A calm approach to the anxiety disorders seen in general practice

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Anxiety is a universal human experience. For most of us most of the time the reasons for the anxiety are both obvious and understandable, and the anxiety will subside when the reasons depart or remain if they do not. For some people it is not as simple as this; they have anxiety disorders.

When is anxiety a disorder, rather than a normal event?

The level of anxiety is not a criterion for determining if it is a disorder. Those hotly pursued by lions will be anxious indeed, but their anxiety will be normal under the circumstances. Disability is not a criterion. If I have a phobia of giraffes I have an anxiety disorder, but if I stay away from the zoo I have no disability.

The need for treatment is no criterion. If I have survived a terrifying air disaster and my occupation makes it necessary for me to fly, then in all probability I shall need treatment before I can fly again. Nevertheless, the anxiety generated by the crash and attached to flying could scarcely be regarded as pathological. A normal state may require treatment.

The criterion is the appropriateness of the anxiety. If someone is terrified by the sight of a mouse, or a moth, then their anxiety is pathological, for it is extremely unlikely that either of these creatures will attack them and unthinkable that harm would arise if they did – and were it to come to combat, there would be no doubt about who would win.

What are the forms of presentation?

The diagnostic manuals categorise the anxiety disorders in a number of ways. Do not be troubled if you cannot remember them or do not see them as sharply defined entities. In the Harvard/Brown Anxiety Disorders Research Program the researchers examined 711 patients with anxiety disorders. A minority had specific disorders, and in some areas comorbidity was virtually ubiquitous.[1]

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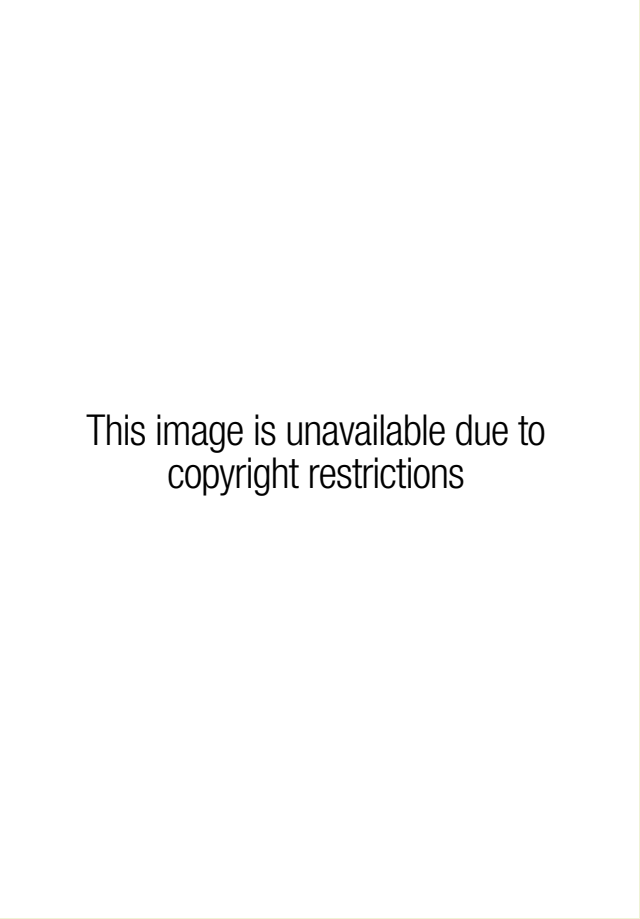

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It is convenient to focus on phobias, generalised anxiety, social anxiety and agoraphobia as commonly seen, but even then there is often an overlap with depression. I believe it is useful to put obsessive compulsive disorder into a category of its own, and I shall not discuss it here.

There are also somatic presentations. In psychiatric practice it is quite common for patients to present with paraesthesiae of the face and hands accompanied by unsteadiness and subjective confusion. These are the usual accompaniments of hyperventilation. Most of the patients have had CT scans and MRIs of their brains – it is much simpler to cause them to hyperventilate right there and then in your office and watch them be amazed as their symptoms appear.

There are some traps in diagnosis:

- Hyperthyroidism, phaeochromocytoma and hypoglycaemia are some of the physical disorders that need to be considered.
- Some psychotic people are manifestly anxious, but very reluctant to uncover their psychotic experiences and ideation.
- More common is withdrawal from sedatives or excessive use

of caffeine, either in coffee or caffeine-containing soft drinks.
- Street drugs can cause a wide array of symptoms and signs and many people use them – they need to be kept in mind.

Why do people get anxiety disorders?

There is no problem in understanding how a single catastrophic experience can cause anxiety or how many traumatic and hurtful experiences in childhood can make someone chronically anxious. On the other hand, the common phobias of childhood (heights, snakes, spiders, the dark, thunderstorms) can arise without any precipitating trauma and then usually decay. In short, both situational and genetic influences can contribute to the causation of anxiety disorders.

The first step is to educate patients about their disorder. They need to understand very clearly that anxiety disorders are common and that they do not foreshadow either physical or mental disintegration. The rapidly beating heart will neither burst nor stop.

There are some interesting findings regarding genetics. For example, in one Spanish family six males suffering from panic disorders and agoraphobia had the same HLA haplotype (A3B18) while others from the same family without anxiety disorders did not.[2] More generally, a twin study has suggested that in twins fears and phobias have a heritability of about 50%.[3]

It is important to take a family history of anxiety disorders because sometimes the familial prevalence can be quite striking. On the other hand, a negative result is of uncertain significance because many people feel that their anxiety disorder is a mark of weakness and to be concealed. Ask your patients how many of their extended family members know that they have the disorder – in most cases few know.

How many of your patients have anxiety disorders?

The Australian Burden of Disease Study ranked generalised anxiety disorder as the fifth of the top 10 causes of disability in women.[4] Depression was the greatest cause of disability for both sexes – remember the overlap with anxiety. Since alcohol dependence and abuse was the third cause of disability for men and does not appear in the female list, one wonders how much dependence in males is anxiety based.

In a family practice survey of 511 patients presenting for routine medical care, 7% suffered from social phobia and many of them also suffered from major depression, panic disorder and generalised anxiety disorder. Few of them had been diagnosed and few were treated.[5]

Remember that you are not likely to discover how many of your patients have anxiety disorders unless you ask about them.

How can the disorders be managed in general practice?

Many patients with anxiety disorders will benefit substantially from treatment that can be provided in general practice. To achieve success, both doctor and patient will have to work at the problem.

The first step is to educate patients about their disorder. They need to understand very clearly that anxiety disorders are common and that they do not foreshadow either physical or mental disintegration. The rapidly beating heart will neither burst nor stop. Since hyperventilation and its consequences are common, this is often a good starting point. A simple explanation of the physiological changes induced by hyperventilation – after the psychological consequences have been demonstrated – removes some of the mystery and provides a basis for understanding. I talk about the change in the availability of the circulating calcium ion and how this affects the functioning of the central nervous system.[6] Put in very simple terms, it makes sense and also makes clear what needs to be done.

Cause your patients to search their minds for thoughts that arise automatically and either initiate or add to their anxiety – for example, 'I must look peculiar when I feel like this and everyone will notice' or 'I'm sure that I'll have a heart attack this time'.

Once these thoughts have been identified they can be examined, and the patients can learn the truth and how to deal with such thoughts.

Relaxation techniques help many patients but not all. It is best that they attend an appropriate therapist (who can be the doctor if he or she is interested in the technique) rather than buy a tape. When the patients have achieved some proficiency in calming themselves, one can move on to graded exposure, a progressive experience of the feared object or situation beginning minimally and advancing cautiously towards the desired goal.

If the anxiety is severe, one can start with mental imagery. A patient of mine with a severe spider phobia began by imagining a dead money spider, pickled in a firmly capped bottle in the British Museum in London, while she remained in Sydney. After some training in relaxation, she could cope with that thought quite calmly and we moved our way up a scale of images until she was prepared to confront a small and harmless spider in the real world – and so on.

What is the role of medication?

First, enquire as to whether or not your patients have been medicating themselves with alcohol or other unorthodox or illegal substances. Many will be taking sedatives provided by other practitioners. While the occasional and moderate use of alcohol has its benefits, to use it to subdue an anxiety disorder is not only unwise but also likely to lead to dependence. One has to handle these problems first. If alcohol or drug abuse is occurring, it must be dealt with; however, its management is outside the scope of this article. More common is dependence on benzodiazepines. If that is the case, the best measure is to change the patient to a long-acting benzodiazepine, such as diazepam, and then reduce the dose very slowly over weeks or even months, giving much support along the way. No medication of any kind should be withdrawn suddenly.

If there has been significant associated depression, keep the medication going for at least six months and resume its use if there is a relapse. Never forget that depression has been shown to be the leading cause of disability in the world.

Most patients prefer to be treated without medication, some because of exaggerated fears of the side effects of psychiatric medication and some – very reasonably – because they feel that if they can conquer their anxiety unaided they have beaten it themselves. Generally this is an achievable goal, but not for all. Perhaps the genetic predisposition is stronger in some than in others, and those with the stronger predisposition are the ones who will need the medication. Here, the literature is an imperfect guide.

Clomipramine is the most useful of the tricyclic antidepressants. The selective serotonin reuptake inhibitors (SSRIs) and the newer medications venlafaxine (Efexor-XR) and mirtazapine (Avanza, Remeron) – which inhibit the reuptake of both serotonin and noradrenaline – are also very helpful for some patients. The fact that the medications that control depression are also effective with anxiety shows that our categories do not reflect nature as closely as we might hope.

In each case, start with the smallest possible dose, having first described carefully to the patient all the possible side effects and discomforts – a simple information sheet given as a handout is very useful. Increase the dose slowly until benefit is obtained and keep it there. There is no rule that will tell you which medication will suit which patient best or who will get which side effects. Emphasise that none of the medications can cause addiction – because you are not using sedatives.

If the combination of psychological help and medication produces a good result, wait several weeks before beginning to remove the medication and make sure that the patient is ready to accept that. If there has been significant associated depression, keep the medication going for at least six months and resume its use if there is a relapse. Never forget that the very large Global Burden of Disease study[7] showed that depression is the leading cause of disability in the world, by far exceeding such things as iron deficiency anaemia, falls, chronic obstructive pulmonary disease and everything else.

Conclusion

The treatment of the anxiety disorders can be very gratifying for all concerned. It is good to watch people put down a burden that they have been carrying for years. If you wish to progress past the few simple principles set out here then buy *The treatment of anxiety disorders*[8] and become an expert. It is an Australian workbook for both doctor and patient and leads both firmly in the right direction. MT

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