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Anxiety Comorbidity in Older Adults with Bipolar Disorders: Overlooked and Underappreciated

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Commentary:

Older adults are a rapidly growing group world-wide. Among the elderly, anxiety disorders are among the most common psychiatric disorders but are highly under-recognized and under-treated in clinical settings. Current diagnostic criteria for anxiety disorder and symptom assessment, primarily developed upon the basis of mixed-age research samples, do not adequately capture the presence of distressing and impairing anxiety symptoms in later life. Cognitive decline and medical illness in the elderly further complicate these diagnostic considerations. Prevalence estimates vary widely, but epidemiological studies suggest anxiety disorder prevalence rates up to 15% among elderly in the community.¹ While most older adults with anxiety disorders have illnesses that first began relatively early in life, there are exceptions, such as generalized anxiety disorder (GAD) where 25% of individuals with GAD have onset of illness after age 50.¹ Adverse life events, chronic medical illness, and cognitive impairment are important risk factors for development of anxiety in the elderly.¹

Anxiety comorbidity is also very common in individuals with bipolar disorder, and in older adults with bipolar disorder (OABD), anxiety symptoms may emerge in the setting of increased medical burden, cognitive decline, and social isolation. A 2018 meta-analysis reported a lifetime anxiety disorder comorbidity (including obsessive compulsive disorder) of 40.5% and current anxiety disorder comorbidity of 38.2%.² GAD and panic disorder were the most prevalent diagnoses in individuals with bipolar disorder, followed by social anxiety disorder and obsessive-compulsive disorder. Higher rates of anxiety comorbidity were found during a bipolar manic phase.² The rates of anxiety comorbidity appear to be comparatively

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lower in OABD, with studies suggesting prevalence rates of about 10%.³ It is not known to what extent this lower prevalence is a function of under-recognition vs. possible other causes such as premature mortality among individuals with more severe symptoms or multi-morbidity. Despite the lower prevalence, presence of comorbid anxiety disorder nonetheless remains a marker of poorer prognosis.

Comorbid anxiety disorders in bipolar disorder are known to be associated with higher severity and worse prognosis across a wide range of measures: greater number of mood episodes, higher rate of mixed episodes and rapid cycling, greater frequency and severity of episodes, greater periods of untreated illness, increased time to remission, increased suicidality, increased risk of substance use, increased risk of severity of medication adverse events, increased health care use, reduced response to treatment, reduced adherence to treatment, and decrease in the quality of life.⁴

Adequate recognition of anxiety in OABD requires the development and use of appropriate diagnostic instruments. While not developed specifically for older people, instruments like the Bipolar Inventory of Symptoms Scale, (BISS)⁵ a structured scale that evaluates a range of bipolar symptoms including mania, depression, irritability, anxiety, and psychosis may help optimize the recognition and evaluation of anxiety. In the anxiety domain, the BISS measures psychic worry, subjective feelings of anxiety, reported somatic anxiety, and fearfulness. Higher scores on the anxiety subscale have been associated with greater severity of bipolar illness⁵. The BISS can also be utilized as a screening instrument for comorbid anxiety disorders in individuals with bipolar disorder. Future efforts should attempt to assess the validity and utility of the BISS and similar instruments in OABD.

Only a handful of studies to date have examined the efficacy and safety treatment of anxiety disorders comorbid with bipolar disorder, and there are no studies specific to anxiety disorders in OABD. The Canadian Network for Mood and Anxiety Treatments (CANMAT) task force has issued recommendations⁴ for the pharmacological management of comorbid anxiety in BD: After ensuring adequate mood stabilization, gabapentin and quetiapine have been suggested as first-line agents for unresolved anxiety symptoms in BD, followed by divalproex, lamotrigine, and serotonergic antidepressants as second-line agents. Lithium, risperidone, aripiprazole, pregabalin and benzodiazepines are noted as third-line agents. Ideally, these medications should be investigated in clinical trials specific to OABD with comorbid anxiety disorders to evaluate possible age-related pharmacological risks.

In summary, clinicians evaluating older people with BD need to assess for anxiety comorbidity, recognizing the potential for under-recognition and overlap with conditions that are relative to aging such as increased medical burden and cognitive decline. In addition to OABD-specific assessment tools and treatments, research needs to be done to better understand how anxiety may be associated with the evolution of bipolar disorder across the life-span.

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