

Mental Health and Primary Care Conference
Anxiety Disorders

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OH & SU

Goals

- Differentiate types of anxiety disorders
- Know appropriate pharmaceutical interventions for these disorders
- Mood disorders and sleep disorders are covered in other presentations
- There is a strong evidence base for the efficacy of cognitive and behavioral therapies in these disorders which will be covered by Josie Juhasz and the panel discussion

Biased?

- Addiction Psychiatrist-full time PVAMC
 - Director Opiate Treatment Program [Methadone]
 - Director substance abuse treatment program-primary addiction + concurrent PTSD, depression, anxiety, psychosis
 - Clinic for patients with pain and addiction-with anesthesia department
 - Smoking cessation program
 - Consultant to Oregon Medical Board
 - No conflicts of interest to disclose

Differential Diagnosis

- Medical conditions such as endocrinopathies, cardiac/pulmonary disease, metabolic, neurologic, etc. [present with somatic and sleep complaints]
- Caffeine, Alcohol, Nicotine, illicit/OTC drugs or prescribed medication
- Most other diagnosis “trump” Anxiety Disorders
- Reaction to psycho-social stresses
- Non-pathological [normal] worry
- Debate continues on whether “pure” anxiety D/O exist

Psychiatric Differential Diagnosis

- “never enjoyed anything in my whole life”
 - dysthymia, depression, personality traits or “style”
- “inwardly I’m tensed up”
 - Somatic components of generalized anxiety
- “terrible feeling like when a car pulls up in front of you”
 - Panic attack?
- “scared of doing things-shopping, going down the road”
 - Agoraphobia, avoidance in ptsd
- “Catholic school”
 - Sexual abuse, PTSD
- “fear of hell-guilt”
 - OCD, depression
- Drinks 6-pack/day to “relax and get to sleep”
 - “unhealthy or dependent drinking”, sleep disorder

Classification of Anxiety Disorders

- Generalized anxiety disorder
- Panic disorder
- Adjustment disorder with anxious mood
- Social phobia (social anxiety disorder)
- Posttraumatic stress disorder
- Obsessive-compulsive disorder
- Simple phobia

Generalized Anxiety Disorder

- Worry/anxiety most days, in multiple areas
- Cannot control the worry, often excessive
- Three of
 - restless/on edge
 - fatigued
 - trouble concentrating
 - irritable
 - muscle tension
 - sleep difficulties
- Causes distress/impairment

Yerkes-Dodson Law-1907

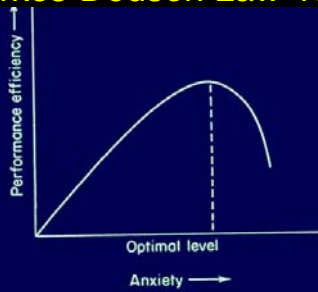


Figure 7.1 The Yerkes-Dodson law illustrating the effect of anxiety on performance efficiency.

Obsessive Compulsive Disorder

- Persistent thoughts and/or repetitive behaviors that are time consuming and cause distress and impairment
- Under diagnosed despite being common [1.5-3%] as patients often reluctant to reveal
- Patients may avoid social interactions and may be housebound [mistaken for social phobia or agoraphobia]

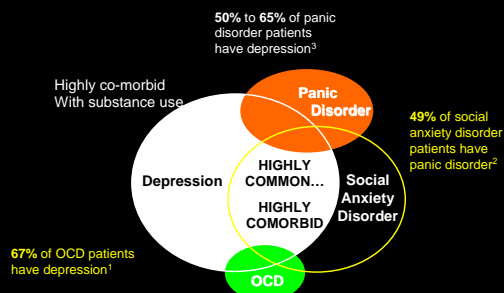
Post Traumatic Stress Disorder

- [A] Exposure to event with serious threat and experienced fear, helplessness or horror
- With each of
 - [B] Re-experiencing-recollections, dreams, reliving with flashbacks, distress with cueing
 - [C] Avoidance and numbing-avoid places, people things, loss of memory, detachment, sense of foreshortened future
 - [D] Increased arousal-poor sleep, startle, hypervigilance, poor concentration, irritability

Panic Disorder

- Recurrent, sudden, unprovoked, "attacks" with intense fear accompanied by somatic and arousal symptoms
- Patients usually believe they have a serious physical illness

Comorbidity of Depression and Anxiety Disorders*



¹ Rasmussen SA and Eisen JL. *J Clin Psychiatry*. 1992;53(suppl):4-10.
² Van Ameringen et al. *J Affect Disord*. 1991;21:33-99.
³ American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. 1994.
* Conceptual representation of comorbidity.

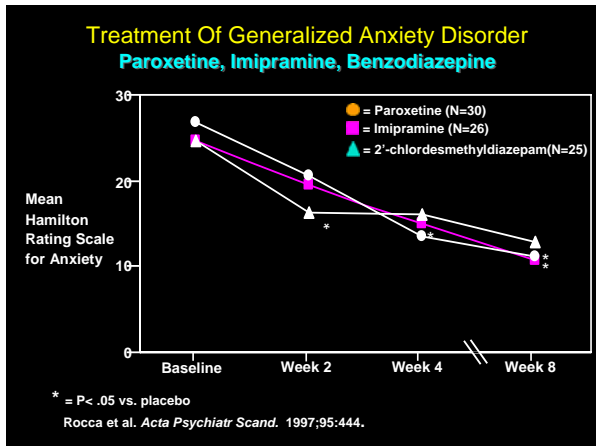
Pharmacologic Treatments for Anxiety Disorders

- Behavioral treatments may be more effective, have fewer side effects and no “rebound” or withdrawal issues
- They may be less available, the onset of improvement may be slower, or have lower patient acceptance

R I S K S / B E N E F I T S

Prescriptions 2001

- | | |
|--------------------|---------------------|
| • Xanax 31 | • Zoloft 28 |
| • Ativan 21 | • Prozac 26 |
| • Valium 13 | • Paxil 26 |
| • Klonopin 13 | • Celexa 17 |
| • Buspar 7 | • Wellbutrin 14 |
| • Other benzos 12 | • Effexor 13 |
| • TOTAL 97 million | • Elavil 17 |
| | • Others [each] <6 |
| | • TOTAL 183 million |



Benzodiazepines: Advantages

- Rapid onset
- Safe
- Good tolerability—rare “paradoxical” activation
- Can be useful as needed for breakthrough symptoms
- Augmentation of SSRIs or other antidepressant therapies
- “Re-enforcing” in some—may increase adherence to treatment and minimize activating symptoms of SRIs

Ballenger et al. *J Clin Psychiatry*, 1998;59(suppl 9):51.
 Furukawa et al. *J Affect Disord*, 2001;65:173.
 Goddard et al. *Arch Gen Psychiatry*, 2001;58:681.

Benzodiazepines: Disadvantages

- No reliable antidepressant activity
- Worsen delirium
- Initial sedation and ataxia, implicated in MVA's—memory problems and falls in elderly
- Tolerance; withdrawal with discontinuation
- Concern over abuse potential
 - Demonstrated in polysubstance abusers
 - Overdose deaths when combined with analgesics
- Sexual dysfunction in a minority

Ninan. *J Clin Psychiatry*, 1999;60(suppl 22):12-17.
 Petursson and Lader. *Br J Addict*, 1981;76:133.

SRI's/SNRI's: Advantages

- Effective for comorbid depression
- Efficacy for many of the anxiety disorders
- Relatively safe and reasonable tolerability
- Prevention of relapse
- No abuse potential
- Once daily dosing

SRI's/SNRI's: Disadvantages

- Onset of action usually delayed for days to weeks
- May activate and transiently worsen anxiety at onset of treatment
- "Black box" warning re suicide
- Sexual dysfunction is common (25%–60%)
- Some produce withdrawal reactions when discontinued
- Increasingly recognized side effect profile
 - Weight gain
 - Rare pancreatitis
 - Rare torsades de pointes
 - Bleeding
 - Osteoporosis
- Eric Turner's work on use in depression raises questions about quality of research re SRI's

Antidepressants vs. Benzodiazepines

- Benzos
 - work more quickly
 - Improve "somatic" symptoms
- Antidepressants
 - Delayed onset
 - Work on "psychic" symptoms [worry]

PTSD

- Only Paroxetine and Sertraline approved by FDA
- Prazosin [unapproved] found to be helpful in nightmares [Raskind; Biological Psych 2007]
- Widespread use of atypicals, anti-convulsants, newer [and older] antidepressants] and other anti alpha adrenergic agents with no FDA approval [Friedman AJP 2006]

Use of Non-Approved Meds for PTSD

- TCA's-"global improvement", useful for concurrent depression/panic-poor side effect profile
- Anti-adrenergic agents [prazosin, propranolol, clonidine, guanfacine], reduce re-experiencing, hyperarousal-hypotension, bradycardia, worsen asthma
- Anti-convulsants [valproate, carbamazepine] may reduce irritability, aggression-variable side-effects
- Atypical Anti-psychotics preliminary data, used for augmentation-metabolic effects
