Recognising and Treating Anxiety Disorders

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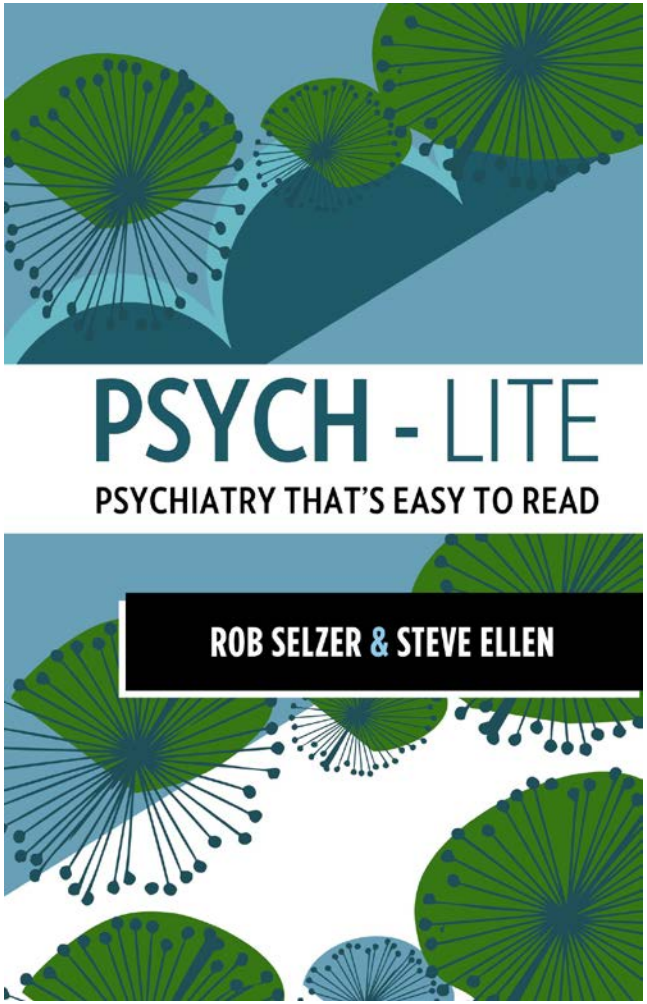
Competing Interests

- Absolutely none that I can think of!
  - No travel for at least 10 years
  - No industry sponsored studies
  - No industry sponsored speaking
  - No industry paid expert advice

However……..


PSYCH - LITE
PSYCHIATRY THAT'S EASY TO READ
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Outline

- Basics of anxiety
- Anxiety disorders
- Management principles
- Office based interventions
- Specialist psychological therapies
- Medications
- Clinical tips

1st - be in the right ballpark

- **The Diagnostic Hierarchy:**

Organic
↓
Psychotic
↓↓
Mood
↓↓↓
Anxiety
↓↓↓↓
Behaviour

Anxiety Vs Depression

- Lots of overlap in symptoms and causes
- Are they actually different?

Anxiety

- Everyone has experienced anxiety
- A little is a good thing, too much and the disadvantages outweigh the benefits
- At some point that anxiety can become so distressing and dysfunctional that people look for help
- Sometimes they choose doctors as the helpers

Anxiety

- Somatic, psychological and cognitive components
  - Fear of dying, fear of losing control
  - Physical symptoms in every system
- Agitation = Anxiety and motor restlessness

Classification

- Primary: anxiety for no apparent reason
- Secondary: Anxiety due to a medical condition, a medication (or drug), or another psychiatric disorder

Secondary - Medical

- Endocrine: hyperthyroidism, hypoglycaemia, phaeochromocytoma.
- Respiratory: hypoxia, asthma, chronic obstructive airways disease.
- Neurological: epilepsy, (especially temporal lobe epilepsy), cerebral trauma and neoplasms.
- Cardiovascular: arrhythmia, congestive cardiac failure, mitral valve prolapse.

Secondary - Drugs

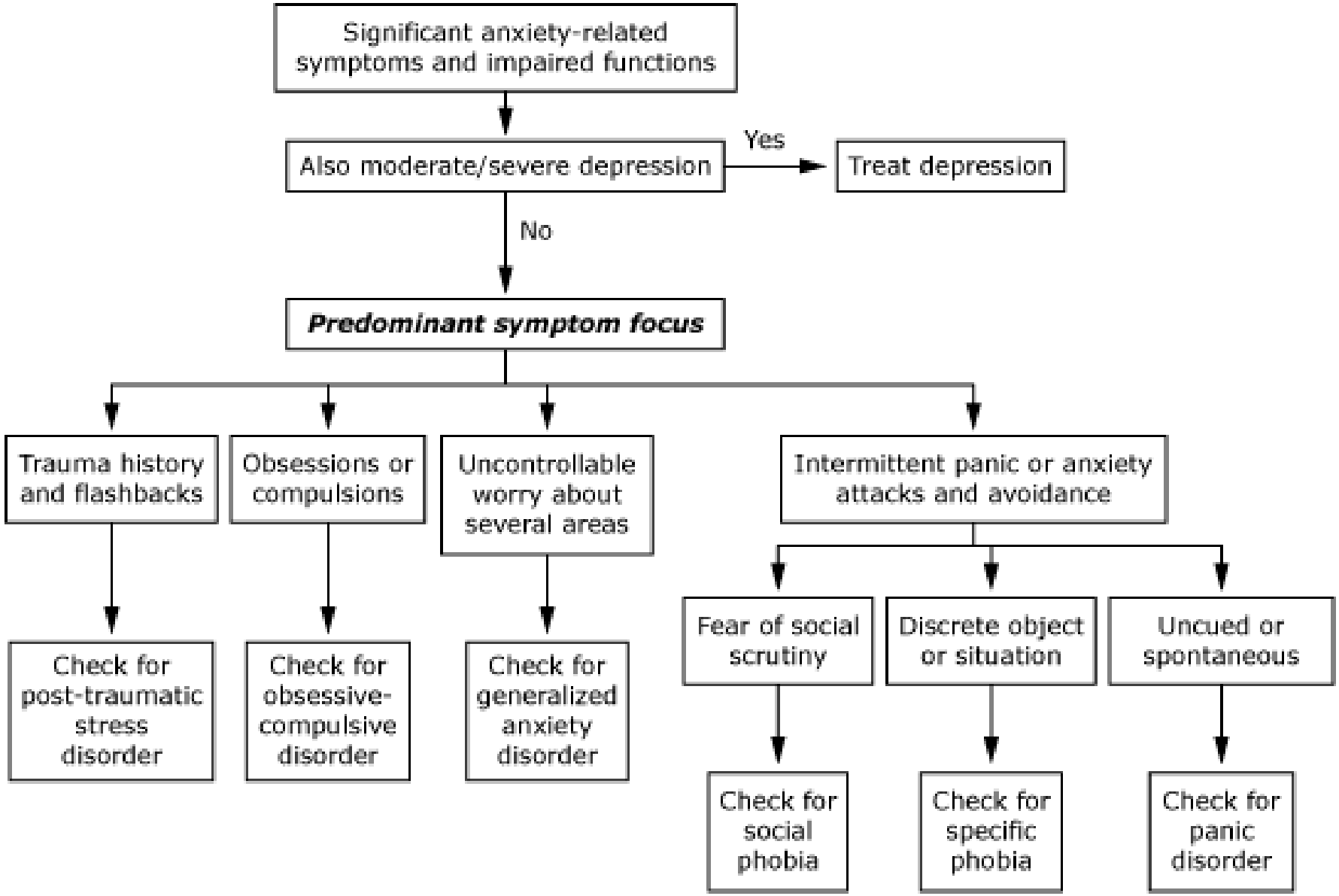
- Everyday drugs – caffeine, nicotine
- Medications e.g. captopril, antihistamines, interferon, baclofen, narcotics, theophylline, salbutamol.
- Illicit drugs: marijuana, amphetamines, ecstasy

Secondary - Psych Disorders

- Depression
- Schizophrenia
- Organic states (delirium, dementia)

Key Questions

- Is this normal anxiety?
  - Patient believes it is not
  - Reaches an agreed cut-off regarding symptom number and duration
  - Interferes with functioning
  - Doctor agrees!
- Is it primary or secondary



From: uptodateonline, Baldwin et al 2005.

Anxiety Disorders

- Panic Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Social Anxiety Disorder
- Specific Phobia’s
- Generalised Anxiety Disorder

Panic Disorder

- Features:
  - Recurrent unexpected panic attacks
  - Ongoing (1 month) concern about the attacks
  - usually with no precipitant
  - physical and cognitive symptoms
  - Duration - seconds to hours
  - anticipatory anxiety
  - with or without agoraphobia (fear of public places)
  - strong avoidance of precipitants

Panic Disorder

- Epidemiology
  - 3% prevalence
  - age of onset, lat teens - 40
  - M:F, 1:3

OCD

- Features
  - Obsessions; recurrent, persistent ideas, thoughts, impulses or images which are experienced as intrusive and senseless and cause anxiety.
    - for example, concern about contamination, doubt, orderliness.
  - Compulsions; repetitive actions which a person feels compelled to carry out even if recognised as senseless, in order to decrease the anxiety
    - for example, checking, washing, counting.
  - Obsessions & compulsions are common, especially in other psych disorders. As a primary anxiety disorder they occur alone, for at least and hour a day, and interfere with function

OCD

- Epidemiology
  - 2%, lifetime prevalence
  - onset, 15-25, M=F

PTSD

- Features
  - Anxiety symptoms following a traumatic event, initially described as a result of war, now shown to exist following any major trauma.
  - The trauma is said to be outside the range of usual human experience.
  - The event is re-experienced in dreams, recollections, flashbacks and if exposed to events that may have been associated.
  - Avoidance of distressing activities and thoughts.
  - Symptoms of increased arousal.
  - Often a delay prior to onset of symptoms.
  - Lasting > 1 month.
  - Frequently associated with substance abuse and depression.

PTSD

- Epidemiology
  - prevalence between 0.5% - 1.5% in community samples
  - After major trauma approx 5 – 10 % (also depression)
  - M<F
  - can occur any age, but most prevalent in young adults

Phobia's

- Specific Phobia's
  - a persistent and irrational fear to a specific trigger e.g. spider
  - Associated avoidance
  - Way more than just normal fear

- Social Anxiety Disorder
  - Persistent fear of social and performance situations
  - Unreasonable and excessive
  - Avoidance and anticipatory anxiety

Generalised Anxiety Disorder

- excessive anxiety and worry, occurring most days for more than six months. It essentially refers to excessive anxiety in a range of situations, that does not fit into any of the above more common syndromes.
- often feel overwhelmed and unable to cope with daily activities

GAD

- 3% (12 month prev. in Aust)
- Twice as high in 1˚ care populations
- BUT, comorbidity is the rule:
  - Depression 40%
  - Panic 20%
  - Social Phobia 25%

Management

- Challenges
- Barriers
- Office based options
- Specialist options

"It's your choice, medicate or meditate?"

Controversies

- When to treat?
- Normal Vs abnormal?
- Real medical problems or a drug company conspiracy fuelled by over-zealous health care workers?

Barriers to getting help

- Non-recognition – by patient and/or doctor
- Lack of “language” to describe symptoms
- Belief that it is not the domain of doctors
- Denial
- Fear
- Stigma
- Distrust of doctors
- Poor medical advice
- Failed first attempt at help seeking

Management

1. Assessment
2. Education & basic psychological first aid
3. Psychotherapy = CBT
4. Medications - anti-depressants or benzodiazepines

Assessment

- Exclude comorbidity
  - Especially depression
- Exclude “organic” causes of anxiety
- Exclude substance abuse
  - Includes caffeine

Lab tests

- Full blood
- Renal
- Thyroid
- ECG if any heart symptoms

Good Mental Health – Psychological First Aid

- Exercise
- Diet (including caffeine & alcohol reduction)
- Relaxation
- Relationships
- Stress management techniques (Problem solving techniques)
  - Many and varied
  - Avoid unnecessary stress
  - Alter the stressful situation
  - Accept things you can't change
  - Adapt to the stressor
  - Stress management plan

Self Help

- Lots of online resources
  - BeyondBlue – www.beyondblue.org.au
  - Panic anxiety disorders association (PADA)
- Books: Issac Marks – Living with fear

  Andrew Page – Don’t Panic

Relaxation Techniques

- Hundreds, take your pick!
  - Slow breathing
  - Progressive Muscle Relaxation
  - Hypnosis
- Preparation & consent

Slow Breathing

- The modern equivalent of breathing into a paper bag
- Anxiety and hyperventilation feed into each other
- Slow breathing does two things:
  - Distracts the patient
  - Corrects the hyperventilation

Slow Breathing

Using the second hand on a watch or clock

- Hold your breath for 6 seconds
- Breath in and out on a six second cycle, saying the word “relax” as you breath out
- After one minute, hold your breath again, then continue to breath on a 6 second cycle
- Repeat until anxiety has diminished

Progressive Muscle Relaxation

- Anything from 5 to 20 minutes
- Easy to do and easy to follow, but clinician needs to guide it constantly, so time consuming. Good if someone else can do it.
- Lots of different scripts
- Hold each tensing for 10 seconds

Hypnosis

- Nothing magic, strange or weird!
- A deeper form of relaxation
- Perhaps with elements of suggestibility & receptivity to suggestion
- In psych terms it’s a dissociative state
- It can occur naturally
- Its not the same as sleep, not an anaesthetic, and you don’t pass out!

Common Uses

- Relaxation
- Anxiety control
- Labour and childbirth
- Performance anxiety
- Phobia’s
- Chronic Pain disorders
- Habit modification (e.g. nail biting, overeating, smoking)
- Forensic uses (memory retrieval)
- Dental anaesthesia
- Minor surgery
- Trauma counselling
- Sleep disorders
- Attitude change
- Memory training

Phases of Hypnosis

1. Preparation - sit or lie comfortably
2. Induction - takes subject from the normal state of awareness to a state of relaxation
3. Deepening - takes subject from the relaxed state to the ‘hypnotised’ state where conscious thinking is minimized
4. Purpose - achieve goal
5. Awakening - reverse the state

Dangers

- Inadequate awakening
- Abreaction
  (reliving intense emotions)
- False memories

- Training!

"Here's a nice cuppa, Dear. You just put your feet up and take it easy."

Structured Problem Solving

1. Identify a problem
2. List all possible solutions
3. Assess each possible solution
4. Choose the “best” or most practical
5. Plan out to carry it out (step wise)
6. Review progress

Graded Exposure

- For fearful situations
- Identify a goal
- Break it down
- Progressively master each step
- Confront fears regularly and frequently
- Emphasize habituation to anxiety in each situation

Tips

- Beware initial frustration
- Keep the patient in control
- Can only be done with regular appointments
- Keep it simple
- Try to avoid too much pseudoscience

Specialist Psychological Therapy

- Cognitive Behaviour Therapy
  - First line
  - In office or via referral (many courses)
  - Mostly accessed via psychologists
  - Education, relaxation, behavioural and cognitive aspects

Treatment - Medications

- Anti-depressants
  - Best medication choice
  - Easy to prescribe, less addiction
- Benzodiazepines
  - Are effective, but doctors tend to avoid because of fears of abuse, but abuse is rare if no past history of drug or alcohol abuse
- Major Tranquilisers
  - Gaining popularity
  - Major side effect issues
  - Proceed with caution and thorough patient consent

Anti-depressants

- Efficacy similar for all
- Some more sedating e.g. mirtazepine and fluvoxamine
- Usually require higher doses for anxiety disorders
- Sometimes get worse anxiety on commencement so SHORT TERM benzodiazepines might be needed
- Will address the core anxiety symptoms, but the behavioural changes still often require psychological input, and so medications should be considered an adjunct to psychological help
- Relapse rates higher than psychological therapies

Benzodiazepines

- Risks – addiction, sedation (driving, work safety etc)
- Caution – if any history of alcohol abuse, or previous drug abuse
- Many problems – tolerance, withdrawal, abuse
- Band aid?
- However
  - Rapid and effective
  - Some people use them successfully for years without problems
  - Thorough patient selection seems to be the key
- To be safe, reserve use for patients who are taking other, definitive (non ‘band aid’) approaches to their anxiety disorder

Major Tranquilisers

- Gaining popularity e.g. quetiapine in GAD
- Effective, especially in low dose for severe anxiety
- Major side effect issues
  - Metabolic syndromes
  - Extra pyramidal side effects
  - Tardive dyskinesia???
- Jury is out in my opinion, therefore absolute last choice where all else has failed!

Treatment - Alternative

- There are multiple herbal remedies, including Kava and Valerian
- It is worth checking if patients are on these, as drug interactions are possible

When to refer

- Usually lead by patient choice
- Earlier if comorbid depression or substance problems
- Tips for referring
  - Patient initiated
  - Knock on a few doors
  - If at first you don’t succeed, try again
  - Psychiatrist or psychologist?

Clinical Issues

- Role of reassurance
  - Don’t tell lies
  - Simple positive statements
    - Politician responses - give the message you want
    - Your voice is as important as the message
      - Slow, soft, calm, deep.
- Management of anxiety requires commitment: time, plan (like asthma management plan), expect set backs, be realistic regarding time (3 to 12 months depending on severity)
- Patient must be motivated and be their own case manager!

Conclusions

- Diagnose the specific syndrome
- Search for co morbidity
- Exclude medical causes
- Develop a comprehensive management plan
- Always address basic psychological first aid
- Encourage psychological therapies as first line
- If medications must be used, favour anti-depressants
- Be patient – a long term approach is needed