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Anxiety: Module 1

Epidemiology, diagnosis and spectrum of illness

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Anxiety disorders are the most common disorders that clinicians should be encountering in the primary and secondary care setting. If they are not common in your practice, you are missing the diagnosis

This report was made possible by an unrestricted educational grant from **Cipla**. *The content of the report is independent of the sponsor.*

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Introduction

Anxiety is part of everyday life, it only becomes a health problem when it leads to undue significant distress and interferes with normal everyday functioning.

Anxiety is a vague term; it reflects a sense of discomfort, a feeling that 'something bad is going to happen', and is distinct from 'fear' which is provoked by a specific incident or event.

Anxiety disorders are the most common of the disorders that clinicians should be encountering in the primary and secondary care setting. If they are not common in your practice, you are missing the diagnosis. Anxiety presents a considerable burden to the healthcare system; frequently, anxiety disorder is masked. The patient presents to the attending clinician with a variety of physical symptoms, which are then often treated unsuccessfully because the prime cause of anxiety has not been recognised or treated. Suboptimal management is also a consequence of the range of different anxiety disorders and their co-occurrence with other conditions such as depression. It is further compounded by a widespread lack of awareness of anxiety disorders, both among individuals themselves and healthcare practitioners; this may may also be due to the low confidence on the part of many practitioners with regard to how to manage these conditions.[1]

Conversely, some patients with only mild or transient anxiety symptoms receive unnecessary, lengthy, inappropriate treatment with agents such as benzodiazepines.

KEY MESSAGES

- Diagnosis and management of anxiety disorders are frequently suboptimal
- Specific anxiety disorders vary in prevalence, with women twice as likely as men to suffer from anxiety disorders
- Key to diagnosing a specific anxiety disorder is identifying whether there is a predominant symptom pattern.

Epidemiology

The prevalence of anxiety disorders in a 12-month period among the general population is approximately 14%,[2] which then increases to 21% if prevalence is measured over a lifetime. Specific anxiety disorders vary in prevalence, with obsessive-compulsive disorder (OCD) occurring at a rate of 0.7% on an annual basis, and other specific phobias occurring at an annual prevalence of 6.4%.[1]

There is also a gender difference, with specific phobias occurring more frequently among women than men; an exception is panic disorder, which is gender neutral. Women are twice as likely to suffer from anxiety disorders as their male counterparts.[2]

In a South African prevalence study,[3] the most prevalent class of lifetime disorder was the group of anxiety disorders (15.8%). This is very similar to the international experience. Importantly, anxiety disorders tend to be chronic and present over many years, with symptoms fluctuating in severity.[1,2]

Diagnosis of anxiety disorders

The diagnostic classification changed recently with the introduction of the *Diagnostic and Statistical Manual of Mental Disorders* 5th edition (*DSM-5*), where some anxiety disorders such as acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) are now classified in a new grouping termed 'Trauma and stressor-related disorders'.

OCD and related disorders are part of a single classification, with a number of conditions such as hoarding disorder and body dysmorphic disorder collected within this class.

Also, *DSM-5* acknowledges that separation anxiety can occur in both children and adults. Specific anxiety disorders are discussed below.[1]

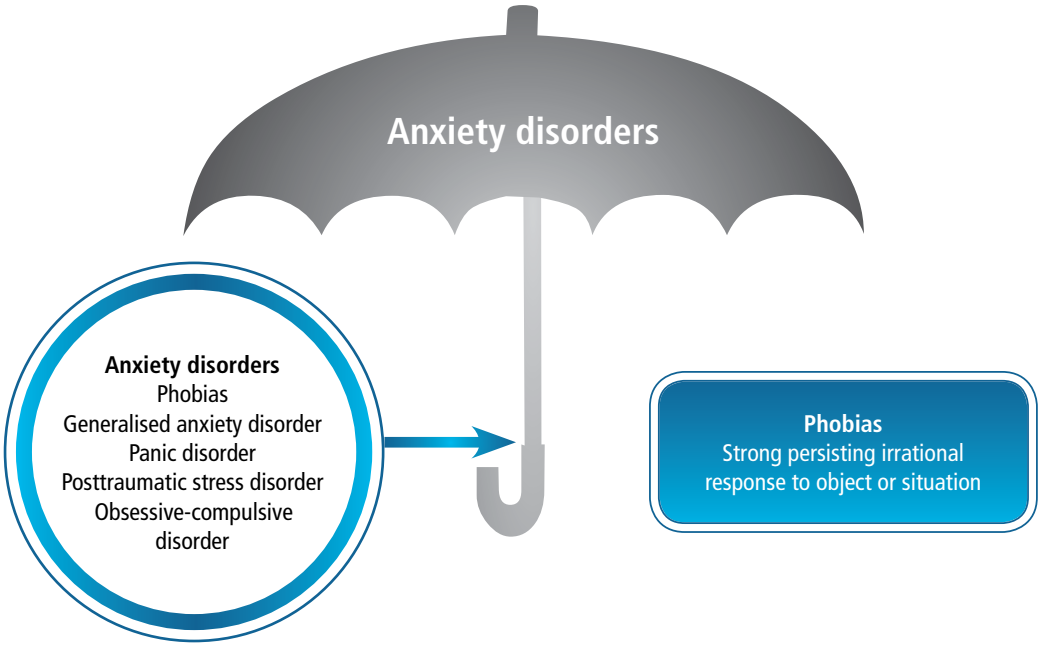

Figure 1. Anxiety disorders

GAD occurs frequently together with depression, panic disorder, health anxiety and OCD

Generalised anxiety disorder (GAD)

Recognised in both *DSM-4* and *DSM-5*, GAD is characterised by excessive and inappropriate worrying that is persistent, i.e. lasting more than a few months, and not restricted to particular circumstances. Typically, patients have both physical and psychological anxiety symptoms, which they typically describe as feeling "restless, keyed up and on edge".

GAD frequently occurs together with depression, panic disorder, health anxiety and OCD.[2] Patients with panic disorder, with or without agoraphobia, typically experience recurrent surges of severe anxiety interspersed with varying periods of anticipatory anxiety between panic attacks. The panic attacks are periods of intense fear or discomfort, patients frequently note the 'intense feeling of going mad'. The attacks typically reach a peak within 10 minutes and last around 30-45 minutes. Patients develop a significant fear of having further attacks.

Approximately two-thirds of patients with panic disorder develop agoraphobia, defined as fear of places or situations from which escape might be difficult or in which help might not be available. These situations include being in a crowd, being outside the home or using public transport, and are either avoided or endured with significant personal distress.

Social anxiety disorder or social phobia

Social phobia is characterised by a marked, persistent and unreasonable fear of being observed or evaluated negatively by other people in social or performance situations. It is associated with physical and psychological anxiety symptoms.

Normal everyday situations, such as talking to unfamiliar people or eating in public, cause excessive distress and anxiety. Diagnosis of these patients is

frequently missed; they self-medicate or request benzodiazepines or other medication, or use alcohol in order to cope with normal life. As a result the diagnosis is not made until the patient presents with substance abuse which, on investigating the patient's history, shows an initial and prevailing social phobia.

Specific phobia

This is, in fact, the most common phobia and is restricted to a single event or situation such as going to a dentist, spiders, fear of flying, getting into lifts or seeing blood. The patient understands their reaction to the situation and endures it, but with significant personal distress.

Separation anxiety disorder

This has now been introduced into *DSM-5* by the American Psychiatric Association. This disorder is characterised by fear or anxiety associated with separation from persons to whom the individual is attached. The person experiences excessive distress when anticipating or experiencing separation from their attachment figure. They also worry about potential harm to the attachment figure when they are not together. Separation anxiety disorder is not only experienced by children but can be, and is, experienced by adults.

PTSD

PTSD is frequently experienced in South Africa with its high levels of violence and violent behaviour. It is a true 'stress disorder' and is characterised by a history of exposure to trauma or to a single traumatic event. The sufferer experiences intense fear, helplessness and even horror; these reactions also manifest as intrusive recollections, flashbacks or dreams. The individual develops avoidance symptoms related to attempts to evade activities that may trigger the violent/traumatic memory. There is a damaging effect on cognition and mood stability, which is not widely recognised clinically. These patients also suffer from hyperarousal symptoms including disturbed sleep, hypervigilance and an over-exaggerated startle response.

OCD

This disorder is not that common, affecting about 1% of the population, but it can be extremely debilitating. It is characterised by obsessive thoughts and images that recur, which leads to recurrent physical or mental rituals (compulsions). These are distressing, time-consuming and cause interference in social and occupational functioning. Common obsessions relate to contamination, accidents, religious and sexual matters. They can lead to frequent obsessive rituals including washing, checking and re-checking alarms, or touching a surface repeatedly ('touching wood'). This syndrome is not as severe as PTSD but is extremely distressing.

Illness anxiety disorder – previously known as hypochondriasis

This is a somatic symptom-related disorder characterised by excessive or disproportionate preoccupation with having or getting a severe illness and high levels of alarm about personal health status. Frequently these patients do not have any physical illness.

Identifying the particular anxiety disorder

This algorithmic clinical pathway shows that patients may present superficially with moderate or severe depression, but by focusing on identifying whether there is a predominant symptom pattern, the presence of an anxiety disorder can be diagnosed (Figure 2).

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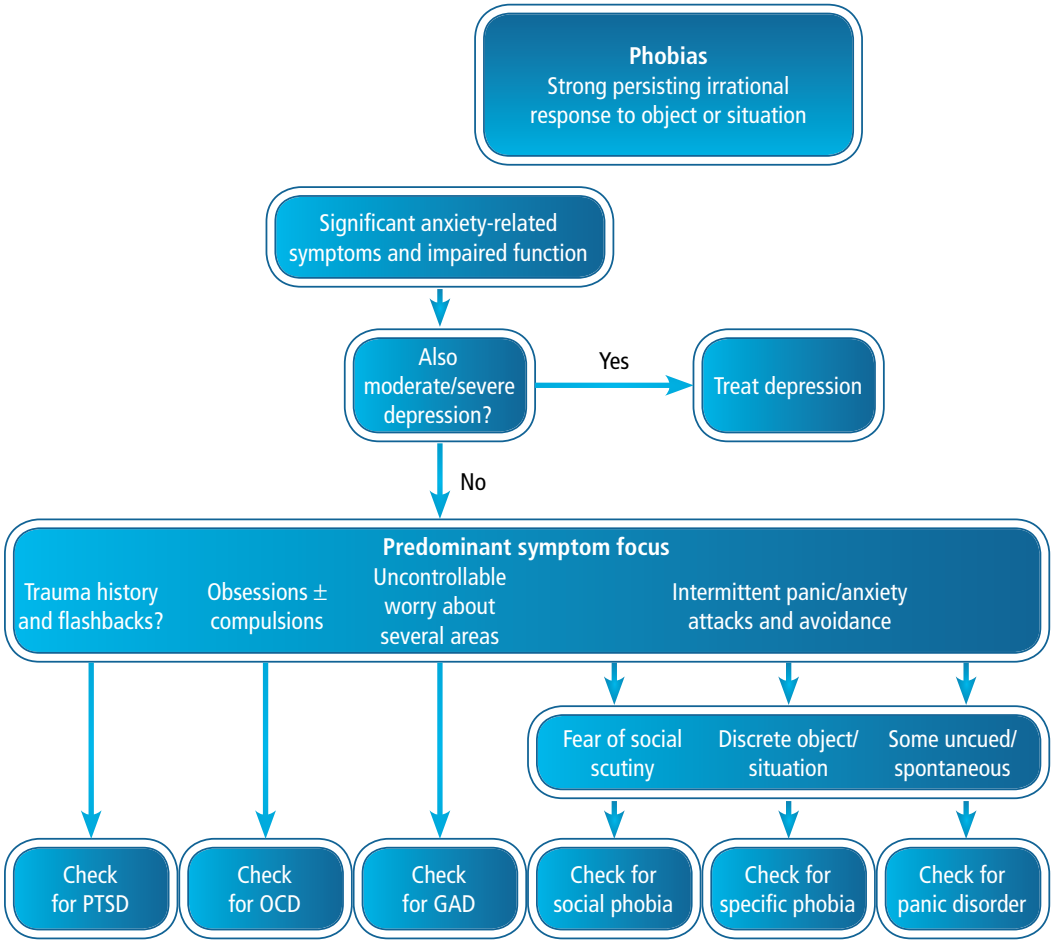

Figure 2. Clinical pathway to assess and identify anxiety disorders

General recommendations

- Benzodiazepines can be effective in many patients with anxiety disorders, but the clinician and patient need to recognise that this should generally only be used short-term
- Benzodiazepines should only be used in the longer term if all other treatment approaches have failed
- The clinician should always discuss the potential for experiencing discontinuation or withdrawal symptoms in the event of unplanned therapy interruption
- The attending healthcare professional needs to remain familiar and up to date with the evidence base for other classes of medication, as patients my respond to different classes of psychotropic agents.

References

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