Anxiety disorders, Obsessive-Compulsive Disorder and PTSD
General considerations for anxiety disorders

- Often have an early onset - teens or early twenties
- Show 2:1 female predominance
- Have a waxing and waning course over lifetime
- Similar to major depression and chronic diseases such as diabetes in functional impairment and decreased quality of life
Normal versus Pathologic Anxiety

- Normal anxiety is adaptive. It is an inborn response to threat or to the absence of people or objects that signify safety can result in cognitive (worry) and somatic (racing heart, sweating, shaking, freezing, etc.) symptoms.

- Pathologic anxiety is anxiety that is excessive, impairs function.
Comorbid diagnoses

- When an anxiety disorder is diagnosed OR patient p/w non-specific anxiety it is critical to screen for other psychiatric diagnoses since it is very common for other diagnoses to be present and this can impact both treatment and prognosis.

- i.e. Consider Comorbidity a given until excluded via assessment.
Primary versus Secondary Anxiety

Anxiety may be due to a primary anxiety disorder OR secondary e.g. Substance-Induced Anxiety Disorder, Anxiety Disorder Due to a General Medical Condition, Due to another psychiatric condition, psychosocial stressors (Adjustment Disorder with Anxiety) or Personality Disorder
Primary versus Secondary Anxiety

- Only focusing on the smoke (anxiety) may lead to not putting out the fire with more appropriate Rx’s.

- e.g. Missing comorbid substance abuse; treating recurrent panic attacks with PRN BNZ & missing underlying mood disorder; missing underlying BPD & using unhelpful meds & not receiving appropriate Rx e.g. DBT.
Primary versus Secondary Anxiety

- Equally important to not miss less obvious anxiety disorder (this may be the ‘fire’)

- Case Study: 46 yo male, stable marriage/family & employment, no SUD, p/w highly recurrent/brief MDE’s. Poor response to ADT’s. Thorough hx revealed ongoing childhood onset Social Phobia as trigger for most recurrent depressive states.

- Responded very well to combination of LTG & CBT for the SAD
Summary of Anxiety Disorders

- **Panic disorder**: Recurrent unexpected panic attacks & >1 month of persistent worry about having additional attacks or worry about the implications of the attacks & significant change in behaviour of the attacks (i.e. panic attacks ≠ panic disorder)

- **Agoraphobia**: Anxiety about being in places or situations from which it is difficult to escape and/or should a panic attack occur e.g. on public transport, in open or closed spaces, outside of home, standing in line or being in a crowd

- **Social phobia (also called social anxiety disorder)**
  Strong fear of social interaction or performance situations because of the potential for embarrassment or humiliation, > 6/12, avoidance of situations or endured with significant distress
Summary of Anxiety Disorders

- **Generalized anxiety disorder**: Long periods of uncontrollable worry about everyday issues or events, which is typically accompanied by feelings of fatigue, restlessness or difficulty concentrating, >6/12.

- **Obsessive-compulsive disorder**: Repeated thoughts, images or impulses that the person feels are inappropriate, and repetitive behaviours, designed to reduce the anxiety generated by the thoughts.

- **Specific Phobia**: Marked or persistent fear >6/12 that is excessive or unreasonable cued by the presence or anticipation of a specific object or situation.

- **Post-traumatic stress disorder**: Recurrent and intrusive memories of a trauma, feelings of emotional numbing and detachment, and increases in emotional arousal, such as irritability and disturbed sleep, resulting from a previous traumatic event. Attempts to avoid the experiences or triggers.
Screening questions

- How ever experienced a panic attack? (Panic)
- Do you consider yourself a worrier? (GAD)
- Have you ever had anything happen that still haunts you? (PTSD)
- Do you get thoughts stuck in your head that really bother you or need to do things over and over like washing your hands, checking things or count? (OCD)
- When you are in a situation where people can observe you do you feel nervous and worry that they will judge you? (SAD)
### Epidemiology of Anxiety Disorders

#### Table 5-1: Prevalence of 12-month anxiety disorders by anxiety disorder type and sex

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Males (%)</th>
<th>Females (%)</th>
<th>Persons (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder</td>
<td>2.3</td>
<td>2.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>2.1</td>
<td>3.5</td>
<td>2.8</td>
</tr>
<tr>
<td>Social phobia</td>
<td>3.8</td>
<td>5.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>2.0</td>
<td>3.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>4.6</td>
<td>8.3</td>
<td>6.4</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>1.6</td>
<td>2.2</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Any anxiety disorder</strong></td>
<td><strong>10.8</strong></td>
<td><strong>17.9</strong></td>
<td><strong>14.4</strong></td>
</tr>
</tbody>
</table>

*Note: Totals are lower than the sum of disorders as people may have had more than one type of anxiety disorder in the 12 months.*
Genetic Epidemiology of Anxiety Disorders

- There is significant familial aggregation for PD, GAD, OCD and phobias
- Twin studies found heritability of 0.43 for panic disorder and 0.32 for GAD.

Treatment
Medication versus Psychotherapy (PT)

- Studies show both are equal in effectiveness for most Anxiety d/o’s
- PT Should be considered 1st line for PTSD +/- Medication
- But higher rates of relapse for medication alone?
- Patient preference & motivation eg PT for motivated pt’s who value problem solving approaches
Medication &/or Psychotherapy?

- Severity of illness
- Clinicians skills & expertise
- Availability of psychological Rx including cost
- Pt’s response to prior Rx
- Comorbid medical or psychiatric disorders
- If start with one and poor response then add the other as second line intervention
<table>
<thead>
<tr>
<th>Psychological interventions</th>
<th>Generalised anxiety disorder (GAD)</th>
<th>Post-traumatic stress disorder (PTSD)</th>
<th>Social phobia</th>
<th>Panic disorder and agoraphobia</th>
<th>Specific phobias</th>
<th>Obsessive compulsive disorder (OCD)</th>
</tr>
</thead>
</table>
General Roles for GP

- Psycho-education about the anxiety d/o(s)
  e.g. Basic Physiology (flight & fight);
  timeframes for response to Rx’s & recovery;
  Tolerability of Rx choices;
  Negative roles of aggravating factors e.g. SUD;
  Sx’s & signs of relapse & relapse preventions strategies;
  self-help reading materials;
  central role of facing fears

- Involve significant others
Medication: Levels of Evidence

1: Metanalysis or \( \geq 2 \) RCT with a placebo condition

2: \( \geq 1 \) RCT with placebo or active comparison condition

3: Uncontrolled trial with \( \geq 10 \) subjects

4: Anecdotal reports or expert opinion
Medication Recommendation Summary (CANMAT)

- **1st Line**: Level 1 or 2 + clinical support for efficacy & safety
- **2nd Line**: Level 3 evidence + clinical support for efficacy & safety
- **3rd Line**: Level 4 evidence or higher + clinical support for efficacy & safety
- **Not Recommended**: Level 1 or Level 2 evidence for lack of efficacy
General Principles: Medication (CANMAT)

- Start at 1st Line
- Try another another 1\textsuperscript{st} Line (could be second SSRI; SNRI)
- 2\textsuperscript{nd} Line agent
- Reassess Dx; Comorbidities; Compliance;
- 3\textsuperscript{rd} Line or Adjunctive Treatment; Alternative Rx’s; Biological Rx’s (via Psychiatrist)
- Remember to consider psychosocial issues at all times & psychotherapy if not already added
Medication Principles

- Cornerstone of medications treatment for anxiety disorders is increasing serotonin

- Most of the SSRIs or Venlafaxine can be used (Nb. authors dislike for Paroxetine)

- NB Agomelatine: in GAD (CANMAT)

- Other main good evidence in short term is for BNZ’s

- 2nd & 3rd line options have poor/limited evidence to back them
How to use antidepressants

- Start at $\frac{1}{4}$ to $\frac{1}{2}$ the usual dose used for antidepressant benefit
- **WARN THEM THEIR ANXIETY MAY GET WORSE BEFORE IT GETS BETTER!!**
- May need to use an anxiolytic while initiating and titrating the antidepressant
SSRI’s

- E.G. use in PD: Start at ½ usual starting dose; In some pt’s may need to start at ¼ tablet if prior hx of sensitivity
- Assuming tolerability, incr 3-7 days after initiation
- Titrate to therapeutic dose over 2-6 weeks e.g Fluoxetine 20-40mg; Sertraline 100-200mg; Escitalopram 10-20mg
- Increases no faster than 1-2 week intervals
- When discontinue slow taper over several months
Venlafaxine XR

- Start at 37.5mg mane;
- 75mg at 1 week (assuming tolerability)
- Increase to 150mg by 2 to 3 weeks
- May need >= 225mg if inadequate response after 6 weeks
- May need very slow taper when ceasing
- Warn about common extreme withdrawal symptoms e.g. ‘brain zaps’
Benzodiazepines

- very effective in reducing anxiety sx however due to the risk of dependence must use with caution
- Aim for s/t use (can some safely benefit l/t?)
- prn basis vs regular? CANMAT advises regular.
- DO NOT USE ALPRAZOLAM
- Consider only dispensing limited amounts at a time
- Avoid for patients with a history of addiction or active drug/ETOH abuse or dependence
Medication for Panic Disorder (CANMAT)

- **1st line:** SSRI’s; Venlafaxine XR

- **2nd line:** Clomipramine; Clonazepam; diazepam, Imipramine, Lorazepam, mirtazapine; reboxetine

- **3rd line:** Buproprion SR, Valproate; Duloxetine; Gabapentin; Moclobemide; Olanzapine, MAOI’s, Quetiapine, Risperidone

- **Adjunctive Therapy:** 2\textsuperscript{nd} Line – Clonazepam; 3\textsuperscript{rd} Line – Aripiprazole, Valproate, Olanzapine, Pindolol, Risperidone

- **Not Recommended:** Buspirone, Propranolol
Medication for SAD (CANMAT)

- **1st Line**: Escitalopram; Fluvoxamine; Paroxetine; Sertraline; Venlafaxine XR; Pregabalin
- **2nd Line**: Citalopram; Clonazepam, Gabapentin, Phenelzine
- **3rd Line**: Clomipramine; Duloxetine; Fluoxetine; Mirtazpaine; Moclobemide; Olanzapine; Topiramate; Selegiline; Atomoxetine; Buproprion SR; Tiagabine
- **Adjunctive Therapy**: Third Line – Aripiprazole; Buspirone; Paroxetine, Risperidone; Not recommended – Clonazepam; Pindolol
- **Not Recommended**: Atenolol*; Buspirone; Imipramine; Propranolol*, quetiapine

*B-Blockers can help in performance situations such as public speaking*
Medications for GAD (CANMAT)

- **1st line**: Agomelatine; Duloxetine; Escitalopram; Paroxetine; Pregabalin, Sertraline, Venlafaxine XR
- **2nd line**: Bromazepam*; Diazepam*; Lorazepam*; Buspirone; Hydroxyzine; Imipramine; Quetiapine XR#; Vortioxetine; Bupropion XL
- **3rd Line**: Citalopram; Valproate; Fluoxetine; Mirtazapine
- **Adjunctive Therapy**: Second Line – Pregabalin; Third Line – Aripiprazole; Olanzapine; Quetiapine; Quetiapine XR; Risperidone; Not Recommended – Ziprasidone
- **Not Recommended**: Beta Blockers (propranolol); Tiagabine
- * BNZ’s: could be 1st line except where risks considered
- # QTP XR: good option but 2nd re: metabolic risks
Medication treatment of OCD (CANMAT)

- **1st Line**: Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline
- **2nd Line**: Citalopram, Clomipramine, Mirtazapine, Venlafaxine XR
- **3rd Line**: Duloxetine, MAOIs, Tramadol (not sure if I would use this for OCD but must have some small evidence internationally)

**Adjunctive Therapy**:
- **1st Line**: Aripiprazole, Risperidone
- **2nd Line**: Memantadine, Quetiapine, Topiramate
- **3rd Line**: Amisulpride, Celxicob, Citalopram, Granisetron, Haloperidol, IV Ketamine, Mirtazapine, N-AC, Olanzapine, Odansetron, Pindolol, Pregabalin, Riluzole, Ziprasidone; Not recommended-Buspirone, Clonazepam, Lithium, Mornphine
- **Not Recommended**: Clonazepam, Clonidine, Desipramine
Medication for PTSD (CANMAT)

- **1ˢᵗ Line**: Fluoxetine, Sertraline, Venlafaxine XR
- **2ⁿᵈ Line**: Fluvoxamine, Mirtazapine, Phenelzine
- **3ʳᵈ Line**: ADT’s- Amitriptyline, Duloxetine, Escitalopram, Imipramine, Moclobemide, Reboxetine, Bupropion SR; AAP's-Aripiprazole, Risperidone, Quetiapine; AC’s- Carbamazepine, Lamotrigine, Topiramate; Other- Memantine, Buspirone

- **Adjunctive Therapy**: 2ⁿᵈ Line- Olanzapine, Risperidone; 3ʳᵈ Line- Aripiprazole, clonidine, Gabapentin, Levetiracetam, pregablain, quetiapine, reboxetine, tiagabine; Not Recommended- Bupropion SR, guanfacine, Topiramate, zolpidem

- **Not Recommended**: Alprazolam, Citalopram, Clonazepam, Desipramine, Valproate, Olanzapine, Tiagabine
PTSD Medication (cont)

- **Clonidine**: for PTSD related nightmares: Start at 1mg nocte X 3 nights then increase by 1mg every 3 nights until nightmares improve or patient develops postural hypotension. Some patients can gain benefit at 1mg and some need >10mgs, up to max approximately 15mg!

- Debriefing immediately following trauma is NOT necessarily effective
Take home points

- Anxiety Disorders are common with a huge amount of suffering associated with these disorders!
- Screening questions can help identify or rule out diagnoses
- There are significant comorbid psychiatric conditions including SUD associated with anxiety disorders!
- Treatments for anxiety may be less effective if comorbid conditions are not identified & addressed
- But there are effective treatments including psychotherapy and psychopharmacology for primary anxiety disorders