ANXIETY DISORDERS

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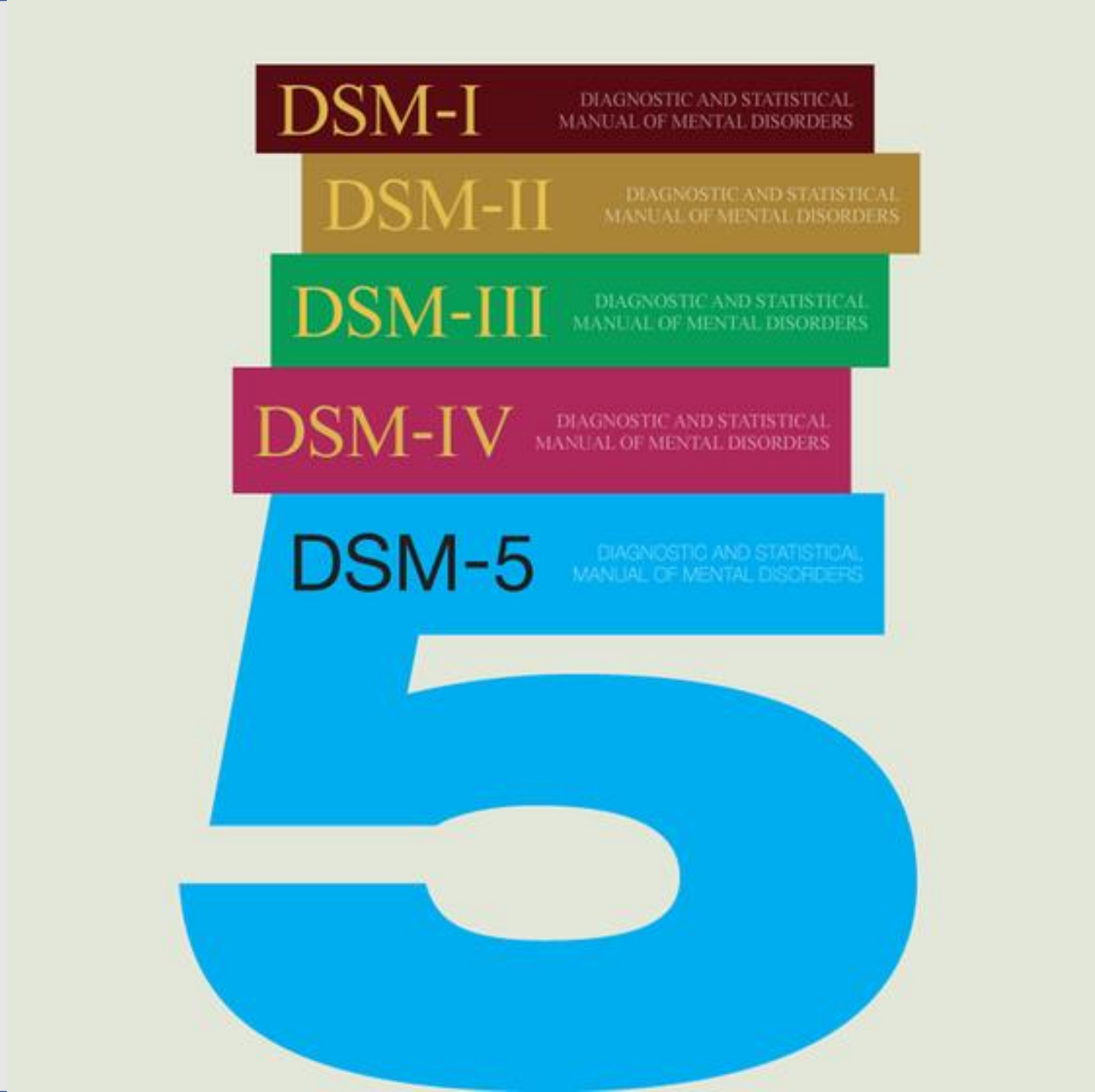
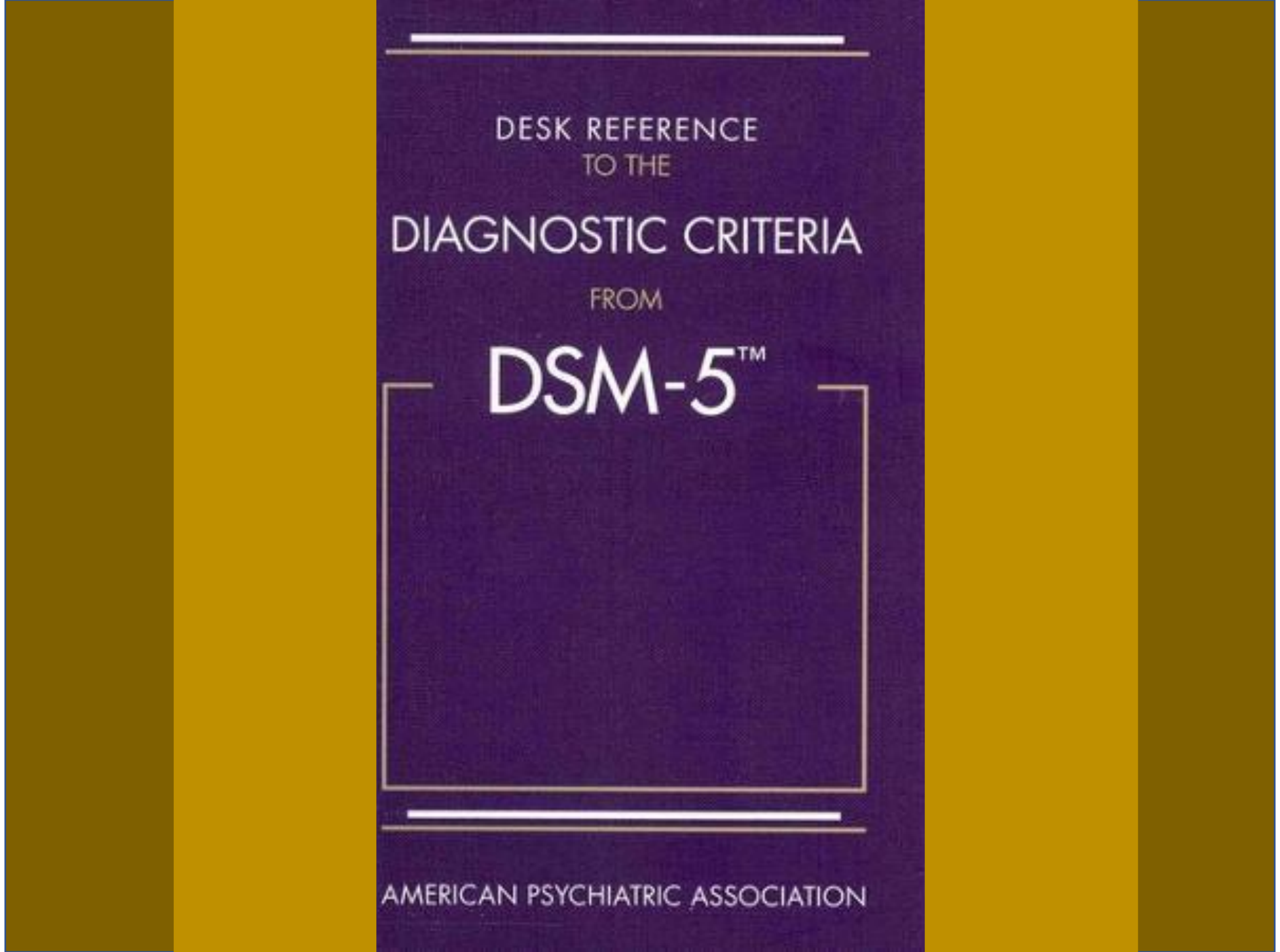
MBChB (UCT), Mmed (UP), FCPsych (by peer review)


DSM-I
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
DSM-II
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
DSM-III
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
DSM-IV
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
DSM-5
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
5


DESK REFERENCE
TO THE
DIAGNOSTIC CRITERIA
FROM
DSM-5™
AMERICAN PSYCHIATRIC ASSOCIATION

- People with anxiety disorders:
  - have fears and worries about ‘what might happen if ...’, and those fears and worries persist on and off for months and years, causing distress and disability.

- The continuing fears and worries, which most patients recognise as somewhat irrational but nevertheless dread, are the basis for making a diagnosis of an anxiety disorder and prescribing treatment.

- Panic disorder – sudden attacks of fear or anxiety (usually brief, but which may be so severe that the person thinks they might collapse or die), concern about the attacks recurring and avoidance of situations in which they might recur.

- Social anxiety disorder (SAD) – fear and avoidance of situations where the person thinks they might be the centre of attention, concern about doing or saying something embarrassing, and that others might notice the anxiety and be critical.

- Generalised anxiety disorder (GAD) – months of excessive worry over everyday things, avoiding or seeking reassurance about situations where the outcome is uncertain, and being overly concerned about things that could go wrong.

- People with panic disorder worry that their panic will result in physical or mental harm,
- People with SAD worry that they will be judged negatively and
- People with GAD worry that disaster will occur across a variety of contexts.

- Anxiety disorders typically start early in life, especially for SAD, and prevalence declines with age (Lampe, 2015; Slade et al., 2009a).
- Developing an anxiety disorder after the age of 40 years is uncommon,
  - When a person over 40 presents with an anxiety disorder for the first time, alternative causes of anxiety such as mood or substance use disorders, physical illness or its treatment should be considered

DISORDER	TYPICAL AGE OF ONSET
Social Anxiety Disorder	13
Agoraphobia without panic	22
Panic disorder	30
Generalised anxiety disorder	33

Australian 2007 National Survey of Mental Health and Wellbeing (Slade et al., 2009a), Te Rau Hinengaro: the New Zealand Mental Health Survey 2006 (Wells et al., 2006).

12 MONTH PREVALENCE	%
Any anxiety disorder	14
Social Anxiety Disorder	5
Generalised Anxiety Disorder	3
Panic Disorder	3
Agoraphobia without panic	3

ANXIETY DISORDERS

DSM IV

1. Generalized Anxiety Disorder
2. Acute Stress Disorder
3. Posttraumatic Stress Disorder
4. Obsessive Compulsive Disorder
5. Panic Disorder with Agoraphobia
6. Panic Disorder without Agoraphobia
7. Agoraphobia without History of Panic Disorder
8. Social Phobia
9. Specific Phobia
10. Anxiety Disorder Due to Medical Condition
11. Anxiety Disorder, NOS

DSM 5

1. Generalized Anxiety Disorder
2. Separation Anxiety Disorder
3. Selective Mutism
4. Specific Phobia
5. Social Anxiety Disorder
6. Panic Disorder
7. Agoraphobia
8. Substance/Medication-Induced Anxiety Disorder
9. Anxiety Disorder Due to another Medical Condition
10. Other Specified Anxiety Disorder
11. Unspecified Anxiety Disorder

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TRAUMA- AND STRESSOR-RELATED DISORDERS

1. Reactive Attachment Disorder
2. Disinhibited Social Engagement Disorder
3. Posttraumatic Stress Disorder
4. Acute Stress Disorder
5. Adjustment Disorders
6. Other Specified Trauma-and Stressor-Related Disorder
7. Unspecified Trauma- and Stressor-Related Disorder

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OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania
- Excoriation Disorder
- Substance/Medication Induced OCD
- OCD and Related Disorder Due to Another Medical Condition
- Other Specified OCD and Related Disorder
- Unspecified OCD and Related Disorder

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OTHER SPECIFIED ANXIETY DISORDER

- Limited symptom attack
- GAD with less symptoms
- Taijin Kyofusho
- Khyâl cap
- Ataque de nervios
- Dhat syndrome
- Kufungisisa
- Maladi moun
- Nervios
- Shenjing shuairuo
- Susto

- Anxiety can often be a symptom of other psychiatric disorders

ANXIETY AND DEPRESSION

- 60 to 80% co-morbid

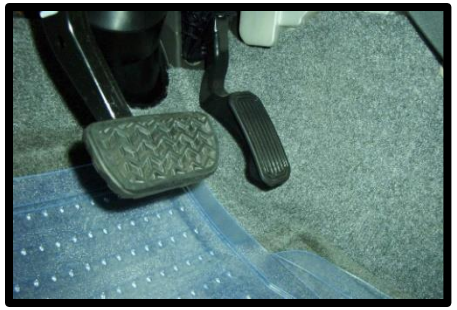
ANXIETY AND ADHD

- 30 - 40% co-morbid

PHYSIOLOGY

- Glutamate → GABA

L-glutamic acid decarboxylase (GAD)



OTHER NEUROTRANSMITTERS

- Serotonin
- Noradrenalin

BAP Guidelines

Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology

David S Baldwin[1,2], Ian M Anderson[3], David J Nutt[4], Christer Allgulander[5], Borwin Bandelow[6], Johan A den Boer[7,8], David M Christmas[9], Simon Davies[10], Naomi Fineberg[11], Nicky Lidbetter[12], Andrea Malizia[13], Paul McCrone[14], Daniel Nabarro[15], Catherine O'Neill[12], Jan Scott[16], Nic van der Wee[17] and Hans-Ulrich Wittchen[18]

Psychopharm

Journal of Psychopharmacology
1–37

DOI: 10.1177/0269881114525674
jop.sagepub.com
SAGE

British Association of Psychopharmacology

Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder

Gavin Andrews[1,2], Caroline Bell[1,3], Philip Boyce[1,4], Christopher Gale[1,5], Lisa Lampe[1,6], Omar Marwat[1,2], Ronald Rapee[1,7] and Gregory Wilkins[1,8]

Your Health in Mind

The Royal Australian & New Zealand College of Psychiatrists

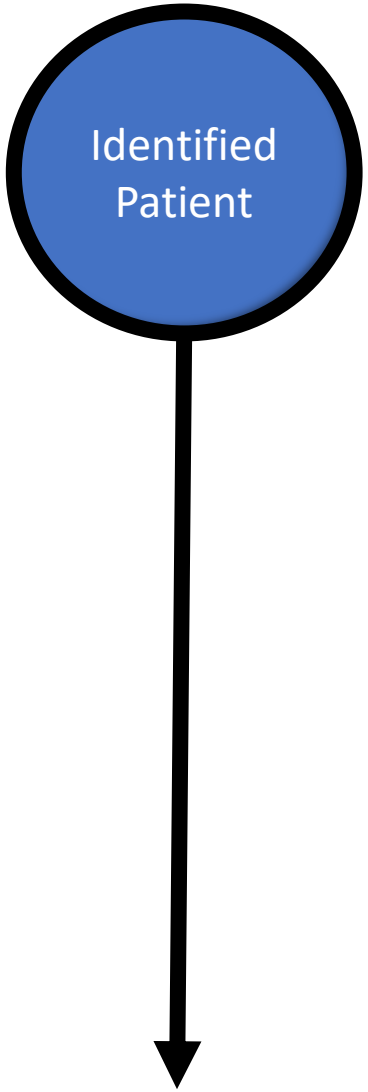
TREATMENT PATHWAY

Prodromal anxiety disorder?

- 30-90% of patients have a prodromal syndrome
- agoraphobic avoidance,
- generalized anxiety, and/or
- hypochondriacal fears

Staging:

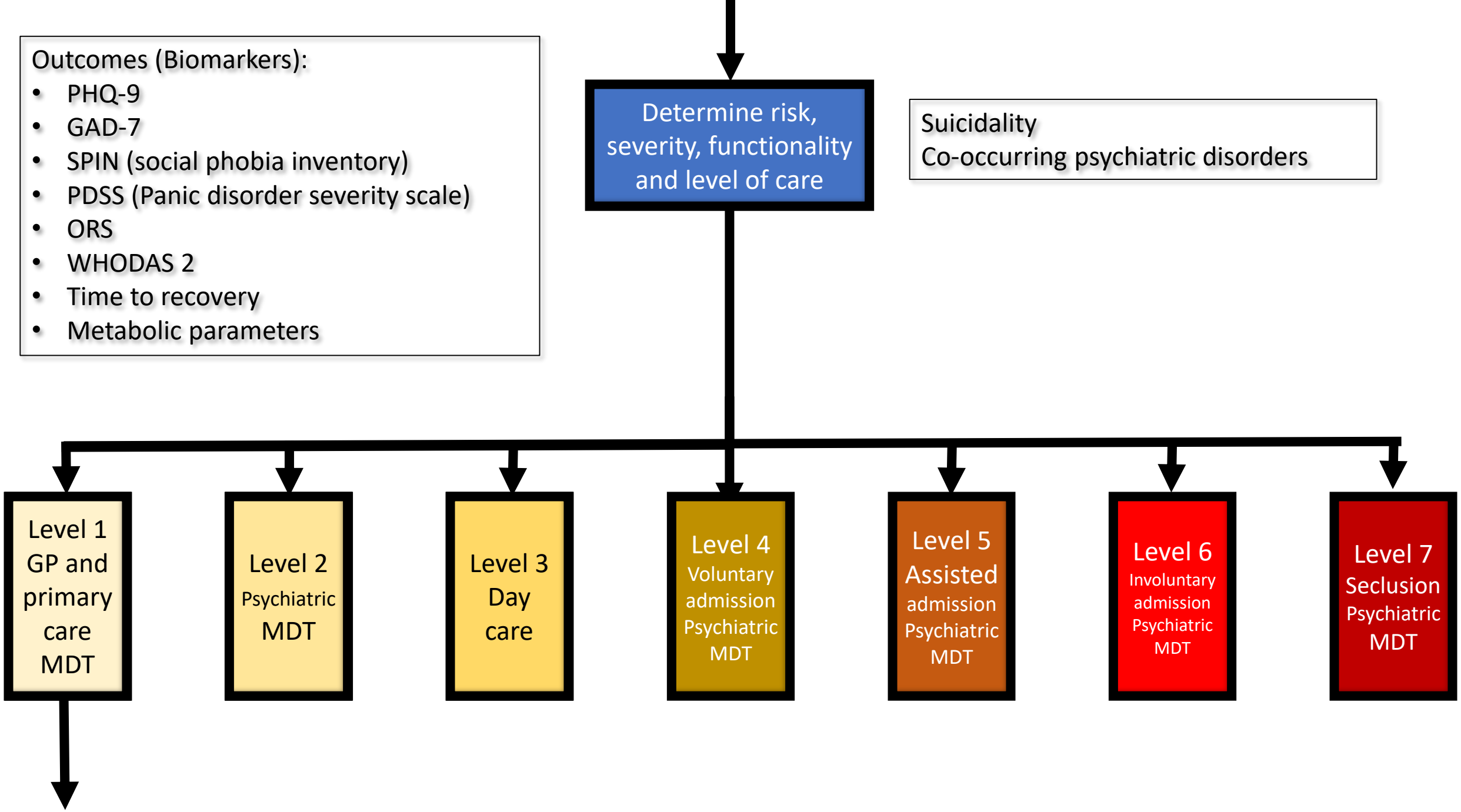
Stage 0: No failure to respond to treatment
Stage 1: Failure to respond to at least 1 adequate therapeutic trial
Stage 2: Failure to respond to at least 2 adequate therapeutic trials
Stage 3: Failure to respond to at least 3 adequate therapeutic trials



Diagnosis: DSM 5 and ICD-10

Exclude or confirm medical conditions
Exclude or confirm psychiatric co-occurring disorders

Vishal B. Pede, Suyog Vijay Jaiswal, and Vishal A. Sawant. Study of prodromal and residual symptoms of depression. Ind Psychiatry J. 2017 Jul-dec; 26(2); 121-127
Giovanni A. Fava and Eliana Tossani. Review Article, Prodromal stage of major depression. Early Intervention in Psychiatry 2007; 1: 9–18
M J Garvey, B Cook, R Noyes Jr. The occurrence of a prodrome of generalized anxiety in panic disorder. Compr Psychiatry. 1988 Sep-Oct;29(5):445-9. doi: 10.1016/0010-440x(88)90059-4.
Sheehan DV, Sheehan KH: The classification of phobic disorders. Int J Psychiatry Med 1982–1983;12:243–266.


Outcomes (Biomarkers):
• PHQ-9
• GAD-7
• SPIN (social phobia inventory)
• PDSS (Panic disorder severity scale)
• ORS
• WHODAS 2
• Time to recovery
• Metabolic parameters
Determine risk, severity, functionality and level of care
Suicidality
Co-occurring psychiatric disorders
Level 1 GP and primary care MDT
Level 2 Psychiatric MDT
Level 3 Day care
Level 4 Voluntary admission Psychiatric MDT
Level 5 Assisted admission Psychiatric MDT
Level 6 Involuntary admission Psychiatric MDT
Level 7 Seclusion Psychiatric MDT

GAD-7

Over the past two weeks, how often have you been bothered by the following problems?		No at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid, as if something awful might happen	0	1	2	3

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

GAD-7 SCORING

- 0-4: Minimal anxiety
- 5-9: Mild anxiety
- 10-14: Moderate anxiety
- 15-21: Severe anxiety

Refer for psychotherapy

Psychotherapies:

1. CBT
2. Problem-solving,
3. Relaxation,
4. Interpersonal therapy,
5. Cognitive bias modification, mindfulness or
6. Psychodynamic approaches,

Choose medication

Choose an antidepressant:

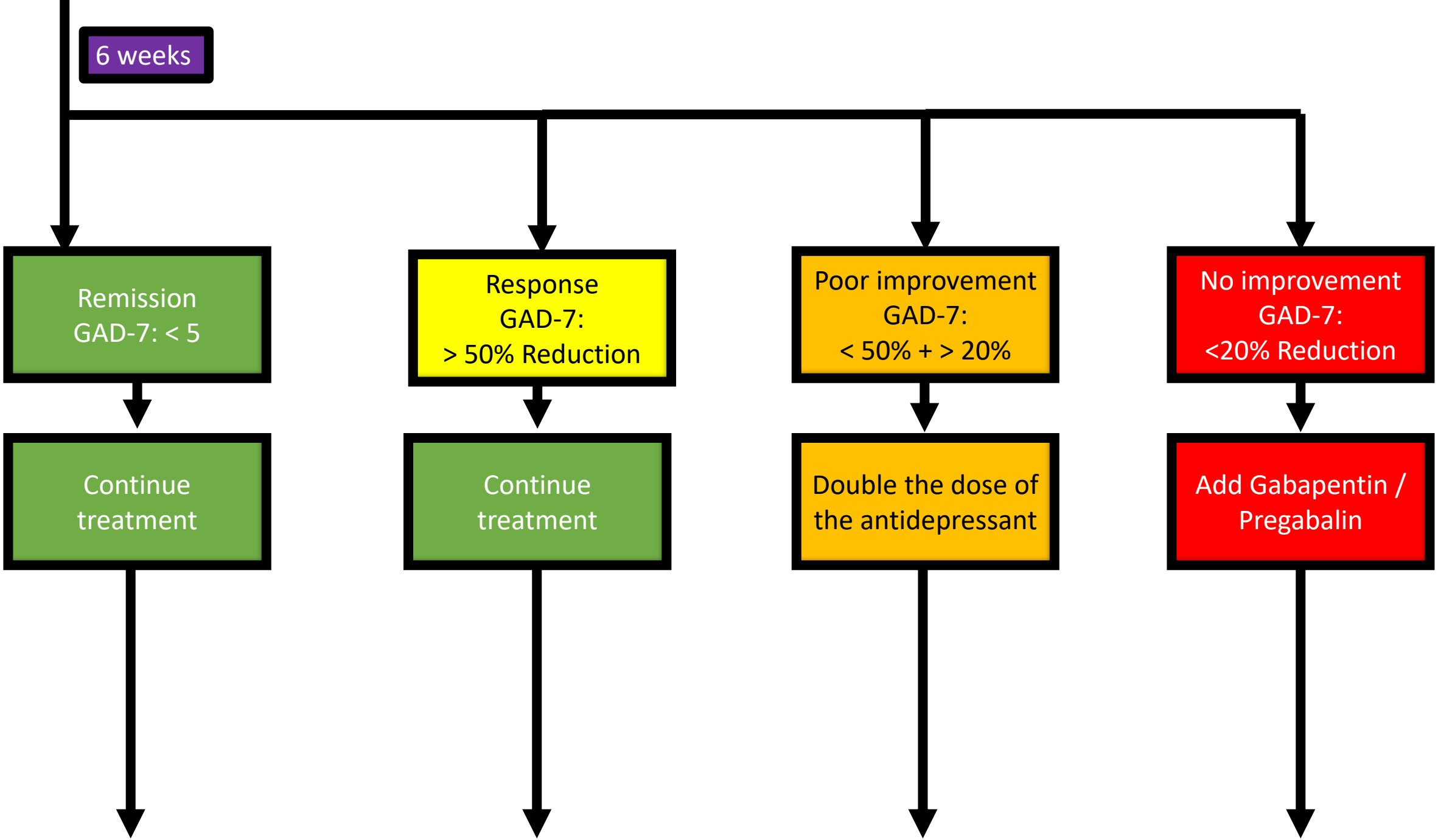
- Serotonergic:
- Noradrenergic:
  - Start low and slow

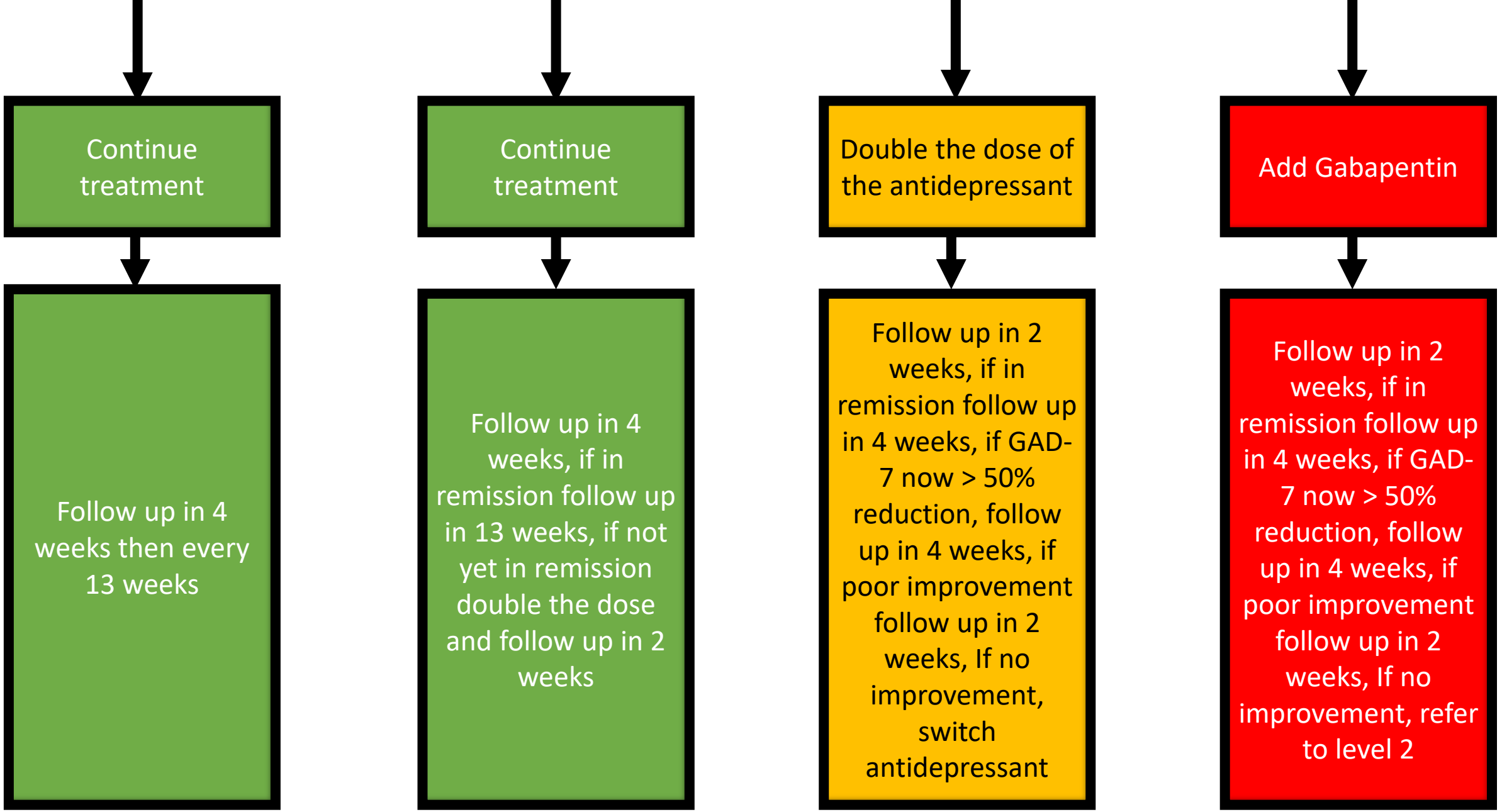
Add on Benzodiazepine:

- Long acting if GAD or SAD
- Short acting if panic disorder and PRN

Gabapentin or pregabalin:

- Off label and low dose


6 weeks
Remission
GAD-7: < 5
Response
GAD-7:
> 50% Reduction
Poor improvement
GAD-7:
< 50% + > 20%
No improvement
GAD-7:
<20% Reduction
Continue
treatment
Continue
treatment
Double the dose of
the antidepressant
Add Gabapentin /
Pregabalin


Continue treatment
Follow up in 4 weeks then every 13 weeks
Continue treatment
Follow up in 4 weeks, if in remission follow up in 13 weeks, if not yet in remission double the dose and follow up in 2 weeks
Double the dose of the antidepressant
Follow up in 2 weeks, if in remission follow up in 4 weeks, if GAD-7 now > 50% reduction, follow up in 4 weeks, if poor improvement follow up in 2 weeks, If no improvement, switch antidepressant
Add Gabapentin
Follow up in 2 weeks, if in remission follow up in 4 weeks, if GAD-7 now > 50% reduction, follow up in 4 weeks, if poor improvement follow up in 2 weeks, If no improvement, refer to level 2

Stages:

- Stage 0
- Stage 1
- Stage 2
- Stage 3

Pathways:

- None
- Remission
- Response
- Poor improvement
- No improvement

Phases:

- Evaluation
- Acute phase
- Continuation
- Discontinuation
- Maintenance

Treatments:

- None
- Medication alone
- Psychotherapy alone
- Combination of medication and psychotherapy

TREATMENT RESISTANT GAD (TR-GAD)

Failure to reach remission after combination treatment with antidepressants and psycho-social therapy with 3 antidepressants at full dose in combination with a Benzodiazepine for an adequate time (6 to 8 weeks)

MANAGEMENT OF TR-GAD

Augment with other antidepressants:

- Evidence not promising

Augmentation with mood Calcium channel blockers:

- Gabapentin / Pregabalin

Other Interventions:

- Augment with Anti-psychotics

Elayne D. Ansara. Management of treatment-resistant generalized anxiety disorder. Ment Health Clin [Internet]. 2020;10(6):326-34. DOI: 10.9740/mhc.2020.11.326

TREATMENT

MEDICATION

- Antidepressants
- Benzodiazepines
- Gabapentin/Pregabalin

PSYCHOTHERAPY

- CBT
- Problem-solving,
- Relaxation,
- Interpersonal therapy,
- Cognitive bias modification, mindfulness or
- Psychodynamic approaches,

GAD

- Antidepressants
  - SSRI's and SNRI's
  - Trazadone
  - Agomelatine
- Benzodiazepines
- Pregabalin
- Quetiapine (add-on)
- Psychotherapy
- Alternatives

ALTERNATIVES

- Multi-faith spiritually based intervention (Koszycki et al., 2010);
- Galphimia glauca (‘thyrallis’) (Herrera-Arellano et al., 2007),
- Matricaria recutita extract (chamomile) (Amsterdam et al., 2009),
- ‘Silexa’ lavender oil preparation (Woelk and Schlaefke, 2010),
- Relaxing room therapy (Sherman et al., 2010),
- Yoga-based breathing programme (Katzman et al., 2012) and
- Balneotherapy (hydrotherapy with massage) (Dubois et al., 2010)

- more investigation of these approaches is needed before they can be recommended.

PANIC DISORDER

- Antidepressants
  - SSRI's and SNRI's
  - Mirtazapine
- Benzodiazepines
- Psychotherapy

PHOBIAS

- Psychotherapy
  - CBT and desentisization
- SSRI’s

SOCIAL PHOBIA

- Psychotherapy
  - CBT > Exposure therapy
- SSRI’s
- Benzodiazepines
- Antipsychotics
  - Olanzepine

ANXIETY DISORDER TREATMENT

GAD

- AD
- BZ
- PREGABA
- AP
- PSYCHOT

PANIC

- AD
- BZ
- PSYCHOT

PHOBIA

- PSYCHOT
- AD
- BZ

SAD

- PSYCHOT

CO-MORBIDITY

Major Depression

- Treat the same as GAD

Bipolar Disorder

- Antidepressants can cause a switch in mood in 20% of patient and best avoided
- Benzodiazepines can cause a switch in patients and best given under strict supervision
- Gabapentin

BENZODIAZEPINES

ADDICTION POTENTIAL

- In the rehab setting (admissions for substance):
  - Alcohol: 39%
  - Dagga: 17%
  - Heroine: 16%
  - Opiates: 9%
  - Cocaine: 7%
  - Methamphetamine: 7%
  - Benzodiazepine: 1%
  - Other: 0.5%

POPULATION STUDIES

- 95% of patients abusing Benzodiazepines reported abuse of another substance in addition to abuse of benzodiazepines

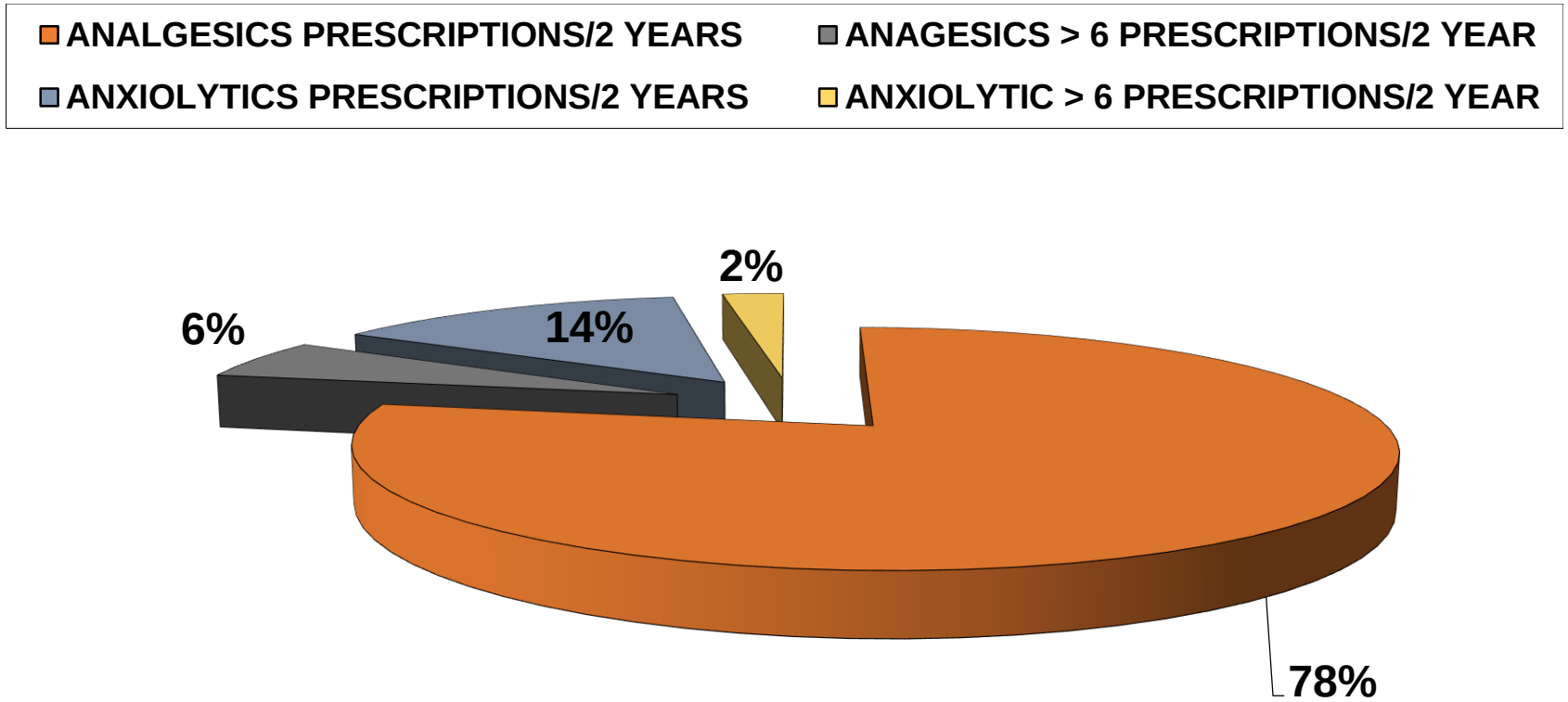
http://www.samhsa.gov/data/2k12/TEDS-064/TEDS-Short-Report-064-Benzodiazepines-2012.htm

ABUSE, DEPENDENCE AND ADDICTION

- Foetal alcohol syndrome
  - 40 to 207/1000 births (+/- 100 000 children/year)
  - In some rural towns up to 17,5% of children have FAS
- 19,3% abuse psycho-active substances
- 14% Alcohol (4.9% world wide)
- 12% Codeine
- 8,3% Cannabis
- 6% Sexual addiction (sexual disorder NOS)
- 1.5% Gambling

L Olivier et al; Burden of fetal alcohol syndrome in a rural West Coast area of South Africa; S Afr Med J 2013;103(6):402-405. DOI:10.7196/SAMJ.6249
MS v Heerden et al; Patterns of substance use in South Africa; Results from the South African Stress and Health Survey; SAMJ; vol 99 N5 May 2009
Karila L, et al;Sexual addiction or hypersexual disorder: different terms for the same problem? A review of the literature. JCurr Pharm Des. 2014;20(25):4012-20.

MEDICATION ABUSE



Analgesics are prescribed 6X more than BZ

Analgesics are chronically prescribed 3X more than BZ

PSYCHIATRIC MANAGEMENT

THANK YOU