Adult Anxiety Spectrum Disorders

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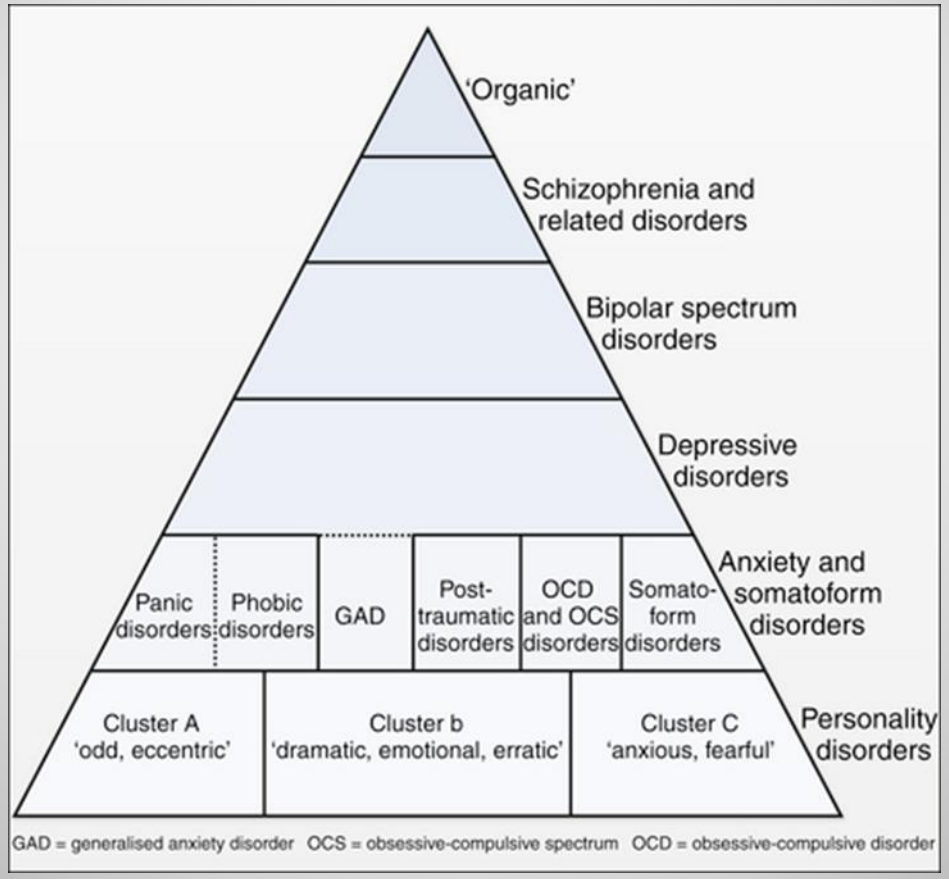
What we will cover

- Generalised Anxiety Disorder
- Panic Disorder and Agoraphobia
- Obsessive-Compulsive Disorder

- Diagnosis
- Treatment in primary care
- When to refer

Fould's Hierarchy or The Psychiatric Surgical Sieve



GAD Diagnosis

- **DSM-5 criteria**
- Too much anxiety or worry over more than **six months.** This is present most of the time in regards to many activities [Everyday life and events]
- Inability to manage these symptoms
- At least three of the following occur:
- 1 Restlessness
- 2 Tires easily
- 3 Problems concentrating
- 4 Irritability
- 5 Muscle tension.
- 6 Problems with sleep

- Symptoms result in problems with functioning.
- Symptoms are not due to medications, drugs, other physical health problems
- Symptoms do not fit better with another psychiatric problem such as panic disorder

- No major changes to GAD have occurred since publication of the Diagnostic and Statistical Manual of Mental Disorders (2004); minor changes include wording of diagnostic criteria

ICD 10 GAD

- **ICD-10 criteria**
- ICD-10 Generalized anxiety disorder "F41.1"
- A period of at least **six months** with prominent tension, worry, and feelings of apprehension, about everyday events and problems.
- At least **four** symptoms out of the following list of items must be present, of which at least one from items (1) to (4).
- **Autonomic arousal symptoms(1) Palpitations or pounding heart, or accelerated heart rate.(2) Sweating.(3) Trembling or shaking.(4) Dry mouth (not due to medication or dehydration).**
- Symptoms concerning chest and abdomen (5) Difficulty breathing.(6) Feeling of choking.(7) Chest pain or discomfort.(8) Nausea or abdominal distress (e.g. churning in the stomach).
- Symptoms concerning brain and mind (9) Feeling dizzy, unsteady, faint or light-headed.(10) Feelings that objects are unreal (derealisation), or that one's self is distant or "not really here" (depersonalisation).(11) Fear of losing control, going crazy, or passing out.(12) Fear of dying.
- General symptoms(13) Hot flashes or cold chills.(14) Numbness or tingling sensations.
- Symptoms of tension(15) Muscle tension or aches and pains.(16) Restlessness and inability to relax.(17) Feeling keyed up, or on edge, or of mental tension.(18) A sensation of a lump in the throat or difficulty with swallowing.
- Other non-specific symptoms(19) Exaggerated response to minor surprises or being startled.(20) Difficulty in concentrating or mind going blank, because of worrying or anxiety.(21) Persistent irritability.(22) Difficulty getting to sleep because of worrying.
- The disorder does not meet the criteria for panic disorder (F41.0), phobic anxiety disorders (F40.-), obsessive-compulsive disorder (F42.-) or hypochondriacal disorder (F45.2).
- Most commonly used exclusion criteria: not sustained by a physical disorder, such as hyperthyroidism, an organic mental disorder (F0) or psychoactive substance-related disorder (F1), such as excess consumption of amphetamine-like substances, or withdrawal from benzodiazepines.

Treatment Generalised Anxiety

- Stepped care
- Psychology first
- SSRI 1st line medication
- Combine Psychology and Medication if complex/refractory

- Address Caffeine and Substance/Alcohol use

GAD

- Benzos 2-4 weeks only
- SSRI first line
- SNRI and Pregabalin are alternatives
- High intensity psychological intervention

Diagnosis Panic Disorder

- The DSM IV diagnostic criteria for panic disorder require **unexpected, recurrent panic attacks**, followed in at least one instance by at least a month of a significant and related behaviour change, a persistent concern of more attacks, or a worry about the attack's consequences. There are two types, one with and one without Agoraphobia. Diagnosis is excluded by attacks due to a drug or medical condition, or by panic attacks that are better accounted for by other mental disorders.

- The ICD 10 diagnostic criteria:
  The essential feature is recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances and are therefore unpredictable.
  The dominant symptoms include:
- sudden onset of palpitations
- chest pain
- choking sensations
- dizziness
- feelings of unreality (depersonalisation or derealisation)
- secondary fear of dying, losing control, or going mad

- Panic disorder should not be given as the main diagnosis if the person has a depressive disorder at the time the attacks start; in these circumstances, the panic attacks are probably secondary to depression

Panic Disorder

- Stepped care
- Psychology first
- SSRI 1st line medication
- Combine Psychology and Medication if complex/refractory

- Address Caffeine and Substance/Alcohol use

Panic / Agoraphobia

- Benzos should not be used
- SSRI first line
- If not then Clomipramine
- Self help and CBT should be encouraged.

- Role of Paroxetine and Venlafaxine (Rebound anxiety)

Diagnosis of OCD

- A. Presence of obsessions, compulsions, or both:
- **Obsessions** are defined by (1) and (2):
- 1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
- 2.The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
- **Compulsions** are defined by (1) and (2):
- 1. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- 2.The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

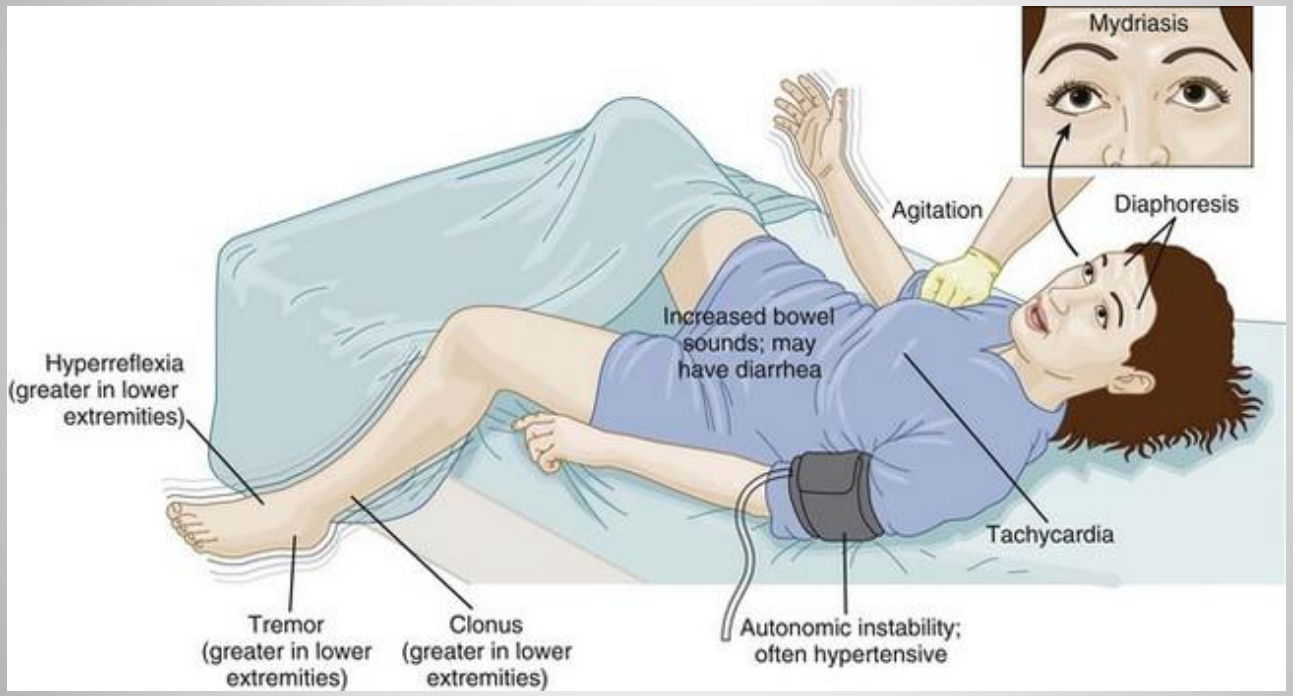
Diagnosis of OCD continued

- B. The obsessions or compulsions are **time-consuming** (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The obsessive-compulsive symptoms are **not attributable to the physiological effects** of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- D. The disturbance is **not better explained by the symptoms of another mental disorder** (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behaviour, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

OCD

- SSRI or intensive CBT
- Combine SSRI and CBT if single strategy fails
- Moving into the complex and away from Primary Care.
- Use Clomipramine if SSRI fails
- Then add low dose antipsychotic (Risperidone) or combine clomipramine and citalopram
- Serotonin syndrome

Serotonin Syndrome

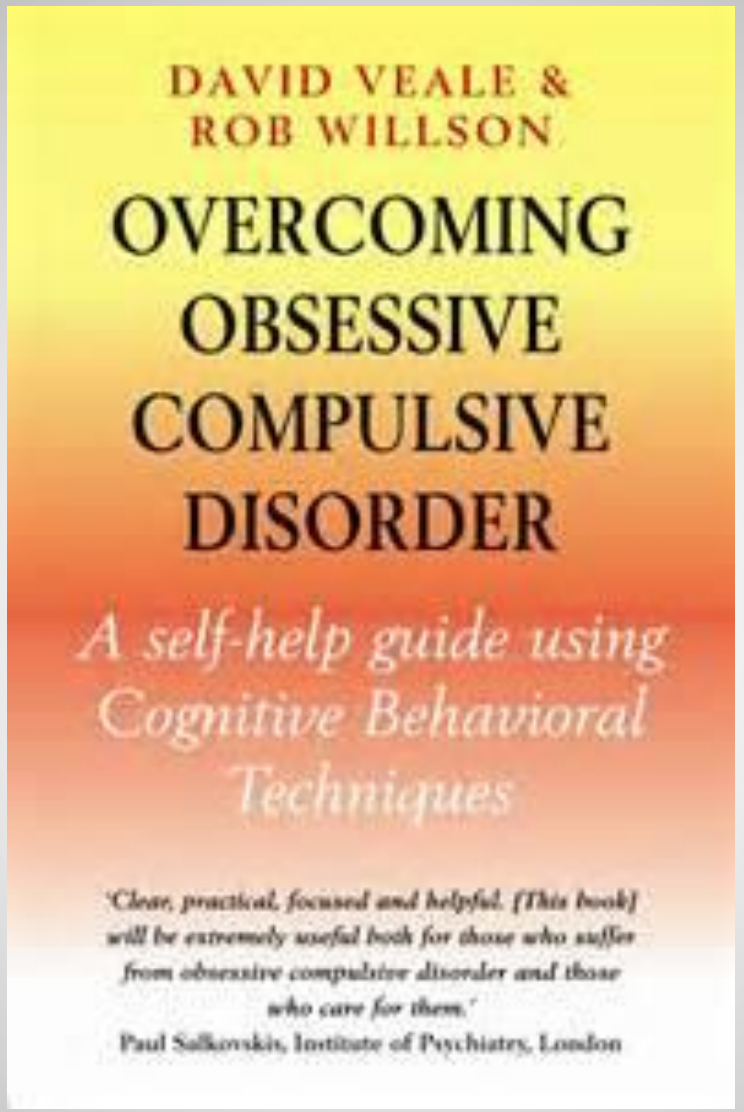


OCD Treatment in Secondary Care

- Refer for CBT specifically Exposure and Response Prevention (ERP)
- Highest dose of SSRI that is tolerable. (Sertraline, Citalopram, Fluoxetine, Fluvoxamine, Paroxetine)
- If SSRI not working switch and titrate to high dose (Citalopram and Clomipramine - Serotinergic)

OCD Summary of NICE guidance

- Stepped Care
- Start with assessment. Degree of distress and functional impairment; comorbid illness, substance misuse; past treatment response.
- Treat primary disorder first
- Psychological therapy first line CBT/ERP
- Pharmacological therapy effective. SSRIs as first line. GP recommended to start Sertraline
- Provide written information - Treatment
- Consider combined therapy for complex or refractory.


DAVID VEALE &
ROB WILLSON
OVERCOMING OBSESSIVE COMPULSIVE DISORDER
A self-help guide using Cognitive Behavioral Techniques
'Clear, practical, focused and helpful. [This book] will be extremely useful both for those who suffer from obsessive compulsive disorder and those who care for them.'
Paul Salkovskis, Institute of Psychiatry, London

Adult Depression and Anxiety Pathway for Primary Care

Helpful primary care advice can be found at:
www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx
www.sabp.nhs.uk/moodhive

DIAGNOSIS

DEPRESSION

Core symptoms:

1. persistent sadness/low mood
2. loss of interest
3. fatigue or low energy

Associated symptoms:

- disturbed sleep (mid-late insomnia)
- poor attention and concentration
- low self-confidence, self-esteem
- increased (or decreased) appetite
- suicidal thoughts
- agitation or slowing
- guilt and unworthiness
- bleak and pessimistic view of future
- Ideas/acts of self harm or suicide

Clinical depression

1 or more core symptom
+ 3 associated = MILD

+ 4-5 associated = MODERATE

+ 6 or more associated = SEVERE

Symptoms present every day, for at **least 2 weeks**

ANXIETY SPECTRUM

Including generalised anxiety disorder, panic disorder, social phobia, OCD, PTSD

- apprehension
- panic attacks
- irritability
- poor sleep (early insomnia)
- avoidance
- poor concentration
- worrying and catastrophic thinking
- external triggers

Other symptoms include somatisation, dissociation, tension, autonomic symptoms.

Ask about:

- hopelessness and thoughts of self harm.
- periods of elated mood, excessive energy and disinhibited behaviour lasting at least several days.

Review 1-4 weeks or if deterioration. Check for suicidality, side effects and compliance.

www.nice.org.uk/guidance/cg90

https://patient.info/doctor/patient-health-questionnaire-phq-9

www.nice.org.uk/guidance/cg113

https://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7

http://www.choiceandmedication.org/generate.php?sid=52&fname=handychartanxiety.pdf

Developed by Dr J. Hague, Dr R. Tandy, and Dr M. Jensen - I&E Suffolk and west Suffolk CCGs and NSFT. October 2017

*SSRI side effects: - Bleeding
- Initial increase in anxiety
- Low sodium
- Loss of libido

TREATMENT

Review 2-4 weeks or if deterioration

Review 1-4 weeks or if deterioration. Check for akathisia, agitation, suicidality, compliance

MILD – MODERATE (+ chronic physical health problem)

MODERATE-SEVERE (+ complex problems/ chronic physical health problem)

Step 1

- **Lifestyle advice** – alcohol, exercise, smoking, relationships, support
- **Self-help** – books on prescription, mindfulness:
  https://readingagency.org.uk/adults/quick-guides/reading-well/
  www.overcoming.co.uk/single.htm?ipg=4795
  www.moodjuice.scot.nhs.uk
  www.littf.com
  www.nhs.uk/Conditions/stress-anxiety-depression/pages/mindfulness.aspx
- **Suffolk Wellbeing Service** (SWS):
  - website resources https://www.wellbeingnands.co.uk/
  - Professional or self-referral: **0300 123 1781**
- **Self-funded psychology:** https://www.bacp.co.uk/

Step 2

Psychology: CBT/IPT/group work
- Self-refer or professional referral to SWS
- Self-funding (BACP)

Pharmacology: Based on patient preference, co-morbidities, age, pregnancy, breast feeding, previous experience with anti-depressants

- **1st line**: SSRI*
  -sertraline for anxiety

See also:
http://www.choiceandmedication.org/generate.php?sid=52&fname=handychartdepression.pdf
http://www.choiceandmedication.org/generate.php?sid=52&fname=handychartanxiety.pdf

-aim for maximum dose, check compliance

- **2nd line:** another SSRI
  SNRI - venlafaxine
  Mirtazapine (sedative)

Need to continue for 6-12 months after recovery to reduce relapse risk

DO NOT PRESCRIBE OR ADVISE ST JOHN'S WORT

Step 3

CONSIDER PHONE/EMAIL ADVICE OR REFERRAL TO AAT USING PROFORMA
Severe functional impairment
Not responded or intolerant to 2 different classes of anti-depressants
Physical co-morbidities impact on management
Moderate – severe symptoms
Significant neurological disorders or cognitive impairment

CONTACT DETAILS:
AAT Tel: **0300 123 1334**
Referral proforma: Available on GP clinical systems and Map of Medicine

For GP advice email:

IDT (For patients known to NSFT)
Mon-Fri 9am -5pm
Bury North: 01638 558650
Bury South : 01284 733188
Central Suffolk: 01449 745200
Coastal Suffolk: 01473 279200
Ipswich: 01473 341100

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