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Psychosocial treatment of late-life generalized anxiety disorder: Current status and future directions

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Abstract

Although generalized anxiety disorder (GAD) was once an understudied illness, there has been an increase in research on the disorder over the past several years. A subset of studies has focused on the psychosocial treatment of late-life GAD. It was initially expected that cognitive behavior therapy (CBT) would prove to be the most effective treatment for GAD in the elderly. Although group format CBT has outperformed no-treatment control conditions in some studies, the existing body of work does not clearly indicate the superiority of CBT over alternative interventions [e.g., supportive therapy (ST)]. Trials of individual format CBT have tested augmented or otherwise nonstandard versions of the therapy. Therefore, it may not be appropriate to assume a smooth transfer of CBT benefits across age groups in the treatment of GAD. This review summarizes and discusses the current state of psychosocial interventions for late-life GAD, including group and individual format CBT, limitations of existing research, and suggestions for future directions.

Keywords: Aging; Anxiety; Generalized anxiety disorder; Cognitive behavior therapy

1. Introduction

The past several years have marked an increase in research on late-life anxiety disorders. This group of studies has provided a preliminary knowledge base on anxiety in the elderly and, to a lesser degree, psychosocial treatment options. This article focuses specifically on the psychosocial treatment of late-life generalized anxiety disorder (GAD), which is one of the most commonly diagnosed disorders in older adults (Stanley & Novy, 2000). Recent estimates of prevalence of GAD in older adults range from 0.71% to 7.10% (Flint, 1994), indicating that it is a considerable mental health issue that warrants continued

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attention from researchers and clinicians. Given that medication is currently the first-line treatment for late-life anxiety (Blazer, George, & Hughes, 1991) and that older adults are at increased risk for side effects and drug–drug interactions (Krasucki, Howard, & Mann, 1999; Sheikh & Cassidy, 2000; Wengel, Bruke, Ranno, & Roccaforte, 1993), identification of effective psychosocial interventions should be made a priority.

Current diagnostic criteria, according to the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (*DSM-IV*; American Psychiatric Association [APA], 2001), require at least 6 months of anxiety and worry about several real-life problems, occurring more days than not. The individual must have trouble controlling the worry and must also endorse at least three associated symptoms (e.g., tension, irritability, trouble concentrating, and insomnia). The symptoms cannot be better explained by another Axis I disorder or by other conditions, such as a medical problem, and must cause clinically significant impairment or distress.

1.1. Clinical presentation in the elderly

Until recently, GAD was a poorly conceptualized and relatively understudied anxiety disorder. The diagnostic criteria for GAD have improved in terms of specificity and reliability, and phenomenology is believed to be similar between older and younger GAD patients (Beck, Stanley, & Zebb, 1996). However, there remain several unique challenges in diagnosing late-life GAD. Older adults tend to experience emotion states that are less severe and frequent than those reported by younger adults (Kogan, Edelstein, & McKee, 1999; Lawton, Kleban, & Dean, 1993). This decreased intensity may be due to age-related physiological changes such as blunted reactivity to stress (Kogan et al., 1999; Whitbourne, 1985) or decreased neurochemical reactivity (DeBeurs et al., 1999). Psychosocial contributors include cohort and mortality effects (DeBeurs et al., 1999) or the hypothesized tendency of older adults to construe emotional disorders as physical problems (Flint, 1994; Shamoian, 1991). Alternatively, Borkovec (1988) has argued that older adults may experience anxiety and worry less frequently than younger adults due to long-term habituation effects, increased coping abilities, or less anxiety about future goals. Similarly, Gross et al. (1997) argue that older adults may have emotion regulation expertise not found among younger adults, leading to less severe emotional expression. Regardless of the cause, this decrease in emotional intensity may change the clinical presentation of late-life GAD, making symptom clusters less cohesive and potentially more difficult to detect.

An additional complicating factor is that older individuals tend to present to a general practitioner for treatment, which may result in the diagnosis of a medical, rather than emotional, condition (Barlow, Lerner, & Esler, 1996; Blazer, 1997; Gurian & Miner, 1991). Indeed, several studies have found that anxiety is common in older medical patients (DeBeurs et al., 1999) and that GAD in adults of all ages is over-represented in high users of outpatient (Katon et al., 1990) and specialized medical services (Kennedy & Schwab, 1997) and in specific patient groups, such as irritable bowel syndrome (Lydiard, Fossey, Marsh, & Ballenger, 1993), cardiac problems (Logue et al., 1993), and undiagnosed medical symptoms (Lloyd, Jenkins, & Mann, 1996). High rates of psychiatric comorbidity can also obscure or complicate the detection of the disorder (Flint, 1999), as can the similarity of GAD to major depression in the elderly (Alexopoulos, 1991; Flint, 1994, 1999).

It may also be difficult to distinguish GAD from subclinical anxiety states, which are believed to be common among the elderly (Wetherell, LeRoux, & Gatz, 2003). For instance, in a recent test of the discriminant validity of a subsyndromal subtype of late-life GAD, Diefenbach et al. (2003) found that