Primary Care Update 2009: Anxiety Disorders

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Anxiety Disorders

• Epidemiology
• “Pathophysiology”
• Assessment and Diagnosis
  – Screening and Key Questions
  – Overview of Anxiety Disorders
    • Panic Disorder
    • Social Phobia or social anxiety
    • Obsessive Compulsive Disorder
    • Post-Traumatic Stress Disorder
    • Generalized Anxiety Disorder
    • Somatoform Disorders and anxiety
• Treatments
  – Psychosocial Treatments
  – Pharmacologic Treatments

Question
What is the prevalence of anxiety disorders in the primary care population?
1) 2%
2) 5%
3) 10%
4) 20%
5) 50%

Answer: 20% (choice 4)
Prevalence of Psychiatric Disorders*

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Lifetime prevalence(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mood disorder</td>
<td>19.54</td>
</tr>
<tr>
<td>Major depression</td>
<td>16.54</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>4.30</td>
</tr>
<tr>
<td>Bipolar I</td>
<td>3.31</td>
</tr>
<tr>
<td>Bipolar II</td>
<td>2.33</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>19.16</td>
</tr>
<tr>
<td>Social anxiety</td>
<td>4.97</td>
</tr>
</tbody>
</table>


Epidemiology

Twelve-month prevalence estimates for anxiety in the general population: 18.1% (Arch Gen Psychiatry. 2005;62:617-627)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence in primary care population (n=965)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>8.6% (83)</td>
</tr>
<tr>
<td>GAD</td>
<td>7.6% (73)</td>
</tr>
<tr>
<td>Panic d/o</td>
<td>6.8% (66)</td>
</tr>
<tr>
<td>Social phobia</td>
<td>6.2% (60)</td>
</tr>
<tr>
<td>At least one d/o</td>
<td>19.5% (188)</td>
</tr>
</tbody>
</table>


Morbidity of Anxiety Disorders

<table>
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<th>Disorder</th>
<th>Twelve-month prevalence estimates for anxiety in the general population: 18.1% (Arch Gen Psychiatry. 2005;62:617-627)</th>
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</tbody>
</table>


Question

What is the prevalence of panic disorder in patients with coronary artery disease?

1) 2%
2) 5%
3) 10%
4) 50%
5) 75%

41% with an anxiety disorder reported no current treatment
Question
What is the prevalence of panic disorder in patients with coronary artery disease?
Answer: 10-50% (choices 3 or 4)


Cardiac Presentations of Anxiety
- GAD was the primary dx among 20% of patients with atypical chest pain (1).
- 55% of patients with chest pain and normal coronary arteries (2).
- 50% of patients seeking cardiac evaluation (3).


GI Presentations of Anxiety:
Irritable Bowel Syndrome

<table>
<thead>
<tr>
<th>Study</th>
<th>Lifetime prevalence of GAD</th>
<th>Current rate of GAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Walker et al. (n=47)</td>
<td>58%</td>
<td>25%</td>
</tr>
<tr>
<td>2. Lydiard et al. (n=35)</td>
<td>28%</td>
<td>13%</td>
</tr>
</tbody>
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"Pathophysiology" of Anxiety Disorders

Anxiety is a normal and natural reaction to environmental stimuli ("fight or flight" response)

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Problematic anxiety can develop because normal human problem solving skills do not work for certain psychological phenomena

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MILK

Anxiety Disorders

Role of Avoidance – avoiding psychological phenomena usually makes them stronger

Many anxiety disorders arise as individuals attempt to suppress or avoid the unavoidable (ie, common mental processes)

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**The Three S’s of the Psychiatric Interview**

1) S – Stressors/triggers
2) S – Suicidality
3) S – Substance Abuse

**Screening Questions**

“Over the last two weeks, how often have you been bothered by the following problems?”

1. **Feeling nervous, anxious, or on edge**
2. **Not being able to stop or control worrying**

0-not at all, 1-several days, 2-more than half the days, 3-nearly every day

Score of 2 or greater, has sensitivity of 0.86, and specificity of 0.70 for any anxiety disorder


**Key Questions**

- Is there an underlying medical disorder or substance abuse?
- Is the anxiety triggered (cued) or not?
- Are there panic attacks?

**Anxiety disorders**

<table>
<thead>
<tr>
<th>Is the anxiety cued or uncued?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cues</td>
</tr>
<tr>
<td>Panic attacks?</td>
</tr>
<tr>
<td>yes</td>
</tr>
<tr>
<td>Specific object or situation → specific phobia</td>
</tr>
<tr>
<td>Social situation → social phobia</td>
</tr>
<tr>
<td>Reminder of traumatic event → PTSD</td>
</tr>
<tr>
<td>OCD, GAD or Anx d/o nos</td>
</tr>
<tr>
<td>closed in spaces (no help) → agoraphobia</td>
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Case Vignette

A 27-year-old woman has dissociative (feelings of unreality) symptoms accompanied by nightmares, hypervigilance, and anger that continue 6 weeks after being a victim of an armed robbery and assault. What diagnosis, if any, should she receive?

1. Acute Stress Disorder
2. Anxiety Disorder, not other specified
3. Generalized anxiety disorder
4. Obsessive-Compulsive Disorder
5. Post-Traumatic Stress Disorder

Case Vignette Answer

5. Post-Traumatic Stress Disorder
Acute Stress Disorder lasts for less than 4 weeks, whereas PTSD lasts more than 4 weeks.

DSM IV Anxiety disorders

- Panic Disorder
- Agoraphobia
- Social Phobia (Social Anxiety Syndrome)
- Specific Phobia
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Acute Stress Disorder
- Generalized anxiety disorder
- Adjustment disorder, with anxious features
- Anxiety Disorder, not other specified
### Panic Attacks: A Syndrome

- Not specific to Panic Disorder
- Occurs in social phobia, specific phobia, PTSD and OCD
- May herald depression
- May be secondary to:
  - underlying medical condition
  - medication side effect
  - illicit drug use

### Panic Attack

- Episodes have a sudden onset and peak rapidly (usually in 10 minutes or less)
- Often accompanied by a sense of imminent danger or doom and an urge to escape
- Frequently presents to ER with fear of catastrophic medical event (e.g., MI or stroke)

### Panic Attack

Discrete period of intense fear or discomfort accompanied by four or more of following:
- Palpitations, Sweating, Trembling
- Choking, Chest pain
- Dizzy, faint, Derealization
- Numbness
- Chills or hot flashes
- Cognitive Triad: Fear of dying, passing out, or going crazy [video]

### Panic Disorder

- Recurrent unexpected panic attacks
- Followed by one or more of the following:
  - Anticipation of additional attacks
  - Worry about implications of attacks
  - Change in behavior
- With or without Agoraphobia
**Agoraphobia**

- Anxiety about being in situations from which escape might be difficult (“safe zones”)
- Usually secondary to panic attacks
- Avoided situations include: driving, bridges, tunnels, elevators, airplanes, malls, long lines, sitting in middle of row, etc.

**Panic Disorder**

**Key Diagnostic Points**

- Panic attacks can occur in a number of Anxiety Disorders in addition to Panic Disorder
- The diagnosis of Panic Disorder requires the presence of recurrent unexpected (uncued) panic attacks.
- The uncued panic attacks of Panic Disorder can progress, over time to the cued attacks of Specific Phobia or Social Phobia (and vice versa).

**Social Phobia**

*(Social Anxiety Syndrome)*

Social Phobia (often overlaps with Avoidant Personality Disorder)

Common, but often difficult to treat

Morbidity may be quite high

**Specific Phobia**

Specific Phobia

Usually best treated with desensitization, but medication augmentation occasionally indicated
Specific phobias (that start with the letter “A”)

- Ablutophobia — fear of bathing, washing, or cleaning.
- Acrophobia, Altophobia — fear of heights.
- Agrapophobia — fear of places or events where escape is impossible or when help is unavailable.
- Allographobia — fear of sexual abuse.
- Allographobia — fear/dislike of cats
- Algophobia — fear of pain.
- Anglophobia — fear of the English or English culture.
- Anthropophobia — fear of people and being in a company, a form of social phobia.
- Anthropophobia — fear of flowers.
- Apiphobia, Melissophobia — fear/dislike of bees
- Aquaphobia, Hydrophobia — fear of water.
- Arachnophobia — fear/dislike of spiders
- Astrapophobia — fear of thunder, lightning, and storms; especially common in young children.
- Autophobia — fear of being alone
- Aviophobia, Aviatophobia — fear of flying.

Obsessive-compulsive disorder (OCD)

Patient usually has obsessions and compulsions:

**Obsessions:**
- Recurrent and persistent thoughts, impulses, or images
- Viewed by patient as intrusive and inappropriate and cause marked anxiety or distress.
- Recognized as a product of his or her own mind.

**Compulsions:**
- Repetitive behaviors or mental acts
- Performed in response to an obsession, or according to rules that must be applied rigidly.
- Generally not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

Typical obsessions:
- Contamination: Fear of dirt or germs, bodily waste or fluids (a feeling of dirtiness)
- Ordering: Concern with order, symmetry (balance) and exactness
- Perfectionism: Worry that a task has been done poorly, or a mistake has been made
- Intrusive thoughts: blasphemous, sexual, violent

Typical compulsions:
- Repeated washing/cleaning, ritual behavior or thinking
- Concern with order, symmetry (balance) and exactness
- Checking drawers, door locks and appliances to be sure they are shut, locked or turned off (see also hypochondriasis)
- Ritual behavior or “superstitious thinking”
- Hoarding
Treatment of OCD

Treatments include:
1) SSRI’s: usually high dose, take longer for effect
2) Clomipramine (Anafranil)
3) Behavior Therapy: Exposure-Response Prevention
4) Psychosurgery for treatment-refractory cases

Post-Traumatic Stress Disorder (PTSD)

Requires history of trauma

Three clusters of symptoms
- Re-experiencing (flashbacks, nm’s)
- Avoidance and numbing
- Arousal (insomnia, hypervigilance)

- Duration of more than one month (duration is the distinguishing factor between Acute Stress Reaction)

Generalized Anxiety Disorder

- Excessive worries for at least six months about real life problems such as school and work performance.
- Accompanied by anxiety symptoms
  - 3 or more of the following:
    - Restlessness or feeling keyed-up or on edge
    - Easy fatigability
    - Trouble concentrating
    - Irritability
    - Muscle tension
    - Sleep disturbance

Case vignette

For the past three months, a 38yo depressed man has been obsessed with thoughts that he is evil and guilty of being insensitive to others. He has intrusive thoughts that he should kneel down in front of his co-workers in the weekly staff meeting and ask their forgiveness. He tries to ignore these thoughts and suppress them by repeatedly counting the number of ceiling tiles in the room when the thoughts occur.

He periodically recognizes that the concerns are excessive but he cannot control them.
Case vignette
Which ONE of following diagnoses is most likely?

a) Generalized anxiety disorder
b) Major depressive disorder
c) Obsessive-compulsive disorder
d) Obsessive-compulsive personality disorder
e) Post-traumatic stress disorder

Case vignette (answer)
Which ONE of following diagnoses is most likely?

**Answer: b) Major depressive disorder**

Guilty ruminations may be part of a depressive syndrome and MDD takes precedence over OCD in this case. However, mood-incongruent obsessions (e.g., sexual obsessions) might lead one to MDD co-morbid with OCD.

OCD is different from OCPD.

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Health Anxiety and Hypochondriasis
- Fear or belief of potential of serious illness
- Misinterpretation of bodily sensations
- Persists despite appropriate medical reassurance
- Lasts for at least six months
- Variant of OCD?
Hypochondriasis and Health Anxiety

• From the Greek hypochondrium
• Affected individuals frequently investigate symptoms through reading or the Internet (cyberchondria)
• “Every physical symptom must have an explanation.”

Hypochondriasis and Health Anxiety

• Reassurance may reinforce fear, particularly if it reduce anxiety temporarily
• “Sick role” may reinforce behaviors
• Physical de-conditioning may increase somatic sensations
• Social isolation (eg, staying home from work) may worsen somatic preoccupation.

Hypochondriasis: Treatment

Possible treatment modalities include:
• SSRI’s
• Cognitive-behavioral therapy (CBT)
• Education about health beliefs


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Psychotherapy of Anxiety Disorders

Psychodynamic psychotherapy

The primary focus is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension (drive theory)

More brief and less intensive than psychoanalysis.

Relies on the interpersonal relationship between client and therapist.

Behavior Therapy

Anxiety disorders are conceptualized as arising from avoidance behaviors. Therefore, treatment is directed at having the individual desensitize to avoided stimuli through exposure and other behavioral interventions. Internal mental states are relatively unimportant.

Cognitive Therapy

Anxiety disorders are conceptualized as arising from cognitive distortions. Thus, treatment is directed at changing unproductive or intrusive thought patterns. The individual examines his or her feelings and learns to separate realistic from unrealistic thoughts.

Cognitive-Behavioral Therapy (CBT)

Combination of cognitive and behavior therapies.

Components of Cognitive-Behavior Therapy (CBT)

- **Education**, how to distinguish between helpful and unhelpful worry. Developing an accepting and proactive response to anxiety.
- **Monitoring**, what triggers it, the specific things that are worried about, and the severity and length of a particular episode. Useful for tracking progress as well as developing “perspective”.
- **Physical control strategies**, Deep breathing and progressive muscle relaxation help decrease the physical over-arousal of the “fight or flight” response.
- **Cognitive control strategies**, Learning to evaluate and alter thinking patterns that contribute to anxiety. Challenge and test thoughts such as: “Worry is uncontrollable” or “If I worry, bad things are less likely to happen.”
- **Behavioral strategies**, Avoiding avoidance. Imagining feared object. Time management and problem-solving skills are also effective behavioral techniques.

Stress Management

Relaxation techniques help individuals develop the ability to cope more effectively with the stresses and physical symptoms contributing to anxiety (eg, breathing retraining and exercise).

Problem solving techniques
Self monitoring
Applied relaxation
Self-Help Books for Anxiety Disorders

- Anxiety and Phobia Workbook, by E. Bourne
- Stop Obsessing, by E. Foa


Websites

Anxiety Disorders Association of America
http://www.adaa.org/

The Anxiety and Phobia Internet Resource (TAPIR)
http://www.algy.com/anxiety/

Case Vignette

A 77yo male, widowed Chinese retired accountant, who is healthy except for mild hypertension and a history of chronic multiple somatic complaints, now complains of a “heavy head”, as well as ongoing complaints of anxiety, decreased energy and insomnia for the past several months or years (hx is vague). Screening neuro exam is unremarkable. Routine labs done two months ago are also noncontributory.

Case Vignette Question

Which of the following is the MOST appropriate in the management of this patient?

- Avoid discussing social issues with patient.
- The goal should be complete remission of symptoms.
- Initiate citalopram 20mg daily.
- Instruct patient to go to Emergency Department “as needed”.
- Instruct patient to return to clinic for follow-up “as needed”.

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Case Vignette

Answers Discussed
a. Focus on social issues
b. “Curing the patient” should not be the goal in this situation
c. Antidepressants can be helpful for subclinical anxious syndromes.
d. Regular visits decreases inadvertent reinforcement of symptom production.
e. As above.

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Anxiety Disorder Treatments

• Psychotherapy
• Psychopharmacological

Effectiveness = [efficacy of treatment] X [degree to which the patient is engaged in treatment]

Robustness = ease of administering a particular treatment (eg, pharmacotherapy more robust than psychotherapy)

Anxiety Disorder Treatments

Psychopharmacological
• selective serotonin reuptake inhibitors
• other antidepressants
• anxiolytics (benzodiazepines)
### Antidepressants

**SSRI’s (selective serotonin reuptake inhibitors)**—first line (fairly safe in OD), recommend 9m minimum duration of treatment side effects:

- a) "long term": weight gain (moderate), sexual side effects (in around 35%)
- b) "short term": nausea, diarrhea, headache, rash, insomnia, sweating
- c) "serotonin syndrome"—usually in combo with two or more serotonergic agents: restlessness, confusion, flushing, tremor progressing to hyperthermia, hypertonicity, rhabdomyolysis, death

Fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), citalopram (Celexa), escitalopram (Lexapro)

**Other antidepressants**

- Mirtazapine (Remeron): sedation and weight gain
- Venlafaxine (Effexor): Mixed NE and 5HT activity, increases BP, similar side effect profile to ssr’s, significant withdrawal
- Duloxetine (Cymbalta): Also mixed NE and 5HT activity, pain
- Bupropion (Wellbutrin): low rate of sexual side effects or weight gain, associated with increase rate of seizures, not for use in patients with eating disorders, prior seizure d/o
- Nefazodone (Serzone): 5-HT2 blocker, often recommended for anxious depression, black box warning for liver failure, low rate of sexual se’s
- Trazodone (Desyrel) – usually prescribed as a hypnotic (ie, sleep aid), priapism

### Anxiolytics

**Buspirone** – partial agonist of 5HT1a

- 5-20mg tid, takes 2-6 weeks
- no w/d sx, easy to use, may be preferred in elderly

**Benzos**
Anxiety Disorders
Benzos

Anxiolytics—benzodiazepines (BDZ)

- All share same mechanism of action
- Vary by speed of onset, metabolism and duration of action
- Shorter-acting usually means faster speed of onset: eg, alprazolam (Xanax), triazolam (Halcion)
- Longer-acting: diazepam (Valium), clonazepam (Klonopin), lorazepam (Ativan)

Main side effects include: sedation, ataxia, amnesia, potential for abuse
- Generally useful for short-term anti-anxiety, tolerance frequently develops within 1-2 weeks
- Should not be discontinued abruptly (esp. shorter acting bdz’s): taper over 1-3 weeks

BDZ’s and the geriatric patient:
It’s not just about addiction
Benzodiazepines associated with:
- Sleep disturbance
- Cognitive difficulty
- Impairment in activities of daily living
- Motor vehicle accidents
- Gait disturbance (with concomitant increased risk of hip fractures)
  [references next slide]

References

Clinician Attitudes

- Geriatric patients have low rate of addiction.
- “If it works and she doesn’t abuse it, who cares?”
- Continuation is compassionate; discontinuation is harsh.
- “In the greater scheme of things I have a feeling there are other problems that are much, much worse.”
- Geriatric patients will be resistant to even discussing it.
- Tapering off benzodiazepines will require a lot of time.

Getting patients off Benzo’s

**Results:** (n=61)
If >8m, withdrawal rate = 43%
if <8m, withdrawal rate = 5%


**Take home message:**
- Short term usage (<6 weeks) unlikely to lead to significant problems with withdrawal.
- Patients who have been on BDZ’s for more than one year will need more careful tapering.


**Tapering Schedule:**
- Week#1: 75% (total dosage per day)
- Week#2: 50% (total dosage per day)
- Week#3: 25% (total dosage per day)
- Week#4: 12.5% (total dosage per day)
Anxiety Disorders Summary

• Epidemiology
  – Around 20% of patients in the primary care setting suffer from anxiety disorders
• “Pathophysiology”
  – Psychological phenomena do not respond to normal human problem solving methods
  – Avoidance is frequently involved in the etiology of anxiety disorders

Anxiety Disorders Summary

• Assessment and Diagnosis
  – Screening and Key Questions
    • Three S’s of psychiatric interview
    • Ask about worry/anxiety
    • Is anxiety triggered by something?
    • What is avoided?

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    • Somatoform Disorders and anxiety: eg, hypochondriasis

Anxiety Disorders

• Treatments
  – Psychosocial Treatments
    • Psychodynamic therapy
    • Cognitive behavioral therapy
    • Bibliotherapy and self-help
  – Pharmacologic Treatments
    • Antidepressants
    • Benzodiazepines