Before the Anxiety Block . . .

(1) Be prepared to explain the diagnosis and treatment patients with anxiety disorders
(2) Be prepared to present what you would tell a patient (regarding efficacy, side effects, etc.) starting an SSRI.
Anxiety: Differential Diagnosis

- Endocrine Dysfunction
  - Hyperadrenalism, hyperthyroidism, hypoparathyroidism, hypoglycemia
- Drug-related
  - Intoxication
    - Caffeine, cocaine, sympathomimetics, theophylline, corticosteroids, thyroid hormones
  - Withdrawal reactions
    - Alcohol, narcotics, sedative-hypnotics
- Cardiovascular/respiratory
  - CV disease, pulmonary embolus
    - COPD, asthma
- Metabolic abnormalities
  - Acidosis, hyperthermia, electrolyte abnormalities
- Neurological disorders
  - Vestibular dysfunction, seizures (esp. temporal lobe epilepsy), Parkinson's, Meniere's disease, MS, migraines, post-concussive syndrome
- Other
  - Pheochromocytoma, carcinoid, insulinoma, et al

ALSO REMEMBER THAT OTHER PSYCHIATRIC DISORDERS ARE ALSO OFTEN ACCOMPANYED BY CONSIDERABLE ANXIETY!!

Anxiety Disorders

- Panic Disorder
- Generalized Anxiety Disorder
- Post Traumatic Stress Disorder/Acute Stress Disorder
- Obsessive Compulsive Disorder
- Phobias

Panic Disorder

- Recurrent, unexpected panic attacks
- At least one attack is followed by 1 month of
  - Persistent concern about having a subsequent attack or
  - Worry about implications of the attack or its consequences (i.e. “going crazy” or having a heat attack)
  - Significant change in behavior related to the attack
- Presence or absence or agoraphobia
- Not better accounted for by another mental disorder or general medical condition
Panic attack

- Discrete period of intense fear, discomfort, with at least four of the following symptoms, which develop abruptly and reach a peak within ten minutes:
  - palpitations, pounding of heart or accelerated heart rate
  - sweating
  - trembling or shaking
  - sensations of shortness or breath or smothering
  - feeling of choking
  - chest pain or discomfort
  - nausea or abdominal distress
  - feeling dizzy, unsteady, lightheaded or faint
  - derealization (feelings of unreality) or depersonalization (being detached from oneself)
  - fear of losing control or going crazy
  - fear of dying
  - paresthesias (numbness or tingling sensation)
  - chills or hot flushes

Agoraphobia

- Anxiety about being in places or situations from which escape may be difficult or embarrassing or in which help may not be available in the event of a panic attack or panic-like symptoms
- The situations are avoided (e.g. travel is restricted) or are endured with marked distress or with anxiety about having a panic attack . . . or require the presence of a companion
- Approximately ¼ of panic disorder patients met criteria for agoraphobia.

Panic Disorder

- Age of onset late teens-20s
- The majority of panic disorder patients have another Axis I psychiatric diagnosis as well.
- There appears to be considerable variability in the long-term course of the disorder. About 1/3rd recover; ½ have only mild impairment, and <20% continue to experience major impairment. Panic disorder symptoms generally wax and wane over time.
- Anticipatory anxiety may persist long after panic attacks and avoidant symptoms remit.
Panic Disorder (Con’d)

- Severity of initial panic and agoraphobic symptoms, duration of illness prior to treatment, comorbid depression, history of parental separation, high interpersonal sensitivity, and personality disorders are predictors of poorer prognosis.
- Panic disorder patients are likely at higher risk of stroke and of cardiovascular death.
- Do not appear to be at higher risk of suicide, though in depressed patients, panic attacks likely confer increased suicide risk.

Panic Disorder Treatment:

- Cognitive Behavioral Therapy (CBT)
- Pharmacotherapies:
  - SSRIs*
  - SNRIs*
  - Benzodiazepines**
  - Rarely, MAOI phenelzine, tricyclics—more problematic side effects, drug interactions, dietary restrictions (with MAOIs). Much narrower therapeutic window with these agents

*May be able to doses lower than in depression
**Generally used only short term

Re: concerns about benzo abuse

- Multiple studies have demonstrated that patients with anxiety disorders are unlikely to take more benzodiazepine than prescribed—often even taking significantly less than prescribed.
- Patients with current or a past h/o substance abuse, females (males higher risk of opiate abuse), lower education levels, and certain personality disorders likely at higher risk.
Signs of benzo abuse

- Requests for increased dose
- Lost prescriptions
- “Only Xanax works for me”
- Forgetfulness; inconsistent or dubious history
- Defensiveness/Anger
- Manipulative or intimidating behavior aimed at getting clinicians to prescribe
- Sedation, cognitive slowing, ataxia (or if in withdrawal) anxiety, tremulousness, and flushing.

Cognitive-Behavioral Therapy (CBT)

- Informational/educational interventions
- Cognitive restructuring
- Relaxation exercises
- Respiratory Training
- Distraction techniques
- Exposure interventions

Generalized Anxiety Disorder

- Excessive anxiety and worry occurring more days than not for at least 6 months, about a number of events
- Worry is difficult to control
- Anxiety or worry is assoc with 3 of the following symptoms:
  - Restlessness or feeling keyed up or on edge
  - Being easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance
- Focus of worry is not confined to features of an Axis I disorder
- Causes significant distress or impairment in social, occupational, or other important area of functioning
- Not due to general medical condition, mood disorder or substances
Generalized Anxiety Disorder

- Mounting evidence of increased mortality in cardiac patients
- GAD is highly comorbid with other disorders. Approximately 90% of GAD patients have another psychiatric disorder—most commonly major depression, alcohol dependence, panic disorder, or social phobia.
- Onset early, often in childhood, though later life onset more common in women

Treatment of GAD

- SSRIs
- Benzodiazepines
- SNRIs
- Buspirone
- TCAs—NOT 1st or 2nd line, however
- Multiple studies have also shown benefit with pregabalin, particularly at high dose.
- NOTE: Insomnia often co-morbid with GAD. Treat it too!

Treatment of GAD (Con’d)

Other/future pharmacologic options

- Trazodone/nefazodone, mirtazapine, hydroxyzine, and atypical antipsychotics may also be used though there is less evidence to support the efficacy of these medications.
- Small but double blind study showed benefit with olanzapine. Small open trials of aripiprazole and of ziprasidone also had promising results.
- Glutamatergic agents (such as riluzole) may play a role in GAD treatment in the future.
Post Traumatic Stress Disorder

- Exposed to a traumatic event in which:
  1. The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury to self or others
  2. The response involved intense fear, helplessness, or horror
- The event is *reexperienced*:
  1. Intrusive recollections
  2. Recurrent distressing dreams
  3. Acting or feeling as if the event were recurring
  4. Intense psychological distress to external or internal cues that symbolize or resemble an aspect of the event
  5. Physiological reactivity on exposure to external or internal cues
- Avoidance of Stimuli associated with the trauma
  1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
  2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
  3. Inability to recall a certain aspect of the trauma
  4. Decreased participation in activities
  5. Feeling of detachment/estrangement from others
  6. Restricted range of affect
  7. Sense of foreshortened future
- Hyperarousal
  1. Poor sleep and concentration, irritability/anger, startle response, hypervigilence
- Disturbance causes distress or impairment
- Disturbance is more than one month

Acute Stress Disorder & PTSD

**Modifiers**

- **Acute Stress Disorder** (not defined as PTSD):
  - Occurs within 4 weeks of the traumatic event and lasts at least 2 days with remission within 4 weeks.
  - In ASD, in addition to reexperiencing, avoidance, and hyperarousal, patients also experience dissociative symptoms, including sense of numbing, detachment or absence of emotions, reduced awareness of surroundings and feelings of depersonalization and derealization.
- Acute PTSD (Onset within 3 months; duration less than 6 months)
- Chronic PTSD (Duration more than 6 months)
- Delayed PTSD (Onset more than 6 months after trauma)

Predictors of PTSD

- Female gender
- Victims of assaultive violence (sexual trauma, domestic violence): Up to 38% of women exposed to physical assault and/or rape develop PTSD
- Prolonged or repeated exposure
- Interpersonal trauma (vs. natural disaster or accident)
- Elevated heart rate and respiratory rate immediately following the trauma
- Childhood trauma (Some controversy regarding the role of antecedent trauma, however)
Predictors of PTSD (Con’d)

- Separation from parents during childhood
- History of psychiatric illness, especially depression and anxiety
- Personality traits/disorders: Borderline, Dependent, Antisocial, Paranoid
- High religiosity may confer less vulnerability to the development of PTSD

Course

- Varies considerably but about half of patients meet full PTSD criteria >2 years post initial diagnosis. In some patients (particularly those with comorbid alcohol abuse and childhood trauma) the disorder can have a chronic, unrelenting course.
- Lowered quality of life on various measures
- Evidence of higher mortality risk and higher risk of developing dementia

Additional info to consider with OEF/OIF Veterans

- Impact of multiple deployments on likelihood of PTSD symptoms
  --AND on family life!!
- Challenges of returning to civilian life
- Incidence of Traumatic Brain Injury (TBI)
- Substance abuse
- Military sexual trauma
- Addressing problems with anger
PTSD Psychotherapies

- CBT/Cognitive Processing
- Exposure therapies
- Imagery Rehearsal Therapy for Nightmares
- EMDR (Eye Movement Desensitization and Reprocessing)—of particular benefit with milder traumas
- Anger management training

PTSD Pharmacotherapy

- In general pharmacotherapy in PTSD is done to augment the effects of psychotherapy (particularly cognitive/exposure therapies—though solid data for EMDR as well) rather than the other way around
- In PTSD, managing other related symptoms, not all directly related to PTSD itself is also of importance: (Examples: affective lability, nightmares, insomnia)
- There have been at least 7 published randomized controlled trials supporting efficacy of SSRIs for acute Rx of PTSD.
- Sertraline and Paroxetine FDA approved for PTSD. (Improvement in all 3 symptom clusters and quality of life measures, treatments safe)

Other meds which may be of some utility in treating PTSD or specific PTSD symptoms
- Prazosin (nightmares)
- Mood stabilizers, particularly divalproex sodium (mood lability)
- SNRIs, TCAs
- Second generation antipsychotics
- Clonidine, propranolol (for autonomic hyperarousal)
- Also, high frequency TMS (particularly left) demonstrated benefit in one study
DSM-IV-TR Definition of OCD

- Either obsessions or compulsions (may be both)
- At some point the person has recognized the obsessions/compulsions to be excessive or unreasonable
- Symptoms cause marked distress, are time-consuming, affect functioning, or relationships

Obsessions

- Recurrent and persistent thoughts, impulses, or images experienced as intrusive & inappropriate & causing marked anxiety or distress
- Attempts to ignore, suppress, or neutralize
- Not worries about “real life” problems
- Recognition that obsessions are not imposed (such as with thought insertion)
Common Obsessions
- Aggressive
- Contamination
- Symmetry/Exactness
- Somatic
- Hoarding/Saving
- Religious
- Sexual
- Miscellaneous (Note >60% more than one)

Common Compulsions
- Checking
- Washing
- Repeating
- Ordering/Arranging
- Counting
- Hoarding
- Miscellaneous
  (>40% have more than one type)

Epidemiology
- 2-3% in U.S.
- Approximately same prevalence in other countries as well
- Male/Female Ratio About 1:1
- Age of Onset generally reported to be in early to mid-twenties; other data suggest average bimodal distribution with one group showing early onset (age 12-14) and another in the twenties.
- Can begin later in adulthood but unusual after 50 and rare after 65.
- Generally has a lifelong, waxing and waning course—worse with stress.
- May be worse during pregnancy and post-partum
- OCD associated with personality disorders?
  (Probably not—once you treat it!)
Factors which may predict poorer response:

- Sexual/religious obsessions (evidence mixed)
- Body dysmorphic disorder
- Poor insight
- Hoarding

- Male gender and early onset?? Earlier studies suggest “yes,” more recent studies conclude “no.”

Frequent Co-Occurrence With Other Conditions

- **Panic Disorder** (12% though 60% or more have panic attacks)
- **Depression** (Point prevalence approx 30%, lifetime approx 60%)
- **Tourette’s** (10-80% of Tourette’s pt’s have OCD sx; approx. 7% of OCD pts have Tourette’s
- **Substance dependence** (14%)
- **Anorexia** (7-17%)
- **Schizophrenia** (11%)

Psychotherapeutic Treatments--

- **Exposure and Response Prevention**
  Treatments (80% response, 70% maintain gains @ 2 years)

- **Cognitive Therapy without E/RP** (Helpful if can’t tolerate E/RP)
Pharmacologic Treatment for OCD

- **SSRIs** are drugs of choice
- **Clomipramine** is a good 2nd line option. No evidence of benefit with other TCAs.
  
  Note that dosages used and time to response (Approximately 12 weeks vs. 4 weeks when used as treatments for depression)

- Some data support the use of venlafaxine as a 2nd line agent as well.
- Doses are usually higher than for other anxiety disorders.
- Atypicals (best data with Risperdal) sometimes helpful as augmenting agents, not helpful as monotherapy, however.
- Possibly a role in the future for glutamatergic agents.

Phobias

**Specific Phobia** generally treated with psychotherapy only

**Social Phobia** treat similar to panic disorder

- Note Propranolol used for performance anxiety.

“We can do no great things, only small things with great love.”

Mother Teresa