ANXIETY DISORDERS

Resource:
First aid for the psychiatry clerkship

DEFINITION

- Anxiety disorders are characterized by excessive or inappropriate fear or anxiety.
- The criteria for most anxiety disorders involve symptoms that **cause clinically significant distress** or **impairment in social and/or occupational functioning**. These symptoms include:

TABLE 5-1. Signs and Symptoms of Anxiety

Constitutional	Fatigue, diaphoresis, shivering
Cardiac	Chest pain, palpitations, tachycardia, hypertension
Pulmonary	Shortness of breath, hyperventilation
Neurologic/ musculoskeletal	Vertigo, light-headedness, paresthesias, tremors, insomnia, muscle tension
Gastrointestinal	Abdominal discomfort, anorexia, nausea, emesis, diarrhea, constipation

ETIOLOGY AND EPIDEMIOLOGY

- Anxiety disorders are the most common form of psychopathology.
- They are caused by a combination of genetic, biological, environmental, and psychosocial factors.
- Primary anxiety disorders can only be diagnosed after determining that the signs and symptoms are NOT due to the physiological effects of a substance or another medical condition.
- Major neurotransmitter systems implicated: norepinephrine, serotonin (5-HT) and GABA.
- More in women than men, 2:1 ratio.

TREATMENT OF ANXIETY DISORDERS

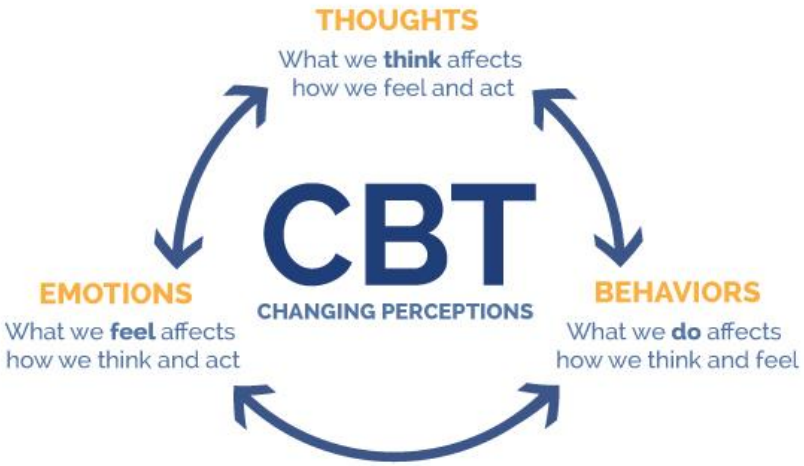
It is based on the severity of symptoms. *Psychotherapy is initiated for mild anxiety while a combination of therapy and medication for moderate to severe anxiety should be considered.*

- Psychotherapy:

1- Cognitive behavioral therapy (CBT)

2- Psychodynamic psychotherapy is **an approach that involves facilitation of a deeper understanding** of the development of anxiety symptoms, leading to more adaptive coping styles and subsequent improvement over time.

- Pharmacotherapy: goal is to achieve symptomatic relief and continue treatment for at least 6 months before attempting to titrate off medications.



PHARMACOTHERAPY (OVERVIEW)

a) SSRIs e.g., sertraline and SNRIs e.g., venla-faxine are first-line medications.

b) Benzodiazepines work quickly and effectively, but regular use results in dependence, so use, duration and dose should be minimized. MOA: enhance activity of GABA at GABA-A receptor.

c) In patients with comorbid substance use, consider non-addictive anxiolytic alternatives for use as needed (PRN), such *as diphenhydramine and gabapentin*.

d) Buspirone is a non-benzodiazepine anxiolytic which has partial agonist activity at the 5-HT1A receptor. Typically prescribed only as augmentation with other drugs.

e) Beta-blockers may be used to help control auto-nomic symptoms (e.g., palpitations, tachycardia, sweating) of panic attacks or performance anxiety.

f) TCAs and MAOIs may be considered if first-line agents are not effective. Their side-effect profile makes them less tolerable and more dangerous.

PANIC DISORDER

A panic attack is a fear response involving a sudden onset of intense anxiety which may be triggered or occur spontaneously. Panic attacks peak within minutes and usually resolve within half an hour. Although classically associated with panic disorder, panic attacks can also be experienced with other psychiatric disorders and medical conditions.

Symptoms of a panic attack include the following

PANIC DISORDER

- Spontaneous, recurrent panic attacks which occur suddenly but patients may also experience some panic attacks with a clear trigger.
- The frequency of attacks ranges from multiple times per day to a few monthly.
- Patients develop debilitating anticipatory anxiety about having future attacks—“fear of the fear.”
- Diagnosis and DSM-5 Criteria

Recurrent, unexpected panic attacks without an identifiable trigger	one or more of panic attacks followed by ≥1 month of continuous worry about experiencing subsequent attacks, and/or a maladaptive change in behaviors	Not caused by the direct effects of a substance, another mental disorder or another medical condition

PANIC DISORDER

- **Etiology** of panic disorder: Genetic and psychosocial factors.

- **Epidemiology**
- Lifetime prevalence: 4%.
- Higher rates in woman compared to men. 2:1.
- Median age of onset: 20–24 years old.

- **Course and Prognosis**
- Chronic course with waxing and waning symptoms.
- Relapses are common with discontinuation of medication.
- Only a minority of patients have full remission of symptoms.

- **Treatment**: Combination of CBT and Pharmacotherapy is most effective
- First-line: SSRIs. SNRIs are also efficacious.

AGORAPHOBIA

- It is an intense fear of being in public places where escape or obtaining help may be difficult. It often develops with panic disorder.
- Diagnosis and DSM-5 Criteria

1- Intense fear/anxiety about being in **two or more situations of the following** due to concerns of difficulty escaping or obtaining help in case of panic (from the figure on the right)

2- The triggering situations cause fear/anxiety out of proportion to the potential danger posed, leading to intense anxiety or avoidance of the triggering situations which may become as extreme as complete confinement to the home.

3- Symptoms cause significant social or occupational dysfunction.

4- Symptoms last ≥6 months.

5- Symptoms not better explained by another mental disorder

AGORAPHOBIA

- Etiology

- Strong genetic factor: Heritability about 60%.
- Psychosocial factor: Onset frequently follows a traumatic event.

- Course/Prognosis

- More than 50% of patients experience a panic attack prior to developing agoraphobia.
- Onset is usually before age 35.
- Course is persistent and chronic, with rare full remission.
- Comorbid diagnoses include other anxiety disorders, depressive disorders, and substance use disorders.

- Treatment

- Similar approach as panic disorder: CBT and SSRIs (for panic symptoms).

SPECIFIC PHOBIAS

- A phobia is an irrational fear that leads to anxiety and/or avoidance of the feared object or situation.
- A specific phobia is an intense fear of a specific object or situation (i.e., the phobic stimulus).
- DSM-5 criteria

Persistent, excessive fear elicited by a specific situation or object which is out of proportion to any actual danger/threat.	Exposure to the situation triggers an immediate fear response.	Situation or object is avoided when possible or tolerated with intense anxiety.
Symptoms cause significant social or occupational dysfunction.	Duration ≥6 months.	Symptoms not solely due to another mental disorder, substance (medication or drug), or another medical condition.

SPECIFIC PHOBIAS

- Common specific phobias include animals and natural environment.
- Epidemiology
- More common in women compared to men (2:1) but vary depending on the type of stimulus.
- Phobias are the most common psychiatric disorder in women
- Second most common in men (substance-related is first).
- Lifetime prevalence of specific phobia: >10%.
- Mean age of onset is 10 years.
- Treatment of choice: CBT.

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

- It is the fear of scrutiny by others or fear of acting in an embarrassing way. As a result, social situations causing significant anxiety may be avoided altogether, resulting in social impairment.
- The diagnostic criteria for social phobia are similar to specific phobia except the phobic stimulus is related to social scrutiny. The patients fear embarrassment, humiliation, and rejection.
- This fear may be limited to performance or public speaking.
- Median age of onset is 13 years.
- Occurs equally in men and women.
- Treatment
- Treatment of choice: CBT.
- First-line medication, if needed: SSRIs
- Beta-blockers may be used for performance anxiety/public speaking.

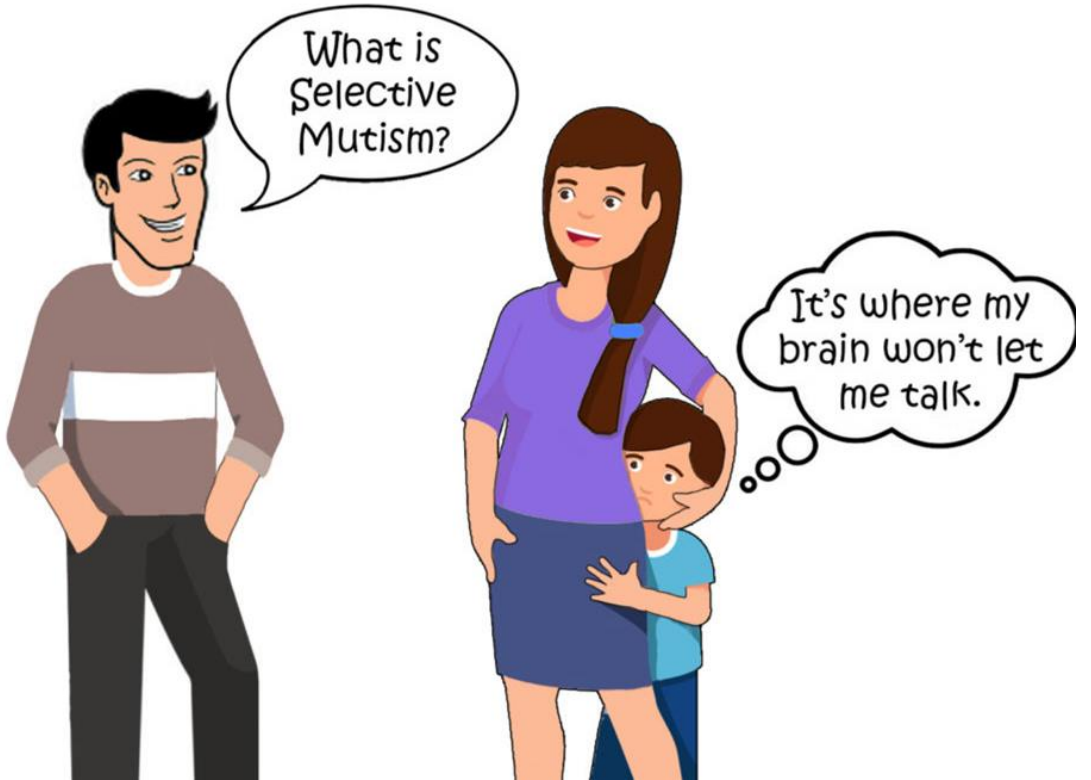
SELECTIVE MUTISM

- It is a rare condition characterized by a failure to speak in specific situations for at least 1 month despite the intact ability to comprehend and use language.

- Onset: typically during childhood.

- The majority of these patients suffer from socia anxiety.

- The patients may remain completely silent or whisper or use nonverbal means of communication, such as writing or gesturing.



SELECTIVE MUTISM

- Diagnosis and DSM-5 Criteria

Consistent failure to speak in select social situations despite speech ability in other scenarios.	Mutism is not due to a language difficulty or a communication disorder.	Symptoms cause significant impairment in academic, occupational, or social functioning	Symptoms last >1 month

- Treatment:

- Psychotherapy: CBT, family therapy.
- Medications: SSRIs (especially with comorbid social anxiety disorder).

SEPARATION ANXIETY DISORDER

- Separation anxiety typically emerges by 1 year of age and peaks by 18 months. When the anxiety due to separation becomes extreme or developmentally inappropriate, it is considered pathologic. It may be preceded by a stressful life event.

- Diagnosis and DSM-5 Criteria

Excessive and developmentally inappropriate fear/anxiety regarding separation from attachment figures, with *at least 3* of the following:

1) Separation from attachment figures leads to extreme distress.
2) Excessive worry about loss of or harm to attachment figures.
3) Excessive worry about experiencing an event that leads to separation from attachment figures.
4) Reluctance to leave home, or attend school or work.
5) Reluctance to be alone.
6) Reluctance to sleep alone or away from home.
7) Complaints of physical symptoms when separated from major attachment figures.
8) Nightmares of separation and refusal to sleep without proximity to attachment figure.
9) Lasts for ≥4 weeks in children/adolescents and ≥6 months in adults.
10) Symptoms cause significant social, academic, or occupational dysfunction.
11) Symptoms not due to another mental disorder

SEPARATION ANXIETY DISORDER

- Treatment

- Psychotherapy: CBT, family therapy.

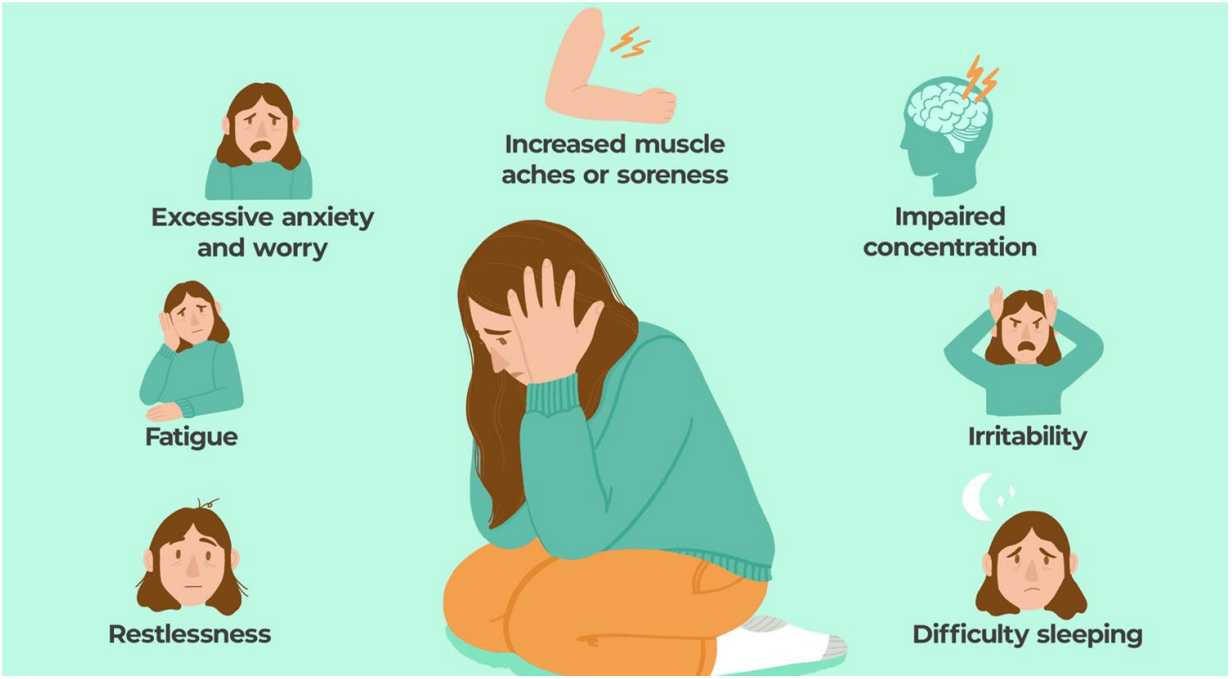
- Medications: SSRIs can be effective as an adjunct to therapy.

Generalized anxiety disorder

A 23 year-old Caucasian lady presents to an outpatient psychiatry clinic because she has been feeling continuously overwhelmed with worry “about everything.” She states she constantly worries about her performance in school, her family and not making enough money in her job. She also reports that she has trouble falling asleep at night and is unable to get a good night’s rest. She often feels "restless" or "on edge", which she associates with not sleeping. The patient also states she wakes up at night with throbbing headaches that last for a couple hours. She also has difficulty paying attention in class and finishing her homework. She has been having these symptoms for 6 months.

GENERALIZED ANXIETY DISORDER (GAD)

Patients with GAD have persistent, excessive anxiety about many aspects of their daily lives. Often they experience somatic symptoms including fatigue and muscle tension.



DIAGNOSIS AND DSM-5 CRITERIA FOR GAD

- Excessive, anxiety/worry about various daily events/activities ≥6 months.
- Difficulty controlling the worry.
- Associated ≥3 symptoms: restlessness, fatigue, impaired concentration, irritability, muscle tension, insomnia.
- Symptoms are not caused by the direct effects of a substance, or another mental disorder or medical condition.
- Symptoms cause significant social or occupational dysfunction.

GENERALIZED ANXIETY DISORDER (GAD)

- Epidemiology/Etiology
- Lifetime prevalence: 5–9%.
- GAD rates higher in women compared to men (2:1).
- One-third of risk for developing GAD is genetic.

- Course/Prognosis
- Symptoms of worry begin in childhood.
- Median age of onset of GAD: 30 years.
- Course is chronic, with waxing and waning symptoms.
- Rates of full remission are low.
- GAD is highly comorbid with other anxiety and depressive disorders.

- Treatment
- The most effective treatment approach combines psychotherapy and pharmacotherapy: CBT and SSRI/SNRI.

THANK YOU

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