Anxiety Disorders: Diagnosis & Treatment

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Disclosures

• I have no financial relationships to disclose relating to the subject matter of this presentation
Learning Objectives

1. Review the DSM-5 diagnostic criteria for Generalized Anxiety Disorder and Panic Disorder
2. Recognize differential diagnosis of GAD and Panic Disorder
3. Appreciate common co-morbidities to Anxiety disorders
4. Understand approach towards management and treatment options for Anxiety disorders in the primary care setting
“Of course you feel great. These things are loaded with antidepressants.”
Primary Care is the ‘De Facto’ Mental Health System

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
What is Anxiety?

Begins as ordinary, day-to-day situation.

Excessive

Begins to effect daily life
DSM-5 Diagnostic Criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (With at least some symptoms having been presents for more days than not for the past 6 months). Note: Only one item is required in children
  - 1. Restlessness or feeling keyed up or on edge.
  - 2. Being easily fatigued.
  - 3. Difficulty concentrating or mind going blank.
  - 4. Irritability.
  - 5. Muscle tension.
  - 6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
DSM-5 Diagnostic Criteria for Generalized Anxiety Disorder (cont.)

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, a negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder.)
GAD: how does it present in the office?

- Prevalence: 3.1% (12-months), 9% (lifetime)
- Median age of onset: 31
- Life stressors
- Somatic symptoms: sleep disturbances, chronic headache, sweating, palpitations, chest tightness, gastrointestinal symptoms, restlessness
- “Do you worry excessively about minor matters?”
## Screening Tool

### GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Score** = Add Columns

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult
## Relationship Between GAD-7 Score and Disability Days, Symptom-Related Difficulty, and Clinic Visits

<table>
<thead>
<tr>
<th>GAD-7 Score</th>
<th>Mean No. of Disability Days (95% CI)</th>
<th>Mean No. of Physician Visits (95% CI)</th>
<th>% of Symptom-Related Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 (n=1182)</td>
<td>3.9 (3.0-4.7)</td>
<td>1.2 (1.1-1.3)</td>
<td>15.0</td>
</tr>
<tr>
<td>5-9 (n=511)</td>
<td>7.5 (6.2-8.7)</td>
<td>1.7 (1.5-1.9)</td>
<td>5.5</td>
</tr>
<tr>
<td>10-14 (n=264)</td>
<td>10.7 (8.9-12.4)</td>
<td>2.2 (1.9-2.5)</td>
<td>13.7</td>
</tr>
<tr>
<td>15-21 (n=171)</td>
<td>16.8 (14.6-19.1)</td>
<td>2.4 (2.0-2.8)</td>
<td>47.4</td>
</tr>
</tbody>
</table>

Spitzer RL, et. al., Arch Intern Med. 2006;166(10):1092-1097
Panic Disorder

Panic Attack ≠ Panic Disorder
Panic Disorder

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

**Note:** The abrupt surge can occur from a calm state or an anxious state.

1. Palpitation, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feeling of unreality) or depersonalization (being detached from one self).
12. Fear of losing control or “going crazy”.

**Note:** Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.
Panic Disorder (cont.)

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).

2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).

DSM-5
Panic Disorder: how does it present in the office?

- Prevalence: 2%-3% (12-months), 4.7% (lifetime)
- Median age of onset: 20-24
- Discrete, somatic symptoms, particularly autonomic hyperarousal (e.g. palpitations, shortness of breath, and dizziness).
- High medical utilization: majority seek care through PCP and/or emergency department

Differential Diagnosis and Comorbidities

- Medical Mimics
- Other Anxiety Disorders
- Depressive Disorder
- Substance use disorders (intoxication or withdrawal)
Medical Mimics

- **Endocrinopathies**
  - Hypo/hyperthyroidism
  - Hypo/hyperadrenalism
  - Menopause

- **Metabolic**
  - Diabetes
  - Porphyria

- **Cardiovascular**
  - ACS
  - Hypertension
  - CHF

- **Pulmonary**
  - Asthma/COPD
  - PE

- **Neurological**
  - Stroke
  - MS
  - Migraine
  - Epilepsy

- **Medications**
  - Steroids
  - Stimulants
  - Anticholinergics
  - Dopaminergics

- **Other**
  - Anemia
  - Vitamin deficiency (B12)
  - Heavy metal poisoning
Comorbidities

- **Other Anxiety Disorders**
  - GAD: Panic disorder (22.6% and 23.5%)

Comorbidities (cont.)

- **Depressive Disorders**
  - Depression: 75% met criteria for an anxiety disorder (lifetime)
  - Anxiety: 79% met criteria for MDD (lifetime)
  - Presence of both disorders together:
    - *Significantly decreases odds of recovery*
    - *Increases time to therapeutic onset for medication*
    - *Associated with a more chronic course*

## Anxiety Disorders and Suicide Risk

<table>
<thead>
<tr>
<th>Questionnaire Item</th>
<th>% endorsing (n=1002)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think that you were better off dead or wish you were dead? (past month)</td>
<td>25.3%</td>
</tr>
<tr>
<td>Want to harm yourself or to hurt or injure yourself? (past month)</td>
<td>5.1%</td>
</tr>
<tr>
<td>Think about suicide? (past month)</td>
<td>13.4%</td>
</tr>
<tr>
<td>Deliberately harm or injure yourself? (past month)</td>
<td>2.2%</td>
</tr>
<tr>
<td>In your lifetime did you ever make a suicide attempt?</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

Bomyea J, et. al., Psychiatry Research 2013, 209(1), 60–65
Comorbidities (cont.)

- **Substance use disorders (SUD)**
  
  - Co-occurs at increased rate with anxiety-related disorders (except OCD), compared to general public
  
  - Co-occurring SUD and anxiety disorder usually presents with a more severe clinical profile
    
    - *More severe mood symptoms, interpersonal/vocational impairments, medical problems, other Axis I and II disorders*

  - Typically, onset of anxiety disorder precedes the onset of SUD

Comorbidities (cont.)

**Take home**: assume patients presenting with an anxiety disorder have more than one historic and/or current DSM-5 diagnosis.
Anxiety Disorder Treatment Options

• Pharmacologic
  • SSRI’s, SNRI’s, benzodiazepines, off-label agents

• Non-pharmacologic
  • Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), exercise

• Combined
Managing the Initial Visits

Supportive Companion

Knowledgeable Consultant

**Comic Strip**

- **Calvin:** Do you have an idea for your project yet?
- **Hobbes:** No, I'm waiting for inspiration.
- **Calvin:** You can't just turn on creativity like a faucet. You have to be in the right mood.
- **Hobbes:** What mood is that? Calvin:** Last-minute panic.
Managing the Initial Visits

- Establish empathetic working relationship
- Motivational Interviewing techniques and spirit
  - [http://uwaims.org/tools/clinicalskills.html#mi](http://uwaims.org/tools/clinicalskills.html#mi)
    - Provide feedback about their disorder
    - What are likely disorders, and severity (GAD-7)
    - Elicit patient’s motivation and barriers to treatment
    - Education: Treatment options and “cycle of anxiety”

THE CYCLE OF ANXIETY

STRESSORS
- Medical illness
- Pain
- Family or Marital problems
- Work problems

GENETIC FACTORS
- Family history of panic
- Early childhood anxiety

HEALTH HABITS
- Poor diet
- Inadequate sleep
- Caffeine and alcohol use
- Lack of exercise

THOUGHTS AND FEELINGS
- Something is wrong with my body
- Worry about everything
- Can’t cope
- I’m out of control
- Depression

PHYSICAL
- Muscle Tension
- Shortness of breath
- Flushing & chills
- Palpitations
- Chest Pain
- Dizziness

BEHAVIOR
- Increased doctor visits because of health worries
- Avoidance of places that make me anxious
- Use of alcohol to cope

CBT TO IMPROVE COPING

MEDICATIONS
# SSRI and SNRI Antidepressant Options

<table>
<thead>
<tr>
<th>Medication</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>Generic available, Long half-life (no withdrawal)</td>
<td>More activating, long time to steady-state</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>Generic available, few drug interactions</td>
<td>Appears to prolong QT interval with increasing blood levels</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>Generic available, mildly sedating</td>
<td>Shorter half-life, FDA advisory in pregnancy, weakly anticholinergic</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>Generic available, few drug interactions</td>
<td>More initial gastrointestinal complaints</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>Few drug interactions</td>
<td></td>
</tr>
<tr>
<td>Duloxetine (Cymbalta)</td>
<td>Useful for treatment of co-morbid pain</td>
<td>More activating</td>
</tr>
<tr>
<td>Venlafaxine ER (Effexor ER)</td>
<td>Useful for treatment of co-morbid pain, few drug interactions</td>
<td>Short half-life, increased blood pressure with increasing doses, hypo/hypernatremia</td>
</tr>
</tbody>
</table>
Crank up the Serotonin!

“Start low, go slow, but go all the way”
Other Pharmacotherapy Options

- **Buspirone (5-60 mg/d divided doses)**
  - Serotonin agonist/antagonist
  - Approved for GAD
  - No prominent side effects

- **Pregabalin (>150mg/d divided doses)**
  - Off-label use for GAD

- **Quetiapine (25-100mg TID prn)**
  - Off-label use for GAD, panic disorder
  - Weight gain, metabolic effects

- **Hydroxyzine (25-50mg TID-QID prn)**
  - Off-label use for GAD
  - Prominent anti-cholinergic effects with increasing dosage
So what about Benzodiazepines?

- Physiologic dependence occurs with chronic use of high doses
- Psychological dependence can develop early in use
  - Abuse potential directly related to the speed of onset (alprazolam/Xanax)
  - Also, lipophilic BZPs (e.g. diazepam) can induce euphoria
- Importance of assessing presence of substance abuse history
  - 85% of BZP abuse occurs in patients with polysubstance abuse histories
- Benzodiazepine reduction vs. benzodiazepine elimination

Adapted from Kaplan and Saddock
# Common Benzodiazepines

<table>
<thead>
<tr>
<th></th>
<th>Comparable Dose mg</th>
<th>Half-life (total) hours</th>
<th>Metabolism</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam (Xanax)</td>
<td>0.5</td>
<td>16-36</td>
<td>Oxidation 3A4 + no active metabolites</td>
<td>tid to qid</td>
</tr>
<tr>
<td></td>
<td><strong>Please, do not use!</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clonazepam (Klonopin)</td>
<td>0.5</td>
<td>19-60</td>
<td>Oxidation 3A4 + no active metabolites</td>
<td>bid</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>5</td>
<td>14-200</td>
<td>Oxidation 3A4 + many active metabolites</td>
<td>bid to qid</td>
</tr>
<tr>
<td>lorazepam (Ativan)</td>
<td>1</td>
<td>8-24</td>
<td>Glucuronidation + no active metabolites</td>
<td>tid</td>
</tr>
<tr>
<td>temazepam (Restoril)</td>
<td>5-10</td>
<td>6-20</td>
<td>Glucuronidation + no active metabolites</td>
<td>qhs</td>
</tr>
<tr>
<td>chlordiazepoxide (Librium)</td>
<td>10-25</td>
<td>6-100</td>
<td>Oxidation + active metabolites</td>
<td>tid</td>
</tr>
</tbody>
</table>
Nonpharmacologic Treatments

• **Exercise**
  - 60%-90% max HR for 20min 3x/wk

• **Yoga**

• **Cognitive Behavioral Therapy (CBT) – most evidence based**
  - Psychoeducation
  - Cognitive: identify and address mental distortions and false beliefs
  - Behavioral: desensitize feared situations by graded exposure and learn relaxation and anxiety reduction procedures

Bibliotherapy

- The Anxiety & Phobia Workbook
  - Edmund Bourne, PhD

- https://feelinggood.com/
  - David Burns, MD
“The core principles of effective integrated care include a patient-centered care team providing evidence-based treatments for a population of patients using a measurement-based ‘treat-to-target’ approach.”
Collaborative Team Approach

PCP

Consulting Psychiatrist

Care Manager

PATIENT
Treatment Pearls

- Incorporate MI to establish a trusting relationship while addressing psychosocial stressors.
- Treatment guidance: patient preference and treatment availability.
- Success with meds relies more on providing good patient information and follow-up than prescribing a specific drug.
- Refer if needed.
Thank you

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