ANXIETY DISORDERS

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ANXIETY DISORDERS

- **Definition**
- Anxiety disorders are a group of disorders in which anxiety is the major element.
- They are the most prevalent group of psychiatric disorders.
- **Anxiety** is a feeling of apprehension caused by anticipation of an ill- defined threat or danger that is not realistically based.

FEAR

- It is the emotional reaction to a known, well defined external threat or danger.

NORMAL AND ABNORMAL ANXIETY

- It is considered pathological when it becomes abnormally severe, pervasive, persistent, irrational, inappropriate and handicapping.

- With optimum level, anxiety can be beneficial, it improves performance.
- In excess, it causes deterioration in performance.

ANXIETY SYMPTOMS

- Physical symptoms:
  - Autonomic arousal
  - Somatic symptoms
- Psychological symptoms

Autonomic arousal	Somatic Symptoms	Psychological Symptoms
* Palpitation, tachycardia, missed beats * Hypo- or hypertension *Chest pain or discomfort *Shortness of breath, hyperventilation *Dry mouth *Difficulty swallowing *Nausea or abdominal distress *Diarrhea *Frequent or urgent micturition *Sexual dysfunction *Menstrual disturbances (discomfort or amenorrhea) *Sweating *Flushing or pallor *Feeling dizzy, unsteady or fainting	*Muscle tension *Tremors *Fatigue *Muscle aches *Headache *Parasthesia (numbness or tingling)	*Fearful anticipation (sense of impending danger) *Restlessness *Irritability *Worrying thoughts *Poor concentration *Hypervigilance (over-alertness, startle response) *Insomnia

TYPES OF ANXIETY DISORDERS

- 1. Generalized anxiety disorder (GAD)
- 2. Panic disorder
- 3. Phobic Disorders
- 4. Obsessive-Compulsive Disorders (OCD)
- 5. Posttraumatic Stress Disorder (PTSD)

- N.B. Anxiety disorders associated with substance abuse/dependence or with a general medical condition are diagnosed according to their etiological factor.

CLINICAL FEATURES OF GAD

- Anxiety is persistent (more days than not) for more than 6 months.
- Anxiety is difficult to control and causes significant distress or impairment of function.
- Only one third of patients seek psychiatric help.
- The rest go to other medical specialties with physical complaints.

EPIDEMIOLOGY OF GAD

- * Lifetime prevalence: 45 %
- * 1-year prevalence: 3-8 %
- * Male to Female ratio is 1 to 2
- * 50-90 % of patients have another psychiatric disorder as well (co-morbidity).
- It commonly co-exists with other anxiety disorders and with depressive disorders

GENERALISED ANXIETY DISORDER

- **Onset, Course & Prognosis:**

* Patients come to clinicians usually in their early 20's
* Course is chronic, but symptoms may decline with age
* Secondary depression is common
* Prognosis is variable with treatment

CLINICAL FEATURES OF PANIC DISORDER

- Recurrent spontaneous or unexpected panic attacks, i.e., acute episodes of intense anxiety.
- It may be associated with agoraphobia (about $^1/_3$ of patients).

- Diagnosis of panic disorder is made if the attacks are repeated (4 attacks in a month), or if the patient becomes concerned about having additional attacks (anticipatory anxiety).

PANIC DISORDER

- **Clinical Features**
- This causes gross impairment of functioning.
- The patient may fear or worry about the implications of the attacks (e.g., developing a heart attack, going crazy, or lose control over oneself).
- **This leads to repeated admissions to ICU and costly investigations.**

THE PANIC ATTACK:

- A panic attack is a discrete period of intense anxiety not related to any particular situation or circumstances.
- It develops abruptly, reaches the peak over 10 minutes, and lasts for a limited time (5-30 minutes).
- During the attack there is a mixture of physical and psychological symptoms.

SYMPTOMS OF PANIC ATTACK

- Physical anxiety symptoms:	Psychological symptoms:
* Palpitation or accelerated heart rate * Chest pain or discomfort * Shortness of breathing or smothering sensation * Sense of chocking * Sweating * Chills or hot flushes * Trembling or shaking *Feeling dizzy, light-headed, unsteady or about to faint * Nausea, abdominal distress, abdominal colics and diarrhea * Parasthesia (numbness or tingling)	* Fear of dying. * Fear of loss of control or going crazy. * Depersonalization and/or derealization

EPIDEMIOLOGY OF PANIC DISORDER

- * Lifetime prevalence: 3-5 %
- * Male to Female ratio is 1 to 2
- * Most of the patients have other psychiatric disorders, particularly depressive disorders and other anxiety disorders.
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PANIC DISORDER

- **Onset, Course & Prognosis**
- * It usually starts in early adulthood.
- The mean age at onset is 25 years.
- * Chronic course with remissions and exacerbations
- * Good to excellent prognosis with therapy

PHOBIC DISORDERS

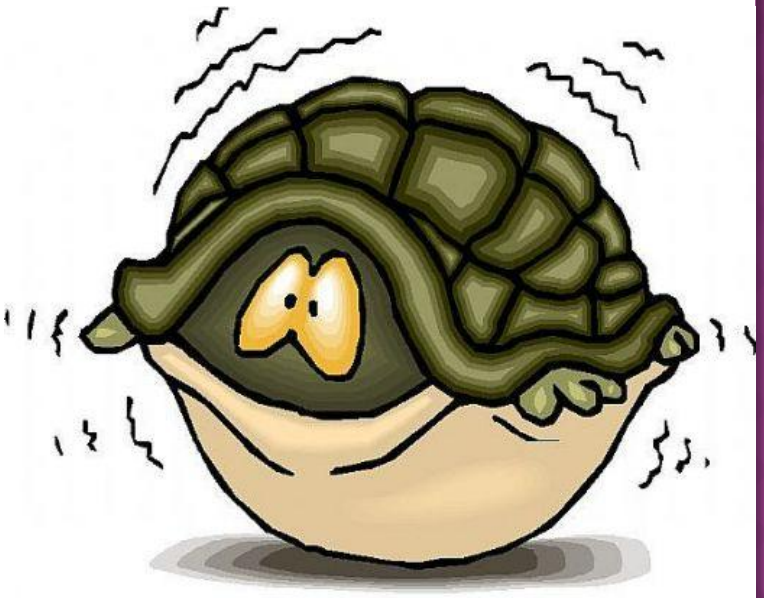
- Phobia is fear related to a particular object or situation.
- A phobic disorder is diagnosed if the experienced fear is ***intense*** or causes the patient to ***avoid*** the phobic object in a manner that limits his activities and ***impairs his functioning***.

TYPES OF PHOBIAS

- According to the phobic object, they are classified into:
- **1. Agoraphobia**
- **2. Social Phobia**
- **3. Specific Phobias**

1. AGORAPHOBIA

- ***Clinical Features***
- * Its name came from Agora == market
- * It is intense irrational fear of being in open places, outside home alone, in a crowd or generally in places or situations in which escape is perceived by the patient as difficult or embarrassing.



1. AGORAPHOBIA

- ***Clinical Features***
- * The patient fears and avoids wide places, highways, bridges or crowded places.
- * It may occur alone or in association with panic disorder.
- Some consider it a consequence of panic disorder as the onset is often triggered by a panic attack in one of those situations.

AGORAPHOBIA

- **Epidemiology**
- * Lifetime prevalence is 2-6 %
- * Male to Female ratio is 1 to 2
- *50-75 % of patients have a co-morbid panic disorder. Patients may have other anxiety disorders or a depressive disorder.

AGORAPHOBIA

- **Onset, Course & Prognosis:**
- * It may develop at any age, but it usually starts in the late 20's.
- * Course is chronic.
- * If there is associated panic, agoraphobia usually improves with reduction in panic attacks.
- * If alone, it is usually resistant to treatment and leads to incapacitation.
- It may be complicated by substance abuse, particularly alcohol and benzodiazepines to alleviate anxiety and social distress.

2. SOCIAL PHOBIA

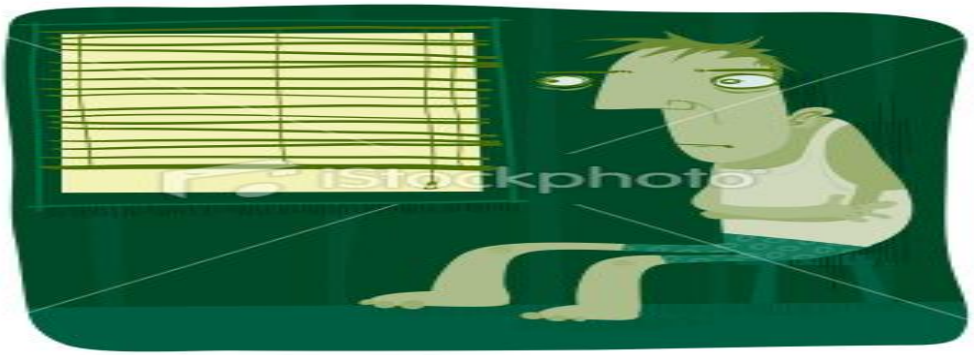
Clinical Features

- * There is intense irrational fear of scrutiny (i.e., being critically observed) by other people in social or performance situations.
- * The person fears that he will act in a way that will be humiliating or embarrassing (i.e., fear of negative evaluation).

SOCIAL PHOBIA

Clinical Features

- * The person recognizes that his fear is excessive or unreasonable.
- Nevertheless, he avoids all situations in which he anticipates anxiety.
- * Functional impairment is sometimes substantial due to loss of opportunities in education and jobs, and due to social restrictions.

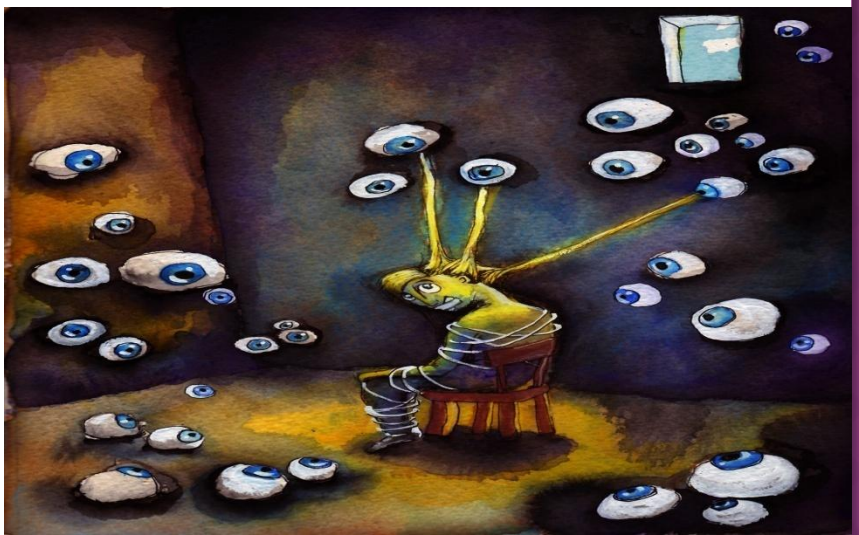


SOCIAL PHOBIA

- **Epidemiology**
- * Lifetime prevalence is 10-14 %.
- * Males and females are equally distributed, although males seek help more readily due to more significant functional impairment. In females, it is mistaken for shyness, which is sometimes an accepted trait.
- * 25 % of patients develop major depression.

SOCIAL PHOBIA

- **Onset, Course & Prognosis:**
- * It usually starts in teens. It may start later in life.
- * Course is chronic.
- * Prognosis is good with therapy, it is better in cases with a more delayed onset.



3. SPECIFIC PHOBIAS

- **Clinical Features**
- * Intense irrational fear of a specific object or situation (e.g., flying, heights, animals, blood, etc...), not including the situations mentioned in agoraphobia and social phobia.

- * The phobic situation is avoided, or tolerated with intense anxiety or distress.
- * The person recognizes that his fear is excessive or unreasonable.

SPECIFIC PHOBIAS

- **Epidemiology**
- *Lifetime prevalence is 10-25 % (the most common anxiety disorder)
- * 6-month prevalence is 5-10 %.
- * Male to Female ratio is 1 to 2

SPECIFIC PHOBIAS

- **Age at onset, Course & Prognosis**
- * Onset is usually in childhood.
- * Course is chronic.
- * Prognosis is good to excellent with therapy. If untreated, it may worsen or spread to include more objects or situations.

OBSESSIVE-COMPULSIVE DISORDER

- **Clinical Features**
- * It is an anxiety disorder in which the patient experiences recurrent obsessions and/or compulsions. They are severe enough to be time consuming, or cause marked distress or significant impairment in functioning.
- * Obsessions are recurrent intrusive ideas, thoughts, images or impulses that cause significant anxiety or distress.

OBSESSIVE-COMPULSIVE DISORDER

- **Clinical Features**
- *Compulsions are repetitive behaviors (e.g., hand washing, checking) or mental acts (e.g., counting, praying) that the person feels driven to perform in response to an obsession.
- These compulsive "rituals" are meant to diminish the anxiety caused by the obsession; or somehow magically prevent a dreaded event or situation.

OBSESSIVE-COMPULSIVE DISORDER

- **Clinical Features**
- * The person recognizes that these obsessions and compulsions are excessive or unreasonable.
- * Both obsessions and compulsions are considered ego-alien (unwanted) and produce anxiety if resisted.

OBSESSIVE-COMPULSIVE DISORDER

- **Epidemiology**
- * Lifetime prevalence is 2-3 % across different cultures.
- * It is slightly more common in males than in females.
- * Two third of cases develop major depression,

OBSESSIVE-COMPULSIVE DISORDER

- **Age at Onset, Course & Prognosis**
- * It usually starts in adolescence or early adulthood.
- *Course is chronic with waxing and waning of symptoms.
- * Prognosis is now fair with recent lines of therapy.
- With the introduction of SSRIs, the prognosis has dramatically improved. However, some cases are intractable.

POSTTRAUMATIC STRESS DISORDER

- It is an anxiety disorder produced by exposure to a severe traumatic event (e.g., war. violent assault, rape, explosion, torture, natural disasters, etc...) that involves threat of death, serious injury, or personal safety.
- It may result from witnessing the traumatic event being inflicted on somebody else.

POSTTRAUMATIC STRESS DISORDER

- Clinical Features:
- 1. Persistent re-experiencing of the trauma
- 2. Efforts to avoid recollecting the trauma
- 3. Hyperarousal

POSTTRAUMATIC STRESS DISORDER

- **Course & Prognosis**
- * Chronic course
- * The trauma may be re-experienced periodically for several years.
- * Prognosis is worse with preexisting psychiatric conditions.

ETIOLOGY OF ANXIETY DISORDERS

- ***Biological Factors***
- **1. Genetic Factors:**
- **2. Autonomic over activity:**
- **3. Neurotransmitter dysfunction:**
- Norepinephrine, Serotonin, Gamma amino butyric acid (GABA)

ETIOLOGY OF ANXIETY DISORDERS

- ***Psychological Factors:***
- **Learning (behavioral) theory:**
- (i.e. modeling by an overanxious adults).
- **Cognitive theory:**
- * Overestimation of danger or harm in a given situation
- *Underestimation of the ability to cope with perceived stress.

MANAGEMENT OF ANXIETY DISORDERS

- ***Pharmacotherapy***

1. **Benzodiazepines:**
2. **Tricyclic antidepressants:**
3. **Selective Serotonin Reuptake Inhibitors (SSRIs):**
4. **Other Drugs:**

e.g.. Beta-blockers

MANAGEMENT OF ANXIETY DISORDERS

- ***Psychotherapy***
  - 1. Supportive Psychotherapy
  - 2. Behavioral Therapy
  - 3. Cognitive-behavioral therapy:
  - 4. Psychodynamic (insight-oriented) therapy:

MANAGEMENT OF ANXIETY DISORDERS

- ***Behavioral Therapy***
- * Techniques used include exposure techniques (systematic desensitization, graded exposure and flooding), response prevention and stop-thought techniques (for O.C.D.), and relaxation techniques.

MANAGEMENT OF ANXIETY DISORDERS

- ***Cognitive-behavioral therapy:***
- It can help in correcting the maladaptive cognitive schemata operating in anxiety disorders, e.g., irrational fears of physical or psychological danger (generalized anxiety) or catastrophic fear of immediate physical or mental disaster (panic).

MANAGEMENT OF ANXIETY DISORDERS

- ***Psychodynamic (insight-oriented) therapy:***
- * It can be helpful with selected patients.
- * Its goal is to develop insight into intrapsychic conflicts or personality deficits which underlie symptom formation with subsequent positive changes.

THANK YOU