

Anxiety Disorders I-II

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I. Anxiety Disorder Overview

- Normal anxiety occurs when we have a normal human response when placed in fearful situations or in situations in which we have social conflicts with other people.
- Pathological anxiety: anxiety due to social insult, general medical conditions, substance-induced or not otherwise specified. Minimal environmental trigger. Exceeds normal comfort level. Persistent symptoms is key to pathology.
- Clinician must be able to assess the patient and differentiate between pathological anxiety and normal anxiety.

A. Panic disorder

1. Fear of being in public places from which rapid exit would be difficult
2. In US, most cases of agoraphobia result from panic disorder.
3. Epidemiology
 - Lifetime prevalence panic disorder = 4%
 - Lifetime prevalence panic attack = 5%
 - Women 3x more likely to have panic disorder
 - Mean age of onset = 25 years
4. Comorbidity
 - 90% have at least one other psychiatric disorder.
 - Rank order
 - Major depressive disorder
 - Other anxiety disorders
 - Personality disorders
 - Substance related disorders
5. Etiology
 - a. Panic inducing substances (to be given only in research settings)
 - Carbon dioxide
 - Sodium lactate
 - Bicarbonate
 - Yohimbine
 - Caffeine
 - Cholecystokinin
 - b. Test tip: look for any of the above substances for panic induction on test.
 - c. TT: look for alcohol abuse, marital and work problems and suicide attempts especially if they have depression or personality disorders.
 - d. Mitral valve prolapse – not true
6. Diagnosis

- a. Panic attack: DSM IV criteria – intense fear or discomfort with 4 or more of the following occurring within 10 minutes
 - Palpitations, pounding heart
 - Sweating
 - Trembling or shaking
 - Sensations of shortness of breath
 - Feeling of choking
 - Chest pain
 - Nausea/vomiting
 - Lightheadedness
 - Derealization
 - Fear of losing control
 - Fear of dying
 - Numbness
 - Chills
 - b. Panic disorder DSM IV criteria
 - 1) Recurrent unexpected panic attacks
 - 2) At least one attack followed by 1 or more months of the following:
 - Concern about other attacks
 - Concern about possible consequences (ie, heart attack, “going crazy” etc)
 - Significant change in behavior due to attacks
 - 3) Presence or absence of agoraphobia
 - 4) Not due to substance abuse or medical conditions
 - 5) Not accounted for by phobias, OCD, PTSD or separation anxiety disorder
7. Clinical features
- First panic attacks are unexpected.
 - Symptoms begin within a 10 minute period
 - Sense of impending doom/death
 - May last 20-30 minutes, rarely > 1 hour
 - May suffer from depersonalization and derealization
 - **Test tip: multiple matching – differentiate depersonalization (subjective sense of oneself being unreal or unfamiliar) from derealization (subjective sense of environment being unreal, strange, unfamiliar).**
 - 20% have syncopal episode, visit ER with c/o chest pain, suspecting impending MI.
 - Look for cardiac symptoms, pulmonary symptoms, GI symptoms, neurologic sx, autonomic arousal, psychological sx.
8. Differential diagnosis
- a. Medical disorders
 - MI: EKG
 - Thyroid: hormone levels
 - Check CBC, electrolytes, fasting blood glucose

- Parathyroid
- Adrenal (pheochromocytoma): 24 hour urine for 5HT and catecholamines
- b. Mental disorders
 - Malingering
 - Factitious
 - Hypochondriasis
 - PTSD, phobias, schizophrenia
 - Substance abuse
- 9. Treatment and prognosis
 - a. Patients with good premorbid functioning and brief symptom duration have better prognosis.
 - b. Drugs
 - 1) FDA-approved
 - Alprazolam
 - Cepraline
 - Paroxetine
 - 2) Off label use
 - SSRI
 - Clomipramine
 - Benzodiazepines
 - c. Cognitive behavioral therapy

B. Phobias

1. DSM IV lists 2 other phobias in addition to agoraphobia:
specific phobia – fear of an object or situation and **social phobia** – fear of embarrassment or humiliation in a public setting. TT: Past boards make you differentiate social phobia versus GAD. Both chronic but remember look for social situations versus general persistent anxiety AND remember people with GAD are co-morbid for social phobia. Social phobia more co-morbid with depression, etoh & substance abuse.
2. Epidemiology
 - Lifetime prevalence of specific phobia – 11%
 - Lifetime prevalence of social phobia – 9%
3. Etiology
 - Specific phobia – associating particular object or situation with fear/panic
 - Social phobia – unknown cause for behavioral inhibition. First degree relative with social phobia leads to 3x higher susceptibility.
4. Treatment
 - Specific phobia – repeated exposure to stimuli in graduating degrees – desensitization – exposure therapy. CBT
 - Social phobia – beta blockers, eg, propranolol, MAOIs, tricyclics, SSRIs, benzos, venlafaxine. Psychotherapy – CBT, exposure therapy

5. **TT: don't be tricked by specific phobia versus: hypochondriasis – fear of having a disease (versus fear of contracting a disease).**
 - **OCD – fear of guns because they might kill their neighbor/relative (versus fear of gun going off and getting hurt)**
 - **Paranoid personality disorder – generalized fear and suspicion**
6. **TT: don't be tricked by social phobia versus: MDD – anhedonia > 2 weeks with 5/9 neurovegetative signs.**
 - **Schizoid personality disorder – lack of interest in socializing**

TT: Avoidant personality wants to have friends but can't in many settings, not just in social situations or groups.
7. Phobic people try to avoid the stimulus whereas people with panic attacks are often unsure about the trigger of their panic attacks.

C. Obsessive compulsive disorder – OCD

1. Recurring obsessions or compulsions severe enough to be time consuming or cause marked distress or significant impairment; they recognize their reactions are irrational or disproportionate. An ego dystonic occurrence
2. Obsession – recurrent and intrusive thought, feeling, idea or sensation which increases anxiety
3. Compulsion – conscious, standardized, recurring pattern of behavior to relieve the anxiety of the obsession
4. Epidemiology
 - Lifetime prevalence 3%, males = females
 - Lifetime prevalence comorbidity:
 - MDD – 66%
 - Social phobia – 25%
 - Alcohol abuse/dependency
 - Specific phobia
 - Panic disorder
 - Eating disorder
5. Etiology: 5-HT dysfunction involving frontal lobe, basal ganglia (caudate) and cingulum
6. **TT look for isolation, undoing & reaction formation with OCD as this appears consistently: look for isolation – defense mechanism, people normally experience the affect and imagery of an emotional idea, whether fantasy or memory of an event. Here the affect and impulse are separated from the ideational component and are pushed out of the consciousness (repressed) and the patient is only consciously aware of the affectless idea related to it.**
 - **Undoing** – compulsive act performed in an attempt to prevent or undo the consequences that the patient

irrationally anticipates from a frightening obsessional thought or impulse

- **Reaction formation** – patterns of behavior and consciously experienced attitudes that are exactly the opposite of the underlying impulses. The patterns may seem to an observer to be highly exaggerated and inappropriate.
7. May manifest as: hand washing, pathological doubt (did I lock the door/stove), intrusive thoughts of sexuality or aggression, symmetry, hoarding, or trichotillomania
 8. Comorbidity: Tourette's – motor and vocal tics nearly every day, 66% fulfill OCD criteria.
 9. Onset is sudden after a stressful experience – pregnancy, trauma, death in the family, and OCD is kept secret. A good prognosis is indicated by good social and occupational adjustment.
 10. Treatment of OCD
 - SSRIs
 - Clomipramine (used to be gold standard)
 - Lithium, venlafaxine, MAOIs less used
 - Behavioral therapy

D. Posttraumatic stress disorder – PTSD

1. Symptoms that develop after a person sees, is involved in, or hears of an “extreme traumatic stressor.” Reacts with fear/hyperarousal and helplessness, persistently relives the event, tries to avoid being reminded of it. Symptoms last more than 1 month. Can specify PTSD whether acute (Sxs less than 3 months), chronic (Sxs greater than 3 months) or whether onset was delayed 6 months or more after event.
2. Clinical features of PTSD: painful re-experiencing, patterns of avoidance, emotional numbing, constant hyperarousal. Dissociative states, panic attacks, illusions and hallucinations. Impairment of memory and concentration.
 - Acute stress disorder – similar to PTSD except it occurs within 4 weeks of the event and symptoms last from 2 days to 4 weeks.
3. Epidemiology of PTSD: 3% of general population, higher in soldiers of combat experience. Women in trauma/assault/rape
4. Differential diagnosis
 - Head injury
 - Trauma
 - Epilepsy
 - Alcohol use disorders
 - Acute intoxication or withdrawal
 - PTSD often misdiagnosed and treated as another disease ineffectually

- Mistaken for pain disorder, substance abuse, anxiety, mood disorders, dissociative disorders, factitious disorders and malingering
 - Dissociative disorder does not have the level of avoidance, autonomic hyperarousal, or trauma that PTSD patients suffer.
5. Prognosis
 - 30% recover completely.
 - 40% recover with mild symptoms.
 - 20% recover with moderate symptoms.
 - 10% no improvement
 6. Good prognostic indicators are: acute onset, strong social support system, good premorbid functioning free of psychiatric, medical, or substance abuse in history.
 7. Treatment
 - a. Sedatives and hypnotics often used for immediate relief of suffering
 - b. Meds
 - Imipramine
 - Amitriptyline
 - SSRIs
 - Trazadone
 - Now valproic acid and lithium being tried
 - c. Therapy
 - Supportive first: support, education, coping mechanisms and acceptance of event
 - Behavioral, cognitive, hypnosis
 - Gradual exposure therapy

E. Generalized anxiety disorder – GAD

1. **Excessive** anxiety that interferes and worry that is **difficult to control** about several events for **a majority of days during a 6 month period**. Physical symptoms of muscle tension, irritability, poor sleep and restlessness
2. Epidemiology
 - 1 year prevalence of 5%
 - Lifetime prevalence of 50%
3. Comorbidity
 - Social phobia
 - Specific phobia
 - Panic disorder
 - Depressive disorder
 - 2 female:1 male ratio
 - Only 1/3 ever seek treatment.
 - Many patients go to multiple doctors seeking somatic treatment for which no medical cause is ever found.
4. Differential diagnosis
 - Heart – EKG
 - Thyroid – TSH
 - Standard blood chemistry

- MDD (can also be comorbid)
 - Dysthymia
 - Adjustment disorder with anxiety (period of having the disorder)
 - Hypochondriasis (more concerned with having a disease, concerned with symptoms)
 - ADD
 - Somatization disorder
 - Personality disorder
5. Comorbidity
- Panic disorder
 - MDD
6. Treatment: old days started with: BuSpar → benzos → SSRIs (tricyclics).

II. Simple Questions and Answers True or False:

A. Questions

1. One need not witness violence for PTSD.
2. Comorbidity of anxiety and depression is unusual.
3. GAD and ETOH abuse are prevalent.
4. Adjustment disorder with anxiety occurs within 3 months of the stressor but lasts less than 6 months.
5. GAD usually lasts more days than not for less than 6 months.
6. Social phobia or performance phobia are treated synonymously on the boards.

B. Answers

1. T
2. F
3. F
4. T
5. F
6. T