Anxiety Disorders: Diagnosis and Treatment

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Anxiety disorders in the DSM IV.

- Acute Stress Disorder
- Generalized Anxiety Disorder [GAD]
- Obsessive-Compulsive Disorder [OCD]
- Panic Disorder (with or without Agoraphobia)
- Phobias (including Social Phobia)
- Posttraumatic Stress Disorder [PTSD]
Prevalence of Anxiety Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Lifetime Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Anxiety Disorder</td>
<td>27</td>
</tr>
<tr>
<td>Social Anxiety Disorder</td>
<td>18</td>
</tr>
<tr>
<td>PTSD</td>
<td>14</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>6</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>3</td>
</tr>
</tbody>
</table>

Kessler et al. *Arch Gen Psychiatry*. 1994;51:8.
Course of Illness

Panic attack: discrete period of intense fear or discomfort – peak within 10 min

GAD: generalized anxiety disorder
I. Symptoms and diagnosis of anxiety disorders
Symptoms of a panic attack

- palpitation, tachycardia
- sweating
- trembling or shaking
- sensation of shortness of breath
- feeling of choking
- nausea, GI symptoms
- feeling dizzy, unsteady, lightheaded or faint
- derealization or depersonalization
- fear of loosing control or going crazy
- fear of dying paraesthesias (numbness or tingling)
- chills or hot flushes

DSM IV: 4 or more of the symptoms above
Panic attack: differential diagnosis

• Comorbid with other psychiatric disorders (e.g. depression)

• Some somatic disorders:
  – phaeochromocytoma
  – cardiac disorders
  – hyperthyreosis
  – Menière syndrome
  – Hypoglycaemia
  – temporal lobe epilepsy
Panic attack: differential diagnosis

- Psychotropic substances:
  - Caffeine
  - Monosodium glutamate – ”Chinese restaurant syndrome” - ?
  - Stimulants (cocain, amfetamimes)
  - Hallucinogenic drugs
  - Sympatomimetic drugs (e.g. nasal drops)
  - Drog and alcohol withdrawal syndroms
Panic disorder

- Unexpected, recurrent panic attacks
- Followed in at least one instance by at least a month of a significant and related behavior change
- Persistent concern of more attacks, or a worry about the attack's consequences
- May be present with or without agoraphobia
Specific phobia

E.g.

- Animals
- Hights
- Flying
- Seeing blood, receiving injection
- Children: eg. loud noise

- The person recognizes that the fear is excessive or unreasonable.
- Interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
Social phobia

• Marked and persistent fear of one or more (generalized) performance situations

• Onset: mostly in childhood
  – 20% before age of 5
  – 40% before age of 10
  – 95% before age of 20

• Rarely diagnosed – treatment often related to alcoholism.

• Difference between „shyness” and social phobia.
Generalized Anxiety Disorder (GAD)

- Anxiety, WORRY about a number of events
- Difficult to control the worry
- Present for at least 6 months
- At least 3 out of 6 symptoms
  1. Restlessness, or feeling keyed up or on edge
  2. Easily fatigued
  3. Difficulty concentrating or mind going blank
  4. Irritability
  5. Muscle tension
  6. Sleep disturbances
Obsessive-compulsive Disorder (OCD)

- **Obsessions**: Thoughts, impulses, images
- **Compulsions**: repetitive behavior; or behavior/mental acts aim at preventing/reducing distress

- “Spektrum” (impulse controll disorders):
  - Trichotillomania
  - Patological gambling
  - Cleptomania
  - Obsessive shopping

(As good as it gets)

- O-C: recognized as excessive or unreasonable
- Are not due to the effect of a substance or general medical condition
OCD - obsessions

Common obsessive thoughts in OCD include:

- Fear of being contaminated by germs or dirt or contaminating others
- Fear of causing harm to yourself or others
- Intrusive sexually explicit or violent thoughts and images
- Excessive focus on religious or moral ideas
- Fear of losing or not having things you might need
- Order and symmetry: the idea that everything must line up “just right.”
- Superstitions; excessive attention to something considered lucky or unlucky
OCD - compulsions

Common compulsive behaviors in OCD include:
• Excessive double-checking of things, such as locks, appliances, and switches.
• Repeatedly checking in on loved ones to make sure they’re safe.
• Counting, tapping, repeating certain words, or doing other senseless things to reduce anxiety.
• Spending a lot of time washing or cleaning.
• Ordering, evening out, or arranging things “just so.”
• Praying excessively or engaging in rituals triggered by religious fear.
• Accumulating “junk” such as old newspapers, magazines, and empty food containers, or other things you don’t have a use for.

http://helpguide.org/mental/obsessive_compulsive_disorder_ OCD.htm#signs
Acut stress disorder

• Severe stress (e.g. war, rape, accident) - 4 weeks

• Symptoms:
  – Anxiety, depression
  – “Flashback”
  – Hyperarousal
  – Avoidance behavior
Posttraumatic stress disorder

• Severe stress – symptoms 4+ weeks
• Chronic course, often with unfavorable outcome

- High comorbidity with other psychiatric disorders, eg. Depression, substance abuse
- Increased suicide attempt risk
- Female-to-male lifetime prevalence ratio of 2:1
Other disorders with anxiety

Somatic disorders (pain!)
Psychiatric disorders (depression, schizophrenia, adjustment disorders, etc.)
Adjustment disorder with anxiety

• „Daily” stress („life events”) – one or multiple
• Life periods (getting married, pension)
• Situations: e.g. medical interventions, exams
Treatment of anxiety disorders:  
I. Psychotherapy
Education/Psychotherapy

- Education
- Behavior therapy
- Cognitive therapy
- Psychoanalysis/psychoanalytically oriented therapies
- Meditation/Relaxation/Hypnosis/Self hypnosis
- Biofeedback
- Exercise/rest
Education: Objectives

• Reduce/diminish initial anxiety
• Enhance physician-patient collaboration and adherence to treatment plan
• Enhance self esteem
Behavior Therapy

• Change specific behavior (e.g. avoidance)

• Short-term approach

• Specific techniques, e.g.:
  – In vivo or in vitro exposure
    • Systematic desensitization
    • Flooding
Cognitive Therapy

- Distorted patterns of thinking
- Structured, specific approaches
Psychotherapy/Counseling

- Communicate directly and honestly
- Encourage the patient to talk
- Listen actively, express empathy
- Be available
Psychotherapy/Counseling: Objectives

• Relieve symptoms
• Correct situational problems
• Restore coping/defenses
• Expand personal skills/abilities
• Prevent emotional breakdown
Meditation/Relaxation/Hypnosis

- Patient sits quietly in a restful environment (15-20 min bid)
- Concentration on breathing
- Progressive muscle relaxation: patient alternate tensing and relaxing specific muscle groups (15-20 min bid)
- Hypnosis/Self hypnosis
Biofeedback

- Use of auditory and visual signals from biological measures
- Patient learns to monitor and modulate biological responses eg. Blood pressure, muscle tension
Exercise/Rest Prescription

• Moderate exercise enhances a sense of well-being and promotes overall fitness (but: exercise can precipitate panic attacks)
• Proper rest
Social Interventions

• Working with the family and social system
  – Sharpens the diagnosis
  – Speeds treatment
  – Improves compliance
Treatment of anxiety disorders: II. Pharmacotherapy
Pharmacological Treatment of Anxiety Disorders

• When to prescribe?
• What to prescribe?
• For how long to prescribe?
When to Prescribe for an Anxiety Disorder?

- Symptom complex is severe and persistent
- Impairment of psychosocial quality of life
- To prevent the potential complications
- Potential benefit outweigh potential risks
What to prescribe?

- **Benzodiazepines**
- **5 HT\textsubscript{1A} ligands:**
  - buspiron
- **Antidepressants**
  - **SSRI-s**
    - citalopram
    - escitalopram
    - fluoxetine
    - fluvoxamine
    - paroxetine
    - sertralin
  - **MAO-I (Mono Amino Oxidase Inhibitors)**
  - **RIMA (Reversible Inhibitor of MAO-A)**
    - moclobemid
  - **Dual action AD-s**
    - venlafaxine
    - duloxetine
  - **Tri- and tetracyclic (old) agents**
    - e.g. imipramin, maprotilin
Dose of medication and length of treatment is different for different anxiety disorders

- Eg. Generalized anxiety disorder vs. Obsessive-compulsive disorder or panic disorder
MECHANISM OF ACTION OF BENZODIAZEPINES

KEY CONCEPT: Benzodiazepines enhance the actions of the inhibitory neurotransmitter GABA – BZD’s facilitate the opening (frequency) of the Cl- ion channel in response to GABA; enhance neuronal hyperpolarization.
Benzodiazepines (BZD)

- BZD have the following (5) effects:
  - anxiolytic
  - sedative
  - antiepileptic
  - amnestic
  - muscle relaxant

- Tolerance to four effects, but clinically the tolerance is insignificant to the specific anxiolytic effect

- BZD bind to the BZD (omega) receptors, increase the frequency of the opening of the chloride ion channel
BZD cont’d

• **High potency** BZD: alprazolam, clonazepam, lorazepam (antipanic)
• **Low potency** BZD: e.g. diazepam, nitrazepam, temazepam
• **Broad indication**
• **Side effects**: sleepiness, dizziness, abuse potential (low as compared to barbiturates, meprobamat and alcohol)
Abuse, Dependence, Withdrawal, and Rebound Anxiety: Benzodiazepines

- Abuse potential decreased when properly prescribed and supervised.

- Dependence may occur at usual doses taken beyond several weeks. (REMEMBER: TOLERANCE is the main criterion!)

- Withdrawal may occur even when discontinuation is not abrupt (e.g., by 10-15% per week). Symptoms include: tachycardia, increased blood pressure, muscle cramps, anxiety, insomnia, panic attacks, impairment of memory and concentration, perceptual disturbances, derealization, hallucinations, hyperpyrexia, seizures. May continue for months.

- Rebound anxiety: return of target („baseline”) symptoms, with increased intensity

- Differentiate from: Recurrence of symptoms (due to lack of effective treatment).
Abusers

- Anxiolytics/sedative-hypnotic drugs are abused by two groups of people...
  - Individuals who overuse these drugs to reduce daily tensions and to aid in sleep
    - These people take excessively large doses on a regular basis
  - Street drug users
    - Attempt to achieve a state of “relaxed euphoria” or to aid in “coming down” from a high caused by taking a stimulant
5 HT$_{1A}$ ligands: buspirone

- Indication: generalized anxiety disorder (only! No efficacy in panic disorder, phobia, OCD, PTSD)
- Late onset of action
- Gastrointestinal side effects
Antidepressants

• Different drugs used in different disorders, e.g.
  – OCD
  – Panic disorder
  – Phobic disorders
  – PTSD
Combination of Drugs

- **BZD + Antidepressants**
  - late onset of action of AD
  - AD may worsen anxiety incl. panic in the first days/weeks of treatment
  - AD - warning in many countries: suicidality
  - BZD may alleviate the side effects of AD (GI)
  - BZD may be indicated as sleeping pills (newer: zopiclone, zolpidem- Non BZD structures)
For How Long toPrescribe?

- As short as possible - BUT anxiety disorders may have a chronic, fluctuating course with poor outcome without treatment
- Discontinuation: Low tapering!
- Important to differentiate between:
  - Withdrawal
  - Rebound
  - Relapse
Combined Treatment - Treatment Oriented Diagnosis

PHARMACOTHEARPY

- Diagnosis includes patient in a category.
- Objective of the treatment is to eliminate the causes of the syndrome - “corrects”, “restores”

PSYCHOTHERAPY

- Diagnosis is problem oriented.
- Compares recent status of the patient to the goal.
- Problems change over time.
- Objective of the treatment is to improve the health and “effectiveness” of the patient.
Combined Treatment - Treatment Oriented Diagnosis (2)

PHARMACOTHERAPY
• Outcome is the “product” of diagnosis and treatment (universal criteria)

PSYCHOTHERAPY
• Criteria for the outcome are different for each patient. The selected criteria determine the objectives and methods of treatment.
Thank you for your attention!

Slides can be found:
www.psych.sote.hu / English version / Lectures in downloadable format (pdf)