Psychosocial treatment of late-life depression with comorbid anxiety

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Why Comorbidity?
Comorbidity is Common

- Common disorders, typically comorbid across the lifespan (Kessler et al., 1996; Kvaal et al., 2008)

- Community sample in Netherlands aged 55-85 yrs comorbid prevalence of major depression and any anxiety disorder was 47% (Beekman et al., 2000)

- Primary care sample (inpatient and outpatient) 35% of those with MDD reported lifetime history of anxiety disorder, and 23% reported a current anxiety disorder (Lenze et al., 2000)
Overlap

- Overlap in terms of risk factors, phenomenology and genetic factors (particularly GAD and MDD) (Kendler et al., 2007; Vink et al., 2008; Watson et al., 1995)
Worse Outcomes

• In older adults, associated with worse outcomes than either disorder alone:
  • increased risk of cognitive decline and dementia (DeLuca et al., 2005)
  • increased risk of suicide, disability, more severe depression, more chronic course (Cohen et al., 2009; Lenze et al., 2000)
  • higher health care costs (Almeida et al., 2012; Vasiliadis et al., 2012)
Poorer Treatment Response

- Comorbid anxiety reduces treatment response of:
  - pharmacological treatment for depression (Cohen, et al., 2009)
  - combined pharmacological and psychological approaches (Hegel et al., 2005)
  - group CBT (Gum et al., 2007)
- Treatment for depression doesn’t produce significant reductions in comorbid anxiety symptomatology (Gum, et al., 2007; Serfaty et al., 2009)
- Treatment for anxiety does improve comorbid depression severity but unclear if there is recovery from comorbid mood disorders (Gorenstein, et al., 2005)
Disorder Specific Treatment

- DEPRESSION: CBT is effective for older adult depression and superior to WL, TAU, other control groups with moderate to large ES $d=0.72$ (Cuijpers et al., 2006; Karel & Hinrichsen, 2000; Mackin & Arean, 2005; Serfaty et al., 2009)

- Recent meta-analysis suggests CBT is superior to non-active controls, but not superior to active controls (Gould et al., 2012)
Disorder Specific Tx continued

- ANXIETY: CBT is effective in older adults and superior to WL, active control for anxiety, although it is likely to be only marginally superior than active control conditions (Gould et al., 2012)
- Little known about treatment of comorbidity and whether if targeting comorbidity would improve outcomes
Psychosocial Treatment for Depression with Anxiety
Sallis et al. 1983

- N=24 Aged 60+ (m=71.3, sd=8.7)
- >12 BDI and >38 STAI
- Compared “Anxiety Tx” (relaxation) with “Depression Tx” (pleasant events & cognitive restructuring) and “Control” (self-disclosure and reflection)
- Found all conditions produced improvements on BDI, blood pressure (resting systolic and diastolic)
- Only the placebo group improved on anxiety (STAI)
Randomised controlled trial of group cognitive behavioural therapy for comorbid anxiety and depression in older adults

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ABSTRACT

Anxiety and depression are commonly comorbid in older adults and are associated with worse physical and mental health outcomes and poorer response to psychological and pharmacological treatments. However, little research has examined the effectiveness of psychological programs to treat comorbid anxiety and depression in older adults. Sixty-two community dwelling adults aged over 60 years with comorbid anxiety and depression were randomly allocated to group cognitive behavioural therapy or a
Group CBT to Wait list

- RCT group CBT versus wait list condition (12 weeks)
- N= 62, Aged 60 + (range 60-84, M=67.77)
- Comorbid depression and anxiety (clinical or subclinical) as assessed by semi-structured clinical interview (ADIS) and self-report questionnaires
- Pre, Post and 3 month follow up

<table>
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<th>Parameter</th>
<th>CBT</th>
<th>Waitlist</th>
<th>Effect size*</th>
<th>ES 95% CI</th>
<th>Effect size*</th>
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Note. Calculations are based on the original dataset. *Effect size expressed as Cohen's d, on the basis of pre–post treatment change within conditions using pooled baseline standard deviations, Cohen's $d = M1 - M2/SDpooled$. ES 95% CI = Effect size with 95% confidence intervals. Confidence intervals for effect sizes were computed using procedures delineated by Odgaard and Fowler (2010).
Results

• Large Effect Sizes (within condition) CBT=1.46 (95%CI: 0.74,2.18),
• Gains maintained at 3 months
• Recovery Rates – for the sample who met full diagnostic criteria at pre
  • CBT 53% recovery (post) and 67% (3 month)
  • Waitlist 11% recovery
RCT 2 – Wuthrich et al. 2015 (Psychol. Medicine)

- DSM-IV anxiety and unipolar mood disorder (either primary)

- Random allocation by block to group treatment 11 sessions (over 12 weeks) CBT vs Discussion group

- Pre, Post and 6 month follow up assessments

- Treatment Adherence and Treatment Credibility
- Therapist Alliance, Group Cohesion, Process changes
Results

• 133 randomly allocated (77 CBT, 57 Disc)
• Age 60-88 years (M=67.35, SD=5.44), Male = 44%
• No significant differences on demographics, treatment credibility, therapist alliance, group cohesion
Results – Mean Disorder Severity

- Pre
- Post
- Follow Up

CBT
Discussion
<table>
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<tr>
<th>Variables</th>
<th>Treatment</th>
<th>Estimated Marginal Means (Standard Error)</th>
<th>Effect Size (Cohen’s d with 95% Confidence Interval)</th>
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<td>CBT</td>
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<td>3.382 (.202)**</td>
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<td>Discussion</td>
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<td>2.904 (.151)**</td>
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<td>Discussion</td>
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<td>3.913 (.175)</td>
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<td>4.964 (.144)</td>
<td>2.909 (.152)**</td>
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<td>Mean Anxiety Disorders</td>
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<td>5.140 (.168)</td>
<td>3.904 (.176)</td>
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<td>2.647 (.157)**</td>
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<td>Discussion</td>
<td>12.035 (.689)</td>
<td>8.168 (.713)</td>
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</table>
Mean Depression/Anxiety

- CBT Anx
- CBT Dep
- Disc Anx
- Disc Dep

Pre | Post | Follow up
## Recovery Rates

**Primary Diagnosis Free**

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<tr>
<td>Post*</td>
<td>54%</td>
<td>24%</td>
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<tr>
<td>Follow Up</td>
<td>46%</td>
<td>36%</td>
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* * p<.001

**Completely Diagnosis Free of all Anx or Mood disorders**

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<td>12%</td>
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<tr>
<td>Follow Up</td>
<td>35%</td>
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* p<.05
Conclusions

- Group CBT is superior to discussion group for clinician rated symptoms in particular (faster recovery)
- Group CBT efficacious for depression with anxiety (on both anxiety and depression)
- Benefits of CBT are maintained at 6 months
Current Directions

• Target amenable risks for cognitive decline
  • Physical inactivity (21% population attributable risk)
  • Low education/mental stimulation (19.1%)
  • Depression (11.1%)
  • Others include: smoking, diet, alcohol, lack of social stimulation and emerging evidence for anxiety
• RCT lifestyle intervention vs bibliotherapy (16 week individual face to face)
• Outcomes changes in risks, cognitive changes up to 3 months (with funding outcomes to 2 years)
Thank you!

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