Anxiety disorders, post-traumatic stress disorder, and obsessive–compulsive disorder

Robert P Gordon

Emma K Brandish

David S Baldwin

Abstract

Anxiety symptoms and disorders are common in community settings and primary and secondary care. Symptoms can be mild and transient, but many people are troubled by severe symptoms causing great personal distress and impairing social and occupational function. The societal burden from anxiety disorders is considerable, but many who might benefit from treatment are not recognized or treated by healthcare professionals. Some patients, however, are given unnecessary or inappropriate treatment. Recognition relies on keen awareness of the psychological and physical symptoms of all anxiety disorders, and accurate diagnosis on identification of the specific features of particular disorders. Need for treatment is determined by the severity and persistence of symptoms, level of associated disability and impact on everyday life, presence of coexisting depressive symptoms, and other features such as good response to or poor tolerability of previous treatments. Choice of treatment is influenced by patient characteristics, patient and doctor preferences, and local availability of potential interventions. There is much overlap between different anxiety disorders in evidence-based and effective therapies (e.g. prescription of a selective serotonin reuptake inhibitor or course of individual cognitive behavioural therapy), but there are important differences. It thus helps to become familiar with the characteristic features and evidence base for each disorder.

Keywords Anxiety disorder; cognitive behavioural therapy; obsessive–compulsive disorder; post-traumatic stress disorder; selective serotonin reuptake inhibitor

Robert P Gordon ***BSc MB BS*** *is an Academic Clinical Fellow in Psychiatry in the Wessex Deanery, UK. Competing interests: Dr Gordon is supported by the University of Southampton National Institute of Health Research Academic Clinical Fellowship programme.*

Emma K Brandish ***BSc BM MRCPsych*** *is an Academic Clinical Fellow in Psychiatry in the Wessex Deanery, UK. Competing interests: Dr Brandish is supported by the University of Southampton National Institute of Health Research Academic Clinical Fellowship programme.*

David S Baldwin ***MA DM FHEA FRCPsych*** *is Professor of Psychiatry in the Faculty of Medicine of the University of Southampton, UK, Honorary Professor of Psychiatry at the University of Cape Town, South Africa, and Visiting Professor at University Guangji Hospital, Suzhou, China. Competing interests: he has held research grants (on behalf of his employer) from a number of companies with an interest in anxiety and depressive disorders (Asahi, AstraZeneca, Cephalon, Eli Lilly, Grunenthal, GSK, Lundbeck, Organon, Pharmacia, Pierre Fabre, Pfizer, Roche, Servier, Sumitomo and Wyeth).*

Key points

- Anxiety disorders, post-traumatic stress disorder (PTSD) and obsessive–compulsive disorder (OCD) are common, often chronic and impairing medical conditions that often precede the development of depression
- The 2013 5th edition of the Diagnostic and Statistical Manual of Mental Disorders classifies OCD and PTSD outside the category of anxiety disorders
- Evidence-based guidelines for the treatment of anxiety disorders, PTSD and OCD typically recommend either a selective serotonin reuptake inhibitor or cognitive behavioural therapy (CBT) as the first-line treatment approach
- For some disorders, combination treatment (CBT plus medication) is known to be superior to either treatment modality given as monotherapy
- Benzodiazepines should be used cautiously and only for short periods in most patients
- Pregabalin is an effective anxiolytic drug but can have a potential for abuse

Anxiety symptoms and anxiety disorders

Anxiety is a normal response to threat or stress, and is usually transient and controllable. It probably represents an 'alarm', allowing someone to prepare a physical response to a perceived danger (the 'fight-or-flight' response). Anxiety is common among patients undergoing clinical examination, investigation or treatment. Anxiety symptoms are clinically important when they are abnormally severe or unduly prolonged, occur in the absence of stress and are associated with impairment of physical, social or occupational functioning. Anxiety symptoms can lead to presentations to emergency departments and to repeated consultations in primary and secondary care settings.

By convention, a distinction is made between physical (or 'somatic') symptoms (e.g. tremor, shortness of breath, palpitations), which are mainly the result of autonomic arousal, and psychological symptoms, including apprehension, irritability and restlessness. Anxiety disorders are diagnosed when a patient has experienced the required number of symptoms for more than a minimum specified period, and these symptoms cause significant distress and are associated with impairment in everyday function.

All disorders share common psychological and physical symptoms but differ in having characteristic features that aid diagnosis (Table 1), for example recurrent unexpected panic attacks and secondary agoraphobia in panic disorder, or the fear of embarrassment and humiliation in social phobia. The differential diagnosis of a suspected anxiety disorder is aided by a simple algorithm (Figure 1). The 5th edition of the Diagnostic and

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Acute presentations of anxiety disorders, PTSD and OCD

Panic disorder	Characterized by recurrent unexpected surges of severe anxiety ('panic attacks'), which typically reach their peak within 10 minutes and last around 30–45 minutes. Many patients believe they are in imminent danger of death or collapse and seek urgent medical attention
Generalized anxiety disorder	Characterized by prolonged and excessive worrying that is not restricted to particular circumstances. Worries often centre on possible physical ill-health, affecting themselves or family members, and patients can repeatedly present with medically unexplained physical symptoms, craving reassurance or requesting inappropriate medical investigations
Social phobia (social anxiety disorder)	People with social phobia have a marked and persistent fear of being observed or negatively evaluated by other people, in social or performance situations. Many avoid consulting doctors, but some present with physical symptoms (e.g. excessive perspiration) or psychological symptoms (e.g. fear of vomiting in public)
Separation anxiety disorder	Characterized by fear or anxiety concerning separation from attachment figures: common features include excessive distress when experiencing or anticipating separation from home, and persistent and excessive worries about potential harms to loved ones or untoward events that might result in separation
PTSD	Typically develops some months after a traumatic event in which the individual felt intense helplessness or horror; characteristic symptoms include intrusive recollections, disturbed sleep and hyperarousal. Patients can also present with symptoms of associated conditions or behaviours, such as alcohol use or after non-fatal self-harm
OCD	OCD is characterized by recurrent obsessional ruminations, images or impulses and/or recurrent physical or mental rituals. Common symptoms include ruminations about possible accidents, and counting or checking rituals. Obsessive–compulsive symptoms can be a feature of some neurological conditions (e.g. Tourette's syndrome)

Table 1

Statistical Manual of Mental Disorders (DSM-5) classification of mental disorders has removed obsessive–compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) from the group of anxiety disorders, although they are considered here because anxiety symptoms are common in both OCD and PTSD. Conversely, DSM-5 includes the diagnosis of separation anxiety disorder within the group of anxiety disorders, noting that it can diagnosed in both children and adults.

A review of epidemiological studies of mental disorder within the 27 European Union countries demonstrated that, when grouped together, anxiety disorders had an estimated 12-month prevalence rate of approximately 14.0%. Using estimates to calculate the size of the population in the European Union that would be affected (69.1 million people), it was estimated that, in 2010, anxiety disorders (excluding PTSD) cost close to €66 billion.

Mixed anxiety and depression

Depressive symptoms often accompany anxiety disorders – and approximately one-third of people with anxiety disorders also fulfil the diagnostic criteria for major depression, sometimes referred to as 'co-morbidity'. Treatment of depression usually reduces anxiety symptoms when depression is the primary diagnosis, but if depression is co-morbid or follows an anxiety disorder, each condition requires separate consideration and often separate treatment.

General considerations in the treatment of anxiety disorders

Anxiety symptoms exist on a continuum, and many people with mild symptoms of recent onset associated with stressful events or situations improve without needing treatment. However, the chronic nature and associated disability of anxiety disorders means that most patients who fulfil diagnostic criteria are likely to benefit from treatment, whether this is psychological or pharmacological.

The need for treatment is determined by the intensity and duration of symptoms, the degree of disability and its impact on everyday life, the presence of coexisting depressive symptoms, and other features such as a good response to, or poor tolerability of, previous treatment approaches. The choice of a particular treatment should be influenced by patient characteristics (e.g. co-morbid physical ill-health or treatment contraindications), by patient and doctor preferences, and by local availability of potential interventions.[1]

In general, the efficacy of psychological and pharmacological approaches is similar in the acute treatment of anxiety disorders, with best evidence for judicious prescription of selective serotonin reuptake inhibitors (SSRIs) or manualized cognitive behavioural therapy (CBT) delivered by trained and supervised staff. With some disorders, it is uncertain whether combining these approaches is associated with greater improvement than with either treatment given alone, and it is best to plan sequential steps in patient management.

Many patients worry about starting pharmacological treatment, fearing problems such as unwanted sedation or the potential risk of becoming dependent on prescribed medication. Conversely, others are reluctant to engage in a psychological treatment that can be limited in availability, time-consuming and costly. Regardless of treatment modality, patients should be advised that transient worsening of symptoms can occur, and

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