to be getting any side effects. These people are



what we call Ultrarapid Metabolizers, where they're just metabolizing not everything, but a lot of drugs at a very rapid rate so the actual plasma level in the bloodstream is way lower than the average person would get in an equivalent dose. I think they can be helpful from that point of view. Just as a start off, as a general way of practicing, I don't think the data really supports it as a general approach. There's a lot of marketing involved these days around this, especially in the US, but I don't think the data supports it.

This testing is very expensive; several hundred dollars.