

Anxiety Disorders

The Sky Is Falling!...

HISTORY OF ANXIETY

We can compare the symptom anxiety to the unpleasant experience of fear in the absence of that of which we might be afraid.

Whats the problem, exactly? Is it...

panic attacks?

Intense short-lived experience of fear, ~10 minutes.

What do we mean by "panic attack": any 4 of the following

- Palpitations, tachycardia
- Sweating
- Trembling or shaking
- Shortness of breath or dyspnea
- Sensation of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded
- Derealization or depersonalization
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias, eg. tingling in fingers
- Chills or hot flashes

PANIC ATTACKS are not necessarily the result of a panic disorder. They can occur with any of the other anxiety-like disorders; eg.

Social Phobia

(panic attacks on exposure to feared social situations),

Specific Phobia

(panic on exposure to a specific phobic situation),

Obsessive-Compulsive Disorder

(e.g., on exposure to dirt in someone with an obsession about contamination)

Posttraumatic Stress Disorder

(e.g., in response to stimuli associated with a severe stressor),

Separation Anxiety Disorder

(e.g., in response to being away from home or close relatives).

A single panic attack is just a panic attack; It can occur in any number of situations and in all sorts of mentally healthy and unhealthy people.

Having established that there has been a panic attack, ASK:

- **IS THIS NOT THE FIRST TIME?** "apprehensive anticipation", the fear of fear itself
- Are you **PERSISTENTLY CONCERNED** about having more panic attacks?
- **WORRIED ABOUT THE IMPLICATIONS** of an attack, eg. losing control, etc?
- Has your **BEHAVIOUR CHANGED significantly** since the attack?
- Has there been at least **ONE MONTH** of these symptoms?

This recurrent sort of picture may be a panic disorder of some sort. Thus: It's a panic disorder if panic attacks are the most worrisome feature.

WHAT BROUGHT THIS ON? You're looking for an underlying anxiety disorder. For example, ANYTHING stressful could provoke this sort of response; SOME SPECIFIC THINGS however are related to disorders:

- **SOCIAL SITUATIONS, UNFAMILIAR PEOPLE, SCRUTINY?** – social phobia
- **SPIDERS, MOTHS, HEIGHTS, SOCK PUPPETS?** – specific phobia
- **TOO MUCH DIRT?** Unable to act out a compulsive routine for some reason? – OCD
- **HORRIBLE EXPERIENCE** of a similar situation in the past? – Post-Traumatic Stress Disorder

The more specific the panic-provoking situation, the more likely is the diagnosis of a

Any number of other stressful evens can cause a panic attack. HOWEVER:

TO HAVE **PANIC DISORDER**, one must not have any specific anxiety syndrome features.

Also, **PANIC DISORDER** is either **WITH** or **WITHOUT AGORAPHOBIA**

AGORAPHOBIA is anxiety about being in places or situations

- from which escape might be difficult
- from which escape might be embarrassing
- in which help may not be available in the event of having a Panic Attack

Avoiding these situations may cause social + occupational dysfunction; thus it's a DISORDER

This includes situations such as being in open spaces, in vehicles, on bridges etc...

IF THE PANIC ATTACKS OCCUR WITHOUT A CLEAR PRECIPITANT, and there seems to be no agoraphobia in the picture, one can make a diagnosis of Panic Disorder Without Agoraphobia.

Lets say there was a HORRIBLE EXPERIENCE: then, is this **POST-TRAUMATIC STRESS DISORDER?**

→ Fear, Helplessness, HORROR experienced in response to nightmarish traumatic event; but

- **IS THE EVENT BEING PERSISTENTLY RE-EXPERIENCED** in one of the following ways?
 - Intrusive recollections of the event or repetitive themed play in children
 - Recurrent disturbing dreams of the event
 - FLASHBACKS eg. illusions and hallucinations when awakening from sleep or when intoxicated
 - Intense distress in response to anything that reminds you of the event
- **IS THERE AVOIDANCE OF RELATED STIMULI**, and **NUMBING** of RESPONSIVENESS? 3 or more of the following
 - efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - efforts to avoid activities, places, or people that arouse recollections of the trauma
 - Inability to recall an important aspect of the trauma
 - Diminished interest or participation in significant activities
 - feeling of detachment or estrangement from others
 - restricted range of affect (e.g., unable to have loving feelings)
 - sense of a foreshortened future (e.g., does not expect to have a career, marriage, or a normal life span)
- **ARE THERE SYMPTOMS OF INCREASED AROUSAL?** 2 or more of the following
 - difficulty falling or staying asleep
 - irritability or outbursts of anger
 - difficulty concentrating
 - **hypervigilance**
 - **exaggerated startle response**

If this has been going on for longer than 1 month, its PTSD. If this has been a short-term reaction to a recent stimulus, within the last 4 weeks, and lasting less than 1 month, it's an Acute Stress Disorder

WHAT ARE YOU SO WORRIED ABOUT? ... everything?

Generalised Anxiety Disorder may not present as a panic attack or anything specific to anxiety.

THE SYMPTOMS ARE PRESENT ON MOST DAYS FOR AT LEAST 6 MONTHS.

There are at least 3 symptoms, or only 1 symptoms in the case of children:

- restlessness or feeling keyed up or on edge
- being easily fatigued
- difficulty concentrating or mind going blank
- irritability
- muscle tension
- sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

The key feature is that these worries are uncontrollable, the person simply cannot put aside the topics of rumination.

Diagnosis of GAD is by exclusion of other anxiety syndromes; i.e the focus of the anxiety and worry is not confined to

- having a Panic Attack (as in Panic Disorder)
- being embarrassed in public (as in Social Phobia)
- being contaminated (as in Obsessive-Compulsive Disorder)
- being away from home or close relatives (as in Separation Anxiety Disorder)
- gaining weight (as in Anorexia Nervosa),
- having multiple physical complaints (as in Somatization Disorder),
- having a serious illness (as in Hypochondriasis), Where the preoccupation is of a sub-delusional intensity
- having had a horrible trauma (as in Posttraumatic Stress Disorder)

MORTALLY AFRAID OF SOMETHING? Find out what, and how afraid.

Specific Phobia can be of any damn thing. An anecdote relates how Sigmund Freud had a phobia of potted ferns.

Main Feature:

Unreasonable, Excessive Fear when Presented with or in Anticipation of the STIMULUS:
Stimulus being the object of the fear, or sometimes the merest mention of it.

Exposure will precipitate symptoms of panic, or a full-blown panic attack.

WORRIED ABOUT BEING AROUND PEOPLE? ... embarrassment, performance anxiety?

Social Phobia, or Social Anxiety Disorder is usually to do with public scrutiny and unfamiliar people.

Interestingly, the patient recognizes that this fear is unreasonable

The stressful situations are **AVOIDED** or **PAINFULLY ENDURED** and this leads to social/occupational dysfunction.

This may extend to ALL SOCIAL SITUATIONS, when combined with Avoidant Personality Disorder

PREOCCUPIED WITH SOMETHING ?

Obsessive Compulsive Disorder: obsession causes compulsion

Obsessions are intrusive thoughts with which you are preoccupied.

- recurrent and persistent thoughts and impulses, intrusive and inappropriate, causing marked distress
- not simply excessive worries about real-life problems
- the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
- NOT DELUSIONAL, i.e the person recognises these thoughts as the products of their own mind.

Compulsions are behaviours which act on the obsessional thoughts.

- The person feels driven to perform these acts in response to an obsession.
- the behaviors or mental acts are **aimed at preventing or reducing distress** or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

You feel **compelled to act on your obsessions**, and you feel anxious if you are prevented from doing so.

This contrasts with a drug habit: going through with the compulsion is not pleasurable or gratifying. It only means that you will worry less.

Interestingly, the patient recognizes that this behaviour is irrational, and yet they are powerless to prevent it.

FAMILY HISTORY: some anxiety behaviour is "learned", modelled on the parents from a young age. Some seems to be inherited as a personality trait. 7 times the risk for first degree relatives

OTHER IMPORTANT HISTORY:

FOR PANIC ATTACKS:

Try to rule out a physiological cause, eg....

- if they complain of chest pain, could there actually be some sort of underlying heart disease?
- Is their hyperventilation and distress due to some sort of acute respiratory thing, eg asthma?
- Has their thyroid ever been checked? Acute thyroid "storm" can produce quite a panic, in the patient as well as their physician

FOR ANXIETY in general:

DRUGS + ALCOHOL: anxious people often "self-medicate"

Accepted vice: smoking, coffee, energy drinks

Risk factors for suicide (see next page)

Approximately 20-30% of individuals with panic disorders have persistent symptoms up to 10 years from the time of initial diagnosis and treatment. The female-to-male ratio of panic disorders is 2:1. OCD occurs earlier in males (6-15y) than in females (20-29 y).

Elements of history most predictive of a serious suicide attempt:

<http://www.drrichardhall.com/suicide.htm> = (Suicide Risk Assessment: A Review of Risk Factors For Suicide In 100 Patients Who Made Severe Suicide Attempts)

- 1) **Severe anxiety (92%)** and/or panic attacks (80%)
- 2) **Depressed mood (80%)**
- 3) **Recent loss of close personal relationship (78%)**
- 4) **Alcohol or substance abuse (68%)**
- 5) **Feelings of hopelessness (64%), helplessness (62%), worthlessness (29%)**
- 6) **Global insomnia (46%) Partial insomnia (DFA or SCD or EMA) 92%**
- 7) **Anhedonia (43%)**
- 8) **A chronic deteriorating medical illness (41%)**
- 9) **Inability to maintain job or student status (36%)**
- 10) **Recent onset of impulsive behavior (29%)**
- 11) **Recent diagnosis of a life-threatening illness -- cancer, AIDS (9%)**

MENTAL STATE EXAMINATION: may not be remarkable or informative

Appearance: not exciting, probably normal

Behaviour: agitated, pacing, nail biting, hand wringing

Speech: no characteristic features; may be faster

Mood: Depression and mania coexist with anxiety

Affect may be depressed or manic

Thought Form may be distorted if there are psychotic features

Thought Content may be delusional, but not necessarily

Perceptual Disturbance should not be present

Insight do they realise they are obsessing needlessly?

Children rarely do. Adults probably will. Most have good insight.

Judgement may be impaired mid-panic attack

Cognitive Testing may not reveal any abnormality

DIFFERENTIALS: Physiological Causes of anxiety: the real list is massive; the following one is but a shadow

Exogenous:

Alcohol withdrawal
Amphetamine intoxication
Stimulants in general
Naltrexone injection
Bronchodilator toxicity

Endocrine:

Phaeochromocytoma
Adrenal Crisis
Hypoglycaemia
Thyrotoxicosis
Thyroid Storm
Pituitary adenoma

Anything that can cause chest pain; Anything that causes increased sympathetic activity Anything that causes shortness of breath Any causes of tremor Any causes of agitation (eg. delirium) Withdrawal from depressants Intoxication with stimulants

Cardiovascular:

Mitral valve prolapse
Pulmonary embolism
Atrial Fibrillation

Endocrine:

Phaeochromocytoma
Hypoglycaemia
Thyrotoxicosis
Thyroid Storm
Pituitary adenoma

INVESTIGATIONS:

FBC may not point towards anything useful

EUC electrolyte weirdness resulting from, say, not eating, or

LFT mainly to see what damage their drinking has been doing

BSL adrenaline excess in response to hypoglycaemia (it mobilises the stored glucose)

TFT for hyperthyroidism and thyroid storm

ECG because they will complain of chest pain and it would be embarrassing to miss an infarct or AF

Chest Xray for similar reasons

Urinary Catecholamines will point towards a catecholamine-secreting tumour

Urinary Drug Screen because they said they don't take drugs, but do you trust them?

Add various endocrine tests to taste.

MANAGEMENT of an ACUTE PANIC ATTACK

Talk therapy: control breathing, sit them down, in a soothing tone explain that they are having a panic attack and that it will pass. IF you cannot summon a soothing tone,

BENZODIAZEPINES will help

Also good for managing anticipatory anxiety

MANAGEMENT of PANIC DISORDER

CBT vs MEDICATION: no objectively demonstrated superiority of one over the other; usually will use both

Cognitive Behaviour Therapy

- weekly sessions for maybe 12 weeks
- if possible, include significant others in therapy sessions
- Disadvantage is that patients have to do "homework", eg. breathing exercises; plus they will have to confront the anxiety-provoking situations
- • Psychoeducation, to identify and name the patient's symptoms, provide a direct explanation of the basis for the symptoms, outline a plan for treatment etc...
- Continuous monitoring of panic attacks and anxious cognitions.
- • Daily anxiety-management techniques (e.g., abdominal breathing retraining) to reduce physiological reactivity
- • Cognitive restructuring to help the patient identify distorted thinking about sensations (e.g., overestimation of probability of negative consequence and other catastrophic thinking.
- Exposure to fear cues (Cues may be internal or environmental)
- Direct the patient to identify a hierarchy of fear-evoking situations
- Encourage the patient to confront feared situations on a regular (usually daily) basis until the fear has attenuated.

Psychodynamic and other psychotherapies

= The treatment of choice for some patients with personality disorders and Axis I comorbidities

• The goal is to elucidate and resolve conflicts and unconscious processes that may be causing or increasing vulnerability to the occurrence of panic symptoms. Focus is on unconscious symptom determinants.

• Place symptoms in the context of the patient's developmental history and current relationships and realities.

Pharmacotherapy

SSRIs: the most favorable balance of efficacy versus adverse effects.

• Response takes 4 weeks; for some full response takes 8 to 12 weeks.

FLUOXETINE is the go, initially- especially if there is comorbid depression

PAROXETINE is more sedating and may be better for anxious insomniacs

TCAs: second line agents

Side-effects limit usefulness

Wait at least 6 weeks after initiation of TCA treatment

(with at least 2 of those weeks at full dose)

before deciding whether a TCA is effective.

**Start any antidepressants on
HALF THE DEPRESSION DOSE:
there may be a hypersensitivity**

MAOIs: third-line, othon-else-works agents

BENZO WITHDRAWAL happens even after 6 to 8 weeks of treatment, but there is usually little dose escalation over time with long-term use.

Benzodiazepines: not good for anything except short-term relief, or before induction of a more permanent course of treatment. No longer than 4 to 12 weeks.

CLONAZEPAM is good, less empirical withdrawal symptoms with discontinuation

ALPRAZOLAM (Xanax) is falling out of favour because of its addictiveness

• To discontinue, taper very slowly, probably over 2 to 4 months and at rates no greater than 10% of the dose per week.

OTHERS: there is limited data to support to use of venlafaxine or nefazodone

MANAGEMENT of GENERALISED ANXIETY DISORDER

CBT vs MEDICATION: no objectively demonstrated superiority of one over the other;
CBT + MEDICATION = possibly more benefit

Cognitive Behaviour Therapy

- Recovery rates around 50% in 6 months; 6-12 weeks
- See above for details; its much the same.

Pharmacotherapy

Benzodiazepines: Mainstay of treatment in the SHORT TERM

Much like for panic disorder, you should not use these for long. PRN only after 4-8 weeks.

5HT-(1a) Partial Agonists:

BUSPIRONE has comparable efficacy to benzodiazepines in treating GAD.
improvement maintained longer, but onset of improvement is slower
Efficacy of buspirone may be decreased by recent benzodiazepine treatment.

TCAs: **IMIPRAMINE** is the only one with any proven effect

SSRIs: **Fluoxetine** and **Sertraline** seems useful;

only **Paroxetine** has FDA approval, seems to work better than benzodiazepines

OTHERS: **VENLAFAXINE** appears to work better than Buspirone

MANAGEMENT of POST-TRAUMATIC STRESS DISORDER

Outpatient treatment is the most appropriate for the majority of patients.

Will probably require a combination of **MEDICAL AND PSYCHOLOGICAL THERAPY**

Cognitive Behaviour Therapy

Target the distorted threat appraisal process (e.g., through repeated exposure or through techniques focusing on information processing without repeated exposure) in an effort to desensitize the patient to trauma-related triggers.

• **May speed recovery and prevent PTSD** when therapy is given 2 to 3 weeks after trauma exposure.

Psychodynamic psychotherapy focuses on the meaning of the trauma for the individual in terms of prior psychological conflicts and developmental experience and relationships. Focuses on the effect of the traumatic experience on the individual's prior self-object experiences, self-esteem, altered experience of safety, and loss of self-cohesiveness and self-observing functions.

Psychological debriefing doesn't work! Supposed to provide education about trauma experiences, the usual chronology of development of PTSD, and emotions associated with a recently experienced traumatic event.

• There is no evidence that psychological debriefing is effective in preventing PTSD or improving social and occupational functioning. **It may actually increase symptoms**, especially when used with groups of unknown individuals with widely varying trauma exposures or when administered early after trauma exposure and before safety and decreased arousal are established.

Pharmacotherapy

... best when resorted to in situations when the patient's mental state forbids psychotherapy.
Severe symptoms eg. insomnia may be treated with prn medication. Otherwise...

SSRIs: Positive effect on all 3 symptom clusters of PTSD. They are effective treatments for psychiatric disorders that are frequently comorbid with PTSD (e.g., depression, panic disorder, social phobia, and obsessive-compulsive disorder).

For Acute Stress Disorder, SSRIs have proven efficacy.

MANAGEMENT OF OBSESSIVE-COMPULSIVE DISORDER

Apply the usual bouquet of psychotherapy, cognitive behaviour therapy, and meds.

Psychological Therapy revolves around exposure to triggers, plus use of relaxation techniques.

PHARMACOTHERAPY:

1st: Start an SSRI: doses in excess of those normally used for depression.

Expect some response in 6 to 10 weeks, no earlier.

No Response? Add CLOMIPRAMINE (TCA)

Still no response? Change Clomipramine to Venlafaxine

STILL NO RESPONSE? Try everything; lithium, neuroleptics, buspirone, ECT...

ANXIOLYTICS IN DETAIL

BENZODIAZEPINES

Cross-tolerance may develop between alcohol and benzos! Plus, some eg. diazepam, have active metabolites, hence the apparently longer half-life.

Bind to specific site on the GABA receptor

This potentiates the effect of GABA; hence chloride influx into the neuron, and hence inhibition.

ALPRAZOLAM (Xanax): half life of about 12 hours, effectiveness lasts even less than that.

No longer a first-line drug; though short activity is tempting- may be good for acute panic.

CHLORDIAZEPOXIDE (Librium): half life over 100 hours! , slow onset of action

Not a first-line drug; consider it in context of alcohol withdrawal.

CLONAZEPAM: half life of about 20 to 50 hours; seems to be the modern benzo of choice for anxiety.
its also good as an **anticonvulsant**.

DIAZEPAM (Valium): half life of about 100 hours, may accumulate with multiple dosing.

!! MOST RAPID ABSORPTION AMONG BENZODIAZEPINES !!

LORAZEPAM (Ativan): half life of about 15 hours, effectiveness lasts even less than that.

Also good for treating acute manic psychosis!

The **ONLY BENZODIAZEPINE** available in intramuscular injection form!

ALPRAZOLAM: half life of about 12 hours, effectiveness lasts even less than that.

No longer a first-line drug; though short activity is tempting- may be good for acute panic.

HYPNOTIC BENZODIAZEPINES

TEMAZEPAM: half life of about 10 hours, it's the **SLEEPING PILL OF CHOICE**.

NON-BENZODIAZEPINE ANXIOLYTICS

BUSPIRONE: serotonin 1a partial receptor agonist;

half life of 2 to 11 hours, Side Effects: Dizziness, headache, GI distress, fatigue.

Buspirone lacks the sedation and dependence associated with benzodiazepines, and it causes less cognitive impairment than the benzodiazepines. **It is less effective in patients who have taken benzodiazepines in the past** because it lacks the euphoria and sedation that these patients may expect with anxiety relief.

Onset of action may take 2 weeks.