

## UNIT NO. 5

# ANXIETY DISORDERS: AN APPROACH WITH FOCUS ON PANIC DISORDER AND GENERALISED ANXIETY DISORDER

Dr Nelson Lee

**ABSTRACT**

**Fear and anxiety are normal emotions felt when exposed to stressful situations. Anxiety disorders happen when the level of anxiety felt is out of proportion to the perceived threat and more importantly affects the person's ability to function. An approach to how to deal with anxiety disorders is presented. Special focus would be directed towards Generalized Anxiety disorder and also Panic Disorder as this are the two most common anxiety disorders encountered in Family Practice. Practical ways to deal with these disorders are discussed in the paper.**

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**INTRODUCTION**

Fear and "Anxiety" are common emotions that we have all felt at some point of our lives. It can be described as a tense emotional state associated with a feeling of impending danger, often accompanied by somatic symptoms. It has also been used to describe the mental and physical response to a feared situation. This would take the form of the flight or fight wired in us which was critical to survival of the species. However, anxiety symptoms can also get out of hand, impairing one's usual functioning and leading to the development of an Anxiety Disorders.

Anxiety often involves both a physical and mental response, manifesting as physical and psychological symptoms. The former includes palpitations, sweating, headaches, muscle tension, dry mouth and other somatic complaints; while the latter involves sleep disturbances, concentration problems, increased tiredness, irritability, etc. The somatic complaints are perhaps what the patient would commonly present with and only by being mindful of the possibility of an anxiety disorder can it be correctly detected and managed.

**WHAT ARE THE SYMPTOMS OF ANXIETY?**

Anxiety can manifest as physical symptoms including:

- Bowel disturbance
- Tremor
- Indigestion
- Dizziness

- Chest discomfort
- Headache
- Difficulty inhaling
- Muscle ache
- Palpitations

It can also manifest as Psychological symptoms including:

- Irritability
- Poor concentration and memory
- Restlessness
- Worrying thoughts
- Sexual Dysfunction
- Insomnia / Nightmares

With the myriad of possibilities, it may seem daunting to identify. However, the family practitioner is in a privileged position of being able to see the same patient over a course of time. Take note of the symptoms that the patient presents with; consider anxiety when there is a constellation of different somatic symptoms which do not add up to a classic physical disorder. Probe then into psychological symptoms of irritability, worrying thoughts, etc and the diagnosis may then be easily clinched.

**WHEN IS ANXIETY ABNORMAL?**

When faced with a patient with symptoms of anxiety, how then do we differentiate normal anxiety from an anxiety disorder? A few simple questions should go through your mind, and this is something that is that can be done even in a busy outpatient clinic setting:

- 1) Is what my patient experiencing Pathological?
- 2) What is the Pattern of the symptoms described?
- 3) What are the present stressors and Problems faced?
- 4) Is a Psychiatric referral necessary?

***1. Is what my patient experiencing pathological?***

This question serves to differentiate normal anxiety from that of an anxiety disorder. As a general rule, anxiety becomes pathological when:

- it is greatly disproportionate to the risks and severity of the danger/stressor faced
- it continues even when the danger/stressor is no longer present
- it interferes with social, vocational or physical aspects of daily life
- it leads to avoidance of certain situations

It would also be useful to exclude other conditions, both medical and psychiatric, which have associated anxiety symptoms. Examples of this would include hyperthyroidism, hypoglycemia, vestibular dysfunction, migraine, neoplasm or temporal lobe epilepsy

## ***2. What is the pattern of the symptoms described?***

The pattern of symptoms often gives us a clue as to what kind of anxiety disorder we are dealing with. My focus would be on helping you recognize generalized anxiety disorder as well as panic disorder which commonly occur in the GP setting.

### **a. Generalized Anxiety Disorder (GAD)**

GAD is characterized by excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance). It has also been called a “free floating” anxiety. The person often finds it difficult to control the worry.

Somatic and psychological symptoms are quite common and the worries are accompanied by at least 3 other symptoms of insomnia, muscle tension, easy fatigability, irritability, concentration difficulties or restlessness lasting longer than 6 months.

Combined this would give a diagnosis of GAD (DSM-IV). Patients with GAD may also experience varied physical symptoms from over-stimulation of the autonomic nervous system, e.g. headaches, dizziness, heart palpitations and shortness of breath.

### **b. Panic Disorder**

Patients with panic disorder can occur with or without agoraphobia. Panic attacks are discrete episodes of severe anxiety characterized by a discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias (numbness or tingling sensations)
- Chills or hot flashes

Panic disorder happens when there are recurrent episodes of panic attacks which are often unpredictable. This leads to anticipatory anxiety of future attacks and also avoidance phenomenon. Agoraphobia is often the end result of the avoidance phenomenon. It can be defined as the fear of experiencing a difficult or embarrassing situation from which the sufferer cannot escape. Patients with agoraphobia often avoid places where they fear escape is difficult or find it hard to travel alone unaccompanied.

## ***3. What are the present stressors and problems?***

The question that comes to mind when dealing with an anxiety or for that matter any psychiatric disorder, should be “why now?” Patients usually present to us when their stressors go beyond their normal ability to cope. When this happens we need to understand what has changed in the person’s environment that has caused the de-compensation. This is important as it gives the key learning how best to manage the condition. While it is important to make the correct diagnosis such that we are able to prescribe the correct medical treatment, finding out the present stressors allow us to help the patient holistically and provide resources for the patient to help deal with the underlying issues.

## ***4. What can I do practically?***

Formal psychotherapy employing the principals Cognitive-Behavioural Therapy (CBT) have been developed and found to be effective for the various anxiety disorders. In the busy family practice setting however, it may prove challenging to do so because of time constraints. Psychological treatment for an anxious patient may however be in the form of simple interventions that can be employed easily even in a busy setting.

### **a. Therapeutic alliance**

First and foremost, the establishment of a therapeutic relationship is key. This sets the foundation for all subsequent interventions. Family practitioners by nature of the work they do often have already honed this skill, as they often have a short contact time to establish this. This is even more important for a patient with a psychiatric condition as it has been found that for many psychological interventions employed, one of the key components that predict how well a patient response, is the therapeutic alliance with the treating doctor.

### **b. Education**

For a patient suffering from an anxiety disorder, an understanding of the underlying disorder can by itself be therapeutic. Much can be achieved by just helping patients understand their symptoms of anxiety. Panic disorders are a good example where psycho-education about the illness can be very useful. For example, in panic disorder, patients commonly think that their symptoms actually herald a heart attack. By being educated about the symptoms of a panic

attack and discounting the possibility of an actual myocardial infarct during an episode, the patient be less fearful when an attack is imminent, thus less likely to trigger the crescendo of anxiety symptoms.

#### c. Teaching relaxation skills

The techniques covered in my section on insomnia would also be useful for the anxious patient. Please refer to that section on this topic.

#### d. Pharmacological management

The mainstay of biological treatment for anxiety would be the antidepressants. Anti-depressants are effective in both anxiety disorders as well as in depression. In terms of efficacy, all the various anti-depressants are actually equal or close to equal at about 60-70%. They vary more in terms of their side-effect profiles. All anti-depressants also take on the average 2-4 weeks to take effect and this should be explained to the patient at the onset. The short term side effects usually also subside after this time, so it may be helpful to tell the patient about these so they know what to expect. It may not be necessary to explain every single side effect but the more commonly experienced ones should be dealt with so that the patient is able to anticipate these should they arise.

### **ADVANTAGES OF ANTIDEPRESSANTS**

- Minimal addictive potential
- No tolerance effects
- Anti-anxiety effects even in absence of depression
- Minimal withdrawal symptoms

#### *Classes*

##### Selective serotonin reuptake inhibitors (SSRIs)

Selective serotonin reuptake inhibitors (SSRIs) are a family of antidepressants considered to be the current standard of drug treatment. SSRIs are said to work by preventing the reuptake of serotonin (5HT) by the presynaptic nerve, thus maintaining higher levels of 5-HT in the synapse.

##### Serotonin-norepinephrine reuptake inhibitors (SNRIs)

Serotonin-norepinephrine reuptake inhibitors (SNRIs) such as venlafaxine (Effexor) and duloxetine (Cymbalta) are a newer form of antidepressant that works on both norepinephrine and 5-HT.

##### Noradrenergic and specific serotonergic antidepressants (NASSAs)

Noradrenergic and specific serotonergic antidepressants (NASSAs) form a newer class of antidepressants which purportedly work to increase norepinephrine (noradrenaline)

and serotonin neurotransmission by blocking presynaptic alpha-2 adrenergic receptors while at the same time minimizing serotonin related side-effects by blocking certain serotonin receptors. The only example of this class in clinical use is mirtazapine (Remeron).

##### Norepinephrine-dopamine reuptake inhibitors

Norepinephrine-dopamine reuptake inhibitors such as bupropion (Wellbutrin, Zyban) inhibit the neuronal reuptake of dopamine and norepinephrine (noradrenaline)

##### Tricyclic antidepressants (TCAs)

Tricyclic antidepressants are the oldest and include such medications as amitriptyline and dothiepin. Tricyclics block the reuptake of certain neurotransmitters such as norepinephrine (noradrenaline) and serotonin.

I will focus mainly on the SSRI's as they are the most commonly used as well as the tricyclic antidepressants as they have been around the longest still commonly used. I will also mention certain useful facts about the drugs in the other classes.

##### Selective Serotonin re-uptake inhibitors (SSRI)

Selective Serotonin Reuptake Inhibitors (SSRI) as a group has come a long way since the advent of Fluoxetine. They are usually safe in overdose and have generally tolerable side effects which explain their growing popularity. Fluoxetine has gone generic, and would be the cheapest SSRI to start. It however can be agitating in the first few weeks and may also cause insomnia in some patients; hence it is usually prescribed as a morning dose. Other common side effects include headaches, gastro-intestinal side effects as well as possibly sexual dysfunction. Doses for anxiety can be given as high as 60 mg a day. It would be prudent to prescribe some benzodiazepines in the first 2-4 weeks while waiting for its effect to kick in, especially if anxiety features or insomnia is prominent in the patient. Other drugs in this class include Sertraline (Zoloft 50-200 mg/d), Escitalopram (Lexapro 10-20 mg/d), Fluvoxamine (Faverin 50-300 mg/d) and Paroxetine (Seroxat 20-60 mg/d). Most of these can be given as a single night dose or in divided doses.

**Table 1. Antidepressants for Treatment of Anxiety**

Generic name	Trade name(s)	Starting dose (mg/day)	Dose (mg/day)
<b>Fluoxetine</b>	Prozac, Magrilan	10-20	20-60
<b>Fluvoxamine</b>	Faverin, Luvox	25-50	50-300
<b>Escitalopram</b>	Lexapro	5-10	10-20
<b>Sertraline</b>	Zoloft	25-50	50-200
<b>Paroxetine</b>	Seroxat, Paxil	12.5-25	25-75

Tricyclic antidepressants

The tricyclic antidepressants have been around the longest and are generally the cheapest. Examples would include Amitriptyline and Dothiepin. They would be a good choice if cost were a big issue. However, they also tend to have the most side effects. Sedation is present, but this may be useful in patients where insomnia is prominent. What are often challenging in our local population are the anti-cholinergic side effects, as well as the postural hypotension from alpha receptor blockade. This often limits the efficacy of this class of drugs as the dry mouth and constipation often limit the use to lower doses. Generally these drugs have to be at least 25-50 mg have any clinical efficacy. Use of tricyclics in patients who are suicidal should also be used with caution because of they are potentially life threatening in an overdose from its cardiac effects.

Benzodiazepines

Benzodiazepines are useful in quick reduction of symptoms of anxiety. However it should be remembered that they do not treat the underlying condition but merely provide symptomatic relief. They may be given in the first 2-4 weeks when initiating treatment and should not be used as monotherapy for the treatment of Panic Disorder and GAD. They should also be given at the lowest possible dose and gradually tapered off. The patient should also be advised from the onset that this is not the definitive treatment for the condition and are meant to provide symptom relief while waiting for the anti-depressant to work. Caution should also be taken when prescribing this class of drugs to patients who are already known to or suspected of dependence to other substances.

**RESPONSE, REMISSION AND DURATION OF TREATMENT**

Patients should also be given an adequate course of treatment. Once the symptoms are in remission, it is generally recommended that the patient be kept on treatment for another 6 months to a year for the first episode. Remember that the dose that gets them well is also the dose that keeps them well and drug doses should not be tapered till the end of the treatment period. Patients with a second episode should be treated for a year to two, and patients with more recurrent episodes or very severe episodes of anxiety especially if co-morbid with depression should be put on long-term treatment.

**WHEN SHOULD I REFER TO A PSYCHIATRIST?**

Generally, most patients with anxiety disorders such as GAD and panic disorder can be managed in a general practice setting. Referral is only necessary if symptoms fail to improve with initial treatment and follow-up. For panic disorders, many improve with medications, but some will benefit from cognitive-behavioural therapy (CBT) to deal better with their symptoms. Patients with psychotic symptoms and those with significant suicide risk should definitely be reviewed by a specialist.

**LEARNING POINTS**

- **Anxiety disorders are common.**
- **Most can be treated in the GP setting.**
- **A combined approach of psycho-education, relaxation training and medications give the best results.**
- **Anti-depressants are the mainstay of pharmacological treatment.**
- **Benzodiazepines when employed should be used at the lowest shortest possible dose for the shortest possible time.**
- **Know when to refer to a psychiatrist.**