

Anxiety

Author: Pamina Mitter (MBBS, Intercalated BSc, MRCPsych.)

Topic Reviewers: Kaz Knudsen (RAN, WA); Vivien (RAN, Amata); Jane Kollner (RAN, Ampilatwatja); Teresa Bowmen (RAN, Papunya)

What is anxiety?

In Western populations it has been shown that perhaps between 17-24% of people could be suffering from neurotic symptoms. The national survey of Mental Health of Australians (1999) found that a little less than one in five Australian adults (17.7%) had an anxiety, affective or substance misuse disorder in the past year. Anxiety disorders were the most common.¹ They affected just under one in ten adults (9.7%). Of these, 7.1% were men and 12% were female. A least 40% of people with anxiety disorders will have one other mental illness.

Post traumatic stress disorder was the most common of the anxiety disorders (3.3%). Obsessive-compulsive disorder was the least common with only 0.4% reporting symptoms consistent with this disorder. The anxiety disorders – especially panic disorder, agoraphobia and post traumatic stress disorder – are more common in females. The anxiety disorders are prevalent in people aged 18 to 54. Their prevalence only begins to decline after the age of 55 years.

Generally, most people with a mental illness respond well to good supportive family relationships, work/ productivity, belonging/connectivity, spirituality, and beliefs about the past, present, and future.²

Different anxiety disorders³

Specific phobia

This is characterised by a persistent and irrational fear and avoidance of a particular object or situation.

Panic disorder

Individuals experience recurrent and unexpected panic attacks which are followed by a persistent concern about having another panic attack or concern about the implications of the panic attack (e.g. that they are going to die or have a heart attack).

Agoraphobia (with or without panic attacks)

Individuals are anxious about being in a situation from which escape maybe difficult or embarrassing, or in which help may not be easily available should panic-like symptoms occur. The anxiety leads to avoidance of certain situations, e.g. going out alone into crowded places.

Social phobia

Individuals are anxious about being in social situations in case they do something embarrassing or look anxious. They often avoid others.

Generalised anxiety disorder

Individuals have persistent, generalised and excessive feelings of anxiety about a number of events or activities. This tends to predominate the clinical picture.

Obsessive-compulsive disorder

Individuals experience unpleasant and intrusive obsess-ional thoughts that are difficult to control, e.g. concern about dirt or about harm coming to their family. This can be associated with carrying out rituals or compulsions regularly, e.g. checking and hand washing excessively.

Acute stress reaction

Following a traumatic event individuals experience a short-term (days) reaction that may involve disorientation, anxiety, amnesia, agitation and withdrawal.

Post-traumatic stress reaction

Individuals experience long-lasting anxiety about memories of a previous traumatic event and may have nightmares, flashbacks and avoidance of cues that act as reminders of the traumatic event.

Adjustment disorder

Individuals experience a short-lived period of distress and emotional disturbance following a significant life change or stress.

Cross-cultural issues

In all mental illnesses it is useful to think in terms of biological, psychological and social factors affecting the individual and possibly contributing to mental illness.

In remote communities it is also particularly useful to consider the cultural and social factors, as these provide the framework through which anxiety reveals itself. These may contribute toward or provide help for anxiety disorders. For instance, if someone has broken traditional law or feels that they have been cursed they may experience anxiety, which may be entirely appropriate from the community's point of view.

On the whole it is less useful to try to divide problems into those that were 'real' biological illnesses or cultural phenomena. It is more helpful to try to work with the client in a way that manages the person using the best available resources. Cultural factors play a part in mental illness all over the world but should not be seen to minimise the significance of the disorder. There is no evidence to show that anxiety disorders should be more or less common amongst different cultures, but they may manifest themselves differently. Often Aboriginal families are very pragmatic and accept medication, seek help from a traditional healer for the psychological and spiritual side, and will mobilise family for social supports.⁴

Diagnosis of anxiety

In Aboriginal clients anxiety is one of the most difficult emotions to detect and to understand its expression in words. There has been some work that shows how non-Aboriginal clinicians can underestimate anxiety and emotional distress in Aboriginal people.⁵ Nonetheless, there has been some linguistic research that shows that Aboriginal languages reveal a surprising array of phrases relating to anxiety and related somatic phenomena.⁶

A complication in making the diagnosis is that often the client will be anxious about having to come to talk about their problems and may appear shy and worried, when in fact this is not their usual behaviour. Conversely, many people who really have these disorders will never come to you to seek help and their families may

have compensated for their problems and let them lead a sheltered life, e.g. tolerated their obsessions or avoidance of panic inducing situations.⁷

Amongst Aboriginal people it will often be much more appropriate for people to seek help from traditional healers for anxiety than from the health service. If people come to seek help it maybe after other strategies have not worked.⁸

Somatisation (feeling physical symptoms from a psychological state) is frequently seen in Aboriginal people as a manifestation of anxiety and distress. Thus, anxiety as well as depression always needs to be considered when people recurrently present with undiagnosable pains and symptoms.⁹

Differential diagnosis of anxiety disorders

Appropriate anxiety

In Aboriginal communities people experience a high rate of significant life events. Fear of disease may be due to recent bereavements or experience of crime or domestic violence. This may be appropriate and need reassurance and problem-solving strategies.

Physical

Thyrotoxicosis, general ill-health, e.g. anaemia, poorly controlled diabetes, hypertension etc may cause or complicate anxiety.

Psychiatric

Depression, early psychosis or early dementia may also be present.

Substance abuse

Excess caffeine, alcohol, petrol/ solvent sniffing, Kava, Marijuana and other illicit drugs may confuse the diagnosis and management. These issues should be simultaneously addressed.

Management

As discussed in the chapter on depression, the use of family and community members to diagnose and manage mental illness is essential.⁴ For more traditional community members the use of a traditional healer and an understanding of the cultural background may be helpful. Beware though, a culturally appropriate explanation may be given – but a treatable psychiatric condition may also be present. The advice of a specialist mental health worker or psychiatrist should always be sought in difficult cases, even if only via the telephone. It is extremely important to exclude physical conditions before diagnosing a psychiatric one.⁴

Psychological therapies

Psychological therapies for anxiety disorders are the ideal first line treatment in many countries. However, this involves using trained staff who have good communication skills and language, and a well-motivated patient with reasonable literacy skills. There is good evidence that cognitive behavioural therapy (CBT) is an effective treatment in developed countries. CBT tries to enable the client to link their behaviour, emotions, and physical symptoms to their thoughts. It helps demonstrate how all these are interlinked and, by use of diaries and homework (or alternative tools in remote Aboriginal communities), it aims to help the client challenge their set patterns of negative thoughts, emotions and behaviour, and hopefully decrease their symptoms.

Obviously, access to these treatments is limited in rural and remote communities and may not always be workable in a very different cultural context. Thus, I have described below easy relaxation and breathing exercises and explained

a little about a behavioural treatment of graded exposure which may be more useable out bush.

After this I shall discuss possible drug treatments of these conditions, which may need to be first-line in remote practice.

Suggested management strategies for anxiety disorders

All medication advice is based on the Prescribing Guidelines in the Australian Medicines Handbook.¹⁰ Please also see the chapter on depression for further information about mental illness and medication.

Specific phobia

Medications are not recommended except in one-off circumstances, e.g. the use of benzodiazepines for extreme flying phobia.

Panic/agoraphobia

Educate the patient about anxiety and reassure them that they are not physically ill.

Advise breathing and relaxation training initially. When they are confident with these techniques plan a supported graded exposure to feared places/objects. (As long as this is not contrary to cultural beliefs and taboos.)

Avoid using drugs or alcohol to reduce anxiety as this will worsen the problem in the long run.

Slow breathing exercise

To be practised regularly and at the first sign of anxiety and overbreathing. Overbreathing can make you feel short of breath, tingling in the toes and hands, like yawning a lot, anxious and around the mouth (hyperventilation syndrome).

1. Hold your breath and count to five (do not take a deep breath).
2. When you get to five, breathe out and say the word "relax" to yourself in a calm, soothing manner.
3. Breathe in and out slowly through your nose in a six-second cycle, i.e. breathe in for three seconds and out for three seconds. Say the word "relax" to yourself every time you breathe out.
4. At the end of each minute, i.e. after 10 breaths, hold your breath again for five seconds and then continue breathing using the six-second cycle.
5. Continue breathing in this way until all the symptoms of overbreathing have gone.

Relaxation exercise

For each muscle group in the body, tense the muscles for 7-10 seconds then relax for about 10 seconds. Only tense your muscles moderately, starting from the muscles in your feet, then your calves, then your thighs etc. until you have tensed and then relaxed your whole body. Then lie still for a few minutes. This needs to be practised twice a day for eight weeks to be really effective.

Principles of graded exposure

1. Use relaxation and breathing exercises before and whilst having exposure to the feared stimulus.
2. Help the person identify any exaggerated fears that occur in the feared situation and decide what is more likely to happen.
3. Remind them that anxiety rises initially when confronting a situation but it also falls within a few minutes. Only by remaining in the situation will they learn that there is nothing to fear.
4. Plan a series of steps to build confidence in feared situations:
 - i. Identify the first small step towards overcoming the feared situation
 - ii. Practise this step until it no longer provokes anxiety

- iii. Move onto a more difficult step and repeat the practice
- iv. Continue this process until the person can manage the feared situation

Do not use drugs or alcohol to cope with the feared situation.

Medication

An SSRI is the first-line pharmacological treatment for panic disorder. An SSRI is a selective serotonin reuptake inhibitor and is a class of antidepressant. There are no trials comparing different SSRIs, which are all probably equally effective.

Doses are: paroxetine starting dose 10 mg (gradually increasing up to 40 mg); fluvoxamine (25-200 mg); citalopram (10-40 mg); sertraline (25-150 mg); or fluoxetine (10-60 mg). The onset of action may not appear for up to six weeks, and the full response up to twelve weeks.

Note:

1. Up to 40% of patients with panic disorder experience an 'activation syndrome' of agitation on starting an SSRI. This can be minimised by education, using half or even quarter the starting dose used for depression and gradually increasing the dose. Fluoxetine might have a greater association with an activation syndrome and so is not usually recommended for panic disorder.
2. About 40% of patients relapse on discontinuation of the SSRI, and so treatment is usually continued for a minimum of 12 months. Once in remission the dose can be reduced slowly.
3. Discontinuation syndromes may occur, especially with shorter acting SSRIs, e.g. paroxetine. Once in remission the dose should be tapered slowly (about 25% every two months). These syndromes can cause dizziness, electric shock sensations, anxiety and agitation, insomnia, flu-like symptoms and mood swings.

Use of benzodiazepines in panic disorder

These drugs tend to be associated with improvement within the first week, but tolerance usually limits their use over the longer term. They are sometimes used when an SSRI is first started, but their use should be limited to a few weeks. They will cause a withdrawal syndrome if used longer term, and if their use can be avoided this is preferable. If they have to be used a planned discontinuation and a tapering of the drug within six weeks is needed. Short acting drugs like alprazolam can cause severe rebound anxiety and should be avoided.

Benzodiazepines should not be used for patients with a history of alcohol or drug abuse. This is because of two main reasons. Firstly, those with a problem of alcohol or drug dependence are at higher risk of becoming dependant on benzodiazepines. Also the benzodiazepines potentiate the sedating effect of alcohol and some other drugs like barbiturates.¹² Taking alcohol and benzodiazepines together can increase the risk of fatal respiratory depression.¹³

Social phobia

For clients with a severe social phobia, or have this combined with depression, a SSRI is recommended. Those with social phobia do not usually experience an activation syndrome and can start on a normal starting dose of the drug.

Dose: paroxetine (20 mg gradually increased to 50 mg); fluvoxamine (50-150 mg); sertraline (50-150 mg); citalopram (20-50 mg); fluoxetine (20-60 mg).

Note:

1. The starting dose is used for 2-4 weeks and then increased if necessary.
2. The onset of action is within six weeks, but full response may take up to 12 weeks.

3. 40% relapse on discontinuation, so a treatment is usually continued for at least 12 months. Once in remission the dose can be reduced slowly.

Generalised anxiety disorders

Use an SSRI or venlafaxine, start at low dose in a similar manner to panic disorder treatment.

Try to avoid the use of benzodiazepines, but if needed use for less than four weeks and use one with a long half-life, e.g. diazepam.

Obsessive-compulsive disorder

An SSRI is the first choice medication.

Dose: fluoxetine starting at 20 mg and gradually increasing up to 80mg; paroxetine (20-60 mg); sertraline (50-200 mg); citalopram 20-60 mg). All SSRIs are probably equally effective, but choice depends on side effect profile. Gradually increase the dose to maximum tolerated within eight weeks of start of treatment. The patient needs to stay on this maximum dose for at least 12 weeks to see if it works. Maintenance on the drug should continue for a year, but the dose can be reduced by up to half the original dose once the patient is better.

The drug should be tapered and stopped slowly to avoid relapse and discontinuation symptoms.

Acute stress reaction

Supportive counselling involving family and community supports is usually effective.

The use of formal debriefing is not clear, and giving non-specific support may be more appropriate.¹¹

Advise against the use of alcohol or drugs to relieve symptoms.

Post-traumatic stress disorder

Refer for specialist psychological therapies if severe; consult with local mental health services on possible referral options.

Treat as for panic disorder initially with an SSRI or venlafaxine.

Avoid the use of benzodiazepines.

References

- ¹. Andrews G, Hall W, Teesson M, Henderson S. The mental health of Australians. Canberra; Commonwealth Department of Health and Aged Care, Mental Health Branch, April 1999.
- ². Curtis L. Personal recovery in psychiatric disorders. In: Central Australian Rural Practitioners Association (CARPA), Standard Treatment Manual. Alice Springs: CARPA, 2002.
- ³ Not used.
- ⁴. Sheldon M. Psychiatric assessment in remote aboriginal communities of central Australia. FRANZCP: Alice Springs, 1997. Dissertation. www.ams.org.au/mark_sheldon/index.htm
- ⁵. Morices R. Know your speech, community. No 1: fear and anxiety. The Aboriginal Health Worker 1977a; 1(1):4-9.
- ⁶. Morices R. Know your speech, community. No. 4 - serious mental illness. The Aboriginal Health Worker 1977d; 1(4):10-15.
- ⁷. Hunter E. Aboriginal mental health awareness: an overview part four, mental state examination. Aboriginal and Islander Health Worker Journal 1993; 17(3):14-20.
- ⁸. Dunlop S. All that rama rama mob, Aboriginal disturbed behaviour in central Australia (2 volumes). Alice Springs: Central Australian Aboriginal Congress, 1988.
- ⁹. Reser J. Aboriginal mental health: conflicting cultural perspectives. In: Reid JT, Trompf P. editors. The health of Aboriginal Australia. Marrickville, NSW: Harcourt, Brace Jovanovich, 1991.
- ¹⁰. Australian Medicines Handbook. Adelaide: AMH, 2001.
- ¹¹. Mendelson G. ed. Australian Forensic Psychiatric Bulletin 2001; 20:25-7.
- ¹². Weatherman R, Crobb DW. Alcohol and medication interactions. Alcohol Res Health 1999; 23(1):40-54.
- ¹³. British National Formulary, 2002.