Diagnosis and Management of Anxiety Disorders

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Anxiety

- Normal reaction to a stressor
- **Disorder:** If the response is disproportionate to the stressor and causes disruption in function
  - Common: ¼ of adult population
  - Symptoms:
    - Excessive worry
    - Fear
    - Apprehension
    - Intrusions/ Compulsions
    - Physical symptoms (e.g., fatigue, heart palpitations, sweating, light-headed, chest tightness, difficulty breathing and tension)
  - Persistent, chronic, frequently comorbid with other psychiatric disorders – including other anxiety disorders, and other medical conditions

(Kessler & Wang, 2008; Benninghoven et al, 2006; Roy-Byrne et al, 2008; Sareen et al, 2006; Weiser, 2007)

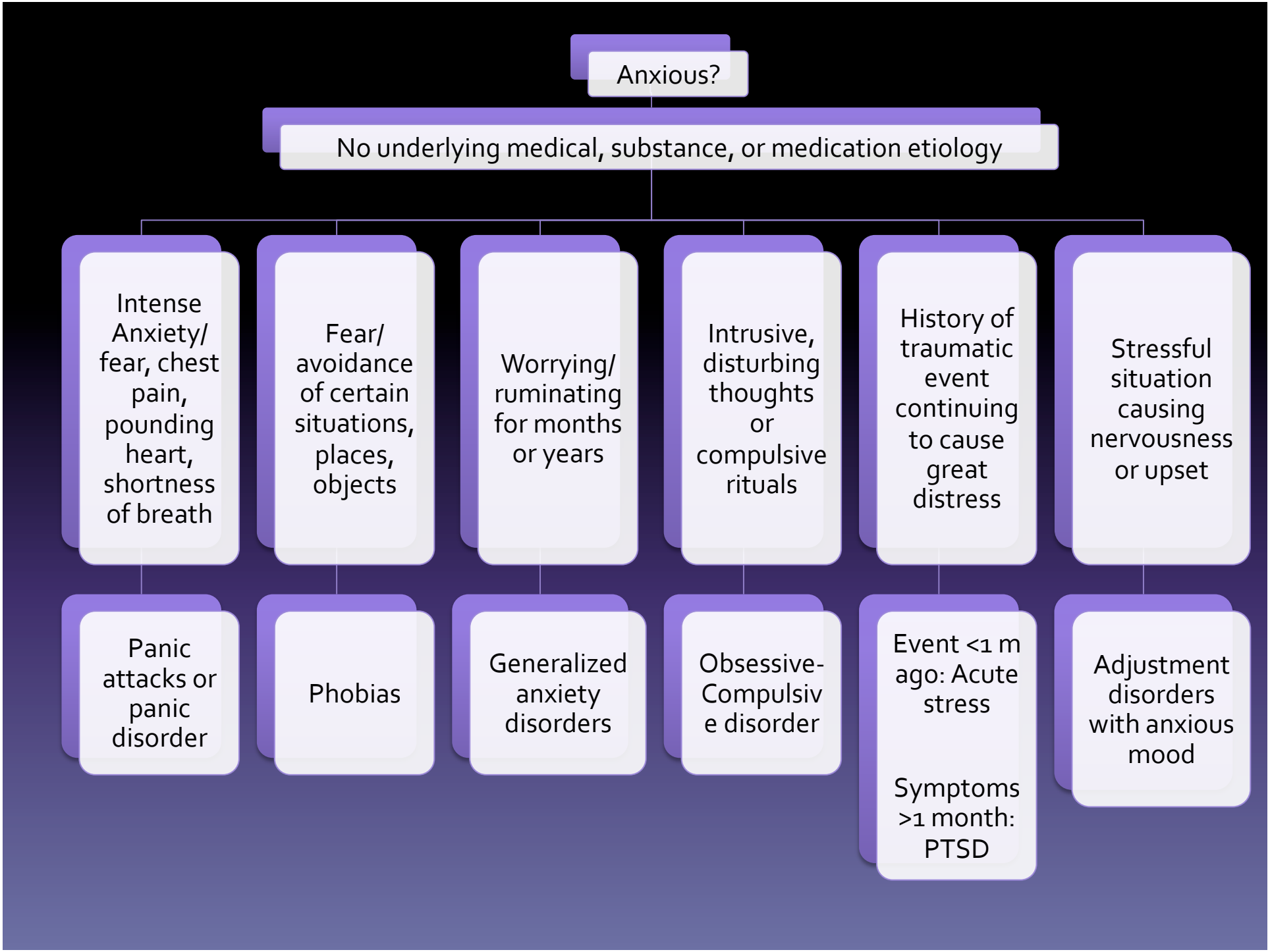
A diagnosis of an anxiety disorder is a diagnosis of exclusion

- Clinicians should consider an anxiety disorder as part of the differential diagnosis when a patient presents with common somatic symptoms for which a thorough evaluation reveals no underlying medical etiology, such as chest pain, diaphoresis, dizziness, gastrointestinal disturbances, and/or headache
- Conversely, when patients complaint of anxiety symptoms, a thorough evaluation is required before diagnosing an anxiety disorder
- Clinicians should routinely log anxiety during the course of the disease as it is a silent comorbidity that negatively impacts HIV and quality of life

Medications That May Cause Anxiety-Like Symptoms in HIV-Infected Patients[a]

Category	Medication
Antihypertensives	• Reserpine, hydralazine
Antituberculous agents	• Cycloserine, isoniazid
Psychopharmacologic agents[b]	• Most antipsychotic medications, most antidepressant medications, amphetamine, methylphenidate
Sympathomimetics	• Ephedrine, epinephrine, dopamine, phenylephrine, phenylpropanolamine, pseudoephedrine
Smoking cessation	• Bupropion, varenicline (Chantix)
Benzodiazepines	• Benzodiazepine withdrawal
Antiretrovirals	• Most antiretrovirals
Other	• Thyroid preparations, interferon-alfa, digitalis, lidocaine, monosodium glutamate, nicotinic acis, steroids, theophylline, aminophyline

[a] Anxiety symptoms can be transient.
[b] Psychopharmacologic agents refer to all psychoactive agents.


Anxious?
No underlying medical, substance, or medication etiology
Intense Anxiety/ fear, chest pain, pounding heart, shortness of breath
Fear/ avoidance of certain situations, places, objects
Worrying/ ruminating for months or years
Intrusive, disturbing thoughts or compulsive rituals
History of traumatic event continuing to cause great distress
Stressful situation causing nervousness or upset
Panic attacks or panic disorder
Phobias
Generalized anxiety disorders
Obsessive-Compulsive disorder
Event <1 m ago: Acute stress
Symptoms >1 month: PTSD
Adjustment disorders with anxious mood

Anxiety & HIV

- Normal anxiety throughout the course of HIV
- Yet, people with human immunodeficiency virus (HIV) show elevated anxiety levels compared to the general population: 5-10 times
- Anxiety can predate HIV infection, be associated with risk behaviors or be triggered by HIV diagnosis and the many stresses that emerge during the course of HIV disease
  - Receiving test results (e.g., +, VL, CD4s)
  - Diagnoses, treatment and side effects, illness episodes, changes due to illness
  - Social stigma/isolation, fear of disclosure
  - Financial burden, relatives/friends bereavement, risk of transmission (self and families)
- Correlated with adherence problems, treatment failure, higher health care utilization, poor health outcomes, poor quality of life and mortality

(Kessler, 2004; Vitielo et al, 2003; Pence, 2009; Reyes et al, 2007; Casadonte et al, 1990; Murphy et al, 2003; Power et al, 2003; Bor et al, 1993; Herek et al, 2002; King, 1990; Antoni, 2003; Chesney 1992; O'Cleitigh et al, 2007; Lesserman et al, 2005)

Systematic Review (N=39 studies)

Clucas C, Sibley E, Harding R, Liu L, Catalan J and Sherr L. *Psychology, Health & Medicine.* 2011

- ½ of them pre-HAART era
- 30 (76.9%) North America, 6 W. Europe, 2 E. Asia, 1 Australia
- 3 studies - prevalence rates 13% to 80%
- Anxiety was measured using 14 different instruments
  - Profile of Mood States (POMS; 12 studies); State-Trait Anxiety Inventory (STAI; 12 studies); Hospital Anxiety and Depression Scale (HADS; 3 studies); Hamilton Anxiety Rating Scale (HARS; 2 studies); Symptom Checklist-90-Revised (SCL-90-R; 2 studies).
- Only adults
- 13 studies recruited men and 20 mostly men ~ 33 (84.6%)
  - 7 studies MSM and 3 mostly MSM
  - 5 studies recruited women/men and 1 women only
- Ethnicity –
  - 32 either did not include or had diverse samples
  - 1 Chinese; 2 mostly African Americans; 4 mostly Caucasians

Systematic Review (N=39 studies)

(Cont…)

- 50 interventions (controlled and open trials)
- 20 directly targeted anxiety:
  - Cognitive Behavioral Therapies, Experiential Therapies, Psychosocial Interventions
  - Nutritional (Selenium)
- 13 targeted HIV/symptoms or associated outcomes/conditions
  - ART, Chinese herbs, lipoatrophy, transmission risks, pain communication
- 17 indirectly targeted anxiety
- Reduced anxiety
  - Yes: 24 (48%)
    - 13 of the 20 targeting anxiety; 11 of the 30 indirect interventions
  - No: 16 (32%)
  - Unknown: 10 (20%)

Psychological interventions, especially cognitive behavioral stress management interventions and cognitive behavioral therapy, were generally more effective than pharmacological interventions

Interventions Demonstrated to Reduce Anxiety symptoms in HIV-Infected P

Intervention	Description and Outcomes
Cognitive-Behavioral Interventions: CBT and CB Stress Management	• CBT and CBSM train patients to use CB techniques to decrease anxiety symptoms
Coping Effectiveness Training (CET)	• CET trains patients to differentiate between modifiable and immutable aspects of stressors and to tailor efforts of coping into tasks that target specific stressors; individuals are also trained to optimize and maintain social support
Symptom Management Intervention	• Intervention that focuses on self-care and training in adherence to HIV treatment with the aim of decreasing emotional distress and optimizing health
Alternative Approaches	• Studies on alternative approaches to anxiety management for HIV-infected patients have reported alleviation of anxiety symptoms through such interventions as art therapy, aerobic exercise in combination with t'ai chi, and acupuncture in combination with spirituality focused training

Management

- Empathy and education: Anxiety is the cause of somatic symptoms
- Psychosocial Intervention:
  - Identify contributing factors (e.g., financial and housing instability, social isolation, relationships' conflict) and refer for supportive services
- Skills Learning:
  - Prepare for stressful situations (coping strategies)
  - Teach simple relaxation exercises: Slow, deep abdominal breathing. Practice for 1 minute 3 times a day, increasing to 5 minutes
- Counsel to lower anxiety-inducing substances (e.g., caffeine, nicotine)
- **Non responders:** Specialized psychotherapeutic and/or psychopharmacologic
  - "start low and go slow"
  - drug-drug interactions

When health providers should refer out or consult?

- Anxiety symptoms do not respond to psychosocial interventions or psychopharmacologic treatment
- The diagnosis of an anxiety disorder is difficult to establish
- Anxiety symptoms are persistent or severe
- Intrusive or disturbing obsessive thoughts or compulsive rituals are poorly controlled with the current treatment
- Anxiety symptoms are occurring in patients with a current or significant past history of substance abuse

Panic Attacks/Panic Disorder

- Symptomatic relief for patients experiencing panic attacks can usually be accomplished with the short-term use of benzodiazepines
- Selective serotonin reuptake inhibitors (SSRIs) are the treatment of choice - prevent panic attacks from recurring.
- Given the morbidity associated with ongoing panic attacks, it is important to provide treatment to prevent recurrence.
- Serotonin–norepinephrine reuptake inhibitors (SNRIs) are also effective in preventing panic attacks, as well as the tricyclic antidepressants, but the latter are limited in their usage due to their side-effect profiles and potential for drug-drug interactions.

Generalized Anxiety Disorder

- Patients with chronic anxiety, consistent with generalized anxiety disorder, may require long-term treatment with psychopharmacologic medication.
- Buspirone should be considered because it is an effective anxiolytic that has no potential for abuse, which is particularly important for patients with a history of substance abuse.
- The SSRIs and SNRIs can also be effective Although some patients may experience relief sooner, the onset of action of buspirone (3-6 weeks) and SSRIs (2-4 weeks) may necessitate the short-term use of benzodiazepines; use with caution

Adjustment Disorder

- Short-term symptomatic relief may be helpful in some patients.
- A time-limited use (2-4 weeks) of benzodiazepines prescribed on a daily or as-needed basis can be effective.

Post-Traumatic Stress Disorder

- There is no single medication that treats all of the symptoms of PTSD.
- Sertraline and paroxetine are the only FDA-approved medications for PTSD.
  - Paroxetine should be avoided in patients less than 18 years old because of its possible association with increased suicide risk.
- All SSRIs and SNRIs (in the same doses used for depression) are helpful in treating symptoms of depression and anxiety (controlled and open trials).
- Open trial studies of mood stabilizers have also shown some benefits.
- Long-term benzodiazepine use is not a preferred treatment due to abuse and/or disinhibition in those with significant dissociative symptoms.

Insomnia

- If an underlying medical etiology or chemical cause has been excluded, insomnia should almost always be considered a symptom of an underlying psychiatric disorder (major depression, adjustment disorder, generalized anxiety disorder, PTSD).
- Diagnosis and treatment of the underlying condition is essential and often results in resolution of the insomnia.
- Nonpharmacologic approaches to treating insomnia should be attempted before prescribing medications
- AIDS Institute, NYS:
  - http://www.natap.org/2010/newsUpdates/insomniascreening.pdf

Treatment of Anxiety Disorders and Comorbid Substance Use

- Substance-induced anxiety disorders can appear similar to anxiety disorders but may have different treatment recommendations
- Specialized mental health provider and/or addiction specialist
  - Risks of dependence, withdrawal, and abuse of benzodiazepines
  - Risk-benefit analysis
- Optimize other treatment options, such as psychotherapeutic or psychopharmacologic interventions
- If actively using alcohol/drugs: Inpatient treatment to better determine the etiology of the patient's anxiety symptoms

Further Research

- Psychosocial – CBTherapies – Psychopharmahology (caution using benzodiazepines)
- There are efficacious interventions
- Next step: Effectiveness, implementation and dissemination
- LMIC?
- Women, Children or adolescents
- Measurement of anxiety?

THANK YOU

GRACIAS

MOLTES GRÀCIES