Anxiety Disorders in Women
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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)

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>


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

(in women, "tend and be-friend")

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

Taxes
“Pathophysiology” of Anxiety Disorders

Role of Avoidance

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

Anxiety in Women

Gender Differences in anxiety

Women (compared with men):
- Are approx. twice as likely to develop anxiety disorders
- Have higher rates of agoraphobia
- Show lower HPA and autonomic reactivity
- Have greater anxiety/disgust sensitivity

Gender Differences in anxiety

Women (compared with men):
- Report a lower sense of personal control over their lives and less self-efficacy
- Have greater tendency to ruminate
- Have heightened sensitivity to social cues
- Demonstrate behavioral avoidance

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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 Issues

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

Anxiety disorders

Is the anxiety cued or uncued?

- No cues
  - Panic attacks?
    - yes
      - Panic disorder
    - no
      - OCD, GAD or Anx d/o nos

- Cued (or triggered)
  - Specific object or situation → specific phobia
    - Social situation → social phobia
    - Reminder of traumatic event → PTSD
    - closed in spaces (no help) → agoraphobia
Anxiety: Key Questions

• How much does this get in the way of your life? (helps prioritize)
• What kinds of things do you avoid?

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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.
Agrophobia, without Panic Disorder — fear of places or events where escape is impossible or when help is unavailable.
Agraphobia — fear of sexual abuse.
Ailurophobia — fear/dislike of cats
Algophobia — fear of pain.
Anglophobia — fear of the English or English culture.
Anthropophobia — fear of people or being in a company, a form of social phobia.
Anthophobia — fear of flowers.
Apiphobia, Melissophobia — fear/dislike of bees
Aquaphobia, Hydrophobia — fear of water.
Arachnophobia — fear/dislike of spiders
Astraphobia, Astraphobia, Brontophobia, Keraunophobia — fear of Thunder, lightning and storms; especially common in young children.
Autophobia — fear of being alone
Aviophobia, Aviatophobia — fear of flying.
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

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.
Obsessive-compulsive disorder

**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.

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<table>
<thead>
<tr>
<th>Typical obsessions:</th>
<th>Typical compulsions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination: Fear of dirt or germs, bodily waste or fluids (a feeling of dirtiness)</td>
<td>Repeated washing/cleaning, ritual behavior or thinking</td>
</tr>
<tr>
<td>Ordering: Concern with order, symmetry (balance) and exactness</td>
<td>Concern with order, symmetry (balance) and exactness</td>
</tr>
<tr>
<td>Perfectionism: Worry that a task has been done poorly, or a mistake has been made</td>
<td>Checking drawers, door locks and appliances to be sure they are shut, locked or turned off (see also hypochondriasis)</td>
</tr>
<tr>
<td>Intrusive thoughts: blasphemous, sexual, violent</td>
<td>Ritual behavior or “superstitious thinking”</td>
</tr>
<tr>
<td>“I might use it later.”</td>
<td>hoarding</td>
</tr>
</tbody>
</table>
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)
Post-Traumatic Stress Disorder (PTSD) - Treatment

Primary treatment is psychotherapy

Medications: (minimize symptoms)

<table>
<thead>
<tr>
<th>SSRIs</th>
<th>Propanolol 10mg tid/qid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other AD</td>
<td>Prazosin 1mg qhs and taper up, helps with sleep</td>
</tr>
<tr>
<td>Atypicals</td>
<td>Clonidine 0.1mg-0.2mg qhs, for NM's, warn about orthostasis</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>Topiramate 25-100mg qhs</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>D-cycloserine: enhances exposure therapy</td>
</tr>
</tbody>
</table>

*(except for paroxetine and sertraline, these are off-label)
See also review: Bisson J, Clin Evid (online) 2010;Feb 3

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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


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?

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

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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Psychotherapy of Anxiety Disorders

Cognitive-Behavioral Therapy (CBT)

Components of Cognitive-Behavior Therapy (CBT)

• Education.
• Monitoring.
• Physical control strategies.
• Cognitive control strategies.
• Behavioral strategies.
Psychotherapy of Anxiety Disorders

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

Problem solving techniques
Self-monitoring
Applied relaxation
Meditation/Mindfulness

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/

eCouch
http://ecouch.anu.edu.au/new_users/welcome01
This site is related to MoodGym

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Anxiety Disorder Treatments

Psychopharmacological
• selective serotonin reuptake inhibitors are the mainstay
• other antidepressants
• anxiolytics (benzodiazepines)

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

- All share same mechanism of action (bind at GABA receptor, which is inhibitory)
- Vary by speed of onset, metabolism and duration of action
- Shorter acting usually related to faster onset

<table>
<thead>
<tr>
<th>Shorter-acting</th>
<th>Longer-acting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>alprazolam (Xanax)</td>
<td>diazepam (Valium),</td>
</tr>
<tr>
<td>triazolam (Halcion)</td>
<td>clonazepam (Klonopin),</td>
</tr>
<tr>
<td></td>
<td>lorazepam (Ativan)</td>
</tr>
</tbody>
</table>

Benzo’s: pharmacokinetics

- Significant first pass metabolism (sublingual faster more effective)
- Eating food or taking an antacid slows absorption
- Duration of action related to lipophilicity rather than plasma half-life
Anxiety Disorders - Benzos

- Main side effects include: sedation, ataxia, amnesia, potential for abuse
- Generally useful for short-term anti-anxiety,
- Tolerance often develops within 1-2 weeks
- Don’t discontinue abruptly (esp. shorter acting bdz’s)

BDZ’s and the geriatric patient: It’s not just about addiction

Benzodiazepines associated with:
- Sleep disturbance
- Cognitive difficulty/delirium
- 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%


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**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.

Getting patients off Benzo’s

Sample 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)

Tips:
• Can go slower
• Write out the schedule for patients


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?

• Gender Differences

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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