Everyday Practice

Anxiety disorders

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INTRODUCTION

Patients with anxiety disorders are commonly seen in general practice. They usually present with physical symptoms and have associated physical and psychiatric problems. General practitioners are strategically placed to timely recognize and intervene and thereby reduce subjective distress and dysfunction of the sufferers and the disease burden of anxiety disorders.

In the present post-Covid scenario there seems to be a marked rise in the occurrence of anxiety and depression in primary care settings. A global increase of 13.8% to 25.6% in the prevalence of anxiety disorders has been reported in the *Lancet*.[1] A similar 25% increase has been reported by WHO.[2] The range of increase (23.7% to 35%) reported from India also seems to fall in line with the global concerns.[3–6]

Anxiety disorders broadly comprise three types such as generalized anxiety disorder (GAD), panic disorder and social anxiety disorder. We discuss the management of GAD and panic disorder because patients with these two conditions commonly present to general practitioners. We emphasize effective screening, careful assessment to rule out associated major depression and risk of self-harm and advise practitioners to use medications judiciously. We advocate the use of simple non-pharmacological strategies to control anxiety and promote general health to prevent anxiety disorders. We finally suggest when to refer patients for specialist psychiatric care. Role of genetics, early life trauma, temperament and stressful life circumstances as aetiological factors of anxiety disorders are kept out of the scope of this article.

ASSESSMENT OF GAD

It is one of the common psychiatric disorders with a prevalence of 3%–8% in the general population. It accounts for nearly 10%–15% patients in general medical practice either alone or with co-existing medical illnesses.[7,8] It is characterized by excessive and persistent worry which is non-specific or generalized and may concern one's health, work or one's family members. The worry is associated with physiological arousal symptoms such as restlessness, trembling, sweating, palpitations or giddiness present throughout the day. The anxiety must be hard to control, affect one's daily functioning and last for at least one month. Clinically, the persons may present with restlessness or feeling keyed up or on edge, difficulty in concentrating, mind going blank, irritability, getting easily fatigued, difficulty falling or staying asleep, light headedness, palpitations, muscle tension, sweating, epigastric discomfort along with apprehensions, worries or fear of something bad may happen to oneself or one's relatives.[9,10]

The following questions are useful to screen and elicit the symptoms of GAD.

- How do you feel in times of stress?
- How good are you in controlling worry?
- How often do you feel worried and tense?
- Do you often experience palpitations and pounding of heart?
- Do you often experience shortness of breath and sweating?
- Do you often feel restless and unable to concentrate on a task?
- Do you get startled easily by any sudden or loud noise?

However, GAD 7[11] is a self-administered screening tool, easy to use in clinical practice and is freely available online.

GAD and comorbid psychiatric disorders. Persistent non-specific worry is an important clinical feature that aids in the diagnosis of GAD. It differs from normal day-to-day worries in that it is hard to control and severe enough to cause distress and impact functioning of the individual. The course of symptoms is often chronic and disabling with frequent episodes of exacerbation of symptoms. It is usually comorbid with other anxiety and mood disorders. Depression is seen in nearly two-thirds of patients with GAD followed by phobic disorders (21%–59%), panic disorder (3%–27%) and substance use disorders particularly harmful alcohol use (2%–4%).[7,8,12,13]

Differentiation from other disorders

Depression. Some of the symptoms of GAD and depression such as restlessness, sleep disturbances, difficulties in concentration do overlap and may be mistaken as prodrome of depression. Loss of interest, hopelessness and depressed mood are more characteristic of depression as against hyper-arousal and vigilance seen in GAD.

Screening questions for depression

- Do you feel low and sad most of the time these days?
- Do you experience lack of initiative in performing most of the important tasks/responsibilities at hand?
- Do you feel frustrated, irritable and agitated most of the days?
- Do you experience lack of interest and enjoyment in day-to-day activities including the ones you used to particularly enjoy earlier?
- Do you experience lack of energy and tend to get tired easily these days?
- Do you often find yourself brooding, complaining and feeling guilty about certain life situations these days?

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- Do you experience difficulty initiating or maintaining your sleep at night?
- Do you find yourself feeling 'helpless' and see no hope for the future?

Alternatively, the Patient Health Questionnaire-9 (PHQ-9) is recommended for screening depression in clinical practice.[14]

Panic disorder. Sudden unexpected panic attacks along with fear of implications of the attack and anxiety about another attack is the main feature of panic disorder. It has acute onset with worries often centred on anticipation of another panic attack, focus on cardiorespiratory distress while the worry and anxiety in GAD is generalized with insidious onset.

Substance use disorder. Anxiety disorders including GAD are common in patients with harmful use of alcohol and benzodiazepines as well as harmful use of stimulants, cocaine and caffeine. Anxiety symptoms induced by alcohol or substance use are limited to 2-to-4 week period of withdrawal from the substance while GAD manifests and continues independent of any substance use.

Suicide risk and GAD

The overall risk of suicide attempts is reported to be 17%–20% higher in patients with anxiety disorders including GAD especially when associated with depression.[15] Suicidality can be screened and assessed in primary care itself and has been reported to be necessary and useful.[16]

Screening questions to assess suicide risk in primary care are:[16]

- Have you ever felt that your life was not worth living?
- Have you wished you were dead?
- Have you ever thought of taking your own life?
- Have you anytime seriously considered taking your life?
- Have you ever attempted to take your life?
- Has any of your family/friend attempted to harm themselves/ died by suicide?

GAD in old age

The prevalence in elderly is reported to be about 4% in the community.[17] It is often masked by associated physical symptoms or discomfort due to primary medical conditions. This often makes a separate diagnosis of GAD difficult. Insomnia or difficulty to initiate and maintain sleep is the commonest symptom reported in this population requiring anxiolytics at night. Insomnia accompanied with anxiety, worries, difficulty to stay alone, frequent indigestion, agitation or restlessness may point to the possibility of an underlying anxiety disorder.

GAD and medical comorbid conditions

Many general medical conditions may mimic or present with prominent anxiety symptoms; the commonest being thyroid disorders and metabolic disorders[7] making it necessary to screen for these conditions whenever suspected in persons presenting with anxiety symptoms. Certain medications are also known to be associated with anxiety symptoms (Table I).

TABLE I. General medical conditions presenting with anxiety symptoms

Endocrine disorders: Hyper- or hypothyroidism, phaeochromocytoma, hypoglycaemia, hyperadrenocorticism
Cardiovascular: Congestive heart failure, angina, myocardial infarction, pulmonary embolism, arrhythmia
Respiratory: Chronic obstructive pulmonary disease, hyperventilation
Metabolic disorders: Vitamin B_{12} deficiency, porphyria
Neurological: Neoplasm, vestibular dysfunction, complex partial seizures
Drugs: Prescription medicines such as hormonal supplements, antihypertensives, antiarrhythmics, bronchodilators, anticholinergics, anticonvulsants

ASSESSMENT OF PANIC DISORDER

Panic disorder draws its name from a Greek god called Pan who was known for suddenly frightening animals and humans 'out of the blue'. The spontaneous 'out of the blue' character of panic attacks is the principal identifying characteristic of panic disorder and central to its recognition and diagnosis.[18] Life-time prevalence of panic disorder is 15%–40%.[18,19]

Panic attacks are periods of intense anxiety, fear or discomfort that develop suddenly and reach a peak intensity in 10–15 minutes. It may last for several minutes to hours at times. The symptoms include palpitation, pounding heart, sweating, trembling, shortness of breath or suffocation, choking sensation, chest pain or discomfort, nausea, paraesthesia, feeling of light headedness, dizziness, fear of losing control and fear of dying. The presentation is more physical leading to frequent presentation in medical or emergency settings. The frequency and intensity of attacks may vary.[9,10,18]

Panic attacks can be extremely frightening for the patient often leading to fear of getting another attack called anticipatory anxiety. Patients may develop fear and avoidance of situations that earlier resulted in panic attacks or where help may not be available. The consequent avoidant behaviour is referred to as agoraphobia that may become disabling with the person finding it difficult to leave home completely without an escort. Common situations or places avoided are crowded places such as markets and other public places from where easy escape may not be possible. Moreover, situational panic attacks can occur in other anxiety disorders such as social anxiety disorder, obsessive–compulsive disorder and specific phobia.

Panic disorder is characterized by recurrent unexpected panic attacks followed by at least 1 month of persistent anticipatory anxiety, worry about the implications of the attacks or a significant avoidance behaviour causing dysfunction and disability. The presence of agoraphobia frequently complicates panic disorder. The following screening questions may help the practitioner diagnose panic disorder.

- Have you had episodes of intense of fear or anxiety that you found hard to control?
- When was it last? Can you describe it?
- When was the onset?
- Do you remember the situation or triggers for such an attack?
- What were the symptoms at its peak?
- How long did it last?
- What did you do to terminate it?
- Has there been any post panic worry for the next attack, any mood changes or any avoidant behaviour?

Panic disorder and comorbid conditions

Depression is the commonest comorbid condition in nearly two-thirds of patients with panic disorder. It may either predate or emerge after onset of panic disorder. The presence of comorbid depression increases the risk of suicide.[1,18] Social

phobia, GAD, post-traumatic stress disorder and obsessive–compulsive disorder are other common comorbid conditions associated with panic disorder.

Harmful use of and dependence on alcohol is seen in 20%–25% of patients with panic disorder.[19] It is possible that patients with panic disorder self-medicate with alcohol to relieve anxiety. The other substances commonly associated with panic disorder are caffeine, cocaine and amphetamines.

MANAGEMENT

Basic principles of management and treatment options remain the same for most anxiety disorders including GAD and panic disorder. Hence a combined approach for management is discussed here (Table II).

A general physical screening examination and laboratory testing to screen for underlying medical disorders is to be done for individuals with suspected physical cause of anxiety (e.g. individuals with weight loss, shortness of breath or chest pain). Usually a complete blood count, thyroid function tests, renal function tests, liver function tests, fasting blood sugar, urine toxicology, urine analysis and electrocardiogram may be necessary depending on the findings of clinical examination.

Many patients presenting with anxiety in general clinical practice may not have significant symptom profile and may benefit from reassurance and supportive counselling. Often explanation of the relationship between physical symptoms and stress can be reassuring thus breaking the negative spiral of health-related worry and anxiety.

It is first necessary for a newly diagnosed patient to decide if she needs treatment. The decision is best arrived on the basis of the severity of the illness (how difficult it is for the patient to control the symptoms), extent of distress and impact of the symptoms on function, presence of comorbid conditions, treatment preference of the patient and past history of treatment, if any.

If the illness is not associated with distress and impairment of functions it is advisable to provide supportive counselling only and review the patient once in 6 months for any exacerbation of symptoms.

For those who need treatment start one of the selective serotonin reuptake inhibitors (SSRIs) such as sertraline, escitalopram, fluoxetine, paroxetine or serotonergic noradrenergic reuptake inhibitors (SNRIs) such as venlafaxine (Table II). It is better to start any of the SSRIs, for example, sertraline. It is safe to start with a low dose, say 25 mg, to avoid agitation with a higher dose. The dose may be increased to 50 mg, which is the minimum effective dose, in 1 week and wait for the response for 4–6 weeks. If there is an insufficient response the dose may be increased by 25 mg per week to a maximum dose of 200 mg per day and wait for 4–6 weeks. Always explain the commonly occurring side-effects such as upper abdominal discomfort, nausea, mild headache and tremulousness of hands. Besides sertraline, paroxetine in dose range of 12.5 mg increased up to 25 mg a day is also preferred particularly in panic disorder.[19–22]

If there is no response to SSRI, consider using venlafaxine 37.5 mg per day. The dose may be increased by 37.5 mg per week up to 225 mg per day depending on the response. The common side-effects are nausea, dizziness, mild headache and increase in blood pressure especially above 150 mg per day.[12,19,20,22]

If there is a response (significant reduction of symptoms, distress and improvement in function) maintain the same dose of the medicine for at least 12 months and then decrease the dose over a few weeks to stop the medicine. In case of a relapse, restart the treatment and maintain for years.[12,22]

In case of patients with GAD with partial response consider adding adjunctive treatment with tablet buspirone 10 mg to start with and increase weekly to a maximum dose of 60 mg or pregabalin 50 mg per day to a maximum dose of 300 mg per day. However, the side-effects of pregabalin such as sedation, dizziness, tolerance and withdrawal symptoms may limit its tolerability among patients.[12,20,22] If there is still an inadequate response, consider referral to a psychiatrist. However, there is not enough evidence to support the efficacy of buspirone and pregabalin in panic disorder.[23]

Use of benzodiazepines such as clonazepam 0.5 mg b.d. or lorazepam 1–2 mg per day can be considered for 3–4 weeks in case of marked agitation. Benzodiazepines should not be continued beyond 4–6 weeks to avoid dependence. In case of patients with comorbid substance use it is advisable to avoid benzodiazepines. In such patients pregabalin or hydroxyzine may be added as safe options. Beta-blockers are used in initial stages if the arousal symptoms such as tremulousness and palpitation become bothersome in certain situations.[8,12,22]

In special populations such as elderly and those with associated medical problems, SSRIs are safe in lower doses (sertraline 25 mg or escitalopram 10 mg). Benzodiazepines are avoided because of the possibility of paradoxical agitation. Tricyclic antidepressants may have an effect on cardiac functions and are best avoided. Mirtazapine in a dose of 7.5 mg may be used in such patients.[17,22] Similarly in children and pregnant or lactating women, SSRIs in lower doses are a safer choice.[22]

Always provide some information about how the medicines help to alleviate anxiety symptoms (for example, stresses often lead to altered chemical balance in the brain and medicines help to restore the balance), that the patient may gradually begin to feel the relief in about 2 weeks and usually the side-effects are mild and tolerable when the medicine is started with a low dose and the dose is optimized according to the tolerability of the patient. The patient may be encouraged to practise deep breathing exercises and to curtail caffeine and alcohol intake as much as possible.

Specific CBT techniques include distraction, activity scheduling, challenging negative thoughts and correcting them, learning new skills for managing stress along with behavioural techniques such as deep breathing and muscle relaxation and cognitive relaxation using visual cues or imagery. CBT is

TABLE II. Treatment of anxiety disorders

Psychological
Reassurance and supportive counselling (to be provided in every case)
Cognitive behaviour therapy (CBT) provided by clinical psychologists and psychiatrists
Pharmacological (if necessary in moderate to severe symptoms)
Selective serotonin reuptake inhibitors (sertraline, escitalopram, fluoxetine, paroxetine)
Serotonin-norepinephrine reuptake inhibitors (venlafaxine)
Adjunctive medications: Benzodiazepines, buspirone, hydroxyzine, pregabalin and beta-blockers
Complementary treatment (always encourage unless contraindicated)
Physical workouts
Intense aerobic exercises
Healthy lifestyle changes
Yoga, meditation
Mindfulness-based relaxation strategies

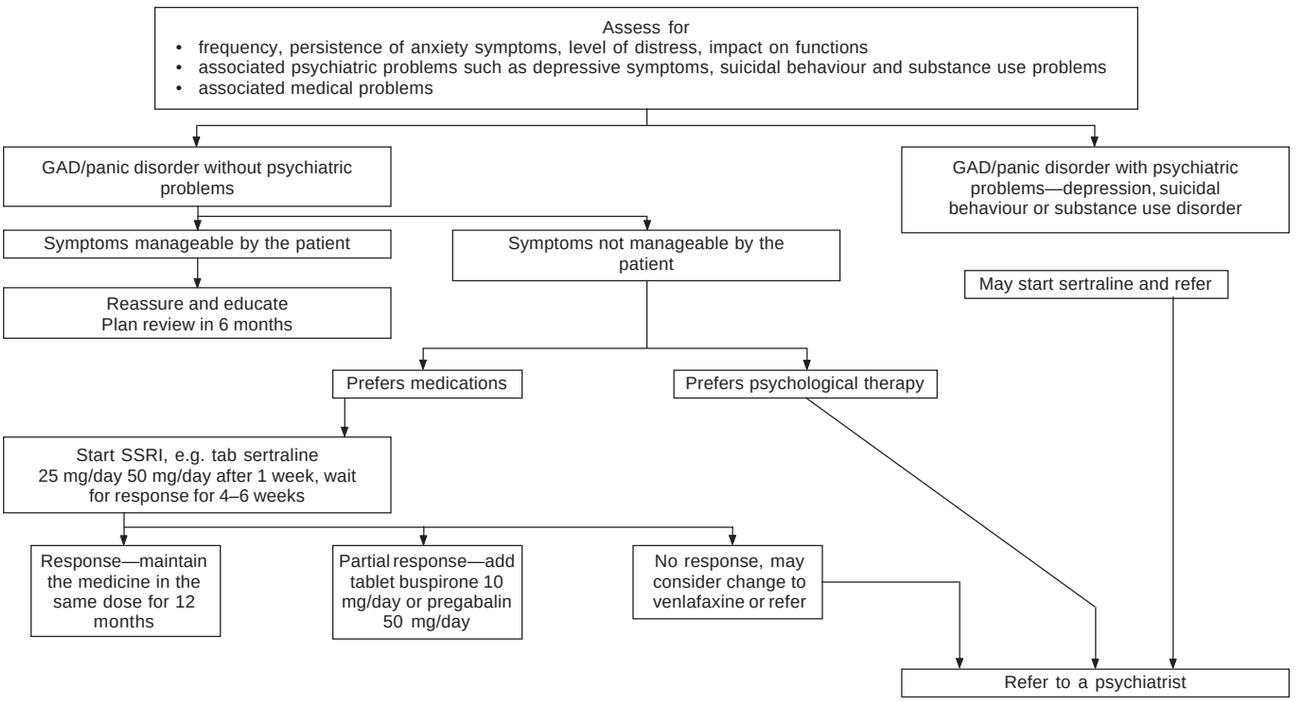

FIG 1. Algorithm for managing a patient presenting with anxiety symptoms in general practice GAD generalized anxiety disorder
SSRI selective serotonin reuptake inhibitor

reported to be as effective as medications and is recommended for improved long-term outcome in GAD.[7,24,25] However, CBT should be provided by well-trained mental health professionals only and patients who prefer this therapy should be referred to a psychiatrist (Fig. 1).

Role of complementary treatments

Recent developments in psychosocial treatments in anxiety disorder have highlighted the role of lifestyle changes and complementary therapies. These strategies are increasingly being recognized as beneficial for controlling the subjective distress of anxiety symptoms other than promoting physical and mental health. These include physical workouts, intense aerobic exercise, meditation, yoga and pranayama, mindfulness-based stress management strategies along with personal ways of finding solace and inner peace such as by prayers and spiritual activities.[7,22,26]

Simple lifestyle changes such as adequate sleep, balanced diet and regular exercise help decrease daily stress and anxiety. It is reported that physical workouts and aerobic exercises for about 30 minutes a day for 5 days a week bring about important health benefits in anxiety disorders. The factors that mediate such benefits include release of good endorphins, increased plasticity of brain, mind going off worries, gain in confidence and copings in healthy ways.[27,28] Even exercising for 10–15 minutes can be useful.

Yoga and pranayama have been traditionally recommended as effective relaxation techniques to reduce physiological and psychological response to stress and anxiety. Yoga uses deep breathing, meditation, sustained concentration and correct posture to help increase strength and flexibility which help activate the parasympathetic system and increase gamma amino butyric acid (GABA; inhibitory neurotransmitter) in the brain. Recent studies and reviews from professional bodies have supported this view.[22,25,29,30]

Another technique that has been in focus is integrating acceptance and mindfulness-based strategies in management of anxiety. Several video clips and TED talks are available on YouTube to be familiar with the concepts and techniques of mindfulness. In simple words, the subject is taught to focus or pay attention to the tasks at hand and inner feelings, reorganize and validate these feelings and let go the negative feelings to help prevent negative reactions and cognitive distortions.[7,31,32]

The following patients should be referred to a psychiatrist: (i) anxiety disorder associated with other psychiatric problems such as major depression, substance use or if there is suicidal behaviour; (ii) partial or no response to two interventions; and (iii) patient prefers to go for psychotherapy only

Box: Key points for practice

- Screen effectively
- Look for any associated medical problems
- Assess for associated psychiatric problems
- Assess risk behaviour: self-harm
- Always provide basic support
- Advocate non-pharmacological strategies
- Use medicine when necessary—start with a low dose.
- Refer for specialist care when indicated.

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