GENERALIZED ANXIETY DISORDER

INTRODUCTION

- Persons who seem to be excessively and persistently anxious about almost everything are likely to be classified as having generalized anxiety disorder.
- Free floating anxiety
- The worry is difficult to control and is associated with somatic symptoms

HISTORY

- Prior to DSM-III, GAD along with panic disorder subsumed under the category of anxiety neurosis.
- GAD was first formalised in DSM-III
- DSM-III to DSM-IIIR- Duration changed from 1 month to 6 months and 18 associated symptoms were added from which at least 6 are required.

HISTORY

- DSM IV-TR- List of associated symptoms was narrowed from 18 to 6, from which at least 3 are required.

- ICD-10- Includes diagnosis of GAD and requires 4 associated symptoms from a list of 22

EPIDEMIOLOGY

- A lifetime prevalence is close to 5 percent with ECA study suggesting a lifetime prevalence as high as 8 percent.
- Onset-late adolescence or early adulthood, although cases are commonly seen in older adults.
- In anxiety disorder clinics- 25 percent of patients

EPIDEMIOLOGY

- 1 year prevalence range from- 3 to 8 percent
- Ratio of women to men disorder- 2 to 1 percent
- Ratio of women to men who are receiving inpatient treatment for the disorder- 1 to 1

COMORBIDITY

- Another mental disorder, usually social phobia, specific phobia, panic disorder, or a depressive disorder.
- 50 to 90 percent have another mental disorder.
- 25 percent experience- panic disorder

COMORBIDITY

- Additional high percentage have- MDD
- Other common disorders associated with GAD- dysthymic disorder and substance-related disorders.

ETIOLOGY

- Cause is not known.

- Currently probable causative factors are-

  (1) Biological and genetic factors
  (2) Psychosocial factors

ETIOLOGY

BIOLOGICAL FACTORS-

- The BZD receptors are abnormal in patients with GAD.
- The regulation of the serotonergic system is also abnormal in GAD.
- Brain areas involved in GAD- the basal ganglia, the limbic system, and the frontal cortex.

ETIOLOGY

- Other affected NTs- norepinephrine, glutamate, and cholecystokinin systems
- PET Scan shows - lower metabolic rate in basal ganglia and white matter in patients with GAD.

ETIOLOGY

GENETIC FACTORS-

- A genetic relation might exist between GAD and MDD in women.
- 25 percent of first-degree relatives of patients with GAD are also affected.
- Monozygotic twins- 50 percent concordance rate
- Dizygotic twins- 15 percent

ETIOLOGY

PSYCHOSOCIAL FACTORS-

- The two major schools of thought are the cognitive-behavioral school and the psychoanalytic school.
- Sigmund Freud first presented this psychological theory in 1909 .
- The psychoanalytic school hypothesizes that anxiety is a symptom of unresolved, unconscious conflicts.
- According to the cognitive-behavioral school, patients with GAD respond to incorrectly and inaccurately perceived dangers.

DIAGNOSIS

DSM-5 CRITERIA-

(A)Excessive anxiety and worry occurring more days than not for at least 6 months, about a number of events or activities.

(B)The person finds it difficult to control the worry.

(C)The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).

- restlessness or feeling keyed up or on edge
- being easily fatigued
- difficulty concentrating or mind going blank
- irritability
- muscle tension
- sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep

DIAGNOSIS

(D)The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(E)The disturbance is not attributable to the physiological effects of a substance.

(F)The disturbance is not better explained by another mental disorder.

DIAGNOSIS

ICD-10 CRITERIA-

(A)There must have been a period of at least 6 months with prominent tension, worry, and feelings of apprehension about everyday events and problems.

(B)At least four of the symptoms listed below must be present, at least one of which must be from items (1) to (4):

-Autonomic arousal symptoms

(1)palpitations or pounding heart, or accelerated heart rate;

(2)sweating;

(3)trembling or shaking;

(4)dry mouth (not due to medication or dehydration);

DIAGNOSIS

-Symptoms involving chest and abdomen

-Symptoms involving mental state

-General symptoms

-Symptoms of tension

-Other non specific symptoms

(C)The disorder does not meet the criteria for panic disorder, phobic anxiety disorders, obsessive-compulsive disorder, or hypochondriacal disorder.

(D)The anxiety disorder is not due to a physical disorder.

CLINICAL FEATURES

- Sustained and excessive anxiety and worry that is free floating.
- Physiological symptoms- motor tension, autonomic hyperactivity, irritability.
- Motor tension-shakiness, restlessness, and headaches.
- Autonomic hyperactivity-shortness of breath, excessive sweating, palpitations and various git symptoms.

DIFFERENTIAL DIAGNOSIS

- Medical disorders- Neurological, endocrinological, metabolic, and medication-related disorders similar to those considered in the differential diagnosis of PD.
- Mental disorders-other anxiety disorders-

  Panic disorder

  obsessive-compulsive disorder (OCD),

  posttraumatic stress disorder (PTSD).
- MDD

COURSE AND PROGNOSIS

- The age of onset is difficult to specify.
- Patients usually come to a clinician's attention in their 20s.
- Only one third of patients who have GAD seek psychiatric treatment.
- The occurrence of several negative life events greatly increases the likelihood that the disorder will develop.
- GAD is a chronic condition that may well be lifelong.

TREATMENT

PHARMACOTHERAPY-

- 3 major drugs - benzodiazepines, SSRIs, buspirone (5-HT_{1A} receptor partial agonist), venlafaxine.
- DOC- Benzodiazepines
- Other drugs- tricyclic drugs (e.g., imipramine), antihistamines, and the beta-adrenergic antagonists (e.g., propranolol).
- Duration- 6-12 mnths, perhaps life long.

TREATMENT

PSYCHOTHERAPY-

- Major includes- cognitive-behavioral, supportive, and insight oriented.
- Cognitive approaches address patients' hypothesized cognitive distortions directly, and behavioral approaches address somatic symptoms directly.
- Supportive therapy offers patients reassurance and comfort.
- Insight-oriented psychotherapy focuses on uncovering unconscious conflicts.

SEPARATION ANXIETY

INTRODUCTION

- Anxiety disorders- affecting >10 percent of children and adolescents.
- Developmentally appropriate separation anxiety typically presents around age 6 months and declines between ages 2 and 3 years.
- Children with SAD have either persistent and worsening or new onset separation anxiety in the school-aged years (i.e., ages 6 to 12 years).

INTRODUCTION

- Separation anxiety disorder is characterized by –

- excessive and developmentally inappropriate fear of being away from home or attachment figures,

- avoidance of such separations,

- irrational beliefs about the consequences of being apart from a caregiver.

HISTORY

- DSM-III-First classified as an anxiety disorder of childhood or adolescence.

- The minimum duration was increased-
- From 2 weeks in DSM-III to 4 weeks in DSM-IV-TR.

- And evidence of serious distress or impairment was added for diagnosis in DSM-IV.

EPIDEMIOLOGY

- Lifetime prevalence of any anxiety disorder in children and adolescents- 8.3 to 27 percent.
- According to a recent epidemiologic survey using PAPA- 2.4 percent preschoolers meeting criteria for separation anxiety disorder.
- SAD- 4 percent in children and young adolescents.

EPIDEMIOLOGY

- More common in young children than in adolescents.
- Occurs equally in boys and girls.
- Onset more common in age of 7-8 yrs, may occur in preschoolers

ETIOLOGY

BIOPSYCHOSOCIAL FACTORS-

- Temperament- may influence the degree of SAD.
- Mothers with anxiety disorders tend to have children with higher rates of anxiety disorders.
- External life stresses often coincide with development of the disorder.

ETIOLOGY

SOCIAL LEARNING FCTORS-

- Fear, in response to a variety of unfamiliar or unexpected situations, may be unwittingly communicated from parents to children by direct modeling.

- Social learning factors in the development of anxiety reactions are magnified when parents have anxiety disorders themselves.

ETIOLOGY

GENETICS-

- Genes account for at least one third of the variance in the development of anxiety disorders in children.
- Temperamental constellation have genetic contribution.
- The presence of an anxiety disorder increases the risk of a future episode of a depressive disord

CLINICAL FEATURES

- Persistent and excessive worry about losing, or possible harm befalling, major attachment figures.
- Persistent reluctance or refusal to go to school or elsewhere.
- Persistent and excessive fear or reluctance to be alone
- Persistent reluctance or refusal to go to sleep without being near a major attachment figure.

CLINICAL FEATURES

- Repeated nightmares involving the theme of separation.
- Repeated complaints of physical symptoms.
- Recurrent excessive distress when separation from home or major attachment figures is anticipated or involved.

DIAGNOSIS

DSM-5-

- Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced **by at least three of the following:**

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.

DIAGNOSIS

4.Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.

5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.

6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.

7. Repeated nightmares involving the theme of separation.

8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea,vomiting) when separation from major attachment figures occurs or is anticipated.

DIAGNOSIS

B.The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.

C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

D. The disturbance is not better explained by another mental disorder.

D/D

- GAD
- depressive disorders
- **conduct disorder**
- major depressive disorder
- panic disorder with agoraphobia

COURSE AND PROGNOSIS

- Course is not consistent.
- Some children with spontaneously remit
- Some remain anxious but are no longer prominently avoidant of separation triggers, and
- Some truly evolve from separation anxiety into other anxiety disorders or depression

TREATMENT

- CBT and antidepressant medications appear to be effective for the short- and longer-term management of children with SAD

- It is unclear at the current time which treatment is most effective for which child, what factors affect treatment outcome, whether combining treatments offers additional benefit.

TREATMENT

PHARMACOTHERAPY-

- SSRIs are the first line treatment.
- No SSRIs are approved by the U.S. FDA for use with children and adolescents.
- Those who benefit acutely continue on a positive trajectory for up to 6 months.
- Benzodiazepines have not been extensively studied for the acute or chronic management of anxiety in children

TREATMENT

- **PSYCHOTHERAPY-**

CBT is considered as the treatment of choice.

It have the following components-

(1) psychoeducation: Corrective information about the nature of anxiety and feared stimuli.

(2) somatic management techniques: Feelings identification, diaphragmatic breathing, and PMR to target autonomic arousal and related physiological responses.

TREATMENT

(3) cognitive restructuring: Identification of maladaptive thoughts and teaching realistic, coping-focused thinking

(4) exposure techniques: Graduated, systematic, and controlled exposure to feared situations and stimuli.

(5) relapse prevention.

THANKYOU