The Diagnosis and Management of Anxiety Disorders
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Anxiety Symptoms
“Angst” fears
- Worry
- Restlessness
- Difficulty concentrating
- Muscle tension
- Obsessions
- Palpitations
- Trembling
- Choking
- Dizziness or lightheadedness
- Increased fear of losing control or dying
- Chills or flushes
- Flashbacks
- Abreactions
- Diminished interest
- Restricted range of affect
- Difficulty sleeping
- Decreased concentration

- Increased startle
- Easily fatigued
- Irritability
- Sleep disturbance (classically initial insomnia)
- Compulsions
- Sweating
- Shortness of breath
- Nausea or sudden GI symptoms
- Derealization or depersonalization
- Parathesias
- Agoraphobia
- Nightmares
- Inability to recall
- Feelings of detachment
- Hyperarousal (persistent)
- Irritability
- Hypervigilance

Major Anxiety Disorders
Generalized Anxiety Disorder (GAD)
Panic Disorder with and without Agoraphobia
Posttraumatic Stress Disorder (PTSD)
Obsessive Compulsive Disorder (OCD)
Phobias
  - Specific Phobia (“Simple” Phobia)
  - Social Phobia (Social Anxiety Disorder)

Generalized Anxiety Disorder

Criteria:
- Excessive anxiety or worry more days than not for 6 months
- Difficult to control the worry
- Anxiety or worry associated with 3 or more of the following:
  - Restlessness
  - Easily fatigued
  - Difficulty concentrating
  - Irritability
Muscle tension
Sleep disturbance

Epidemiology:
- Onset early 20s, may have increased separation anxiety as child
- 2.5%-8% one year prevalence (ECA)
- 2female:male
- anxiety disorders 20% higher in relatives
- monzygotic concordance disappears if panic is removed
- 2/3 to 9/10 of people with GAD also have another Axis I diagnosis

Etiology:

Medical: GABA receptors in the occipital lobe (area of highest concentration) are believed to be integral because of the effectiveness of benzodiazepines.

Psychological: conflict between instinctual drive and internal inhibition. The ego fears external consequences for following the drives and thusly defends against them. Signal anxiety warns the ego of this conflict.

Differential Diagnosis:

Medical:
- SVT
- Irritable bowel syndrome
- Substance induced
  - alcohol
  - caffeine
  - cocaine
  - amphetamines
  - decongestants
  - herbals
- Infection
- Thyroid

Psychiatric:
- Dysthymia
- Social phobia
- Panic disorder
- Depression
- Hypochondriasis
- Personality disorder

Work-up:
- Symptom driven much like panic (ie headache, or GI work-up)
- Labs, including WBC, lytes, thyroid, EKG
- Consider urine drug screen

Treatment: 2/3 judged to need treatment never receive it

Bio:
- Benzodiazepines
- Buspirone
- SSRIs
Beta-blockers block the peripheral symptoms

Psycho:
Psychotherapies from problem solving, and stress reduction, to insight oriented. Cognitive behavioral therapy remains one of the most common approaches

Social:
Relaxation techniques, self help groups, church or religious involvement

Prognosis:
- Chronic and fluctuating course
- Not good data but “clinical lore” suggests outcome associated with social support, ego strength, environmental stressors

Panic Disorder

Criteria:
Panic Attack ≠ Panic Disorder

4 or more developed abruptly and reached a peak in 10 minutes
- palpitations
- sweating
- trembling
- shortness of breath
- choking
- nausea or sudden GI symptoms
- dizziness or lightheadedness
- derealization or depersonalization
- excessive fear of losing control or dying
- parathesias
- chills or flushes

Agoraphobia
- Anxiety about being in situations or places from which escape might be difficult situations are avoided, a companion may reduce anxiety (not so for social phobia)
- Not part of another anxiety disorder

Epidemiology:
- 1.6-2.2% lifetime prevalence
- Onset early 20’s
- 2Female:male
- 1/3 to ½ have agoraphobia
- If panic disorder then MDD 50-60% lifetime prevalence
- If MDD then 15-30% panic disorder
- MDD precedes panic in 1/3 of cases (MDD coincides or follows in the other 2/3 of cases)

Etiology:
Biological:
- Highly familial
- 8 times more likely in first degree relatives of probands
- early onset more likely to be familial
- Locus coruleous

**Psychological:**
- Intense fear reaction from real or perceived threat (“fight or flight”)

**Differential Diagnosis:**

**Medical:**
- Substance induced
  - Withdrawal (alcohol)
  - Intoxication (amphetamine, cocaine, caffeine)
- Cardiovascular
  - SVT, HTN, MVP, MI
- Pulmonary
  - Asthma, PE
- Neurological
  - CVA, Seizures, MS
- Endocrine
  - Hypoglycemia
  - Thyroid disease

**Psychiatric:**
- Specific phobia
- PTSD
- GAD
- OCD
- Malingering
- Factitious
- Somatoform
- Hypochondriasis
- Depression
- Schizophrenia

**Work-up:**
- Symptom directed work-up
- Electrolytes including blood glucose
- EKG (WPW, SVT etc.)
- Thyroid function tests
- Urine drug screen (consider BAL)

**Treatment:**

**Bio:** TCAs, SSRIs, benzodiazepines in early course
- Treatment is generally for 12-18 months
- 8 to 12 weeks to respond
- MAOI in resistant cases

**Psycho:** CBT (12 weeks)

**Social:** Psychoeducation, relaxation techniques, regulation of psychoactive substances
Prognosis:

- Generally favorable
- 30-50% asymptomatic at five years
- 30-50% symptomatic but “normal” life
- 10-20% still with severe symptoms

**Posttraumatic Stress Disorder**

Criteria:

- Trauma personally witnessed to self or others, where the person’s response involved intense fear, helplessness or horror
- Reexperienced
  - Flashbacks
  - Nightmares
  - Abreaction
  - Trigger events
- Avoidance
  - Thoughts
  - Places or activities
  - Inability to recall
  - Diminished interest
  - Feelings of detachment
  - Restricted range of affect
- Hyperarousal (persistent)
  - Difficulty sleeping
  - Irritability
  - Decreased concentration
  - Hypervigilance
  - Startle
- Duration of symptoms 1 month or greater

**Epidemiology:**

- 1-3% lifetime prevalence
- More likely in single, divorced, widowed, lower socioeconomic
- Primarily a disease of young adults

**Etiology:**

**Biological:**

- Risk factors
  - Childhood trauma
  - Other Axis I diagnosis
  - Recent alcohol intake
  - Female
Psychological:
- Personality disorders
- Most common trauma is the recent loss of a loved one
- The more severe the trauma the greater the likelihood of PTSD
- Primarily and civilian’s disease

Differential Diagnosis:
Medical:
- TBI during the trauma
- Seizures

Psychiatric:
- Depression
- Dissociative d/o
- Borderline PD
- Factitious/Malingering
- Substance abuse (intoxication and withdrawal)
- Anxiety disorders
- Somatoform d/o

Treatment:
Bio:
- Symptomatically driven
- Antidepressants (SSRIs and TCAs)
  (note unique effectiveness of trazodone/nafazodone with nightmares)
- Benzodiazepines
- Neuroleptics
- Mood stabilizers

Psycho:
- Earlier the better-debriefing, psychoeducation and coping mechanisms
- CBT
- Group
- Psychodynamic

Social:
- Self help groups
- Religious groups

Prognosis:
- Delay of symptoms can be 1 week or 30 years
- 30% recover completely
- 40% continue to have mild symptoms
- 20% continue to have moderate symptoms
- 10% continue to worsen
• generally very young and old have more trouble with trauma
• good prognosis
  high premorbid functioning
  no substance abuse
  social support
  no Axis I or II

**Obsessive Compulsive Disorder**

**Criteria:**

- **Obsessions**
  Recurrent or persistent thoughts or impulses that cause marked anxiety
  Not simply excessive worries about real life problems
  Patient attempts to ignore, suppress or neutralize them with some thought or action
  Not a product of thought insertion or other thought disorder process

- **Compulsions**
  Repetitive behaviors or mental acts that the person feels driven to perform
  in response to an obsession
  The behaviors are aimed at reducing distress or preventing a dreaded situation, however, the acts are not connected to the obsession in a real way

- The person recognizes the acts as unreasonable (ego dystonic)
- Marked distress

**Epidemiology:**

- 2-3% lifetime prevalence
- female=male
- female onset earlier than male
- white>black
- onset in early 20s
- 5% with onset after 40

**Etiology:**

- **Biological:**
  ADHD, tics, and OCD associated in children (PANDAS in children)
  20% have tics (changes in basal ganglia, cingulum, striatum, frontal lobes)
  Multiple neurotransmitter model (particularly responsive to SSRIs)
  high concordance in monozygotic twins
  35% in first-degree relatives of probands

- **Psychological:**
  “Undoing” psychodynamic defense

**Differential Diagnosis:**

- **Medical:**
  TBI
  Post encephalopathy
Tourettes
TLE

Psychiatric:
- Schizophrenia
- OCPD
- Phobia
- Delusional D/O

Treatment:

Bio:
- SSRIs
- Augment with lithium
- MAOI
- Clonazepam
- Buspirone
- ECT
- Psychosurgery (cingulate)
- Neurontin (gabapentin): Gabapentin is a lipophilic structural analog of GABA. Unlike GABA, gabapentin readily crosses the blood-brain barrier, achieving a cerebrospinal fluid concentration that is about 9%-14% that of the serum. Gabapentin does not act as a GABA agonist; it does not bind to GABA receptors nor does it alter the neuronal content or reuptake of GABA. Gabapentin may bind to an ill-defined amino acid transporter. It may also inhibit GABA-aminotransferase, increase the rate of GABA synthesis, and reduce monoamine (dopamine and noradrenaline) release, and it may also inhibit activity at NMDA receptors (Goa and Sorkin 1993; Patsalos and Duncan 1993).

Psycho:
- CBT

Social:
- Psychoeducation

Prognosis:
- 1/3 of OCD have MDD
- 1/3 improve
- 1/3 moderate improvement
- 1/3 little improvement
- Variable course
- Poor prognosis associated
  - Early onset
  - Severity
  - Poor premorbid function
  - Comorbid Axis I or II

Variable course
Poor prognosis associated
  - Early onset
  - Severity
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Phobias

Specific and Social Phobia (Social Anxiety Disorder)

Social Phobia

Criteria:

- A marked and persistent fear of social or performance situations in which embarrassment may occur. Exposure to the social or performance situation almost invariably provokes an immediate anxiety response.
- The experience concerns about embarrassment and are afraid that others will judge them to be anxious, weak, "crazy," or stupid.

Epidemiology:

- Female > Male
- Lifetime prevalence ranging from 3% to 13%.
- In outpatient clinics, rates ranged between 10% and 20% of individuals with Anxiety Disorders

Treatment:

- Bio
  - SSRIs
  - Benzodiazepines
  - Gabapentin
- Psycho
  - Psychotherapies
- Social
  - Psychoeducation
  - Support groups

Specific Phobia (aka “Simple Phobia)

Criteria:

- The essential feature is a clearly circumscribed situation (e.g. dentist visits) or discrete thing (e.g. spiders, snakes, needles) consistently provokes fear and an intense anxiety reaction that includes a situational panic attack.
- This diagnosis is only appropriate if there is significant dysfunction in the individual’s life characterized by social, occupational dysfunction or the person is markedly distressed by this.
- The anxiety is invariably felt when confronted with the situation or object.
Etiology:

**Biological**

Vasovagal response is characteristic of blood-injection-injury type specific phobia, which may occur as frequently as 75% of the time. (Bienvenu and Eaton study this type of specific phobia in the general population and found that the lifetime prevalence of phobias of blood, injections or dentists was 3.5% with a median age of onset of 5.5 years. Almost 80% had had symptoms within the past six months. Subjects with phobias had higher lifetime histories of fainting and seizures than those without. While over half had told a physician or other health care professional of their fears, none reported seeking mental health treatment for their phobias.)

**Psychiatric**

Possibly a conditioned response

Epidemiology:

- more common in those with less education and in females.
  - The sex ratio varies across different types of Specific Phobias.
    - Approximately 75%-90% of individuals with the Animal and Natural Environment Type are female (except for fear of heights, where the percentage of females is 55%-70%). Similarly, approximately 75%-90% of individuals with the Situational Type are female. Approximately 55%-70% of individuals with the Blood-Injection-Injury Type are female.
  - 4-8 times the expected lifetime prevalence of other psychiatric conditions including major depression, obsessive-compulsive disorder, panic disorder, agoraphobia, social phobia, and other simple phobias.
  - The content of phobias as well as their prevalence varies with culture and ethnicity.
  - The one-year prevalence is 9% with lifetime rates ranging from 10.0% to 11.3%.

Differential Diagnosis
Specific Phobia is characterized by clinically significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behavior.

Social Phobia is characterized by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior. Different from agoraphobia in that agoraphobia is related to the inability or fear of not being able to escape or rescued. Whereas social phobia involves embarrassment in a social situation. A question that helps to differentiate the two is if having someone with you diminishes the anxiety; this would be more likely to be true in agoraphobia and not social phobia.

Treatment:

- Medications involve prn usage of a benzodiazepine
- If more pervasive dysfunctioning then systematic desensitization