Ending the Worry

Over Anxiety Disorders

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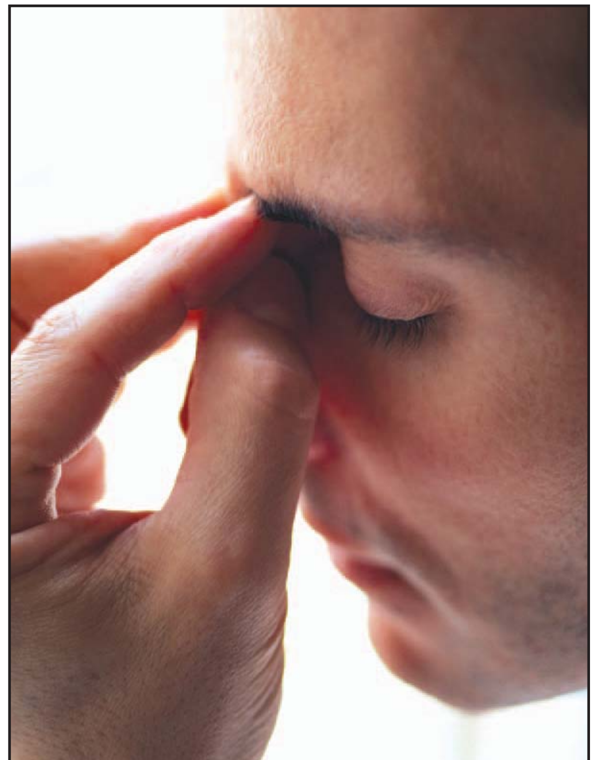

In this article:

1. How do you detect anxiety disorders?
2. What is the significance of the followup visit?
3. What are the different types of anxiety disorders?
4. What are the treatment options — including medications and psychotherapy?
5. Are these treatment options effective?

How do you detect anxiety disorders?

Anxiety disorders are the most common psychiatric disorders, with a lifetime prevalence of over 20%.[1] Symptoms of anxiety are universal, however, anxiety disorders are distinct, just as intense sadness is not the same as clinical depression. Consistent with all formal psychiatric disorders, anxiety disorders include clusters of symptoms and impairment as cardinal features.

Detecting anxiety disorders may be complicated by several factors, starting with the fact that most patients with psychiatric symptoms are embarrassed by them and are reluctant to seek medical attention.[2] Other key factors, including differentiating situational stress from true anxiety disorder, the manifestation of many anxiety disorders through multiple physical symptoms and contributing factors (*i.e.,* substance abuse, particularly alcohol), "muddy the waters" of diagnosis. Patients with a rapid heart rate or problems with diarrhea and abdominal cramping naturally require assessment for other medical problems. Unfortunately, in cases where no other medical disorder is found,

Practice Pointer

Reviewing various physical symptoms and subjective sensations include questions about:

- Any other non-psychiatric illness that might explain the symptoms
- The intake of alcohol and caffeine
- A brief review of any major life stressors

patients are left with the understanding that it is “just” anxiety, which undermines the move towards a successful treatment program.

Screening for anxiety begins with a brief review of the various physical symptoms and subjective sensations reported by the patient. Such information should be followed by questions about any other non-psychiatric illness that might explain the symptoms, questions about intake of alcohol and caffeine, and a brief review of any major life stressors. If these questions lead to the possibility that the patient may be suffering from anxiety, more specific questions should be asked (*i.e.,* questions about depressed mood and inability to experience pleasure [anhedonia], as well as symptoms of anxiety, such as panic attacks). Some family physicians find it prudent to end a medical visit at this point by suggesting to the patient that the symptoms may be related to several factors, such as a specific physical illness (*i.e.,* anemia, hyperthyroidism, *etc*.), substances (if appropriate), acute stress, or the “possibility of an anxiety disorder or depression.” The initial visit should end with steps to clarify the diagnostic possibilities (*i.e.,* blood work, an electrocardiogram or a limited physical examination) and a followup visit should be scheduled for one week later. Simple supportive strategies include advising the patient to get more sleep, consume less alcohol and coffee, and get some exercise.[1]

What is the significance of the followup visit?

At the time of the next visit, symptoms since the previous week should be assessed and laboratory results may be reviewed. Persistent symptoms will point to the possibility of an anxiety disorder or depression. Assuming there are no other indications of physical illness, the patient can now be informed that such persistent symptoms are likely the result of a mental health disorder. Pointing out potential differential diagnoses to the patient (including a psychiatric problem in the first visit, but only confirming it in the second visit) helps prepare him/her for further exploration of mental health symptoms and builds the physician’s credibility. At this point, specific questions about depression or anxiety disorders may be asked. Depression often includes anxiety and if such symptoms are present, the patient should be treated initially for depression. Anxiety symptoms should be recorded for further action, if necessary.

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Practice Pointer

These issues help clarify the diagnosis:

- Sudden episodes of severe anxiety (panic)
- Avoiding activities or places due to anxiety (panic, specific phobias)
- Persistent worry about routine things (generalised anxiety disorder)
- Flashbacks of painful memories or a recurrent state of being on guard or hyperaroused (post-traumatic stress disorder)
- Unwanted repetitious behaviours or unpleasant thoughts (OCD)

What are the different types of anxiety disorders?

The Ontario Treatment Guidelines for Anxiety Disorders classify anxiety disorders into four categories: the phobic group (including panic disorder, specific phobia and social phobia, also called generalized social anxiety disorder); the worrying group (generalized anxiety disorder [GAD]); trauma and stress-related (acute stress disorder and post-traumatic stress disorder [PTSD]); and obsessive-compulsive disorder [OCD].[3]

Specific questions to clarify the diagnosis sequentially are as follows: sudden episodes of severe anxiety (panic); avoiding activities or places due to anxiety (panic, specific phobias); persistent worry about routine things (GAD); flashbacks of painful memories or a recurrent state of being on guard or hyperaroused (PTSD); unwanted repetitious behaviours or unpleasant thoughts (OCD).

For more information on these guidelines visit the Web site at *www.opot.org/ guidelines/anxiety.pdf* (Table 1).

Only panic disorder is generally associated with dramatic physical symptoms. Mild persistent physical symptoms, and especially disproportionate complaints of these, are more typical of GAD. Social phobia can be identified as going beyond a simple fear of public speaking since an extreme fear of criticism or public scrutiny (*i.e.,* fear of eating in public) is manifested. Agoraphobia, which frequently coexists with, or becomes a consequence of, panic, involves a fear of

Table 1

Key Physician and Medication Resources

Canadian Network for Mood and Anxiety Treatments	www.canmat.org
Canadian Mental Health Association	www3sympatico.ca/cmha.toronto
Centre for Addiction and Mental Health	www.camh.net
Canadian Health Network	www.canadian-health-network.ca
NIMH Anxiety Disorders Education Program	www.nimh.nih.gov/anxiety/anxietymenu.cfm

constrictive places and such patients frequently stay home to avoid imagined danger or the provocation of a panic attack.

Both PTSD and OCD are complex disorders that require detailed evaluation and complex management. Patients with PTSD suggest having experienced a severe stress (*i.e.,* sexual trauma, car accident, war experience) more than one month prior to the assessment. The disorder is accompanied by recurrent memories of the event and unpleasant sensations. Such patients scan the environment frequently and excessively for dangerous situations (hypervigilance). Individuals with OCD have repetitious behaviours (*i.e.,* checking doors many times per hour, excessive handwashing, *etc.*) and/or uncontrollable, recurrent unpleasant thoughts. Truly uncommon thoughts (*i.e.,* paranoid or delusional) are not typical of an anxiety disorder, but may be a sign of another serious problem, such as schizophrenia.

Practice Pointer

Psychosocial interventions for anxiety disorders may be considered in several categories:

- Psychoeducation
- Behaviour therapy
- Cognitive therapy
- Other therapies

Do medications work for anxiety disorders?

Anxiety disorders are very responsive to treatment. The Ontario Treatment Guidelines review treatment options, both pharmacologic and psychosocial, for each disorder.[3]

Benzodiazepines are often helpful for many of the symptoms of anxiety disorders, but are best used as a bridge to definitive treatment with an antidepressant. If psychosocial treatments are to be the main treatment, benzodiazepines should be avoided to allow for the proper use of psychotherapeutic techniques and

> Starting low and going slow with dosage increases are essential.

behavioural interventions. The usual caveats about benzodiazepines apply — use small doses and avoid use beyond six weeks.

A wide variety of antidepressants, particularly older tricyclic agents and monoamine oxidase inhibitors have been helpful in treating most anxiety disorders. Safer strategies involve using only the new antidepressants in primary-care settings, with agents, such as selective serotonin reuptake inhibitors (*i.e.,* fluoxetine, fluvoxamine, sertraline, paroxetine and citalopram) and serotonin norepinephrine reuptake inhibitors (venlafaxine) being the agents of choice.

One key prescribing strategy is to begin with a very low dose (at least one half of the usual starting dose for depression treatment). Patients with anxiety disorders are both psychologically and biologically sensitive to medication side effects and are vigilant about any abnormal body sensations. Starting low and going slow with dosage increases are essential. However, the target dose and the duration of treatment is similar to that of depression, as patients should not be left taking modest doses of antidepressants, because symptoms will break through and generally discourage the patient and the physician about the likelihood for successful treatment. Of the agents noted, paroxetine, sertraline and venlafaxine have the best evidence across the spectrum for anxiety disorders, and sertraline and venlafaxine have few drug interactions.[3,4] More specific recommendations are provided in the treatment guidelines.

A variety of other agents are used for refractory anxiety disorders, including antipsychotic agents, mood stabilizers (*i.e.,* valproic acid) and anticonvulsants (*i.e.,* gabapentin). Such agents carry other complications and are best prescribed by

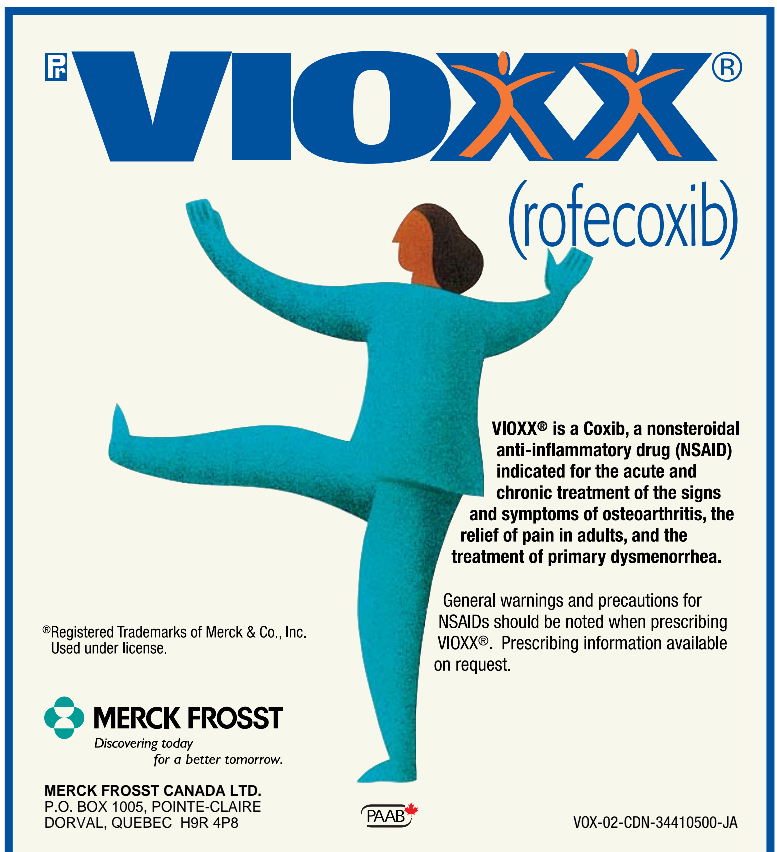

Table 2
Categories of Psychosocial Interventions

Psychoeducation: Informing the patient of the diagnosis and key illness factors, including supportive measures (*i.e.*, stress reduction, avoiding alcohol and caffeine, the use of time management skills).
Behaviour therapy: Informing the patient about relaxation therapy, yoga, tai chi, acupuncture and specific behavioural exercises.
Cognitive therapy: Informing the patient about this specific form of psychotherapy.

a specialist. Avoid prescribing buspirone, beta blockers and the antidepressant bupropion when treating anxiety disorders since evidence for efficacy is poor.[3,5] Finally, management of PTSD and OCD should be left to a specialist, although primary-care physicians may start a treatment plan with caution.

Does psychotherapy work to treat anxiety disorders?

Ideally, psychosocial interventions are the first step in treating anxiety disorders (Table 2). Psychosocial interventions for anxiety disorders may be considered in several categories: psychoeducation, behaviour therapy, cognitive therapy and other therapies. Psychoeducation involves informing the patient of the diagnosis and key illness facts, including supportive measures that help reduce suffering (*i.e.,* stress reduction, avoiding alcohol and caffeine, and time management). Behavioural techniques include relaxation therapy, yoga, tai chi, acupuncture and specific behavioural exercises (*i.e.,* graded exposure to feared situations). Many of these approaches have been tested empirically and are found to be helpful in milder anxiety disorders, especially early in the course of illness.[3]

Cognitive therapy is a specific, time-limited form of psychotherapy that has a well-defined theoretical basis, as well as hundreds of published studies attesting to its effectiveness.[6] In most cases, behavioural measures are combined with cognitive therapy, otherwise known as cognitive-behavioural therapy (CBT). While it is impossible to review CBT in detail here, it is worth noting that a number of self-help books use it.[7,8,9] Such books may be recommended to patients with the physician serving as a coach and symptom monitor, as the patient goes through the books chapter by chapter. Many mental health clinics also have short-term group treatments using CBT, and results are generally good.

Historically, many other types of psychotherapy have been used for patients with anxiety disorders. While other approaches may be helpful for some patients, none have either the published studies or the practicality of CBT to back their

effectiveness. Current evidence suggests that while psychoeducation should precede or be concomitant with all other treatments, CBT may be used before, during and even after successful use of medications. Patients who experience persistent symptoms following the use of psychotherapy alone should be prescribed medication. Similarly, persistent symptoms after medication use also indicate the need for CBT. Successful treatment of anxiety disorders is one of the most common and gratifying areas of psychiatry and primary-care medicine. CME

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