Accurate Diagnosis of Anxiety Disorders

By Nizar Ladha, MD, FRCPC, DABPN

Table 1

Cognitions Distinguishing the Different Anxiety Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Cognitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Anxiety Disorder</td>
<td>Worry about ordinary things: meta-worry.</td>
</tr>
<tr>
<td></td>
<td>Anticipation that things will go wrong (future).</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>Worry involving magical things.</td>
</tr>
<tr>
<td></td>
<td>Senseless, irrational, aggressive obsessions (egodystonic).</td>
</tr>
<tr>
<td></td>
<td>Pathologic doubt.</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>Worry about dying, going crazy, losing control.</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>Worry about scrutiny, negative evaluation, embarrassment, humiliation.</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>Worry about reliving or being reminded of trauma.</td>
</tr>
<tr>
<td></td>
<td>Nightmares, flashbacks.</td>
</tr>
</tbody>
</table>

This article will review the spectrum of anxiety disorders, discuss the detection and diagnosis of these disorders, and present cases and their treatments. Psychiatric disorders are common and pervasive. Anxiety disorders are very common problems presenting to the primary-care physician. These disorders are often comorbid with depression and substance abuse. Patients often use substances such as alcohol to self-medicate.

Anxiety is ubiquitous. It is present as part of many physical and psychiatric disorders. These disorders carry a lifetime morbidity and, in some cases, are fatal.
Anxiety disorders include social anxiety disorder (SAD), post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), panic disorder and obsessive compulsive disorder (OCD).

Lifetime prevalence of major depression, alcohol dependence, social anxiety disorder and simple phobia is high. The lifetime prevalence rate for social anxiety disorder is 13%, for post-traumatic stress disorder 7% to 8%, for generalized anxiety disorder 5.1%, for obsessive compulsive disorder 2% to 3% in Canada, and for panic disorder 3.5% (Figure 1). Significant numbers of patients have more than one psychiatric disorder present at any one time. The National Comorbidity Survey estimated that 14% of patients had a history of three or more psychiatric illnesses. Any patient with alcohol abuse or dependence should be screened for an anxiety disorder and depression. Anxiety disorders can be distinguished from each other by the cognitions, which present in each of the disorders. These disorders also present with physiologic symptoms of anxiety. Table 1 outlines the thought patterns that patients have in specific anxiety disorders.

**Social Anxiety Disorder (SAD)**

**Case 1**

A 32-year-old single man, JH, said he was late for work because he had to check and recheck his stove to make sure it was turned off. He also double-checked his door locks. At work, he could not make eye contact with his customers, he often spoke softly, and he avoided social situations. He did not finish high school. He was quiet in class, lacked confidence, and never spoke up. He could not make presentations in class and never took part in any school or class activities.

Anxiety disorders include social anxiety disorder (SAD), post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), panic disorder and obsessive compulsive disorder (OCD).

Figure 1
Spectrum of Depression and Anxiety Disorders: Lifetime Prevalence

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>17%</td>
</tr>
<tr>
<td>Social anxiety disorder</td>
<td>13%</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>7.8%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>5.1%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>3.5%</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>2.3%</td>
</tr>
</tbody>
</table>


Dr. Ladha is associate professor of psychiatry at Memorial University of Newfoundland, St. John's, NF.
On clinical examination, he had poor eye contact. He was visibly uncomfortable as he sat in his chair. He said he would blush and feel hot before speaking to anyone; he was afraid that he would sound silly. He avoided gatherings of coworkers. He was uncomfortable using public washrooms. He had no symptoms of depression. He did not use alcohol or drugs. He did not have thoughts of suicide.

SAD starts early in life and, in a large number of cases, persists for a lifetime. JH had SAD onset as early as adolescence and probably earlier. At 32 years of age, his social and work life were severely impaired. SAD causes significant morbidity as illustrated by JH’s case. He was not able to achieve his educational potential, quite possibly because of disabling shyness. He was uncomfortable at work and he had no social life.

After the diagnosis was made, the illness was explained to JH. Psycho-education is an important part of treatment. He was made aware of his thought patterns. For example, it was not that other people thought that he was silly; it was not that other people wanted to humiliate him. He was shown that these were his own thoughts about himself which he was attributing to others. Understanding and changing these thought patterns to engender a positive evaluation of oneself form part of cognitive behavior therapy. JH was made to understand why he avoided social situations and encouraged to participate in social activities. This formed part of his behavioural therapy: he would force himself to be part of a social situation and deal with the ensuing anxiety by deep breathing and diverting his thoughts to thinking about pleasant situations. He was started on selective serotonin reuptake inhibitor (SSRI), paroxetine, 10 mg in the morning, which was later increased to 20 mg.

JH has shown significant improvement. He is now more assertive when he speaks. He smiles and makes eye contact. He speaks spontaneously. At work, he attends employee gatherings. He chats with customers. He plays pool and has made friends. He is thinking of upgrading his education. JH’s case illustrates the essential features of SAD and its treatment.

There are two types of social anxiety disorders. Generalized SAD consists of:
• Marked fear of most social situations;
• Fear of humiliation;
• Anxiety in social situations or performance demands;
• Situation avoidance; and
• Excessive anxiety.

JH has generalized social anxiety disorder.

The second type of social anxiety disorder is specific phobia, which was formally called simple phobia. The patient fears a specific object, for example, blood, an animal, or a specific situation, such as flying. Treatment for this disorder includes gradual exposure to the phobic situation and management of ensuing anxiety. SSRIs can also be prescribed. A benzodiazepine, such as lorazepam, may be useful to manage the anxiety in an acute situation. Benzodiazepines should be used sparingly and only over a short period of time.

Obsessive Compulsive Disorder (OCD)

Case 1 also illustrates features of obsessive compulsive disorder. Before leaving for work, JH worries that his stove is not turned off and that his door is not locked. He cannot rid himself of these thoughts. He checks and rechecks the stove and locks — if he does not, he becomes anxious. He recognizes that what he does is absurd and excessive and yet he cannot
control his repetitive thoughts and acts. Such actions are compulsions and there is significant accompanying anxiety.

OCDs can be difficult to treat. The treatment for JH was to help him change his thought patterns, gain confidence in himself, and learn to depend on his actions. Anxiety was managed with relaxation, deep breathing, and imagery. JH responded to 20 mg of paroxitene. However, OCD may require 60 mg to 80 mg of paroxitene a day. Other SSRIs, such as fluoxetine, fluvoxamine and sertraline, can also be used.

The diagnosis of OCD, modified from DSM IV, includes:
- Recurrent persistent thoughts or impulses;
- Intrusive thoughts which cause marked anxiety;
- Thoughts or impulses which are recognized as absurd by the individual;
- Repetitive, purposeful behaviors which are performed in response to obsessive thoughts;
- Marked anxiety; and
- Interference with functioning.

### Post-Traumatic Stress Disorder (PTSD)

#### Case 2

A 40-year-old married woman, KA, presented after a suicide attempt using an overdose of drugs. She gave a history of feeling depressed for many years. As a child and a teenager, she was sexually abused by her brother. On clinical examination, she described feeling repeatedly anxious. She had tachycardia, headache, and a feeling of dread. She had feelings of horror and helplessness. She was hypervigilant and she re-experienced the trauma of sexual assault. She also had nightmares.

KA exhibited essential features of PTSD:
- Re-experience of traumatic events;
- Hypervigilance;
- Avoidance; and
- Recurrent anxiety and fear.

The above symptoms list is modified from DSM IV.7

KA also had comorbid major depression. She was treated with venlafaxine XR 337.5 mg once a day, clonazepam 1 mg three times a day, and latterly with topiramate 150 mg once a day.

After receiving psychotherapy, her ability to function improved significantly.

PTSD can follow traumas, such as assaults, motor vehicle accidents, and natural disasters. Lifetime prevalence of PTSD in the U.S. is 7.8%.8 Much larger numbers of individuals experience trauma but only a minority develop PTSD.8 Other major factors that effect the incidence and chronicity of PTSD include victimization in childhood, the magnitude of the traumatic event, and support following the traumatic event.9
Generalized Anxiety Disorder (GAD)

GAD is characterized by uncontrollable worry often accompanied by somatic symptoms. There is often associated restlessness, easy fatigue, irritability, and muscle tension. GAD can start in childhood. A patient with GAD rarely feels well; the worry waxes and wanes (Figure 2).

Case 3

A 52-year-old professional man, DM, complained about feeling irritable at work and with family members. He could not concentrate at work and he was fatigued. He constantly worried about trivial matters. His first marriage ended because of worry, irritability, and restlessness. He often relieved symptoms with alcohol.

DM had always been a worrier. He remembered being an unhappy youth. He attributed the failure of his first marriage and excessive use of alcohol, at least partly, to his GAD. He responded to treatment with clonazepam, 1 mg twice a day, and venlafaxine XR, 187.5 mg once a day. Pharmacotherapy was supplemented by cognitive behavior therapy.
Panic Disorder

Panic disorder can occur with or without agoraphobia. Panic attacks consist of anticipatory anxiety followed by a peak of intense fear which builds rapidly over 10 to 15 minutes and resolves over 30 to 90 minutes. The resolution period may be prolonged. There is often apprehension about another attack in the future.10 (Figure 3). The attack consists of physical symptoms, such as palpitations, sweating, chest pains, choking sensations, and fear of dying.7 These patients often present to hospital emergency departments.

Agoraphobia is the fear of being in places from where escape may be difficult.7 Patients experience panic attacks in places such as shopping malls, buses, and queues.

Panic disorder can be treated with SSRIs and benzodiazepines. Psychotherapy consists of behavior therapy in which the patient is conditioned to feel comfortable in places which trigger agoraphobia.

Treatment of anxiety disorders should include:

• Patient education;
• Psychotherapy including supportive psychotherapy and cognitive behavior therapy; and
• Pharmacotherapy.

Pharmacotherapy can be initiated with SSRIs or venlafaxine. Benzodiazepines can be added for acute control of anxiety. Benzodiazepines should be tapered off gradually after symptom control is achieved.

Anxiety disorders are serious debilitating illnesses. SAD, PTSD, GAD, OCD and panic disorders can be differentiated. Anxiety disorders are treatable.

References