# *Anxiety and Depressive Disorders in the Primary Care Clinical Setting*

Lelis L. Nazario, MD

Chair, Department of Psychiatry

UPR, School of Medicine

# Objectives

- Overview important concepts related to anxiety and depressive disorders, including clinical manifestations, comorbidity.
- Review  relationship of these disorders with medical conditions/manifestations.
- Review treatment options and when to refer patients.

# Overview

- Anxiety is an expected, normal, and transient response to stress; it may be a necessary cue for adaptation and coping.
- Pathologic anxiety is distinguished from a normal emotional response by four criteria:
  - Autonomy: it has no or minimal recognizable environmental trigger.
  - Intensity: it exceeds the patient's capacity to bear discomfort.
  - Duration: the symptoms are persistent rather than transient.
  - Behavior: anxiety impairs coping, and results in disabling behavioral strategies, such as avoidance or withdrawal.

# *Manifestations of Anxiety*

- **Physical symptoms**: related to autonomic arousal (e.g. tachycardia, tachypnea, diaphoresis, diarrhea, and lightheadedness).
- **Affective Symptoms**: that range in severity from mild (e.g. edginess) to severe (experienced as terror, the feeling that one is “going to die” or “lose control”).
- **Behavior**: is characterized by avoidance (e.g., noncompliance with medical procedures) or compulsions.
- **Cognitions**: include worry, apprehension, obsessions, and thoughts about emotional or bodily damage.

# *Epidemiology*

- Anxiety Disorders are the most prevalent psychiatric disorders in the general population and cause considerable functional impairment and distress.
- First degree relatives of patients with anxiety disorders have a significantly increased risk for anxiety disorders compared to those in the general population.
  - First-degree relatives of patients with panic disorder have a four- to eight-fold increased risk.
  - Limited data from twin studies are also consistent with a genetic contribution.

# Course of Anxiety Disorders

- Anxiety Disorders are associated with marked impairments in physical and psychosocial function, as well as quality of life.
- Panic Disorder is associated with increased rates of alcohol abuse, marital and vocational problems, and suicide attempts (in individuals with comorbid depression an personality disorders).

# Course of Anxiety Disorders

- Panic and Phobic anxiety are also associated with increased rated of premature cardiovascular mortality in men.
- Patients with Panic Disorder lose workdays twice as often as the general population, with 25% of panic patients becoming chronically unemployed, and up to 30% receiving public assistance or disability.

# Course of Anxiety Disorders

- Patients with panic disorder are 5-7x more likely to be high utilizers of medical services compared to non-panic individuals.
- Most patients with anxiety disorders improve with treatment.
- High rated of relapse after discontinuation of pharmacotherapy support the need for maintenance therapy for many individuals.

# *Differential Diagnosis*

- Anxiety Disorders should be differentiated from medical and psychiatric conditions associated with anxiety.
- It is also important to recognize when anxiety symptoms mimic the symptoms of medical illness.

# Causes of Anxiety

- Six factors associated with an “organic” anxiety syndrome can help differentiate it from a primary anxiety disorder:
  - Onset of symptoms after the age of 35y/o
  - Lack of personal or family Hx of an anxiety disorder
  - Lack of a childhood Hx of significant anxiety, phobias, or separation anxiety
  - Absence of significant life events generating or exacerbating the anxiety symptoms
  - Lack of avoidance behavior
  - A poor response to antipanic agents

# Causes of Anxiety

- Common medical conditions associated with anxiety include:
  - A. Endocrine: hyperadrenalism (pheochromocytoma), hypothyroidism, hyperparathyroidism
  - B. Drug-related:
    - **Intoxication**: caffeine, cocaine, sympathomimetics, theophylline, corticosteroids, thyroid hormones
    - **Withdrawal**: alcohol, narcotics, sedative-hypnotics
  - C. Hypoxia: all causes of cerebral anoxia, including cardiovascular (arrythmias, angina, CHF, anemia) and respiratory (COPD, pulmonary embolism).

# Causes of Anxiety

- D. Metabolic: acidosis, hyperthermia, electrolyte abnormalities (e.g. hypercalcemia)
- E. Neurological: vestibular dysfunction, seizures (especially temporal lobe epilepsy)

# *Anxiety that Complicates Medical Illness*

- Anxiety is particularly common in the general medical setting.
- The National Ambulatory Medical Care Survey (1980-1981) revealed that anxiety is the presenting problem for 11% of the patients visiting primary care physicians (PCPs), and is the most common psychiatric problem seen by PCPs.

# *Anxiety that Complicates Medical Illness*

- More than 90% of the patients with anxiety present primarily with somatic complaints. Moreover, most patients with anxiety first seek help in primary care settings or emergency rooms.
- High rates of anxiety disorders are found in patients presenting with the symptoms of chest pain, dizziness, IBS, and dyspnea.

# Anxiety Disorders

# Panic Disorder

- . Panic Disorder and Agoraphobia
  - Panic Disorder is a syndrome characterized by **recurrent** unexpected panic attacks about which there is a persistent concern.
  - Panic attacks are discrete episodes of intense anxiety, which **develop abruptly and peak within 10min**.

# PANIC DISORDER

- Panic Attacks are associated with at least **four other symptoms of autonomic arousal.** Associated symptoms include:
  - **Cardiac symptoms**: palpitations, tachycardia, chest pain, or discomfort
  - **Pulmonary symptoms**: SOB, a feeling of choking
  - **GI symptoms**: nausea or abdominal distress
  - **Neurological symptoms**: trembling and shaking, dizziness, lightheadedness, or faintness, paresthesias
  - **Autonomic arousal**: sweating, chills, or hot flashes
  - **Psychological symptoms**: derealization, depersonalization, a fear of losing control or going crazy, or a fear of dying

# PANIC DISORDER

- Whereas the initial panic attack is usually spontaneous, subsequently, apprehension frequently develops about future panic attacks (**Anticipatory Anxiety**).
- **Agoraphobia**, a complication of panic disorder, involves anxiety about, or avoidance of, places or situations from which ready escape might be difficult, or from which escape might be embarrassing, or where help may be unavailable in the event of a panic attack.

# PANIC DISORDER

- Disease course and Treatment
  - Panic Disorder is a chronic disease.
  - Untreated Panic Disorder is often complicated by persistent anxiety and avoidant behavior, social dysfunction, marital problems, alcohol and drug abuse, increase utilization of medical services, and increase mortality (from cardiovascular complications and suicide).
  - Affected patients may experience chronic distress or demoralization which can trigger depression.
  - The established treatments for Panic Disorder include use of antidepressants, high potency benzodiazepines, and cognitive behavioral therapy.

# GENERALIZED ANXIETY DISORDER

- Generalized Anxiety Disorder (GAD
  - Patients with GAD suffer from excessive anxiety or worry, that is out of proportion to situational factors; it occurs more days than not for **longer than six months**.
  - The anxiety is usually associated with muscle tension, restlessness, insomnia, difficulty concentrating, easy fatigability, and irritability.
  - Affected patients typically experience persistent anxiety rather than discrete panic attacks as in panic disorder.

# GENERALIZED ANXIETY DISORDER

- Diagnostic Criteria.
  - Excessive anxiety and worry regarding a number of events or activities, that occurs more days than not for at least 6 months.
  - The individual finds it difficult to control the worry.
  - **Three out of six symptoms**: restlessness, easy fatigability, difficulty concentrating, irritability, muscle tension, insomnia) are present.
  - The worry is not related to features of other disorders.
  - The anxiety causes significant distress or impairment in function.
  - The anxiety is not attributed to an organic cause (e.g. substance use, medical condition).

# GENERALIZED ANXIETY DISORDER

- Treatment:
  - The Treatment  for GAD includes pharmacotherapy (antidepressants,such as Paxil, Effexor,Lexapro; Benzodiazepines, Buspirone) and cognitive-behavioral therapy.

# SPECIFIC PHOBIA

- Specific Phobia.
  - Patients with specific phobia have marked and persistent fear of circumscribed situations or objects (e.g. heights, closed spaces, animals, or the sight of blood).
  - Exposure to the phobic stimulus results inn intense anxiety and avoidance which interferes with the patient's life.

# SPECIFIC PHOBIA

- Diagnostic Criteria:
  - Persistent, excessive unreasonable fear of an object or situation.
  - Exposure to a feared stimulus invariably provokes anxiety, including panic.
  - Recognition that the fear is excessive or unreasonable.
  - The phobic stimulus is avoided or endured with dread.
  - The fear and the avoidant behavior interfere with the person's normal routine or cause marked distress.
  - **In a patient under the age of 18y/o, symptoms last longer than 6months**.
  - The symptoms are not better accounted by another disorder (e.g. obsessive-compulsive disorder, panic disorder).
  - Specific subtypes (e.g. animal, natural environment, blood-injection-injury, situational) should be specified.

# SPECIFIC PHOBIA

- Treatment:
  - Benzodiazepines are useful acutely to decrease phobic anxiety and to facilitate exposure (e.g. to take an airplane flight). However, cognitive behavioral therapy, involving exposure and desensitization to the feared stimulus, offers more comprehensive and persistent benefits.

# SOCIAL PHOBIA

- Social Phobia.
  - Patients with Social Phobia fear of being exposed to public scrutiny; they fear that they will behave in a way which will be humiliating or embarrassing.
  - This perception leads to persistent fear and ultimately to avoidance or endurance with intense distress of the social situation.
  - The anxiety can be limited to circumscribed performance situations, i.e., “performance anxiety” (e.g. speaking, eating, using a public bathroom, writing in public), or can affect more general situations.

# SOCIAL PHOBIA

- Diagnostic Criteria:
  - Fear of showing anxiety symptoms or acting in a way that will be embarrassing or humiliating when scrutinized by others.
  - The situation almost invariably provokes anxiety.
  - The patient recognizes that the fear is excessive or unreasonable.
  - The phobic stimulus is avoided or endured with intense anxiety.
  - The fear and the avoidant behavior interfere with the person's normal routine or cause marked distress.
  - **In a patient under the age of 18y/o, symptoms last longer than 6months**.
  - The symptoms are not better accounted by an organic condition or by another mental disorder (e.g. trembling in Parkinson's Disease, stuttering).
  - The subtype ("performance anxiety" vs generalized) should be specified.

# SOCIAL PHOBIA

- Treatment
  - Pharmacotherapy (antidepressants, such as MAOIs, and SSRIs, benzodiazepines ( Ex. Clonazepam-Klonopin) , beta blockers) and cognitive-behavioral therapy.
  - Paroxetine:SSRI formally approved ; SSRI's First Line  of treatment

# OBSESSIVE COMPULSIVE DISORDER

- Obsessive-Compulsive Disorder (OCD)

  OCD is characterized by recurrent, intrusive, unwanted thoughts (i.e. obsessions, such as fear of contamination), or compulsive behaviors or rituals (e.g. repetitive hand washing).

# OBSESSIVE COMPULSIVE DISORDER

- Obsessions are recurrent, persistent thoughts, impulses or images, characterized by four criteria:
  - They are experienced as intrusive and inappropriate and cause marked anxiety and distress.
  - They are not simply worries about real-life problems.
  - Attempts are made to ignore obsessions or neutralize them with some thought or action (compulsion).
  - The person recognizes the obsession as a product of his/her own mind, rather than imposed from the outside as in thought insertion.

# OBSESSIVE COMPULSIVE DISORDER

- Diagnostic Criteria:
  - The presence of obsessions or compulsions.
  - The patient is or was able at some point to recognize that the obsessions or compulsions are excessive or unreasonable.
  - The obsessions or compulsions cause marked distress, are **time-consuming (more than 1h/day)**, or significantly interfere with the person's normal routine.
  - The content of the obsessions or compulsions is not restricted to the features of any concomitant Axis I Disorder.
  - The obsessions or compulsions can not be attributed to an organic cause (i.e. substance abuse, medical condition).

# POST TRAUMATIC STRESS DISORDER

- Posttraumatic Stress Disorder (PTSD)
  - Patients with PTSD have experienced an event that involved the threat of death, injury, or severe harm to themselves or others; their response involved intense fear, helplessness, or horror.
  - Patients frequently re-experience the traumatic event in the form of nightmares, flashblacks, or by marked arousal when exposed to situations reminiscent of the event.
  - PTSD patients avoid situations which remind them of the trauma. They may become emotionally numb, irritable, hypervigilant, or have difficulties with sleep and concentration.

# PTSD

- The complications of PTSD include social withdrawal, depression, suicidality, as well as alcohol and drug abuse.
- Psychosocial risk factors for PTSD include previous personality disorder, early trauma, a chaotic childhood, and previous mental illness.
- Protective factors include good self-esteem, external control, and social support.

# PTSD

- Diagnostic Criteria:
  - The patient must have experienced, witnessed, or confronted an event that involved actual or threatened death, serious injury or threat to the physical integrity of self or others.
  - The person's response involved intense fear, helplessness or horror.
  - Persistent re-experiencing of the trauma in the form of intrusive recollections, nightmares, flashbacks, psychological distress and psychological reactivity occurs on cue exposure.

# *PTSD*

- Diagnostic Criteria (cont.)
  - Persistent avoidance of stimuli (thoughts and activities) associated with the trauma; numbing of general responsiveness (detachment or estrangement from others, sense of foreshortened future).
  - Symptoms of increased arousal (sleep disturbance, irritability and anger, difficulty concentrating, hyper vigilance, startle response).
  - Symptoms last for **more than one month**.
  - Symptoms cause significant distress and impairment.
  - Subtypes:
    - Acute: symptoms for less than 3 months
    - Chronic: symptoms for more than 3 months
    - Delayed onset: onset more than 6 months after the trauma

# *Anxiety and SUD*

- Most common symptom of people with Substance Abuse disorders.
- Treatment of mild anxiety can be postponed to see if it resolves as addiction treatment progresses.

(Ref. US Department of Health and Human Services- Substance Abuse and Mental Health Services Administration ;Center for Substance Abuse Treatment, www.samhsa.gov)

# *Anxiety :Substance – Induced*

- Never assume anxiety symptoms or depersonalization are related to substance abuse.
- Substance- induced conditions:

*Panic *OCD

*Phobias *PTSD

(Ref. US Department of Health and Human Services-Substance Abuse and Mental Health Services Administration ;Center for Substance Abuse Treatment, www.samhsa.gov)

- Long-term treatment:
- Medications are not a substitute for addiction treatment
- Cognitive –Behavioral  techniques are often as effective as medications, but generally take longer to achieve an equivalent response in the treatment of Anxiety Disorders.

(Ref. US Department of Health and Human Services-Substance Abuse and Mental Health Services Administration ;Center for Substance Abuse Treatment, www.samhsa.gov)

*For Dual Diagnosis patients, psychotherapy has significant advantages over substance abuse counseling alone, and can be incorporated into the substance abuse treatment.

(Ref. US Department of Health and Human Services-Substance Abuse and Mental Health Services Administration ;Center for Substance Abuse Treatment, www.samhsa.gov

# Anxiety Treatment

- Can be postpone unless anxiety interferes with Substance Abuse Treatment.
- Anxiety symptoms may resolve with abstinence and Substance Abuse treatment.
- Affect-liberating therapies should be postpone until patient is stable.
- Psychotherapy , when required, should be recovery oriented.

# Anxiety Treatment

- Non-psychoactive medications should be used when medications are needed.
- Antianxiety treatments such as Relaxation Techniques , can be used with and without medications.
- A healthy diet, aerobic exercise, and avoiding caffeine can reduce anxiety .

(Ref. US Department of Health and Human Services-Substance Abuse and Mental Health Services Administration ;Center for Substance Abuse Treatment, www.samhsa.gov )

# Depressive Disorders

# *Need for Treatment and Prevention of MDD and Dysthymic Disorder*

- These disorders are prevalent & recurrent
- Have high rates of comorbidity
- Accompanied by poor psychosocial outcomes
- Associated with high risk for suicide
- Associated with high risk for substance abuse

# *Major Depressive Disorder*

A. Five or more of the following; present for 2-wks; either (1) depressed mood or (2) loss of interest or pleasure;

-weight loss or weight gain

-insomnia or hypersomnia

-fatigue or loss of energy

-worthlessness or inappropriate guilt

-↓ability to think or indecisiveness

-recurrent thoughts of death

# *Major Depressive Disorder*

B. Do not meet criteria for a Mixed Episode

C. Significant distress or impairment, in social, occupational, or other important areas of functioning.

D. Not due to a substance or GMC

E. Not better accounted for by Bereavement

# *Clinical Variants of MDD: Need for Different Intervention Strategies*

- Psychotic Depression
- Bipolar Depression
- Atypical Depression
- Seasonal Affective Disorder
- Subclinical or Subsyndromal Depression
- Treatment-Resistant Depression

# *Causes of Secondary Depression*

- Trauma to brain tissue- Ex. Stroke, HIV
- Endrocrine/Humoral- Ex. Thyroid, Pancreatic CA
- Iatrogenic (medications)- Ex. Propanolol, OCP, Cimetidine
- Comorbidity of other psychiatric illness- Ex. Anxiety Disorders

# *Dysthimia*

- A. Depresed Mood For most of the day, for more days than not, for at least two years.
- B. Presence, while depressed, of two or more
  - Poor apetite or overeating
  - Insomnia or hypersomnia
  - Low energy
  - Low self esteem
  - Poor concentration
  - Feelings of hopelessness
- C. During the two year period the person has never been without the symptoms of A and B for more than two months at a time.

# Dysthimia

- D. No major depressive episode has been present for the first two years of the dis turbance
- E. There has never been a manic, mixed or hypomanic episode, nor cyclothimic disorder
- F. The disorder does not occur exclusively during the course of a chronic psychotic disorder.
- G. Not due to a substance or GMC
- H. Marked impairment in occupational functioning or in usual social activities

# *Differential Dx: Complexities of General Medical Conditions*

- May be accompanied by symptoms of depression
- Impact course of depressive disorder
- MDD can be diagnosed if depressive symptoms preceded or not solely due to medical illness or medications to treat medical illness
- Incidence of MDD higher in certain medical illnesses
- Chronic illness may affect sleep, appetite, energy
- Guilt, worthlessness, hopelessness, suicidal

## *Differential Dx: Medical Conds. Often with Depressive Symptoms*

- Cancer, hypothyroidism, lupus erythematosus, acquired immunodeficiency syndrome, anemia, diabetes, epilepsy
- Chronic Fatigue Syndrome: symptoms similar to MDD but with more somatic symptoms, less mood, cognitive, social symptoms
- Medication induced symptoms: stimulants, neuroleptics, corticosteroids, contraceptives

# *Differential Diagnosis: Bereavement*

- Similarity of symptoms
- Diagnosis of MDD made if bereaved child/adolescent has moderate or severe functional impairment, psychosis, suicidal ideation or acts, prolonged course
- Following bereavement, predisposition to MDD may be related to prior MDD or family history of MDD (uncomplicated bereavement often remits in 6-12 months after death)

# Comorbidity

- Present in 40%-90% of youth with MDD; two or more comorbid disorders present in 20%-50% youth with MDD
- Comorbidity in youth with MDD: Dysthymia or anxiety disorders (30%-80%), disruptive disorders (10-80%), substance abuse disorders (20%-30%)
- MDD onset after comorbid disorders, except for substance abuse
- Conduct problems: May be a complication of MDD & persist after MDD episode resolves
- Children manifest separation anxiety; adolescents manifest social phobia, GAD, conduct disorder, substance abuse

# *Treatment*

- For Depressive Disorders:
  - Antidepressants can be classified into a several categories
  - TCAS and tetracyclic antidepressants
  - Monoamine oxidase inhibitors (MAOIs)
  - Selective serotonin reuptake inhibitors- Exs. Paroxetine, Sertraline, Citalopram, Escitalopram, Fluoxetine
  - Atypical antidepressants- Exs. Bupropion, Duloxetine, Venlafaxine, Trazodone

# Treatment

- All antidepressants are equally effective in treating MDD
- Response rates range from 60% to 80% for drugs
- Decision concerning which antidepressants to use are based on side effects profiles history of response, family history of response, potential for drug interactions, risk of overdose or aggravating an existing medical condition, depression subtypes and cost

# *Side Effects*

- Side effects: (Depending on antidepressant use)
  - Are related to receptor blocking properties
  - Muscarinic blockade: dry mouth, constipation, blurred vision, and difficulty initiating urination
  - Alpha 1 – adrenergic blockade: orthosthatic hypotension
  - Histaminic blockade: weight gain and sedation

# *Side Effects*

- Are related to receptor activation:
  - NE: rapid hear rate, increased anxiety, insomnia, tremor, and diaphoresis
  - Serotonin: insomnia, sexual dysfunction, GI disturbances, headaches, appetite loss
  - Dopamine: psychosis, agitation, elevated blood pressure

# *Electroconvulsive Therapy*

- The primary indications for ECT include failure of several antidepressants trials, severe depression with psychotic features, high risk of suicide, medical emergency due to severe weight loss, previous good response to ECT

# Psychotherapy

- Supportive psychotherapy
- Cognitive behavior therapy
  - The primary tasks are to identify distorted beliefs
- Interpersonal psychotherapy
  - IPT focuses on interpersonal losses, social isolation, deficits in social skills, etc.

# Questions?