APPROACH TO ANXIETY DISORDERS IN PRIMARY CARE

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PANIC DISORDER

- Lifetime prevalence 15% of panic attacks
- Lifetime prevalence 4.7% panic disorder
- Up to 50% have agoraphobia
- Women > men
- Late adolescence/early adulthood

DSM-V Criteria for Panic Attacks

A discrete period of intense fear or discomfort, in which 4 or more of the following symptoms developed abruptly and reached a peak within minutes.

1. Palpitations, pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feeling of choking

DSM-V Criteria for Panic Attacks

- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, light-headed
- Chills or heat sensations
- Paresthesias
- Derealization/depersonalization
- Fear of losing control or going crazy
- Fear of dying

PANIC ATTACK VS PANIC DISORDER

- “Out of the blue” vs situational
- if linked only to social situations, then social phobia
- if linked to past traumatic memories, then post traumatic stress disorder
- if linked to specific stimuli, then specific phobia

DSM-V Diagnosis of PD

The person has experienced both of the following:

- Recurrent unexpected panic attacks
- One or more of the attacks has been followed by 1 month or more of one or more of the following:

    - Persistent concern about having additional attacks (anticipatory anxiety
    - A significant change in behaviour related to the attacks (e.g. behaviours designed to avoid panic attacks)

DSM-V Diagnosis of PD

- The panic attacks are not due to substance abuse, a medication, or a general medical condition
- The panic attacks are not better accounted for by another mental disorder.

DIAGNOSIS:

- R/O medical problems eg.
  - hyperthyroid (TSH)
  - cardiac arrhythmia's (EKG)
  - carcinoid syndrome (5HIAA)
  - pheochromocytoma (MHPG)
  - hypoglycemia (Glucose)
  - alcohol, barbiturate, benzodiazepine withdrawal
  - caffeine use
  - cocaine, amphetamines, marijuana use
  - Cushing's Syndrome
  - Menopausal symptoms

“Problems” with DSM-V

- Terminology unacceptable to patients. Conveys doubt as to reality and genuineness of their suffering
- Somatoform disorders do not form a coherent category
- Inherently dualistic. How do we know that something is NOT organic, at least partially. “Somatizing” may be overly reductionistic
- Incompatible with other cultures (China, less dualistic)

Screening Questions

Panic Attacks

- Do you have panic attacks or anxiety attacks, and by that I mean a sudden attack of anxiety with physical sensations. It's hard to breathe, your heart pounds, you are sweating, shaking.
- Does that happen to you?

Screening Questions

Agoraphobia

- Do you avoid going to certain places because you are fearful of having a panic attack and thus have restricted your activities.

TAKING A HISTORY

- do you get anxiety attacks
- Can they occur out of the blue, or do they happen in certain specific situations
- how long do they last
- how long have they been happening
- what physical symptoms do you experience
- are you avoiding doing any activities because of these anxiety attacks
- Are you nervous about when your next panic attack may happen?

"THE GREAT IMITATOR"

- cardiac - SOB, palpitations, CP
- neuro - lightheaded, dizzy, ataxia
- GI - vomiting, nausea, bouts of GI distress

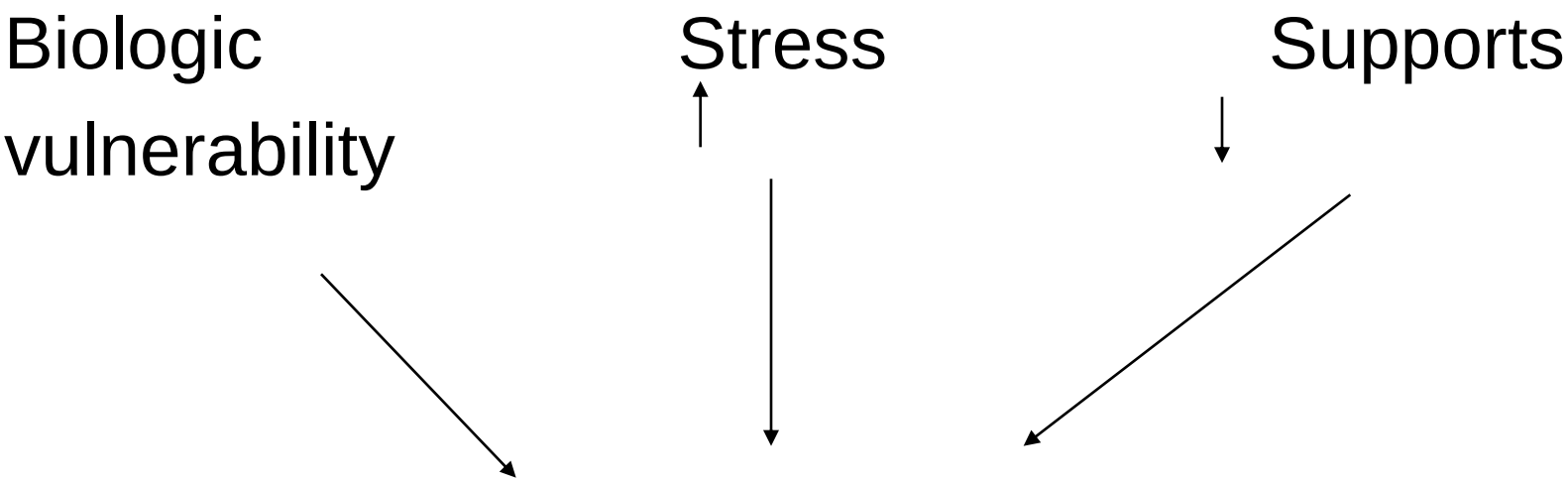
CBT

- psychoeducation: explain what is happening, a common condition, effective treatment is available. This can decrease stress.
- cognitive distortions corrected e.g. fears of sudden death, going crazy, etc; not life threatening ↓
- teach relaxation techniques eg. progressive muscle relaxation

Systematic Desensitization

- if agoraphobia present, can use systematic desensitization techniques
- hierarchy of behaviours to be approached, paired with relaxation training
- make sure behaviour is conquered before stopping activity

STRESS DIATHESIS MODEL



- Often panic attacks are precipitated by stressful life events, and this can be dealt with in psychotherapy

I START WITH:

- d/c caffeine, alcohol, marijuana
- correct cognitive distortions
- relaxation training
- provide supportive counselling (increase support, decrease stress)
- if not effective after a few weeks, start SSRI, NSRI
- sooner, if patient requests.

Recommendations for Pharmacotherapy for PD

First Line

Citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, paroxetine CR, sertraline, venlafaxine XR

Second-Line

Alprazolam, clomipramine, clonazepam, diazepam, imipramine, lorazepam, mirtazapine, reboxetine

Recommendations for Pharmacotherapy for PD

Third-line

Buproprion SR, divalproex, duloxetine, gabapentin, levetiracetam, milnacipran, moclobemide, olanzapine, phenelzine, quetiapine, risperidone, tranylcypromine

Adjunctive Therapy:

Second-Line: alprazolam ODT, clonazepam

Third-Line: aripiprazole, divalproex, olanzapine, pindolol, risperidone

Not recommended

Buspirone, propranolol, tiagabine, trazodone

meds

- SSRI or NSRI
- Benzodiazepine as adjunct. Here I would use lorazepam 0.5-1.0 mg. po or s/l prn

Agoraphobia

- Marked fear or anxiety about two or more of the following:
  - Using public transportation
  - Being in open places (bridges, marketplaces)
  - Being in enclosed places (shops, cinemas, theatres)
  - Standing in line or being in a crowd
  - Being outside of the home alone

Agoraphobia

- Avoids these situations because of a fear of panic attacks or other embarrassing symptoms
- Situations are avoided or require presence of a companion, or endured with intense fear
- Lasts for >6 months
- Causes distress/impairment of functioning

Generalized Anxiety Disorder

- Lifetime prevalence is 6%
- Women > men
- High rates of comorbidity
- GAD-7

DSM-V Diagnosis of GAD

- Excessive anxiety and worry (apprehensive expectation) occurring for at least 6 months about several events or activities
- Person finds it difficult to control the worry
- The anxiety and worry are associated with 3 (or more) of the following:
  - Restlessness or feeling on edge, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbance

GAD

- Anxiety and worry are not due to substance abuse or another medical or mental disorder (took out mood disorders)
- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Screening Questions

- Would you describe yourself as a chronic worrier? Would others see you as a worry wart?
- Do you worry about anything and everything as opposed to just one or two things?
- How long has this been going on for?
- Some people tell me that they are worriers but they can usually handle it; other people tell me that they are such severe worriers that they find that it gets in the way of their life or simply paralyzes them. Is this the case for you?

GAD and Somatizing

Watch for:

Somatic presentations, e.g., “irritable bowel syndrome”, fatigue, aches and pains.

Unexplained GAD is underdiagnosed.

R/O Organic:

- Caffeine use
- Hyperthyroid (TSH)
- Alcohol withdrawal/Benzo withdrawal
- Amphetamine/Cocaine use

Lifestyle Issues

- Discontinue Caffeine

Caffeine

Discontinue caffeine!!!

I mean it!

- coffee
- tea
- cola
- chocolate

Caffeine

Mg. Caffeine/6 oz or 120 ml)

Coffee: Filter Drip 108 - 180

- Automatic percolated 72 - 144
- Instant 60 - 90

Tea: Strong 78-108

Cola: 1 can (12 oz or 355 ml) 28-64

- Dr. Pepper - YES
- Mountain Dew - NO - in Canada; YES in USA

Caffeine

Cocoa	*6 oz. Or 180 ml.*
Hot chocolate	6 – 30 mg.
Dark chocolate (56g)	30-40 mg.
Milk chocolate (56g)	3 – 20 mg.

Lifestyle Changes

- Increase exercise
- Improved sleep habits
- Changes in job environment/home stressors

Psychological Treatments

CBT -cognitive Therapy

- identify automatic thoughts that cause worry
- challenge these (evidence for and against)
- Reformulate

Behavioural

-Progressive muscle relaxation

Recommendations for Pharmacotherapy for GAD

First-line

Agomelatine, duloxetine, escitalopram, paroxetine, paroxetine CR, pregabalin, sertraline, venlafaxine XR

Second-line

Alprazolam, bromazepam, buproprion XL, diazepam, hydroxyzine, imipramine, lorazepam, quetiapine XR, vortioxetine

Third-line

Citalopram, divalproex, chrono, fluoxetine, mirtazapine, trazodone

Recommendations for Pharmacotherapy for GAD

Adjunctive Therapy

Second-line: pregabalin

Third-line: aripiprazole, olanzapine, quetiapine, quetiapine XR, risperidone

Not recommended: Ziprasidone

Not recommended:

Beta blockers (propranolol), pexacerfont, tiagabine

Note: Benzos

- Benzos can be used for GAD, if other meds not effective
- Tolerance has been widely overstated (APA study group). Most people do not need continuing increased dosages
- Would recommend clonazepam as long acting
- May be on for long period. That's Okay!

Meds

- SSRI, NSRI
- Benzodiazepines--here I would try clonazepam

SOCIAL ANXIETY DISORDER

- Lifetime prevalence 8-12%
- Women > men
- Peaks between 0-5, 11-15
- Onset after age 15 is rare
- Social phobia inventory (SPIN)

DSM-V Diagnosis of SAD

- Marked and persistent fear of social or performance situations
- Fear of negative judgment
- Avoidance of feared situation or endurance with distress
- Persistent, >6 months

DSM-V Diagnosis of SAD

- Avoidance or fear cause significant distress or impaired functioning
- Fear or avoidance are not due to another medical or mental disorder
- Specify if:
  - Performance only

Screening Questions

- Do you generally avoid social situations, especially with people you don’t know well, such as parties
- Can you eat in restaurants in front of other people
- Can you do presentations in front of others
- Do your social fears get in the way of your life

Common Components of CBT for SAD

Education

- Education about the disorder and its treatment
- Recommends self-help materials

Common Components of CBT for SAD

Exposure

- Offers imaginal exposure to situations that are difficult to practice regularly in real life.

- Offers in vivo (real life) exposure to situations that provoke social anxiety during treatment

Common Components of CBT for SAD

Cognitive Restructuring

- Aims to reduce negative beliefs about self and others
- Works to reduce the excessive self-focus that is characteristic of social anxiety disorder

Recommendations for Pharmacotherapy for SAD

First Line

Escitalopram, fluvoxamine, fluvoxamine CR, paroxetine CR, pregabalin, sertraline, venlafaxine XR

Second Line

Alprazolam, bromazepam, citalopram, gabapentin, phenelzine

Recommendations for Pharmacotherapy for SAD

Third-Line

Atomoxetine, buproprion SR, clomipramine, divalproex, duloxetine, fluoxetine, mirtazapine, moclobemide, olanzapine, selegiline, tiagabine, topiramate

Adjunctive Therapy:

Third-line: aripiprazole, buspirone, paroxetine, risperidone

Not recommended: clonazepam, pindolol

Not recommended

Atenolol, buspirone, imipramine, levetiracetam, propranolol, quetiapine

OBSESSIVE COMPULSIVE AND RELATED DISORDERS

OBSESSIVE COMPULSIVE DISORDER

- Lifetime prevalence 1.6%
- Age of onset is 14 to 30 (median 19)
- 60% female
- Can occur in kids
- (Y-BOCS) Yale-Brown Obsessive Compulsive Scale

DSM-V Diagnosis of OCD

Either obsessions or compulsions:

- Obsessions as defined by the following:
  - Recurrent and persistent thoughts, urges or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress
  - Not simply excessive worries about real-life problems

DSM-V Diagnosis of OCD

- Compulsions as defined by the following:
  - Repetitive behaviours (for example, hand washing, ordering, checking) or mental acts (for example, praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rigid rules

DSM-V Diagnosis of OCD

- The obsessions or compulsions cause marked distress, are time consuming (take > 1 hour daily), or significantly interfere with the person's normal routine, or occupational, academic, or social functioning

- The obsessions or compulsions are not due to substance abuse, or another medical or mental disorder

OCD

- Specify if:
  - With good or fair insight
  - With poor insight
  - With absent insight/delusional beliefs

- Specify if:
  - Tic related

Screening Questions

Do you have any unusual or silly thoughts that you know are silly but you simply cannot stop thinking about them, such as being contaminated by germs? Do you feel there are certain rituals you have to do such as tap your hand a certain way or do things in sets of threes or touch certain things before you can enter the room or things like that?

Common Components of CBT for OCD

Education

- Educate about OCD, including typical obsessions, compulsions, and coping strategies

- Recommends relevant self-help readings or manuals.

Common Components of CBT for OCD

Exposure

- Offers in vivo (real life) exposure to situations that provoke anxiety and compulsive behaviour (for example, touching contaminated objects)

- Offers imaginal exposure to feared obsessive thoughts (for example, especially concerning religious, aggressive, or sexual content)

Common Components of CBT for OCD

Response Prevention

- Gradually reduces and eliminates:
  - Compulsive behaviour (for example, hand washing) including mental compulsions or rituals (for example, saying a prayer after having a harmful thought)
  - Excessive safety behaviour (for example, wearing gloves or other protective clothing to avoid coming in contact with contaminated objects)

Common Components of CBT for OCD

Cognitive Interventions

- Reappraisal of beliefs concerning the danger involved in situations that provoke obsessions and compulsions. This involves estimation of likelihood of a negative outcome occurring

Recommendations for Pharmacotherapy for OCD

First-line

Escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline

Second-Line

Citalopram, clomipramine, mirtazapine, venlafaxine XR

Third-Line

IV citalopram, IV clomipramine, duloxetine, phenelzine, tramadol, tranylcypromine

Recommendations for Pharmacotherapy for OCD

Adjunctive Therapy:

First-Line: aripiprazole, risperidone

Second-Line: memantine, quetiapine, topiramate

Third-Line: amisulpride, celecoxib, citalopram, granisetron, haloperidol, IV ketamine, mirtazapine, N-acetylcysteine, olanzapine, ondansetron, pindolol, pregabalin, riluzole, ziprasidone

Not recommended: buspirone, clonazepam, lithium, morphine

Not recommended: Clonazepam, clonidine, desipramine

Body Dysmorphic Disorder

- Preoccupation with one or more defects in physical appearance that are not observable or appear slight
- Has performed repetitive behaviours in response to appearance concerns
- Gets in the way of social/occupational functioning
- Not about concerns with body weight

BDD

- Specify if:
  - With muscle dysmophia

- Specify if:
  - With good or fair insight
  - With poor insight
  - With absent insight/delusional beliefs

Hoarding Disorder

- Persistent difficulty discarding or parting with possessions
- Results in congestion and clutter of active living areas
- Causes distress and impairment
- Not due to another medical or mental disorder

Hoarding

- Specify:
  - With excessive acquisition

- Specify
  - With good or fair insight
  - With poor insight
  - With absent insight/delusional beliefs

Trichotillomania (Hair-Pulling Disorder)

- Recurrent pulling out of one's hair, resulting in hair loss
- Repeated attempts to decrease/stop
- Causes distress/impaired functioning
- Not due to another mental or physical disorder

Excoriation (Skin-Picking) Disorder

- Recurrent skin picking resulting in skin lesions
- Repeated attempts to stop/decrease
- Causes distress/impairment of functioning
- Not due to another medical or mental disorder

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