Anxiety Disorders

Taylor Preston, MD
Associate Professor of Psychiatry
Psychiatry Residency Training Director
University of Alabama at Birmingham

Disclosure Statement

- I have no conflicts of interest to disclose.

Anxiety

- Subjective experience of fear & its physical manifestations
- Symptoms of anxiety may include:
  - palpitations, sweating, dizziness, GI disturbances, trembling, "butterflies" in the stomach, tingling in extremities, shortness of breath, or choking
- Anxiety is a common, normal response to perceived threat
- Distinguish between normal & pathological anxiety
- In pathological anxiety, symptoms interfere with daily life and interpersonal relationships
- Anxiety disorders are the most prevalent type of psychiatric disorders.

Panic Attack

- A discrete period of intense fear & discomfort in which four or more of the following symptoms develop abruptly:
  - Palpitations
  - Sweating
  - Shaking or trembling
  - Shortness of breath
  - Choking sensation
  - Chest pain or discomfort
  - Nausea
  - Light-headedness or dizziness
  - Depersonalization or derealization
  - Fear of losing control or "going crazy"
  - Fear of dying
  - Numbness or tingling sensations
  - Chills or hot flushes

Panic Disorder--Criteria

- Recurrent, unexpected panic attacks
- At least one of the attacks has been followed by at least 1 month of one or more the following:
  - Persistent concern about having additional attacks
  - Worry about the implications of the attack or its consequences (ex: losing control or "going crazy")
  - A significant change in behavior related to the attacks
- Commonly co-exists with agoraphobia
- Note: You can have a panic attack without having panic disorder!

Agoraphobia

- Commonly comorbid with panic disorder
- Is now it's own disorder- separate from panic disorder
- Anxiety about being in places or situations from which escape might be difficult, or in which help would not be readily available in the event of a panic attack

Panic Disorder

- Triggers: Caffeine & nicotine can trigger or worsen anxiety symptoms
- A thorough medical and social history is crucial!
- Rule out:
  - Medical conditions
  - Substance intoxication
  - Substance withdrawal

Panic Disorder--Treatment

- Maintenance treatment with SSRIs, such as paroxetine (Paxil), sertraline (Zoloft), or fluoxetine (Prozac)
  - Usually need higher doses of SSRIs to treat panic disorder compared to depression
  - Take at least 2 weeks to have clinical effect
- Can consider acute initial treatment with benzodiazepines. Use while awaiting effect of SSRI.
  - Be wary of their use in patients with a substance abuse history!
  - Beta-blockers such as propranolol can be used (but this is off-label).
- Psychotherapy
  - Cognitive Behavioral Therapy (CBT)
    - Exposure Therapy
    - Breathing/relaxation exercises

Phobias

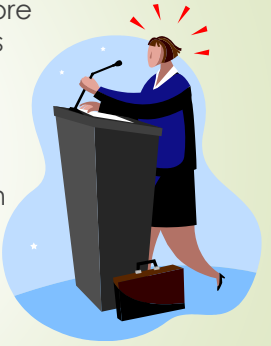
- Phobia: Irrational fear that leads to avoidance of the feared object or situation
- Specific Phobia: Strong, exaggerated fear of a *specific* object or situation
- Social Phobia: Fear of *social* situations in which embarrassment can occur

Specific Phobia--Diagnosis

- Rarely show up in general psychiatry clinic
- Exposure to the situation or object brings about an immediate anxiety response (such as a panic attack).
- Patient recognizes that the fear is excessive
- Situation is avoided when possible or tolerated with intense anxiety
- Interferes with patient's functioning

Social Phobia--Diagnosis

- Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others.
- ***Situation is avoided*** when possible or tolerated with intense anxiety
- This is not just being shy! It interferes with patient's functioning.



Phobias--Treatment

- Therapy
  - Exposure Therapy including systematic desensitization-this is the gold standard!
  - Cognitive Behavioral Therapy (CBT)
- Benzodiazepines can have a role in specific phobia, but there are no meds with robust evidence.
- Beta-blockers such as propranolol can be effective (again, this is off-label). Especially good for a phobia such as public speaking.
- For social phobia, maintenance treatment with SSRIs: Paroxetine (Paxil), sertraline (Zoloft), or fluvoxamine XR (Luvox). Venlafaxine XR (Effexor) also has an FDA indication.

- http://www.youtube.com/watch?v=oZ54PfXdVXQ

Obsessive-Compulsive D/O--Diagnosis

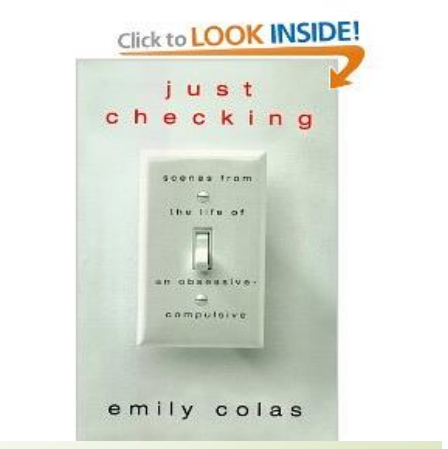
- Either obsessions or compulsions or both:
  - Obsessions:
    - Recurrent & persistent ***intrusive*** thoughts or impulses that cause marked anxiety & are not simply excessive worries about real problems.
    - Person attempts to suppress the thoughts
    - Person realizes thoughts are product of own mind
  - Compulsions:
    - Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession or "rules"
    - Behaviors are aimed at reducing distress or preventing a dreaded event, but there is no realistic link between the behavior & what it is trying to neutralize or prevent
    - Often compulsions are aimed at relieving an obsession

OCD--Diagnosis continued

- Person is aware the obsessions & compulsions are unreasonable & excessive
- In other words, *ego-dystonic*.
- Symptoms cause marked distress, are time consuming (>1 hr per day) or significantly interfere with the person's functioning.
- Not to be confused with Obsessive-Compulsive Personality Disorder (OCPD).

OCD

- Common patterns:
  - Contamination
  - Doubt
  - Symmetry
  - Intrusive thoughts without compulsions (violent or sexual)
- Increased incidence in those with 1st degree relative with Tourette's Disorder. Both are associated with the cingulate.



OCD--Treatment

- SSRIs, especially paroxetine (Paxil), sertraline (Zoloft), or fluoxetine (Prozac)
  - Fluvoxamine (Luvox) also has FDA approval for treatment of OCD
  - Almost always need higher doses of SSRIs
- Tricyclic Antidepressants (TCAs), especially **clomipramine**, can be used (but SSRIs are first line due to safety profile).
- Therapy
  - Exposure & Response Prevention- A type of Exposure therapy

Posttraumatic Stress Disorder (PTSD)

- Patient experienced, witnessed, or was confronted with a traumatic event that was potentially harmful or fatal (but this does not have to be related to the military).
- DSM-5 has added that this can be from hearing about the trauma happening to a loved one or from repeated exposure to aversive details.
- The response to the event involved intense fear, helplessness or horror.

PTSD

- Note the four types of symptoms present: re-experiencing, avoidance, hyperarousal, negative alteration of cognitions or mood.
- Traumatic event is persistently ***re-experienced*** (such as in nightmares, flashbacks, or intrusive thoughts).
- Stimuli associated with the trauma are ***avoided.***
- Symptoms ***of increased arousal***
- Negative alterations of **cognitions or mood**
- Duration of disturbance is greater than **one month**

PTSD

- Medication Treatment:
  - SSRIs are first line treatment, also the SNRI venlafaxine
  - Paroxetine, Sertraline and Venlafaxine have formal FDA indications for PTSD
  - Avoid benzodiazepines
  - Prazosin- Helpful for nightmares
- Prolonged Exposure Therapy
- Cognitive Processing Therapy
- Eye Movement Desensitization & Reprocessing (EMDR)

Acute Stress Disorder

- Just think PTSD symptoms <1 month duration
- Similar symptoms & criteria as PTSD

No FDA approved treatments for acute stress disorder

Generalized Anxiety D/O

- Excessive anxiety & worry most days out of the week for at least 6 months, about a number of events or activities
- Usually they have experienced this most of their lives.
- Anxiety & worry are associated with 3 or more of the following:
  - Restlessness, feeling keyed up or feeling on edge
  - Being easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance

GAD--Treatment

- SSRIs are first line
- SNRIs such as venlafaxine (Effexor) are also indicated
- Benzodiazepines (preferably short term use)
- Hydroxyzine (Vistaril)
- Beta-blockers such as propranolol (Again, off-label)
- Buspirone (BuSpar) Therapy
- Cognitive Behavioral Therapy (CBT)

Benzodiazepines

Medication	Brand Name	Dose Equivalent	Usual Daily Adult Dose	Half-life
Diazepam	Valium	5	2.5-40 mg	30-100 hours
Clonazepam	Klonopin	0.25-0.5	0.5-4 mg	20-50 hours
Alprazolam	Xanax	0.5	0.5-6 mg	6-12 hours
Lorazepam	Ativan	1	0.5-6 mg	14 hours
Oxazepam	Serax	15	15-120 mg	8 hours
Chlordiazepoxide	Librium	12.5	10-100 mg	5-30 hours *3-200 H (active metabolites)
Temazepam	Restoril	10	7.5-30 mg	8 hours

Case 1

- 34 year old male presents to primary care with complaint of longstanding worry. He reports this as being a problem since childhood, but that it has be a more impairing over the past 8 months since he started a new job. He notes worsening insomnia, muscle tension and difficulty focusing at work.
- What is the diagnosis?

GAD

- What treatment would you like to offer?

- You start sertraline 50mg.
- 4 weeks later the patient reports modest benefit but complains of sexual side effects.

Other treatment options

- Switch SSRIs
- Change to Buspirone
- CBT referral

Case 2

- 26 year old female patient presents to primary care with a complaint of multiple episodes of heart palpitations, shortness of breath, and sweating. She reports she felt like she was about to die. Twice she presented to the ED and had a negative cardiac work-up. Over the past few weeks she's been skipping many of the lectures for her grad school program because she is afraid she will have such an episode and feel trapped.

Diagnosis?

Panic Disorder

- Treatment options?

- SSRI?
- Bridge with a benzodiazepine?
- Other options: SNRI? Buspirone? Propranolol?

Follow-up

- You start the patient on sertraline and titrate to 100mg over 2 weeks. At 6 week follow up, her panic attacks are less frequent, but she still reports 2 attacks per week.
- What now?

Case 3

- 52 year old female patient presents for care 3 months after being the victim of a sexual assault. She complains of nightmares several times per week. She reports she feels "paranoid" and is always looking at men around her wondering if they might be a danger to her. She also has been avoiding males in general, which has been problematic in her workplace. She socially isolates and rarely goes out with friends anymore.

- Diagnosis?

PTSD

- Treatment options?

- SSRI?
- SNRI?
- What about for insomnia and/or nightmares?
- What do you make of her "paranoia?"