An introduction to anxiety disorders:

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Aims of this session

This session will enable students to:

- List characteristic symptoms and signs associated with generalised anxiety, panic disorder, phobias and obsessive-compulsive disorder.
Daily incidence of acute myocardial infarction in ICCU during Jan 8–25, 1991 (closed columns), compared with same period in 1990 (open columns).

Large arrow = beginning of Gulf war; small arrows = missile attacks on Israel.
## Elevated Risk of Fatal CHD and Phobic Anxiety Index in Men:
### Health Professionals Follow-up Study

<table>
<thead>
<tr>
<th>Symptom</th>
<th>RR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always feeling panicky in crowds</td>
<td>10.8</td>
<td>2.2 - 52.5</td>
</tr>
<tr>
<td>Worrying unduly when relatives are late coming home</td>
<td>2.3</td>
<td>1.2 - 4.2</td>
</tr>
<tr>
<td>Definitely feeling more relaxed indoors</td>
<td>3.7</td>
<td>2.1 - 6.4</td>
</tr>
</tbody>
</table>

RR: Relative risk

Kawachi et al (1994)
Anxiety disorders

symptoms of clinical importance when -

- Autonomy – “life of its own”
- Abnormally severe
- Abnormally prolonged
- Functional impairment
- Behavioural change
- Health seeking
Anxiety disorders:

- Panic disorder
- Social anxiety disorder
- PTSD
- GAD
- Specific phobia
- OCD
Symptoms of Panic

- Dizziness
- Chills / hot flushes / blush
- Chest pain
- Nausea
- Trembling
- Urge to defecate

Cognitions: fear of dying, loss of control, collapse, going mad

- Depersonalisation
- Derealisation
- Choking
- Palpitations
- Shortness of breath
- Sweating
- Pins and needles
Development of Panic disorder

(1) Stress

(2) FBPA

(3) Anticipatory anxiety

(4) Phobic avoidance

Baseline anxiety

Time

Anxiety
NICE Guidance Panic Disorder

- Offer one of the following, taking into account pt preference
  - CBT – trained supervised staff; Weekly, 4 months, 7-14 hours

- Licensed SSRI – initial low dose; Regular review

- Self-help CBT based bibliotherapy, support groups, exercise. Regular review

- Use questionnaires to monitor. If 2 interventions fail, refer to mental health services

- Meta-analysis of 106 studies (n=5011), suggests that combination of antidepressants + in-vivo exposure is most effective rx for PD with agoraphobia (Van Balkom et al, 1997)
Social anxiety disorder:

- Disorder often begins in early teens. Intense anxiety [often FBPA] in social situations

- fear and/or avoidance of -
  - being the focus of attention
  - behaving in embarrassing or humiliating way
Social anxiety disorder - feared situations

- being introduced
- meeting people in authority
- using the telephone
- receiving visitors
- being watched doing something
- writing in front of others
- speaking in public
Post-Traumatic Stress Disorder:

- exposure to traumatic event
- ‘re-experiencing’ symptoms
- persistent avoidance and numbing
- increased arousal
Generalised Anxiety Disorder:

- ‘free-floating’ anxiety
- excessive worrying
- prominent physical symptoms
- need for reassurance
Obsessive Compulsive Disorder:

- Subjective compulsion despite conscious resistance
- Ruminations – cf tune in head – often sex/death/accidents/violence. Recognised as own
- Rituals – repetitive/time consuming/distressing
Examples of compulsions include: Washing, checking, counting, touching, hoarding, repeating
Specific phobia:

- Persistent, inappropriate fear of a circumscribed external event, leading to avoidance
- Start in childhood (statistically normal)
- Usually clear or mild
- 10% population have clinically significant, but most do not need/seek help
- Incapacity depends on likelihood of encountering
Specific phobia treatments:

- Graded in vivo exposure usually efficacious
- 75% improvement after few sessions
- Blood injury phobics may develop hypotension/bradycardia – may need additional tension exercises
- Paroxetine effective in resistant cases
Differentiating anxiety disorders:

<table>
<thead>
<tr>
<th></th>
<th>Panic attacks</th>
<th>Spontaneous or cued</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD</td>
<td>Y</td>
<td>S</td>
<td>20s</td>
</tr>
<tr>
<td>SAD</td>
<td>Y</td>
<td>C</td>
<td>Social interactional 2nd decade</td>
</tr>
<tr>
<td>PTSD</td>
<td>Y</td>
<td>C</td>
<td>Major stressor</td>
</tr>
<tr>
<td>GAD</td>
<td>N</td>
<td>-</td>
<td>Worries</td>
</tr>
<tr>
<td>SpP</td>
<td>Y</td>
<td>C</td>
<td>Snakes etc. 1st decade</td>
</tr>
<tr>
<td>OCD</td>
<td>N</td>
<td>-</td>
<td>Ruminations</td>
</tr>
</tbody>
</table>
Some questions to ask:

- Where is the most distressing place in a supermarket for someone with S.An.D?
- Where will someone with panic disorder sit in cinema/café?
Efficacy of SSRIs across the spectrum of depression and anxiety disorders

- PTSD
- GAD
- Social anxiety disorder
- OCD
- Panic disorder
- Depression

Drugs:
- Paroxetine
- Fluvoxamine
- Fluoxetine
- Sertraline
- Citalopram
Co-morbidity

- Anxiety disorders often co-morbid
- Self medication with alcohol/illicitis common
- Always ask re anxiety in pt presenting with substance misuse and vice versa
<table>
<thead>
<tr>
<th>Survey</th>
<th>ADS</th>
<th>Drug problems</th>
<th>Drug dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECA</td>
<td>1.8</td>
<td>2.3</td>
<td>2.4</td>
</tr>
<tr>
<td>NCS [Male]</td>
<td>2.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCS [Female]</td>
<td>3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICPE</td>
<td>2.5</td>
<td>3.0</td>
<td>4.8</td>
</tr>
</tbody>
</table>
Fig 1: Process whereby anxiety can lead to self-medication with alcohol and consequent dependency.

Anxiety
Tolerance

Alcohol

Dependency

↑ Alcohol

W/D

↑ Anxiety

↓ Anxiety
Summary:

- Anxiety disorders common
- Diagnosis is relatively easy (if often overlooked)
- Beware secondary morbidity
- Treatment effective