

Understanding the Experiences of Anxiety in Community Dwelling Older Adults

—Understanding Anxiety in Older Adults

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Abstract

Objectives: Anxiety is commonly reported as being experienced by older adult patients. However most of the theories on anxiety in older adults are developed from clinical measures rather than open-ended questionnaires. Consequently, little is known about the day to day experiences of anxiety in the lives of older adults, and the functional impairment that may result. **Method:** Community dwelling older adults (n = 135) were administered an open-ended questionnaire eliciting their experiences of anxiety using a cognitive behavioural framework. Directed content analysis was applied to discover the shared experiences of anxiety in older adults. **Results:** Although 64% of older adults reported avoidance behaviour that appeared anxiety driven, they generally denied experiencing anxiety themselves. Thought content and processes were idiosyncratic however commonalities were thinking positively (34%), problem solving (31%), rumination (31%) and difficulty concentrating (19%). A broad range of physical symptoms including those that may relate to medical conditions and depression were reported as resulting from anxiety, most commonly headaches (26%) and gastrointestinal disturbances (26%). **Conclusion:** Anxiety driven behaviours were common and appeared to negatively impact their quality of life through avoidance behaviours. Older adults may benefit from education to destigmatise the experiences of anxiety and improve reporting of functional impairment due to anxiety.

Keywords

Anxiety, Beliefs, Qualitative Methods, Assessment, Older-Adults

1. Introduction

Anxiety forms part of the human experience and at times can be a strong influence on our thoughts and behaviour. Yet within New Zealand there is little visibility

of anxiety in our day-to-day conversations—for a phenomenon that has so much potential to create action or inaction. Older adults have competing problems that negatively impact their wellbeing, e.g. medical comorbidities, financial constraints, diminishing social resources. Anxiety is a phenomenon that can creep in, unspoken, and through doubt, draw the older adult away from competing positive experiences and negatively impact quality of life [1].

Up until recently, our understanding of anxiety in older adults was limited by the application of theoretical models of anxiety that were developed in younger adults and generalised to older adults. A proportion of existing research has been undertaken using the constraints of psychometric tests that have been developed and tested in younger populations. By not venturing outside of the boundaries of psychometric tests, the understanding of the experiences of anxiety in older adults will be limited to what the test is able to provide.

Much of the research into anxiety has focused on psychological disorders that fall within the diagnostic boundaries within the Diagnostic and Statistical Manual of Mental Disorders [2]. However older adults experience significant functional impairment from sub-threshold anxiety [3], and this can create equal burden on primary care when compared to older people who have a diagnosable anxiety disorder [1] [4].

Studying non-clinical samples of older adults may provide longer-term benefits to clinical populations. Huppert [5] argued that whilst reducing the psychological distress of individuals is an important objective, taking a population based approach ensures that there are fewer people suffering in the longer-term. Rose [6] illustrated that as people with clinical disorders originate from the non-clinical general population, a small preventative intervention at population level created a larger benefit to the high-risk groups that outweighed targeting individuals within the high-risk groups. Taking this argument to older adults, through understanding how the general population of older adults experience anxiety, health promoters can facilitate the population of older adults to make a small change that could produce a larger effect than would be accomplished through targeting individual of older adults with severe anxiety.

Research into anxiety in older adults has at large been undertaken in the Northern Hemisphere. Australia and New Zealand older adults have developed in a different cultural climate and consequently may experience anxiety differently to their American counterparts. Stoicism was encouraged in pioneering New Zealand, and as such emotions were encouraged to be internalised rather than sharing with others [7]. Older Adult New Zealanders have been observed to employ an avoidant coping style when faced with negative emotions, including anxiety [8]. Andrew and Dulin [8] reported that experiential avoidance significantly predicted anxiety and depression, and suggested that avoidance could negatively impact help-seeking.

Study Aims: The present study intends to validate and extend the current understanding of anxiety in community dwelling older adults in order to determine the essential content for inclusion on a new psychometric measure of anxiety

for older adult in development. The study will use an open-ended self-report questionnaire developed from existing anxiety theory. Participants' responses will be evaluated using directed content analysis [9]. Characteristics of anxiety in community dwelling older adults will be discussed, and interventions to improve the wellbeing of this population will be made.

2. Method

2.1. Participants

Community dwelling New Zealand European older adults aged 60 - 80 (n = 135; Male n = 35, Female n = 95, not specified n = 5) were recruited through researcher presentations at older adults' organisations and through word of mouth from August to October, 2008. Participants collected an anonymous questionnaire to complete at home and returned by mail. Consent was implied by completing the questionnaire. Participants in rest-homes or hospitals were excluded to minimise variance caused by possible cognitive impairment. Ethical approval was granted by the Massey University Human Ethics Committee Northern.

2.2. Questionnaire

Participants completed an anonymous open-ended questionnaire based on the Cognitive Five Part Model [10] structured to elicit the behavioural, cognitive, physical, and emotional aspects of anxiety in a self-chosen recent worrying situation. Participants were also asked to report their worry topics, the language used to describe worry, and their perception of another older adult's experience of anxiety.

Directed content analysis [11] was chosen for this research as it is a method that enables prior knowledge of a phenomenon to be validated and further expanded upon. Stage one: An initial meeting between the two clinical psychologists undertaking content analysis determined the approach to coding that incorporated understanding from a literature review of anxiety in older adults and knowledge gained through the researchers' clinical practice with older adults, but was flexible to enable older adults' original responses to be identified and included. Stage two: both researchers independently read and re-read the completed questionnaires and recorded initial codes (smaller categories) for participants' responses. The researchers coded responses based on the categories of emotional, physical, behavioural, cognitive, worry topics, language used to describe worry, and DSM-5 [2] anxiety and depression symptoms. Stage Three: The researchers compared and refined the codes generated and interrater reliability ($r = 0.76$) was assessed through cross-checking of codes from ten randomly drawn participant questionnaires. A visual map was created to link categories of codes and to identify any new higher order categories. Stage four: Codes and categories were evaluated and refined to ensure each category was consistent internally and was distinct. Stage five: Participant responses, codes, and categories were evaluated against the visual map re-checked and refined.

Stage six: The list of codes and categories were entered into a spreadsheet and frequencies and percentages were calculated. The open-ended nature of the questionnaire elicited many idiosyncratic responses and therefore codes with commonality between participants of less than 10% were removed from final analysis.

3. Results

3.1. Language Describing Experiences of Anxiety

Participants predominantly listed that they experience “worry” (68%), followed by “stress” (30%), “concern” (22%), “anxiety” (18%), and “fear” (16%).

3.1.1. Worry Topics

Participants reported a broad range of topics that caused anxiety, the majority did not meet the 10% commonality threshold. Health concerns were the most commonly reported (46%):

“Worry sometimes if aches and pains and other minor health symptoms are going to turn into something serious.” (ID023)

“I don’t mind dying but worry how I’ll go e.g. Alzheimer’s etc.” (ID070)

A second large theme was worries relating to the wellbeing of family members (41%), including their health and life circumstances:

“When my children are happy or at peace with their life and lifestyle, then I basically feel happy in myself—and the reverse is the case when they are not.” (ID095).

The third most common theme related to finances (37%):

“Upheavals in the financial markets. Financial companies going into liquidation. Increasing costs of food and fuel.” (ID012)

Participants were aware of their vulnerability in the community and at home, with 13% reporting concerns related to security, which included being the victim of crime.

“Avoiding groups of young men. Going out at night alone. Walking in parks with lots of trees. At home keep screen doors locked, windows secure. Lock car doors when driving. Only walk in safe places.” (ID030)

Participants worried about their loss of independence (11%), and their ability to maintain their home (13%). Although beneath the 10% commonality threshold, it was noted that groups of participants were also concerned with dropping society standards (7%) and political issues (7%)

“Future of the world; diminishing resources of the planet; ... the future of NZ—what sort of place will it be for my grandchildren to grow up in?” (ID014)

“One of the amorphous grey group who no longer matter.” (ID032)

3.1.2. Physical Sensations

Headaches (26%) and gastrointestinal disturbances (26%; constipation, diarrhoea, nausea, and other bowel comments) were the most commonly reported physical sensations. Tiredness (19%), tension (16%), aches (16%), appetite

changes (14%), and restlessness (13%) were the next most common.

“Mostly tiredness—not necessarily due to insufficient sleep.” (ID086)

Less than 10% of participants reported cardiovascular symptoms (chest pain, increased pulse, increased blood pressure), butterflies, and shaking that are commonly associated with anxiety.

“Fast heart beat. Flushed cheeks. Headache. Some angina pain and palpitations. Intestinal discomfort.” (ID095)

3.2. Cognitive

Thought Process. Older adults reported rumination (31%), difficulty concentrating (19%), forgetfulness (13%), confusion (12%), preoccupation (12%), and difficulty retaining objectivity (10%).

“Constantly focus on the reason for worry. Hard to get your mind off it.” (ID054)

Thought Content. The diversity of anxiety provoking situations reported by older adults meant that there were many topics that did not reach the 10% threshold for a theme. Although themes of imagining the worst-case scenario or other negative outcomes were common (22%), there was a theme of thinking positively (34%) and trying to solve the problem (31%).

“I never dwell on ‘what ifs’—Take life with a positive attitude and things will work out.” (ID102)

Emotional Experiences

In a situation causing anxiety, participants most commonly also described irritability (24%), anger (16%), depression (26%), overwhelmed (24%), and panic (22%).

“Frustration. ANGER. Hopeless. Weepy. Helpless. Murderous. Suicidal.” (ID051)

3.3. Behaviour

Behaviour related to problem solving was reported by 44% of participants. Other positive behaviours related to managing their anxiety included distraction techniques such as keeping busy (31%) and exercising (21%):

“Try and keep busy. I have many interests, but it is at night, worries flood back.” (ID087)

Sleep disturbances. Older adults commonly reported that they experienced sleep disturbances (27%), which included frequent night waking, difficulty falling asleep, or early waking.

“Went over and over the situation in my head, especially in the small hours.” (ID095)

“Unable to sleep and so get more exhausted achieving less.” (ID032)

Avoidance behaviour. Most participants (64%) reported some avoidance behaviour in order to reduce their anxiety, the remainder reported that they had no limitations (24%) or did not answer the question (12%).

“No! I try to keep up usual activities as I am not a negative person.” (ID038)

Driving was not a commonly listed topic causing anxiety for participants, however 18% of participants engaged in some form of avoidance behaviour relating to driving anxiety. Limitations included driving only to familiar places, avoiding areas and times of day when high density traffic was expected, and only driving during daylight.

“Limiting driving to places I know” (ID010)

Most of the avoidance behaviour was within activities of daily life, such as within social relationships (31%) e.g. avoiding “socialising” or conflict with others; or avoiding new situations (16%).

“Don’t like being in new situations... I like to keep to a familiar routine and activities.” (ID116)

Religious behaviour. Participants discussed their faith as helping to reduce their anxiety in the longer-term, but in the short-term used prayer (10%) and attended church as a means to resolve their problems which caused anxiety:

“I do not become anxious—my faith in God has assisted me to calmly accept my situation.” (ID 122)

Sharing worries with others. Participants almost equally took two divergent approaches to discussing their worries. Thirty-four percent of participants favoured keeping their worries to themselves, whereas 33% talked to others about their issues.

“Too good at hiding feelings—they think I am cheery and happy at all times.” (ID093)

“Talked to family, friends, selectively.” (ID027)

3.4. Perception of Other Older Adults Experience of Anxiety

Overall participants reported that others thoughts and physical experiences of worry were similar to their own. However although participants seldom reported engaging in the following behaviours, a considerable proportion perceived others would: cry (18%), visit the doctor more (12%), or use alcohol or cigarettes (10%).

Although few participants worried about death (3%), 16% perceived that others were. Participants thought others were likely talk persistently about the problem (41%)

“The wife gets very weepy, can’t make simple decisions and is constantly ringing friends for advice and support.” (ID111)

Participants less often described themselves as forgetful compared to their perception of other older adults (13% self; 25% others). Although 31% of participants viewed themselves as problem solving when anxious, they less commonly attributed this behaviour to others (8%). Whilst 10% felt that they lose objectivity when anxious, 33% attributed this behaviour to others. Participants reported they were positive thinkers when faced with worries (34%) but rarely attributed positive thinking to others (4%).

3.5. Perceived Age-Related Differences in Worry

Twenty-two percent of older adults reported that their vulnerability from physical health and awareness of their limitations brought an increase in anxiety compared to younger adults. Twelve percent of older adults viewed life experience as a protective factor against anxiety.

“We have too many experiences to compare with which either makes us able to cope better with situations or become more anxious as more outside influences seem to take over our decisions.” (ID093)

Younger adults were perceived as having less awareness of what could go wrong (24%) and consequently were considered to be less anxious.

“Older adults have years of experience and have experienced a wide variety of outcomes/results. They need to feel secure. Some younger adults feel untouchable or they know they are young enough to recover from any setbacks.” (ID091)

Older adults perceived that younger adults would worry about different topics to older adults (44%), and 11% recorded that the only difference between younger and older adults was their worry topics.

“They worry about different things, but the way we worry is exactly the same as when we were young.” (ID014)

Some participants thought that younger adults would display their emotions more readily:

“People of our age do not “let it all hang out” as the younger people do—we tend to keep somewhat reserved about our emotions.” (ID068)

3.5.1. Distancing from Negative Connotations of Anxiety

Participants often took care to point out to the researcher were not “negative” or “a worrier” (17%). However some of this group either then went on to describe experiences consistent with anxiety.

“...I’m not a big worrier. You just get on with life...” (ID093).

3.5.2. Hiding Anxiety

Twenty-one percent of participants reported actively concealing their anxiety from others through their demeanour, expression, or avoiding talking about worries.

“I try to be ‘bright’ and positive and rarely tell other people how I really feel” (ID83).

4. Discussion

The present study revealed that many older adult New Zealanders experience limitations through the presence of anxiety in their everyday lives, despite not reaching the level of requiring specialist intervention. Symptoms of anxiety were similar to those observed in clinical samples. Older adults concealed their anxiety, distanced themselves from the negative associations of mental illness, and attributed others as experiencing stronger symptoms and limitations when compared to themselves. This is problematic as anxiety negatively impacts quality

of life [3], and concealing emotional experiences intensifies negative emotions and create barriers to accessing support [8].

Worry topics. Similar to previous research [12] [13], participants' reported developmentally and contextually appropriate worry topics of health, family, and finances. The broad range of idiosyncratic topics reported supports previous research that suggests process rather than content factors may be helpful in identifying pathological worry in older adults [14] [15].

Physical sensations. The present sample reported a diverse range of physical sensations when they were aware of experiencing anxiety. Similar to previous research [16], participants showed awareness that their physical conditions such as aches, were related to their anxiety. This contrasts the popular anecdote that older adults somaticize their anxiety due to a lack of emotional awareness [17] [18]. The high incidence of headaches and gastrointestinal disturbance illustrates the benefit of looking beyond diagnostic criteria, as these symptoms are not within the DSM 5 criteria for GAD [2].

Cognitive experiences. Participants commonly reported rumination, loss of concentration, forgetfulness, confusion, preoccupation, and loss of objectivity. Older adults' thought content included imagining negative outcomes and attempting to problem solve. Previous studies with older adults have also observed a high prevalence of difficulty concentrating [14] [19].

Previous authors have suggested that people with GAD use their worry as a way of problem solving [20]. Depending on the duration and frequency of this thought process, the problem solving reported by this sample may clinically be considered to be rumination. Participants also commonly attempted to think positively when faced with worries.

Emotions. The present research supported the finding of emotional complexity in older adults found in other studies [21]. Older adults reported numerous emotions in a situation they reported as causing anxiety. The high presence of sadness, anger, and irritability may support the notion of an overlap between depression and anxiety symptoms in the literature [22]. Participants also asserted their ability to conceal their emotional experiences from others, which lends further support to previous New Zealand research with older adults [8] and would create barriers to accessing both formal and informal emotional support.

Behaviour. Sleep disturbances found in the present research is a well-established finding across previous studies in both older and younger adult populations [16] and are present in numerous anxiety disorders within the DSM-5 [2]. Consequently assessing sleep disturbances in older adults could be a key diagnostic indicator of psychological difficulties [23], but must be differentiated from sleep disturbances due to medical conditions. Brenes *et al.* [24] found 90% of older adults with GAD reported dissatisfaction with sleep, and 52% - 68% experienced moderate to severe insomnia. Sleep onset and maintenance difficulties were most common in older adults with GAD, followed by early morning waking and initial insomnia.

Despite being a non-clinical sample recruited from community organisations, the majority of participants reported avoidance behaviours which could contribute to functional impairment and social isolation. This finding supported previous research that found older adults restrict their activity to familiar and non-demanding situations to avoid anxiety [25].

Differences between own experiences and the perception of others. Participants tended to perceive other older adults as having experiences of anxiety similar to their own. Of note, others were described using stronger emotional language (e.g. fearful, lonely, sad, angry) and suggested to be less able to cope, be more forgetful, and display negative affect openly. Participants perceived that others had more restrictions in their behaviour due to anxiety, and used maladaptive coping strategies (e.g. drinking alcohol and smoking) more often. This could reflect a social desirability effect, as in another study of a randomly selected sample of 141 New Zealand adults over 65 found that 100 currently used alcohol, and of those 68% reported drinking to help them relax, and 59% because it helped them feel better [26].

The differences between participants' perceptions of their own behaviour and that of other older adults could relate to several factors. Problems relating to mental health are associated with stigma and despite anonymity older adults may have downplayed socially undesirable experiences such as vulnerability. Alternatively, participants may have based their responses for others on a person with higher severity anxiety than their own.

Participants in this study consistently downplayed their anxiety through the use of milder descriptive language (e.g. "concern", "worry"), they distanced themselves from describing themselves as anxious (e.g. "I'm not a worrier"), they emphasised their ability to think positively, solve their problems, and use positive means of coping. They also appeared to take pride in their ability to conceal their emotional experiences. They more confidently and negatively described the experiences of others, and attributed to others the use of maladaptive coping strategies such as substance abuse.

5. Conclusions and Recommendations

The participants in this study were community-dwelling older adults who were active in community organisations. Despite this, the majority reported symptoms of anxiety, and avoidance behaviour was a core feature of participants. This in turn may increase functional impairment and social isolation, which may negatively impact their wellbeing. Following the argument of Huppert [5], a population-based intervention to make minor changes in the experiences of anxiety in older adult New Zealanders may have a long-term impact in reducing the overall severity of anxiety in clinical groups of anxious older adults.

Older adults may benefit from a public awareness campaign that specifically focuses on recognising and alleviating anxiety symptoms, the benefits of sharing emotional experiences with others, and the detrimental effects of emotional

suppression. Increasing public awareness on anxiety, particularly for older adults, has been recommended elsewhere [27]. The public awareness campaign “Like Minds” has shown to be effective in reducing stigma associated with mental illness and increasing public acceptance of people experiencing mental illness in the target age group of 15 - 44 [28]. The present research demonstrates that older adults still experience stigma from mental illness and may benefit from a similar campaign targeting their age group. However it is noted that the cultural and clinical generalisability of this study may be limited by the community dwelling nature of these participants from a New Zealand context.

Older adults reported broader experiences of anxiety than are captured in DSM 5 criteria for GAD [2], including the new finding of a high prevalence of headaches and gastrointestinal disturbances when anxious. This supports previous assertions that the use of existing diagnostic criteria and psychometric measures for anxiety may have limited validity when used in older adult populations [3] [4]. Consequently, clinicians and researchers assessing anxiety in older adults should expand their questions beyond DSM-5 based symptoms to include idiosyncratic anxiety experiences.

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