APPROACH TO ANXIETY DISORDERS IN PRIMARY CARE

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Presenter Disclosure

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Relationships with financial sponsors:

- **Any direct financial relationships, including receipt of honoraria:** OCFP,Pri-Med Canada/Humber River Hosp., Touchstone Institute, McMaster U. Continuing Education, U of Ottawa Dermatology, CME Away by Sea Courses, KW Family Medicine Dept., MD Psychotherapy Association
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Objectives

1. Describe how to diagnose the anxiety disorders in a time efficient manner
2. Describe psychotherapeutic treatments for the different anxiety disorders
3. Describe psychopharmacologic treatments for the different anxiety disorders, based on recent guidelines

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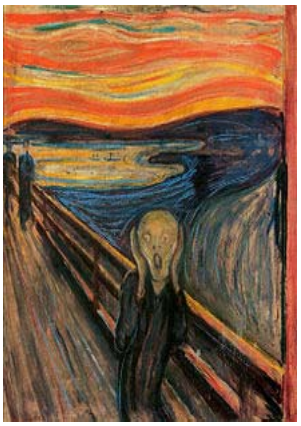
PANIC DISORDER

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



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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

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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

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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

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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)

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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.

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Question

- You have a 25 year old male patient, who is avoiding leaving his house due to fear of having a panic attack. In order to help, you ask him to reduce some of his substance use. Which of the following substances may worsen panic attacks:

A) Caffeine
B) Alcohol
C) Marijuana
D) All of the above

■Answer: D

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DIAGNOSIS:

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

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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?

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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.

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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?

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"THE GREAT IMITATOR"

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

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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

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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.

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Using Meds in Anxiety Disorders

- Same idea as depression, same ranges.
- Start at a half increments the 1st week. (more prone to side effects)
- We go up to the max dose with each pill in the same way.

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X-Crossover

- For use when switching to a different antidepressant
- Lower first drug by typical increment q7days
- Start 2nd drug at half dose along with starting dose of first drug for 5 days
- Increase second drug to full starting dose while discontinuing the 1st drug

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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

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meds

- SSRI or NSRI (as per Katzman et al)
- Benzodiazepine as adjunct. Here I would use lorazepam 0.5-1.0 mg. po or s/l prn

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Generalized Anxiety Disorder

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

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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

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GAD

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

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R/O Organic:

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

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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?

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GAD and Somatizing

Watch for:

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

Unexplained GAD is underdiagnosed.

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Psychological Treatments

CBT -cognitive Therapy

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

Behavioural

-Progressive muscle relaxation

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Question

- You have a patient with an anxiety disorder, who develops side effects to all the antidepressants that are recommended for this disorder. You have heard that Pregabalin may be very helpful for some of the anxiety disorders. Pregabalin is considered a first line medication for which of the following anxiety disorders.

A) OCD
B) PTSD
C) GAD
D) Panic Disorder

E) Answer: C

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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

Propranolol NOT recommended

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Meds

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

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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)

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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

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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

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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

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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

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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

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Question

- You have a 19 year old male patient who comes to you because he is so shy, it is getting in the way of his life. You refer him for counselling, and you start him on a medication. Which of the following drugs is considered first line in the treatment of social anxiety disorder:

A) Amitriptyline
B) Alprazolam
C) Escitalopram
D) Olanzapine

- Answer: C

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Recommendations for Pharmacotherapy for SAD

First Line

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

Second Line

Alprazolam, bromazepam, citalopram, gabapentin, phenelzine

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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

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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

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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

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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?

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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

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Common Components of CBT for OCD

Exposure:
Touch a doorknob

Response prevention:
Wait 30 seconds to wash hands.
Then 1 minute, 2 minutes, etc.

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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

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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

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Hoarding Disorder

- Persistent difficulty discarding or parting with possessions
- Results in congestion and clutter of active living areas
- Causes distress and impairment

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Trichotillomania (Hair-Pulling Disorder)

- Recurrent pulling out of one's hair, resulting in hair loss
- Repeated attempts to decrease/stop
- Causes distress/impaired functioning

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Excoriation (Skin-Picking) Disorder

- Recurrent skin picking resulting in skin lesions
- Repeated attempts to stop/decrease

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Questions?

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