

Anxiety in family practice

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Abstract

Anxiety disorders represent some of the most common mental disorders. The lifetime prevalence rates for the different disorders are between 1% and 13%. Most anxiety disorders have a chronic, waxing and waning course. The impairment patients suffer due to the anxiety disorders ranges from mild to incapacitating. It is important that general practitioners understand the diagnostic and treatment concepts of the anxiety disorders to ensure early diagnosis and intervention in order to prevent undue suffering and impairment.

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Introduction

According to the DSM-IV-TR (Diagnostic and Statistical Manual – 2000 version) anxiety is the apprehensive anticipation of a future danger or misfortune that is accompanied by a feeling of dysphoria or somatic symptoms of tension.¹ Anxiety is a normal phenomenon. When anxiety is accompanied by undue subjective distress or causes impairment of general functioning, a mental disorder may be present. This paper deals with anxiety disorders in adults.

Anxiety disorders represent some of the most common mental disorders. The lifetime prevalence rates for the different disorders are between 1% and 13%.¹ Most anxiety disorders have a chronic, waxing and waning course. The impairment patients suffer due to the anxiety disorders ranges from mild to incapacitating.¹ It is important that general practitioners understand the diagnostic and treatment concepts of the anxiety disorders to ensure early diagnosis and intervention in order to prevent undue suffering and impairment.

Understanding the diagnostic concepts as defined by the DSM-IV-TR or

ICD-10 (International Classification of Diseases – latest version) criteria may already be daunting, but to complicate matters further, anxiety disorders seldom present in isolation. Furthermore anxiety may be the presenting symptom of another psychiatric disorder or of a physical illness, for example, the presenting complaint of a patient with a major depressive disorder may be anxiety, and that of hypochondriasis may be worry. Hyperthyroidism may present with anxiety and so may caffeine intoxication.

Often there are comorbid disorders like other psychiatric disorders and physical illnesses.² This implies that a medical practitioner having detected an anxiety disorder should search for the presence of other psychiatric disorders and physical illnesses. The physical illnesses may be the cause of the anxiety or may be completely unrelated to it.

The anxiety disorders

The DSM-IV-TR differentiates between twelve anxiety disorders.¹ They are listed in Table 1. Although it is not an anxiety disorder, an *Adjustment Disorder With*

Anxiety has been included here for the purposes of discussion.

The DSM-IV-TR should be consulted for the exact criteria of the different disorders. Here the basic concept behind each of the disorders will be introduced. If one is familiar with the basic concept behind the disorder, one is more likely to suspect its presence and to check whether the criteria have been met.

The main feature of an *Anxiety Disorder Due to a General Medical Condition* is the presence of prominent symptoms of anxiety judged to be caused by the direct physiological effects of a medical condition. Chronic obstructive airways disease, for example, can cause anxiety that may manifest with panic attacks.

The main feature of a *Substance-Induced Anxiety Disorder* is the presence of prominent symptoms of anxiety judged to be caused by the direct physiological effects of a drug of abuse, a medication, or a toxin. Thyroxin, for example, can cause anxiety that may manifest with a generalised anxiety or panic attacks.

For the other anxiety disorders the main features hold true as long as one excludes medical conditions or substances, and sometimes another psychiatric disorder that may better explain the symptoms and signs.

A *Panic Disorder* is characterised by recurrent, unexpected panic attacks that trouble the patient in some way or lead to changes in behaviour. If agoraphobia occurs it is called *Panic Disorder With Agoraphobia*; if not, *Panic Disorder Without Agoraphobia*. Agoraphobia's main feature in a *Panic Disorder* context is a fear of experiencing panic attacks

Table 1: Anxiety disorders ¹

Anxiety Disorder Due to a General Medical Condition
Substance Induced Anxiety Disorder
Panic Disorder Without Agoraphobia
Panic Disorder With Agoraphobia
Agoraphobia Without History of Panic Disorder
Social Anxiety Disorder (Social Phobia)
Specific Phobia
Obsessive-Compulsive Disorder
Post traumatic Stress Disorder
Acute Stress Disorder
Generalised Anxiety Disorder
Anxiety Disorder Not Otherwise Specified

in situations where escape would be difficult or where leaving would be embarrassing or where help may not be available. Such situations are therefore avoided or distressfully endured.

Agoraphobia Without History of Panic Disorder does not comprise full-blown panic attacks; however, there are still panic-like symptoms present (palpitations, sweating, breathing distress, etc). The patient fears these panic-like symptoms in situations where escape would be difficult or where leaving would be embarrassing or where help usually may not be available. Patients usually avoid these situations or endure them with great distress. The main feature of **Social Anxiety Disorder (SAD)** is experiencing distressing anxiety in certain social or performance situations. Those situations are mostly avoided or endured with much distress.

Specific Phobia refers to distressing anxiety precipitated by specific objects or situations (other than agoraphobic or social situations). Those objects or situations are then avoided by patients or endured with much distress.

Obsessive-Compulsive Disorder (OCD) is characterised by the presence of obsessions and/or compulsions that are distressing, time-consuming or cause functional impairment.

Post-traumatic Stress Disorder (PTSD) is characterised by having experienced an extremely severe stressor, having experienced much distress while the stressor was present and then having recurrent, distressing re-experiences of that stressor. Such patients also have avoidance behaviour and a numbing of general responsiveness. They also suffer symptoms of increased arousal. **Acute Stress Disorder (ASD)** is much like PTSD, but a time criterion is included: symptoms must start within four weeks, last a minimum of two days and a maximum of four weeks.

The main features of **Generalised Anxiety Disorder (GAD)** are excessive anxiety and concern for at least six months accompanied by certain psychological and physical symptoms of autonomic arousal.

Anxiety Disorder Not Otherwise Specified designates distressing or dysfunctional anxiety that does not fit the description of a known DSM-IV-TR disorder.

Adjustment Disorder With Anxiety (ADWA) is a self-limiting disorder characterised by the presence of excessive anxiety that is distressing or that impairs func-

tioning. It develops following an identifiable stressor. It should not be better explained in terms of another psychiatric disorder.

Management

Further Investigations

Known medical illnesses, medication, toxins, and substances of abuse causing anxiety should be investigated as appropriate in each instance. Collateral information may help to clear up uncertainties. When a functional anxiety disorder is present one should still have a high index of suspicion for a medical illness as primary cause. Baseline laboratory studies such as thyroid functions, urea and electrolytes, basic full blood count and serum glucose are often indicated. Liver functions and pregnancy studies may be indicated in selected cases. Prominent cardiac symptoms may warrant an electrocardiogram or even blood test for heart enzymes. An electroencephalogram should be considered when prominent symptoms of depersonalisation, derealisation or changes in consciousness are present.

Psychoeducation

Psychoeducation is an important part of the management of any psychiatric disorder and anxiety disorders are no exception. In some cases psychoeducation may be all that is needed,³ for example, patients suffering from ADWA may be relieved to know the reason for their anxiety, and that it is a transient condition. Following adequate explanation and concrete guidance they may be able to carry on without the temporary use of anxiolytics. If a general practitioner is trained in problem solving techniques it may be usefully applied in such instances.

Sometimes people suffering from a chronic anxiety disorder find it difficult to distinguish between normal and abnormal anxiety. They misinterpret the unavoidable experiencing of normal anxiety as an exacerbation of their disorder. Careful explanation may allay their concerns.

Psychoeducation includes informing patients about the cause, course, treatment and prognosis of the disorder. Understanding the disorder better may help with compliance. Side-effects should be explained. It is especially important to explain that some patients' anxiety may worsen initially (on antidepressants) before it gets better. It is also important to explain the delayed onset

of action. Sometimes it may take as long as three months to experience the full benefit of a drug.

Education about medication and substances that cause or exacerbate anxiety disorders should be given. The intention would be to withdraw and stop them where possible.

Psychopharmacology

The anxiety disorders for which drug therapy has been established by placebo-controlled trials are listed in Table 2. They will be discussed first.

Table 2: Anxiety disorders for which drug therapy has been established

- Panic Disorder Without Agoraphobia
- Panic Disorder With Agoraphobia
- Social Anxiety Disorder (Social Phobia)
- Obsessive-Compulsive Disorder
- Post-traumatic Stress Disorder
- Generalised Anxiety Disorder

For all of the anxiety disorders in Table 2 the selective serotonin re-uptake inhibitors (SSRI's) like citalopram, escitalopram, fluoxetine, fluvoxamine, venlafaxine and paroxetine are efficacious.⁴ In addition, buspirone is a first-line drug of choice for GAD. The anxiety disorders need SSRI doses equivalent to and higher than those for Major Depressive Disorder. If a specific drug is effective, treatment should be continued for at least 6-12 months. However for many patients treatment will prove to be life-long since the incidence of relapses after stopping medication is high. Continued drug treatment significantly reduces the risk of relapse, but does not guarantee it.

Because it takes weeks for the SSRI's (and buspirone) to have an effect, it may be necessary to add a benzodiazepine initially when more rapid onset of action is required. The idea is to provide rapid relief with the intention of tapering the benzodiazepine later on. Examples are severe GAD that causes significant distress, that causes functional impairment, or that worsens a medical condition. In such cases oxazepam, lorazepam, and many other benzodiazepines would help. Similarly, for severe **Panic Disorder**, alprazolam and clonazepam are useful. The other benzodiazepines do not reliably prevent panic attacks. Rather than prescribing the benzodiazepines as needed, they should be prescribed in a way that prevents anxiety (for example once to thrice a day). This helps prevent

undue reliance on these drugs later on. Keep in mind and warn patients that using benzodiazepines involves a risk of addiction, drowsiness, slowed reaction time, reduced concentration and memory problems.

In the case of *Substance Induced Anxiety Disorder* or *Anxiety Disorder Due to a General Medical Condition* the ideal would be to stop the offending drug or substance and to treat the underlying medical condition. However, it may not always be possible. In that case the approach would be similar to the approach to the "functional" *Anxiety Disorder*.

Referral

Referral to a psychiatrist should be considered for all patients suffering from ASD, PTSD and OCD. These conditions are often difficult to treat. Patients suffering from an anxiety disorder due to a medical condition, or a substance induced anxiety disorder, should also be considered for referral to a psychiatrist. All cases that are complicated, atypical, or that do not respond adequately to treatment should be considered for referral to a psychiatrist.

Cognitive-behaviour therapy (CBT) should be considered for all patients who suffer from an anxiety disorder. Table 3 lists anxiety disorders where CBT has proved to be effective.⁵ For *Specific Phobia* and *Agoraphobia Without a History of Panic Disorder*, CBT is the only reliable treatment. Patients should be referred to psychiatrists and

Table 3: Anxiety disorders for which CBT has been established

- Panic Disorder Without Agoraphobia
- Panic Disorder With Agoraphobia
- Social Anxiety Disorder (Social Phobia)
- Obsessive-Compulsive Disorder
- Specific Phobia
- Agoraphobia Without History of Panic Disorder
- Acute Stress Disorder
- Post-traumatic Stress Disorder
- Generalised Anxiety Disorder

clinical psychologists who are adept at CBT. However, not all patients are in favour of CBT, therefore, referral should be discussed with them beforehand. To help patients with the management of stressful life conditions an appropriate referral to other members of the mental health team may be considered (psychiatrist, clinical psychologist, mental health occupational therapist or mental health social worker).

Follow-Up

Once a patient has been stabilised on drug therapy, CBT, or a combination of the two, the general practitioner may be in a good position to do the follow-up of the patient in a comprehensive primary health care setting. 🙋

See CPD Questionnaire, page 43

P This article has been peer reviewed

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Press Release



GlaxoSmithKline launches HIV/AIDS and Mental Health Newsletter.

It is well known that HIV/AIDS is the single largest contributor to South Africa's burden of disease. It is less well appreciated that neuropsychiatric disorders comprise the second largest component of our national burden of disease.¹

The National Research Foundation has provided funding for a Cross-University Brain-Behaviour Initiative (CUBBI). This is a research initiative that is focused on the psychobiology of vulnerability and resilience after psychological trauma, but also hopes to obtain additional funding to tackle other brain-behaviour areas that are key in the South African context, including HIV/AIDS and substance abuse.

GSK initiated this newsletter, in association with the CUBBI, as a service to the medical community. This highly informative newsletter will provide practitioners with a series of updates on HIV/AIDS and mental health, written by respected professionals in their individual fields of expertise.

Prof Dan Stein, Professor and Chair of the Department of Psychiatry, University of Cape Town and Director, MRC Unit on Anxiety and Stress Disorders, University of Stellenbosch, is appointed as editor.

The newsletter aims to raise awareness and highlight the role and gravity of

mental health in HIV/AIDS patients. The first issue will be available at the end of June 2007.

Parties interested in receiving or contributing to future issues of the newsletter are welcome to contact Madelein Steyl, CNS Brand Manager, GSK South Africa on Tel: +27 (0)11 745 6046 or e-mail: madelein.m.steyl@gsk.com.

Reference

1. Bradshaw D. (2003). Initial Burden of Disease Estimates for South Africa, 2000. Cape Town, MRC.