

# WORRY, ANXIETY AND TENSION — IMPORTANCE, IDENTIFICATION AND MANAGEMENT IN PRIMARY CARE

*Worry, anxiety and tension are emotions familiar to all of us in varying degrees and serve an adaptive function to the daily challenges of our environment. In extreme circumstances these emotions may serve as an essential survival mechanism.*



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Adaptive anxiety ensures that you safely navigate the road in your car every day and prepare adequately for examinations. Losing money, having a car accident or a fight with a loved one will normally result in worry as we try to understand and cope with the consequences and emotions that these events have caused. It is also normal for people to worry about predictable problems. Worry helps to develop strategies to avoid negative outcomes if the event cannot be avoided altogether, e.g. escalating household debt and expenses, concern about important relationships, and increased, and perhaps inappropriate, responsibility at work.

How then do we distinguish normal from unwanted worry? How do we know when we or our patients are 'worrying too much'? While there is no absolute answer, some general guidelines may help. Thinking about past events might be normal shortly after the event, but persisting worry about situations that cannot be changed may be maladaptive. Similarly, when worrying about expected problems or events, anticipating the outcome and planning ways to avoid bad outcomes is generally adaptive, but excessive attention to the challenge may also be maladaptive. For example, a patient who worries about a dark spot that occurs on his/her skin is wise to have a doctor examine it, as an adaptive thought leading to the adaptive response of consulting a doctor. However, to worry about it continually until the appointment would be non-productive, because the likelihood of cancer occurring is low. Finally, to worry about it after seeing a doctor and having been reassured that it is not cancer is even less adaptive. In general, worry is maladaptive if the things people worry about are not likely to happen.

The importance of identifying maladaptive worry and anxiety is that, if left unchecked, it may become chronic and precipitate symptoms of anxiety disorders that may be accompanied by significant and enduring impairment.

**Definitions**

**Worry:** A lasting preoccupation with past or future bad events — essentially cognitive.

**Tension:** Increased and unpleasant motor and psychological activity or a state of mental or emotional strain or suspense.

**Anxiety:** A diffuse sense of unpleasant and vague apprehension focusing on possible future sources of threat — often accompanied by autonomic symptoms and with an insidious course.

**Fear:** An alerting signal to an identifiable threat/danger.

Anxiety disorders are the most prevalent psychiatric disorders in primary care, accounting for 25% of all presenting problems.<sup>1</sup> Chronic anxiety confers a substantial burden on quality of life,<sup>1</sup> cost<sup>2</sup> and use of health care services.<sup>3</sup> Frequently, health care workers are frustrated by patients who repeatedly present with vague and unexplained symptoms and who fail to improve after numerous

attempts at symptomatic treatment. Identification of treatable anxiety symptoms in primary care is universally poor, which undoubtedly impacts on patient frustration. Knowing which factors have been identified as barriers to identification provides a basis from which to effect changes within one's clinical setting.

A general practitioner seeing an average of 40 patients a day will encounter 10 patients who will require specific intervention for anxiety and depressive disorders.

**BARRIERS TO IDENTIFICATION OF ANXIETY**

**For health care workers**

- Limited training and awareness of mental health problems
- Focus on disorders of a physical nature
- Limited knowledge of available treatments
- Fear of suggesting a diagnosis of mental illness to patients
- Belief that identified symptoms will simply resolve with time
- Misperceptions of mental illness.

**For patients**

- Presentation of physical (somatic) symptoms only
- Lack of awareness of emotional connection to physical symptoms
- Chronicity and consequent normalisation of symptoms
- Fear of stigmatisation or going 'mad'.

**In the consultation**

- Short duration of consultation
- Seldom see 'textbook presentation'
- Lack of empathic interview style
- Doctor leading interview — not listening to patient's view of illness.

To improve diagnosis, anxiety disorders should not be viewed as a diagnosis by exclusion, but should be seen as potentially causative of or at the very least contributory to presenting

symptoms. Empathic listening, asking questions pertaining to emotional well-being and critical appraisal of diagnoses when responses to initial treatment have failed, are some strategies that may increase recognition rates. Doctors and other health professionals should actively seek opportunities for continued education and training to improve their management of these disorders.

**IDENTIFYING ANXIETY**

Looking for anxiety disorders is particularly important in a number of high-risk groups in which symptoms are frequently overlooked. These include:

- Children and adolescents who present with changes in behaviour — truancy, enuresis, attachment difficulties, defiant behaviour, deteriorating school performance.
- Women in the post-partum period who present with problems of infant feeding/sleep/failure to thrive.
- Sufferers of chronic disease — tendency to focus on chronic illness only.
- Sufferers of chronic pain.
- The elderly — most notably those in elderly care facilities and the bereaved.

Fig. 1. depicts a flow chart for managing anxiety in primary care.

**ASSESSING ANXIETY**

Anxiety presents with a wide range of symptoms and, as most patients present with somatic complaints, the clinician must enquire specifically about anxiety and related symptoms. A number of non-threatening questions are listed below.

- Questions for initial assessment of anxiety
- Do you feel on edge or tense?
  - Do you find that you worry a lot?
  - Are you more irritable than usual?
  - Do you find it difficult to relax?
  - Do others say that you worry too much?

Questions should assess the range of symptoms (cognitive, psychological and physical) that are frequently seen in anxiety disorders:

**Somatic**

**Respiratory:** Tachypnoea (episodic), shortness of breath, choking

**Cardiovascular:** Tachycardia, palpitations, chest pain, blushing

**Neurological:** Headaches (throbbing), dizziness (lightheadedness), paraesthesias and numbness, insomnia

**Gastrointestinal:** Nausea and vomiting, dry mouth, diarrhoea, abdominal pain, weight loss

**Musculoskeletal:** Muscle pain, stiffness/tension, restlessness

**Cognitive**

Impaired attention and concentration (distractible)

'Patchy', inconsistent and variable memory impairment

**Psychological**

Excessive (irrational) attention to illness — defies reassurance

Irritability

Rapid thoughts — 'unable to switch off'

Depersonalisation/derealisation

**IF ANXIETY IS PRESENT — WHAT OF FURTHER ASSESSMENT?**

It is important to understand the focus of anxiety (situations) as well as the course and duration of symptoms. Compensatory and avoidant behaviours are frequently the cause of significant distress and impairment and should be enquired about. Anxiety disorders are currently classified on the basis of their primary focus of anxiety and include the following:

**Panic disorder.** This is characterised by panic attacks (sudden feelings of intense fear) that occur repeatedly and typically, although not invariably without warning. In addition, panic attacks are accompanied by a range of physical symptoms of anxiety. The resulting anticipation of future panic attacks and avoidance of situations that may provoke them and from which 'escape' may be difficult (agoraphobia), are the main causes of impairment.

**Generalised anxiety disorder.**

This is a syndrome of chronic (> 6 months), excessive uncontrollable

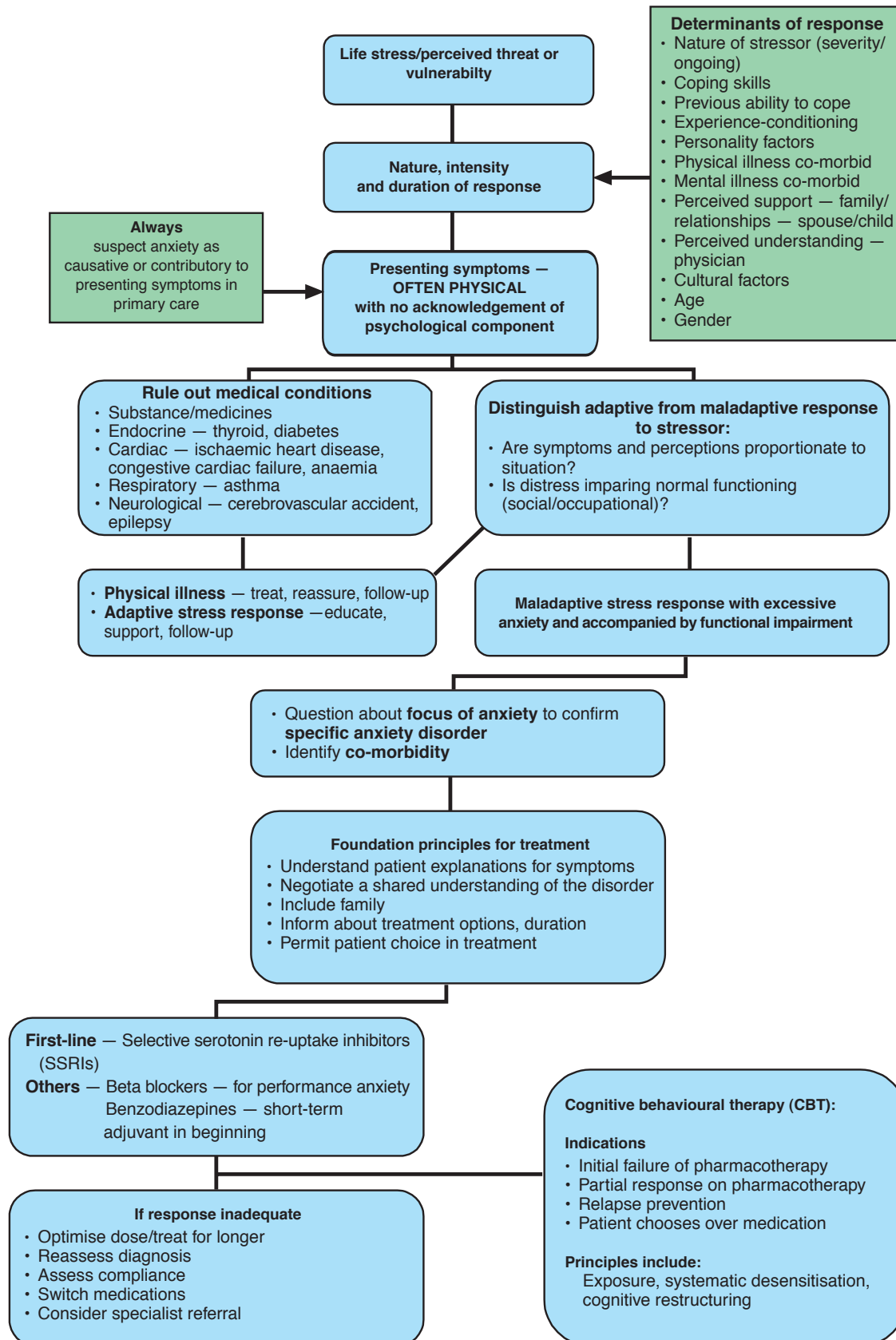


Fig. 1. Flow chart for managing anxiety in primary care.

worry about everyday situations in which the worst outcome is always anticipated. Physical symptoms of chronic anxiety and tension are always present.

**Social anxiety disorder.** This entails irrational and excessive fear of negative scrutiny and possible embarrassment when exposed to situations that involve social interaction or performance. Consequently either limited or more generalised exposure is avoided or endured with extreme discomfort.

**Post-traumatic stress disorder.** This is an abnormal response to severe trauma, characterised by distinct clusters of symptoms. These include re-experiencing of the event (flashbacks, dreams, or distress in response to reminders of the trauma); avoidance; numbing of responsiveness to the environment; and increased arousal (insomnia, irritability, heightened vigilance and being easily startled).

**Obsessive-compulsive disorder (OCD).** OCD is characterised by obsessions (unwanted, persistent, distressing thoughts) and compulsions (repetitive acts to relieve anxiety caused by obsessions). These are recognised as irrational and uncontrollable and may greatly impact on normal functioning.

**Specific phobia.** Extreme, disabling and irrational fear of something that poses little or no actual danger, with resultant avoidance that may impact on functioning.

### DIFFERENTIAL DIAGNOSIS OF ANXIETY

Numerous causes for anxiety exist. Careful history-taking should elicit background information on areas relevant to the current presentation and include:

- medical — current and past history
- psychiatric — including co-morbid conditions and family history
- substance use — prescribed, over-the-counter (OTC) and illicit drugs

- recent and past stressful life events. A problem-focused, comprehensive history will guide clinicians in their physical examination and provide the rationale for additional special investigations if required.

### WHEN DOES WORRY BECOME GENERALISED ANXIETY DISORDER (GAD)?

GAD is the anxiety disorder that most closely resembles adaptive or normal worry. In some primary care settings, it complicates up to half of all conditions diagnosed. It is generally poorly recognised, because symptoms of anxiety are frequently neglected in favour of the presenting medical condition. In GAD the focus of anxiety is typically around everyday events or situations, but the chronic (most days for 6 months or more), excessive and uncontrollable nature of this worry/anxiety are its hallmarks. GAD is frequently reported to have been present for up to 20 years when eventually diagnosed. It may have its onset in childhood and uncommonly begins after age 60. While the course is clearly chronic and seldom self-limiting, there may be considerable fluctuations in intensity of symptoms over time.

Uncertainty about the diagnosis, coupled with the substantial co-morbidity and lack of experience in treating GAD, pose challenges to diagnosis. In addition to a number of physical conditions mentioned below, from which it should be distinguished, some conditions have significant overlap with GAD and should be identified and managed in their own right:

- **Adaptive worry** involves everyday situations, but it is less pervasive and disabling.
- **Panic disorder.** Panic attacks frequently occur in GAD in the context of the situation about which the person is worrying, whereas in panic disorder attacks occur unexpectedly and are specifically anticipated, leading to avoidant behaviours.
- **Hypochondriasis.** While in GAD concerns about health may be the focus of worry and anxiety, in

hypochondriasis the hallmark is the preoccupation with the fear of developing or contracting a physical illness based upon the misinterpretation of real physical symptoms.

- **Depression.** In chronic, less severe depression (dysthymia) the distinction may be particularly difficult, with overlapping symptoms, an insidious onset and a fluctuating and chronic course being common to both. At times, this distinction may be inappropriate and justify a diagnosis of mixed anxiety-depression.
- **Substance-induced anxiety.** Self-medication with alcohol, benzodiazepines, caffeine and other OTC medications may precipitate a cycle of symptom relief and withdrawal which may prove difficult to distinguish from GAD.

While anxiety may present with physical symptoms, it is essential to remember that a number of important medical conditions may also present with anxiety or have a prominent anxiety component. Some of those more frequently encountered are listed below.

- **Cardiovascular:** Angina, supraventricular tachycardia, cardiac failure, anaemia
- **Pulmonary:** Asthma, hyperventilation, pulmonary embolism
- **Neurological:** Transient ischaemic events, epilepsy, migraine, Ménière's disease
- **Endocrine:** Hypoglycaemia, hyperthyroidism, Addison's disease, carcinoid syndrome, pheochromocytoma
- **Substances:** Amphetamines, cocaine, cannabis, nicotine, caffeine, theophylline
- **Substance withdrawal:** Alcohol, benzodiazepines, caffeine, opiates

### TREATING WORRY AND ANXIETY

Most worry- and anxiety-related conditions can and should be managed at a primary care level.

**Approach to reduce worry**

- **Worrying is a habit.** Explain this to patients. Habits are repeated involuntarily and developed through practice. This is important and has implications for management.
- **Managing worry involves developing new habits that counter the present habit of worry.** The more strategies used to counter worry, the more likely the 'new habit' will succeed.
- **What works for one person may not work for another.** Assessment of worry using some of the principles described above will help clinicians to identify which strategies might be most suited to individual patients.

**Methods for reducing anxiety**

- Count your worrying — increase awareness
- Postpone worries to a dedicated 'worry period'
- Attend immediately to environmental determinants of worry
- Use worry periods constructively for problem solving
- Utilise relaxation techniques (breathing, meditation, exercise)

**General treatment principles for anxiety disorders**

Assuming that a definitive diagnosis of an anxiety disorder has been made, the following principles will help in managing patients.

- Attempt to understand patients' explanations and models for their symptoms. This is crucial in a cross-cultural practice.
- Negotiate a shared model of understanding symptoms. This helps establish a foundation for understanding the condition and together defining the goals of treatment.
- Include family members, where appropriate, in the treatment plan as they may frequently and inadvertently support avoidant behaviours.
- Educate patients about available treatment options, duration of treatment and negative effects of treatment non-adherence.

Unequivocal evidence now supports the use of selective serotonin re-uptake inhibitors (SSRIs) as first-line treatments for a range of anxiety disorders. SSRIs should be initiated at standard doses and increased as indicated after 4 - 6 weeks. A small proportion of patients will not tolerate standard starting doses; they should have the dose lowered to accommodate side-effects. If side-effects are too bothersome, it may be necessary to seek an alternative agent. SSRIs offer an advantageous side-effect profile over the older agents and are also useful for common mood co-morbidities.

Benzodiazepines remain the most frequently prescribed anxiolytic agents. These have a role to play in initial treatment but have considerable disadvantages, including cognitive slowing/sedation and problems of dependence and withdrawal. Symptom relief is rapid, but may be short-lived as tolerance develops. Limited evidence suggests that longer-acting slow-release benzodiazepines may have a role in the primary management of panic disorder. In general, however, short-term use of benzodiazepines while initiating SSRIs may be helpful and should include a clear plan of taper and discontinuation once SSRI therapy is established.

Definitive evidence in support of cognitive behavioural psychotherapies (CBT) now exists for a range of anxiety problems (see more about CBT for anxious patients, p. 571). This can be costly if specialists are used. However, knowledge and basic training in the principles of CBT can be applied by most practitioners in most primary care settings. Basic principles include exposure to the source of anxiety, systematic (hierarchical) desensitisation and cognitive restructuring of irrational beliefs about the source of anxiety. To date there are very limited data to support the intuitively appealing combination of psychotherapy and pharmacotherapy. However, psycho-education and supportive therapy should be combined with pharmacotherapy to optimise effectiveness. Cognitive psychotherapy appears to have particular

benefits when it is focused on relapse prevention, which can have a major impact on the long-term outcome of anxiety disorders.

**When to refer to a specialist**

- Failure of first-line treatments
- High suicidal risk
- Complex co-morbidity
- Diagnostic uncertainty
- Substance abuse/dependence co-morbidity
- Patient failure to engage in primary care treatment options

References available on request.

**Further reading**

Stein DJ. *Clinical Manual of Anxiety Disorders*. Arlington, Va: American Psychiatric Publishing, 2004.  
 Stein DJ, Seedat S, Niehaus DJH, Pienaar W, Emsley RA. *Psychiatric Algorithms in Primary Care — Algorithms and Guidelines*. Cape Town: Mental Health Information Centre, 2003.

**IN A NUTSHELL**

Worry is abnormal if it is excessively distressing or persistent.

A total of 25% of primary care visits relate to anxiety and depression.

Enquiry about symptoms is central to more effective identification.

Populations with a higher risk for anxiety include children, women in the post-partum period, the chronically ill and the elderly.

Comprehensive evaluation and examination is essential for appropriate management.

SSRIs are recommended first-line treatments for anxiety disorders.

Benzodiazepines may be helpful for short-term relief of symptoms.

CBT may be particularly helpful for relapse prevention.

Referral to a specialist is necessary in cases of failure to respond to treatment and in those of complex co-morbidity.