Understanding Generalised Anxiety and the Anxiety Disorders in General Practice

Author:

John Butler MSc, BSc, RN

Lecturer / Practitioner in Mental Health,
Bedfordshire and Luton Community NHS Trust
&
Neurolink Board Member
(Neurolink is supported by an educational grant from Wyeth Laboratories)

May 2002

Introduction

Most of us will have experienced feeling anxious at times – when going for the driving test, when attending an interview or giving a presentation. Related to the fight or flight response, anxiety is part of the spectrum of normal human behaviour and experience, and has a self-preserving and protective function.

Many of us will also recall thinking or hearing phrases like: 'I'm going mad / crazy'; 'I'm losing control'. However, anxiety does not mean weakness, going crazy, being mad or having personality problems. Heightened or persistent states of anxiety, often occurring in the absence of an actual fearful situation, can have a negative effect on the individual in terms of significant and prolonged emotional distress and/or a change / disturbance in behaviour or functioning.

With depression, the anxiety-related disorders represent the most common and significant mental health problems seen in the practice setting, and it is now generally accepted that practice nurses and other primary care professionals have an important role in the recognition and management of mild to moderate mental health problems, in accordance with local practice protocols (DOH, 1999). Already frequently involved in providing emotional health-care, it has been suggested that there is scope for practice nurses and other primary care professionals to improve their knowledge, skills and training in providing brief interventions for the common mental health problems presenting in primary care, such as anxiety, in realising a valuable and more effective contribution to mental health care (Mead et al, 1996; Crosland & Kai, 1998; Plummer, 1999; DOH, 1999, p29; Butler, 2000).

Key issues relating to the recognition and management of anxiety disorders, with a particular focus on generalised anxiety disorder (GAD), are explored, with particular reference to recently published practice guidelines (WHO, 2000; Neurolink, 2001).

Anxiety – normal or pathological?

An anxiety disorder, then, refers to the presence of specific recurring fears which the patient may recognise as irrational, with significant emotional distress and disruption to work, social or family life. This is distinct from the 'healthy coping reaction' of anxiety.

The difference between normal and pathological anxiety concerns the level and persistence of anxiety and the effects upon the individual: frequency, intensity and duration of distress; impairment of functioning. What causes one person to develop a mood or anxiety disorder over another is thought to be the effects of biochemical neurotransmitter imbalances; inherited factors which may underlie a certain vulnerability to stressors; in addition to a component of personality, experience and learning processes such as conditioning.

The Impact of Anxiety

Anxiety disorders affect around 16% of the population, with almost one in five of these people experiencing GAD (Jenkins et al, 1997). It is estimated that nearly one in 20 people will develop GAD at some time in their lives (Kessler et al, 1994), with women being twice more likely to develop this disorder. More specifically, the weekly prevalence of anxiety disorders in general practice has been estimated as (OPCS, 1995):

GAD: 31 per 1,000 adults aged 16-64
Phobias: 11
Obsessive-compulsive disorder: 12
Panic Disorder: 8
Mixed Anxiety & Depression: 77

The anxiety, worry or physical symptoms of GAD can cause clinically significant distress or impairment in functioning: poor self-perceived health; increased help-seeking behaviour; poor performance at work; longer periods of absenteeism; higher rates of school drop-out, teenage child-bearing, relationship breakdown; poor career choices and low 'quality of life' scores (Judd et al, 1998; Kessler et al, 1999; Wittchen et al, 2000). They cause as much suffering and social disruption as the depressive disorders, irrespective of age group, and the risk of suicide may be as high as that for depression. Furthermore, about two-thirds of those with an anxiety disorder do not receive professional treatment (Wittchen, 1998).

Anxiety disorders account for about 10% of all UK general practice costs (Andrews et al, 1994, p17). In a US study, 54% of general practice costs were found to be due to non-psychiatric medical treatment (Greenberg et al, 1999). Furthermore, Katon et al (1990) reported that GAD occurs in 21.8% of high utilisers of medical care, second only to major depressive disorder.

Co-morbidity

However, the recognition of anxiety disorders, including GAD, can be difficult because many patients are highly likely to have comorbid depression (62%), another anxiety disorder or a co-existing physical condition (Kessler et al, 1994; Judd et al, 1998). There is a considerable overlap of the symptoms of these illnesses: GAD and depression have common features such as appetite and sleep disturbances, fatigue, poor concentration, irritability, agitation and restlessness, in addition to differentiating features (Neurolink, 2001). Furthermore, due to this high prevalence of co-morbidity, anxiety and depression have previously been viewed by many as a single disorder. However, contemporary views see these conditions as distinct in symptomatology, course of illness, required treatment strategies and response to treatment, with GAD being regarded as a risk factor for other disorders such as major depression (Neurolink, 2001). Clarifying recognition, in part helped through successive revisions of diagnostic manuals, has led to more precisely targeted management approaches.

Nutt et al (2001) highlight the risks associated with co-morbid GAD and depression: increased severity of symptoms, increased suicide risk, heightened social dysfunction, and more frequent consultations.

In summary, then, GAD is a common mental health problem, with an early age of onset, a chronic course and a high degree of comorbidity with other anxiety and mood disorders (Kessler et al, 2001). It is thus clear that more widespread awareness, recognition and appropriate early intervention is likely to be of significant value.

Identification: recognising the type of anxiety disorder

The main types of anxiety disorders seen in general practice are briefly summarised in Table 1, together with their key feature(s). A number of types of anxiety have been described, with generalised anxiety being the most common.

Table 1: Types of Anxiety Disorder (after: WHO, 2000; Neurolink, 2001)

Anxiety Disorder	***Key feature(s)***
Specific Phobia	an unreasonably strong fear or marked avoidance of a specific situation / object
Panic Disorder (with or without agoraphobia)	sudden intense fear / anxiety, with characteristic physical and psychological symptoms and fear / avoidance of situations (especially in agoraphobia)
Social Phobia / Social Anxiety Disorder	fear of scrutiny by others leading to avoidance of social situations
Generalised Anxiety	persistent excessive and uncontrollable worry and anxiety about everyday things, which is out of proportion to the situation(s)
Obsessive-Compulsive Disorder	anxiety associated with intrusive, recurring thoughts (obsessions) which may result in compulsions to perform particular mental rituals or behaviours
Post Traumatic Stress	symptoms of re-experiencing, avoidance / emotional numbness, hyper-arousal and impaired functioning which follow a threatening or catastrophic traumatic event, emotional shock or severe stress
Related Disorders	***Key feature(s)***
Somatoform Disorders (Health Anxiety)	history of complaints of multiple and variable physical symptoms (somatisation) or having one or more serious and progressive physical disorders (hypochondriacal) that cannot be explained by detectable physical disorders (investigations), with persistent refusal to accept medical reassurance
Mixed Anxiety / Depression	symptoms of anxiety and depression are both present, but neither is clearly predominant, and neither type of symptom is present to justify a diagnosis if considered separately

Recognising the type of anxiety is particularly important in identifying the most effective approaches for helping the person to manage their anxiety. This requires careful exploratory assessment, as some types of anxiety have often been confused, for example – agoraphobia and social phobia, leading to

ineffective treatment. Using direct open questions to explore specific examples of anxiety-provoking situations will be helpful.

It is also important to assess for and exclude other causes, such as: hyperthyroidism, idiopathic hypoglycaemia, carcinoid syndrome, the excessive use of alcohol and subsequent withdrawal, the use of stimulants such as caffeine and recreational drugs.

Identification: recognising the signs and symptoms

The core signs and symptoms of the anxiety disorders are summarised in Table 2. As shown, the individual may describe a range of physical, cognitive, affective, behavioural and more general symptoms associated with anxiety.

Table 2: Signs & Symptoms of Anxiety (after: WHO, 2000; Neurolink, 2001)

Physical (autonomic)	***Physical (general)***	***cognitive***	***affective***	***behavioural***
trembling / shaking sweating heart racing / pounding dry mouth dizziness / faint light-headedness breathlessness stomach churning chest pain / discomfort nausea headaches choking sensation	hot flushes / cold chills muscle tension numbness / tingling sensations restlessness fatigue sleep problems appetite changes	fear of impending doom fear of going crazy fear of dying fear of losing control fear of passing out fear of scrutiny / embarrassment excessive worrying negative anticipation / predictions jumping to conclusions self-blaming	anxiety panic fear guilt depression anger irritability derealisation depersonalisation	avoidance escape safety behaviours checking reassurance-seeking hypervigilance tearfulness agitation fidgeting inhibition substance use self-medicating

The particular symptoms which are experienced will vary with the type of anxiety disorder. So for GAD, the individual will characteristically describe excessive anxiety and worrying which is difficult to control, occurring with a number of other symptoms such as: restlessness; irritability; fatigue; sleep disturbance; difficulty concentrating and muscle tension.

In recognising the anxiety disorders, it will be useful for the Practice Nurse to incorporate some general screening questions into the assessment interview, such as those suggested by WHO (2000): Have you been feeling tense or anxious?; Have you been worrying a lot about things recently? Further more detailed questions can be asked following positive responses to these screening items (WHO Anxiety Checklist). This will mean giving a little more time to psychological screening during the assessment interview.

As an adjunct to clinical interview, screening and recognition can be improved by using brief psychological assessment tools such as the Hospital Anxiety

and Depression Scale (Zigmond & Snaith, 1983): a quick, easy to administer, short 14-item self-report measure for detecting anxiety and depression. Well-accepted by patients and clinicians, the HAD scale has good reliability, sensitivity and specificity, and is useful both as a screening instrument and in assessing changes over time. It also excludes somatic items, thus helping to differentiate between anxiety, depression and physical complaints.

If time allocation or screening is insufficient, then there is a greater risk of accepting somatic complaints and causes: the person with anxiety will often present a range of somatic signs and/or symptoms (e.g. atypical chest pain), and may believe or be convinced that his/her problems have a physiological cause or be actively seeking a medical rather than psychological diagnosis. Reluctance to admit the latter may be the result of stigma and denial.

Careful assessment is thus required if the anxiety disorder is to be detected and treated.

Managing Anxiety: the role of the practice nurse / professional

The recommended treatment approach for the anxiety disorders and GAD is cognitive-behavioural intervention, with combination pharmacotherapy in the event of significant comorbidity, poor treatment response or severely disabling symptoms (Roth & Fonagy, 1996; Enright, 1997).

The practice nurse will have an important role in helping the person to cope with his/her anxiety, thus enhancing their quality of life. It is recognised that the practice nurse is unlikely to have time to provide the intensive intervention which may be offered by specialist mental health team-members, although s/he will have a valuable role in providing brief interventions, more often in a self-help format. This will involve the following elements:

1. To recognise the anxiety disorder which the patient presents.

2. To assess for suicide risk by asking direct questions about suicidal ideation, planning and any previous attempts / incidents of self-harm, paying particular attention to those individuals who report hopelessness, severe and persistent symptoms, and especially if s/he has made a recent attempt at suicide or self-harm, and/or with evidence of planning or preparation.

3. To discuss with the patient the main approaches to managing anxiety which are available and indicated – non-pharmacological and pharmacological, taking account of his/her preferences. This involves providing accurate, detailed, appropriate and true information, in a way that can be understood, referring to a more knowledgeable practitioner as required.

4. To assist in selecting and offering appropriate treatment approaches, which will most likely be non-pharmacological:

- Use active listening skills and provide emotional support.
- Provide education about the nature of arousal & anxiety, hyper-ventilation (if panic), the limitations of escape, avoidance and safety behaviours, which all serve to maintain anxiety, emphasising the need to learn and use new skills.
- Provide education in reducing or stopping alcohol intake, smoking, tea / coffee / cola and stopping recreational drugs.
- Consider engaging in self-help approaches – self-help literature / manuals (e.g. Kennerley, 1997) & computer-aided materials. Whilst self-help and manualised approaches help in widening access to treatment, these approaches may be more effective for the more motivated person, with a positive attitude towards trying out self-help orientated skills-based interventions. In a systematic review of self-help treatments for anxiety and depression in primary care, Bower et al (2001) concluded that whilst self-help approaches were of moderate clinical value and may have much potential, further trials are needed to establish their clinical and cost effectiveness.
- Provide training in basic anxiety management techniques, including: relaxation methods, such as progressive muscular relaxation; controlled breathing; physical exercise (Kennerley, 1997; WHO, 2000).
- Provide education, guidance and encouragement in the use of structured problem-solving (WHO, 2000).
- Develop the individual's use of practical coping strategies, particularly if there are difficult problems where short-term solutions appear unlikely.
- Provide brief cognitive-behavioural interventions, such as those shown in Fig. 1, which specifically relate to the problem presented (Greenberger and Padesky, 1995; Kennerley, 1997; WHO, 2000; Neurolink, 2001).
- Encourage to make / increase social contacts and outlets.

Fig. 1: Cognitive-behavioural Interventions for Anxiety

Basic cognitive-behavioural interventions for anxiety will include:

- self-monitoring through the use of anxiety / panic diaries
- relaxation training and use of physical exercise
- distraction methods (although *only* a short-term solution)
- identifying and challenging anxious thoughts / beliefs, usually through the keeping of a thought diary
- assigning worry time / devising worry postponement strategies
- planning / resuming activities which have been dropped
- problem-solving
- setting specific practical goals and behavioural experiments
- graded exposure to feared / avoided situations
- setting goals to eliminate safety, escape and avoidance behaviours
- relapse prevention planning – encouraging the person to identify and recognise the early signs of a potential relapse and then forming a written personal action-plan aimed at the early management of these initial signs e.g. acting early to prevent relapse

5. To openly discuss drug therapy with the patient, which will require maintaining an up-to-date knowledge and consulting the latest pharmacological data (*full product summaries should always be consulted*; Bazire, 2001; Taylor et al, 2001; www.bnf.org). The main options for the pharmacological treatment of GAD are shown in Fig. 2. In addition, there is

some evidence for the use of certain tricyclic anti-depressants in GAD, and suggested efficacy for certain SSRI anti-depressants (Bazire, 2001).

Fig. 2: Some Treatment Options for GAD (Neurolink, 2001; Bazire, 2001)

GAD – the main licensed pharmacological treatment options include:

- Benzodiazepines: starting with low dose prescriptions, these have a rapid onset of action, help to promote sleep, have a greater effect on somatic symptoms than the anti-depressants, and are generally well-tolerated by patients. Diazepam is the preferred option, although it is recommended that these medications are ONLY prescribed for short-term use (less than 4-weeks) due to the potential for withdrawal effects upon discontinuation and dependence in long-term use.
- Buspirone: indicated for the short-term treatment of anxiety disorder and anxiety associated with depression, this is also generally well-tolerated and is not associated with tolerance, dependence or withdrawal symptoms.
- Anti-depressants: efexor XL 75mg once daily (venlafaxine) is the only anti-depressant licensed for the long-term (6–months) treatment of GAD, and has a good adverse event profile, a reduced risk in overdose and is generally well-tolerated by patients at effective doses.

As regards the other anxiety disorders, various of the SSRI anti-depressants are licensed for use: paroxetine and citalopram for panic disorder and for agoraphobia with or without panic disorder; paroxetine for post-traumatic stress disorder; paroxetine for social anxiety disorder; fluoxetine, sertraline, paroxetine and fluvoxamine for obsessive-compulsive disorder. The SSRI anti-depressants have a good adverse event profile, a reduced risk in overdose and are generally well-tolerated at effective doses (*full product summaries should always be consulted*).

It is useful to remember that the actual choice of prescription will depend upon a number of factors, which include: the key features of the anxiety disorder; evident suicide risk; co-morbidity; the need for concomitant therapy; the time needed to reach therapeutic action; and, the side-effect profile and tolerability by the patient.

Similarly, some of the key messages relating to medication which need to be remembered are (Bazire, 2001; Taylor et al, 2001):

- whichever prescription is given, the patient should always be provided with clear, accurate, appropriate and true information, and provided with supporting written information and telephone helpline numbers;
- provide the patient with up-to-date information about the likely benefits and drawbacks of taking and complying with the medication, including information about side-effects;
- ensure the prescribing of an effective dose of sufficient duration;
- encourage the patient to take the medication as prescribed (compliance);
- monitor compliance, the effectiveness of the prescribed medication, and the presence of any side-effects
- and, withdraw gradually over 2 – 4 weeks, or longer if necessary.

6. To refer on to the GP or assist referral to specialist services / teams, particularly if the individual presents serious suicidal intent (urgent referral), shows no or a poor response to treatment, where the problem is unclear, to access a specific psychological intervention which is not available in the practice and is outside his/her scope of practice, where there is significant comorbidity, or for sharing the care due to the demands of the patient.

Managing Anxiety: finding resources

There are a growing number of useful patient-related materials (WHO, 2000; Neurolink, 2001), services and helplines (Table 3) available to the person with an anxiety disorder. For GAD, a useful patient workbook was recently produced by Neurolink (2001), providing structured exercises as mentioned above: relaxation; breathing control; challenging anxious thoughts; planning activities / goals; encouraging social contacts.

Table 3: Useful Contacts / Resources *

Service / Helpline	***Contact***
Mental Health Foundation	020 7535 7400 www.mentalhealth.org.uk
National Phobics Society	0870 7700 456 www.phobics-society.org.uk
Neurolink (practical solutions for anxiety and depression)	0845 7023 070 www.neurolink.org
No Panic	01952 590545
Obsessive Action	020 7226 4000 www.obsessive-action.demon.co.uk
Phobic Action	020 8559 2453
Social Anxiety Organisation	www.social-anxiety.org
Stress Management Training Institute	01983 868166 www.smti.org
StressWatch Scotland	01563 528910
The Anxiety Panic Internet Resource (TAPIR)	www.algy.com/anxiety
Trauma AfterCare Trust	0800 1696 814 www.tacthq.demon.co.uk
Triumph over Phobia UK	01225 330353
UK Trauma Group	www.traumatic-stress.com
Victim Support	0845 3030 900

(* the above are suggestions only and no particular recommendations are made)

The practice nurse is also encouraged to identify local sources of information and support.

In Conclusion

Anxiety disorders, such as GAD, are amongst the most common mental health problems seen in the general practice setting. Patients with anxiety are likely to present to any practice professionals involved in screening and assessment. The addition of basic direct screening questions to the Practice Nurse's assessment should assist in detecting anxiety disorders such as

GAD, and assist the patient to access appropriate treatment approaches for an all too often disabling problem. There are now a range of effective treatment approaches which include non-pharmacological self-help and guided skills-based interventions, with the option of combination pharmacotherapy for enhancing effect. The Practice Nurse / professional may need to consider arrangements for acquiring basic skills-based training and supervision in the recognition and management of anxiety, approaching specialist teams and primary care facilitators for this support.

Key Points

1. Anxiety disorders, such as GAD, are very common, generally under-recognised and cause significant burden to the individual.
2. Recognition of the anxiety disorders will be enhanced through the routine use of basic screening questions / tools with all patients.
3. Careful detailed assessment is required in establishing the type of anxiety being presented and distinguishing this from co-morbid conditions, as this will affect treatment options.
4. Basic cognitive-behavioural interventions are effective in managing anxiety, and can be applied by the Practice Nurse. Interventions will range from providing education, offering guidance on the use of self-help materials, through to more structured skills-enhancing exercises.
5. Drug treatment in the management of anxiety disorders has a secondary place to the psychological interventions, for use with those who have more severe and persisting symptoms, where there is comorbidity or in the event of no / poor response to non-pharmacological approaches.
6. Forming a local directory of useful resources and contacts relevant to recognising and managing anxiety will be helpful to the practitioner.
7. Links with local specialist mental health teams will be helpful in accessing advice, informal supervision and basic training in the recognition and management of the anxiety disorders.

References

Andrews G, Crino R, Hunt C, Lampe L, Page A (1994) *The Treatment of Anxiety Disorders – Clinician's Guide and Patient Manuals.* Cambridge University Press, Cambridge

Bazire S (2001) *Psychotropic Drug Directory 2001/02 – the professional's pocket handbook and aide memoire*. Quay Books Division, Mark Allen Publishing Ltd., Dinton

Bower P, Richards D, Lovell K (2001) The clinical and cost -effectiveness of self-help treatments for anxiety and depressive disorders in primary care: a systematic review. *British Journal of General Practice* **51**: 838-845

Butler J (2000) Mental Health in Primary Care: an audit of training needs amongst Primary Care Nurses. *Bedfordshire / Luton Trust Journal of Clinical Practice* **2**: 46-50

Crosland A, Kai J (1998) They think they can talk to nurses – practice nurses' views of their roles in caring for mental health problems. *British Journal of General Practice* **48**: 1383-1386

Department of Health (1999) *National Service Framework – modern standards and service models.* DOH, London
Enright SJ (1997) Cognitive-behaviour Therapy – clinical applications. *British Medical Journal* **314**: 1811-1816
Greenberg PE, Sisitsky T, Kessler RC, Finkelstein SN, Berndt ER, David son JR, Ballenger JC, Fyer AJ (1999) The economic burden of anxiety disorders in the 1990s. *Journal of Clinical Psychiatry* **60**: 427-435
Greenberger D, Padesky CA (1995) *Mind Over Mood – change how you feel by changing the way you think* Guilford Press, London
Jenkins R, Lewis G, Bebbington P, Brugha T, Farrell M, Gill B, Meltzer H (1997) The National Psychiatric Morbidity Surveys of Great Britain – initial findings from the household survey. *Psychological Medicine* **27**: 775-789
Judd LL, Kessler RC, Paulus MP, Z eller PV, Wittchen HU, Kunovac JL (1998) Comorbidity as a fundamental feature of generalized anxiety disorders: results from the National Comorbidity Survey. *Acta Psychiatrica Scandinavica Suuplement* **393**: 6-11
Katon W, Von Korff M, Lin E, Lipscomb P, Russo J, Wagner E, Polk E (1990) Distressed high utilizers of medical care – DSM-IIIR diagnoses and treatment needs. *General Hospital Psychiatry* **12**: 355-362
Kennerley H (1997) *Overcoming Anxiety – a self-help guide using cognitive-behavioural techniques*. Robinson Publishing Ltd., London
Kessler RC, Keller MB, Wittchen HU (2001) The epidemiology of generalised anxiety disorder. *Psychiatric Clinician North America* **24**: 19-39
Kessler RC, DuPont RL, Berglund P, Wittchen HU (1999) Impairment in pure and comorbid generalised anxiety disorder and major depression at 12-months in two national surveys. *American Journal of Psychiatry* **156**: 1915-1923
Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS (1994) Lifetime and 12-month prevalence of DSM-IIIR psychiatric disorders in the United States: results from the National Comorbidity Survey. *Archives of General Psychiatry* **51**: 8-19
Mead N, Bower P, Gask L (1997) Emotional problems in primary care – what is the potential for increasing the r ole of nurses? *Journal of Advanced Nursing* **26**: 879-890
Neurolink (2001) *Beating Worries That Won't Go Away – your personal guide to fighting general anxieties and worries*. Intramed, London
Neurolink (2001) *Neurolink Anxiety Guidelines – recognition and man agement in primary care*. Intramed, London
Nutt D, Argyropoulos S, Forshall S (2001) *Generalised Anxiety Disorder – diagnosis, treatment and it's relationship to other anxiety disorders . 2nd edn*. Martin Dunitz Ltd., London
OPCS (1995) *Survey of Psychiatric Morbidity – Report 1*. HMSO, London
Plummer S (1999) The role of practice nurses in mental health care. *Progress in Neurology and Psychiatry* **3**(5): 18-21
Roth A, Fonagy P (1996) *What works for whom? – a critical review of psychotherapy research*. Guilford Press, London
Taylor D, McConnell H, McConnell D, Kerwin R (2001) *The Maudsley Prescribing Guidelines. 6th edn.* Martin Dunitz Ltd., London
Wittchen HU (1998) Recognition and Management of Anxiety Syndromes. *British Journal of Psychiatry* **173**: 1-3
Wittchen HU, Carter RM, Pfister H, Montgomery SA, Kessler RC (2000) Disabilities and quality of life in pure and comorbid generalized anxiety disorder and major depression in a national survey. *Internat. Clinical Psychopharmacology* **15**: 319-28
World Health Organisation (2000) *WHO Guide to Mental Health in Primary Care*. Royal Society of Medicine Press Ltd., London
Zigmond A, Snaith R (1983) The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica* **67**: 361-370