Identifying comorbid anxiety disorders as potential treatment targets may contribute to more positive outcomes for patients with schizophrenia. Details here.

The presence of anxiety disorders in persons with psychotic disorders is gaining increased attention. The evolution of the diagnostic criteria in the different editions of DSM has contributed to an increased awareness of these comorbidities. For instance, in DSM-III an anxiety diagnosis could be given only if anxiety was clearly “not due to” another Axis I disorder, while in DSM-III-R and DSM-IV, diagnosis was allowed if anxiety was “unrelated to” or “not better accounted for by” the main diagnosis, respectively. While such criteria allow a comorbid anxiety disorder diagnosis in persons with schizophrenia, overlaps between the symptoms of anxiety disorders and those of psychosis may complicate the application of these hierarchical rules.

While the diagnostic criteria have not changed significantly from DSM-IV to DSM-5, the latest revision of DSM provided an opportunity to discuss the potential benefits of a dimensional approach rather than a categorical approach to diagnosis. While the implementation of such a dimensional approach was judged premature given its potential impact on clinical practice, these discussions emphasized that patients can present with symptoms that cross the established diagnostic boundaries.

Using a meta-analysis, we identified high rates of anxiety disorders in patients with schizophrenia—38.3% of patients presented with at least one anxiety disorder. The mean prevalence for individual anxiety disorders ranged from 5.4% for agoraphobia to 14.9% for social anxiety disorder. Another striking finding from this meta-analysis was the puzzling variations in rates reported between studies. For instance, rates for obsessive-compulsive disorder (OCD) varied from 0.6% to 55%. While some partial explanations for these variations were uncovered, they remained largely unexplained. Nonetheless, the meta-analysis allowed us to highlight several factors that could contribute to increased detection of anxiety disorders in schizophrenia. For example, social anxiety disorder, OCD, and panic disorder were more often identified in outpatients than in inpatients. This finding suggests that these disorders are easier to assess and to distinguish from symptoms of psychosis once acute symptoms have abated.
Comorbid anxiety disorders were typically more prevalent in studies that assessed diagnoses with the Structured Clinical Interview for DSM (SCID) and those that supplemented the SCID with additional scales that targeted the anxiety symptoms. The latter method of assessment had a significant effect, particularly for social anxiety disorder, OCD, and PTSD.

In a recent study, we used a comprehensive semistructured interview that included all SCID-IV questions as well as the questions from the Liebowitz Social Anxiety Scale and from the Yale-Brown Obsessive Compulsive Scale to identify anxiety symptoms in outpatients with recent-onset psychosis (M. A. Roy, MD, MSc, et al, unpublished data, 2014). The study comprised 80 outpatients with recent onset of a schizophrenia spectrum disorder, 53% of whom also had a current anxiety disorder; the lifetime prevalence was 60%.

In 48% of patients, DSM-IV criteria for a social anxiety disorder were met; however, 41% of these patients had not spontaneously reported social anxiety symptoms when asked using the SCID gate questions about social anxiety (unpublished results). These cases were only detected when questions from the Liebowitz Social Anxiety Scale were added. This supports the idea that asking more specific questions can uncover some unsuspected anxiety symptoms. Anxiety comorbidity may be overlooked when basic clinical methods are used, but identification of anxiety symptoms and anxiety comorbidity may be facilitated by using targeted questions, such as those of anxiety scales, and may also be facilitated in stabilized patients.

It is increasingly recognized that positive outcome for patients with schizophrenia should not be limited to controlling the positive and negative symptoms of the disorder, but should aim to help patients achieve good functioning and quality of life. Identifying comorbid anxiety disorders as potential treatment targets may contribute to more positive outcomes. For instance, an increase in the rate of suicide attempts and poorer functioning have been reported for schizophrenia patients who present with comorbid anxiety disorders.²

CASE VIGNETTE

Christian is a 21-year-old who is seen a few months after experiencing a first psychotic break. He has responded well to monotherapy with 15 mg/d of olanzapine, but he is convinced that some of his thoughts have been put into his head by an unknown outside force. His psychiatrist asks him about the origins of this preoccupation. Christian describes a silly, repetitive sentence that kept popping into his mind—a sort of mantra—that happened before his psychotic break: he was aware that it originated with him and tried to resist it. During the psychotic episode, he developed a delusional belief about the origin of this mantra. On further questioning, he described signs of an undiagnosed Tourette disorder during his adolescence, a condition closely related to OCD. After an explanation that this repetitive thought could be an obsession, he agreed to citalopram supplementation, titrated to 30 mg/d. Shortly thereafter, the repetitive thought and its delusional explanation disappeared.

CASE VIGNETTE

Felix is an 18-year-old with psychotic symptoms that warranted a diagnosis of schizophrenia, because the symptoms persisted during an inpatient stay of several weeks despite recreational drug abstinence (verified with regular urine checks). Because of an insufficient response to 2 antipsychotics, clozapine was introduced. His symptoms and his functioning both improved. However, Felix asks for a dosage increase because his “crazy ideas are coming back.” He describes having homosexual urges whenever he meets one of his close friends and fears that his friend may become aware of these ideas. He is advised not to try to resist the thoughts; rather, he should accept that they are there. Eventually he agrees that if he does not appear worried, nobody will have
a clue about these thoughts. During the following 3 months, he reports some recurrences of the thoughts, but they rapidly vanish when he ignores them.

Conclusion
Given the limited empirical evidence from randomized trials, it is difficult to make strong recommendations about either pharmacological treatment or psychological treatment for comorbid anxiety disorders in patients with schizophrenia. However, given the impact of these comorbid conditions on health outcomes, addressing them can certainly be beneficial for patients. The accumulating evidence warrants an individualized approach—adding an SSRI or another drug while carefully monitoring the results. CBT also seems to provide interesting advantages to control anxiety symptoms, with strong evidence for social anxiety and emerging evidence for other disorders. Although there are basic guidelines for treatment strategies, taking into account the patient’s specific needs is fundamental in treating these comorbidities.

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