

Clinical Practice Guidelines for the Management of Generalised Anxiety Disorder (GAD) and Panic Disorder (PD)

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INTRODUCTION

Short description of anxiety disorders

Generalized Anxiety Disorder (GAD)

Definition: One of the anxiety disorders, where the primary symptoms of anxiety are present at most days for at least several weeks at a time, and usually for several months. The symptoms should usually involve elements of:

- Apprehension (worries about future misfortunes, feeling “on edge”, etc)
- Motor tension (restlessness, inability to relax, trembling)
- Autonomic over activity (light-headedness, sweating, tachycardia, tachypnea, dry mouth etc)

The transient appearance of depressive symptoms, does not rule out the diagnosis of GAD as main diagnosis. The sufferer must not meet the full criteria for depressive episode, phobic disorder, panic disorder or OCD.

Patients with generalised anxiety disorder have high anxiety and are worried about intrapsychic conflicts or external environmental events. They have multiple somatic symptoms of anxiety, restlessness, difficulty in concentration, irritability, fatigue, muscular tensions and difficulty in sleeping particularly early insomnia. They have vague apprehension about future events and fear of unknown. Common features observed in anxiety disorders include:

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Panic Disorder- Episodes of intense fear or discomfort accompanied by severe autonomic activity, palpitations, sweating, dyspnoea, choking sensation or other somatic symptoms like chest pain, trembling, nausea, discomfort or fluttering sensation in abdomen and impending fear of death. Patient perceives it as a serious medical condition and invariably reaches to a medical emergency setup where after thorough physical evaluation he is declared normal.

Phobias- Many patients with GAD suffer from irrational, unrealistic fears and acute autonomic reactions to certain specific situations or extreme fear to certain inanimate objects. They include agoraphobia (fear of open spaces) fear of crowds, being out side home alone or traveling in a bus train or car. Some may have fear in closed spaces (claustrophobia) fear of heights (acrophobia) fear of opposite sex (hetero-phobia) fear of sight of blood (erythrophobia) or fear of facing certain social situations (social anxiety disorder) the common feature among all phobias being intense fear, increased autonomic activity and avoidance behavior (avoiding the fearful object or situation).

Obsessive compulsive disorder- (OCD) has been separately dealt with in details in these guidelines however the patients suffering from OCD have recurrent repetitive unwanted intrinsic thoughts (obsessions) or actions (compulsions) or both which lead to extreme distress, loss of time and impairment of functioning of the individual. The obsessions include doubts, ideas of contamination, sexual thoughts or religious preoccupations or negative thoughts towards gods/goddess, the compulsions include activities like counting, checking, repeating, washing hoarding and touching objects, some have to and fro movements of body parts. Patient is aware of the irrationality of thoughts/actions but cannot control them, which produces intense anxiety and autonomic arousal with feelings of helplessness and guilt.

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Post-traumatic stress disorder (PTSD) - Usually it occurs after a terrifying event that involving physical or psychological traumatic event. It may also occur because of witnessing or experiencing a serious harm to other significant persons in life. Patients have terrifying recollections of the event, or nightmares. Some patients have an experience of living the event in an illusionary or imaginary situation with hallucinations, or flashback episodes. The patients suffer from intense psychological or physical distress. Many patients develop loss of interest, estrangement from others, sleep disturbances, irritability, difficulty concentrating, hypervigilance, and exaggerated startle response. This phenomenon may persist for one month or more before it is diagnosed.

Natural history and course

The age of onset is difficult to specify, as most of the patients have been anxious for long but report late. Nearly 1/3rd of the patients who have GAD seek psychiatric treatment. Many go to GPs, physicians, cardiologist, chest specialist for the somatic component of the disorder. Because of the high incidence of co-morbid mental disorders, the course and prognosis is difficult to predict. The occurrence of several negative life events greatly increases the likelihood that the disorder will develop. In all, a chronic condition may be life long.

COMMON INGREDIENTS OF MANAGEMENT PLAN (FLOW CHART-1 AND 2)

The aim of management is to provide relief in psychological and somatic symptoms and minimize the impairment. This can be addressed in following ways.

1. Pharmacotherapy

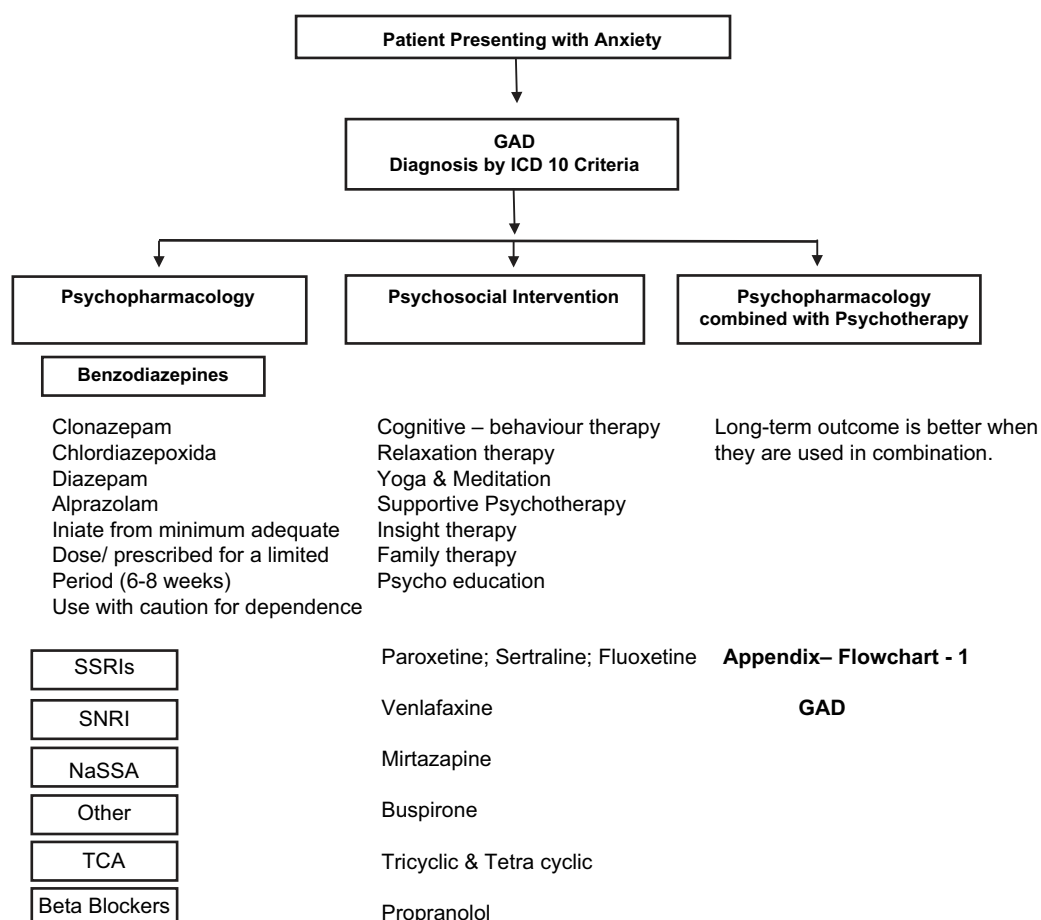
The drug treatment of GAD is some times required as long as 6-12 month treatment, some evidence indicate that treatment should be long term.

2. Psychotherapy

- Cognitive behaviour therapy
- Behavioural techniques
- Supportive Psychotherapy
- Insight oriented Psychotherapy

Goals

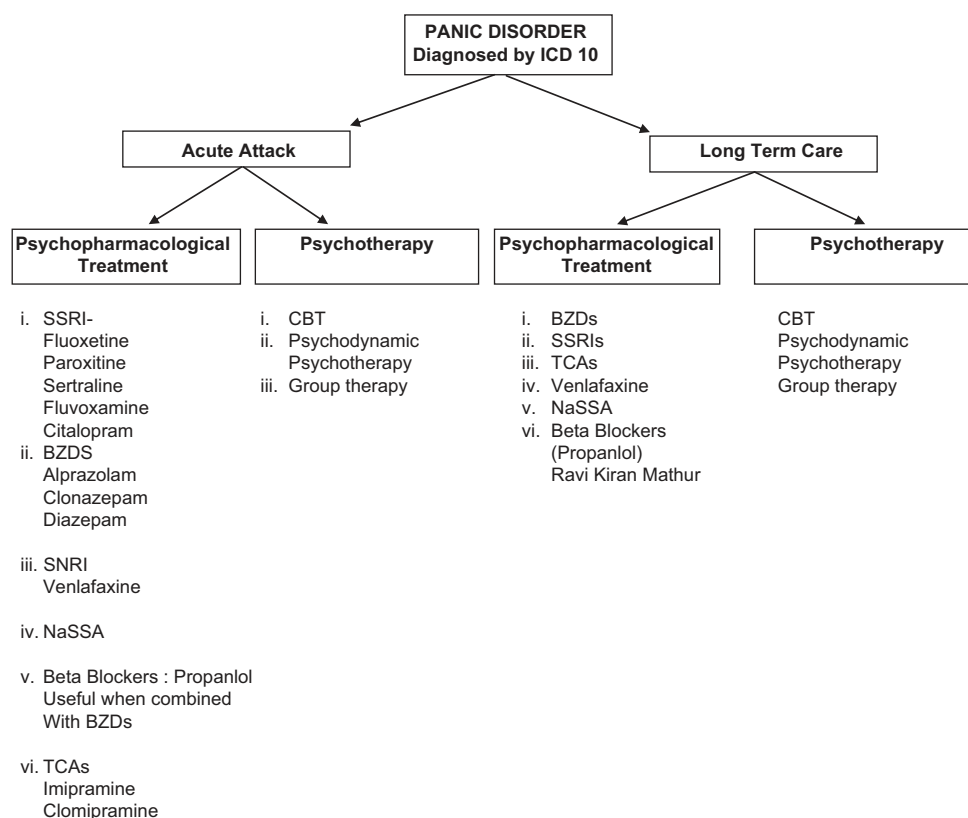
- Psycho-education Direct explanation of the symptoms and disorder to the patient and the family.
- Monitoring of anxiety
- Cognitive restructuring: Corrects the hypothesized cognitive distortions and helps to identify and counter fear of bodily sensations.



Appendix– Flowchart - 1

GAD

Flowchart 1: Management of Generalized Anxiety Disorder



Flowchart 2: Management of Panic Disorder

Efficacy

Cognitive Behavioural Therapy has proven efficacy other psychotherapies do help in ameliorating symptoms of anxiety. It addresses cognitive distortions and somatic symptoms. More effective with chronically anxious patients, may need 8-10 sessions. It has been shown that yogic techniques produced greater motivation to practice than progressive relaxation. Meditation was found to be as effective as pharmacotherapy in controlling symptoms of anxiety. The overall efficacy claims are backed by very few Indian studies, but are useful. It requires considerable time and discipline from the patients.

Adverse effects

These are relatively benign. Some patients may develop dependence on the therapist and that needs cautious vigil.

3. Combined pharmacological and psychotherapeutic intervention

Long-term outcome is better when they are used in combination.

ASSESSMENT AND EVALUATION

1. Performing a diagnostic evaluation

Psychiatric evaluation and physical examination is necessary.

It includes history of present illness, current symptoms; past psychiatric history, general medical history and history of substance use, personal history (eg. psychological development, life events and response to those events), social, occupational and family history; review of the patient's medications; physical and mental status examination and adequate diagnostic tool and criteria. Diagnose GAD according to ICD-10 (W.H.O,1992).

Anxiety should not be due to the other Axis I disorder (eg. mood disorder, psychotic disorder, social phobia, OCD, somatization disorder, hypochondriasis, PTSD) or a general medical condition (eg. hyperthyroidism) or substance use disorder (intoxication or withdrawal), (see appendix-1 for flow chart).

2. Evaluating particular symptoms

Patients experience excessive anxiety but many of them experience panic attacks, which may worsen the clinical picture. The prolonged illness may cause depressive symptoms with emergence of suicidality and substance abuse.

3. Evaluating severity of functional impairment

Many may continue to function in their social and occupational lives with some impairment, others may become severely incapacitated and give up their jobs and social duties. The impairment in different areas can be assessed self-administered visual analog scale.

FORMULATING TREATMENTS AND CHOICE OF TREATMENT SETTINGS

The aim of management is to provide relief in psychological and somatic symptoms and minimize the impairment. This can be addressed in following way.

1. Establishing and maintaining atherapeutic alliance

The treatment of GAD may be long lasting hence the alliance is crucial. Understanding the life events, the extent and severity of symptoms requires confiding and lasting therapeutic relationship.

Attention to the patient's worries and fears are essential for long term gains

2. Monitoring the patient's psychiatric status

The symptomatic improvement in psychological and autonomic symptoms leads to greater confidence in the treating doctor. The anxiety goes slowly with treatment and bursts of severe symptoms during the treatment need constant monitoring.

3. Pharmacotherapy

The drug treatment of GAD is some times is seen as a 6-12 month treatment, some evidence indicate that treatment should be long term.

a). Goals

Reduce psychological and autonomic symptoms and other co morbid conditions. Improve occupational and social functioning.

b). Efficacy

Little Indian data to address the issue; mainly western data available.

c). Adverse effects

Different for different class of drugs.

Selective serotonin reuptake inhibitors (SSRIs), **serotonin-norepinephrine reuptake inhibitors (SNRIs)**, and **pregabalin** are recommended as first line drugs due to their favorable risk-benefit ratio, with some differentiation regarding the various anxiety disorders. The common category of pharmacological agents used in management of generalised anxiety disorders include SSRIs, SNRIs, Pregabalin, TCAs, Benzodiazepines, Antihistamines, Atypical antipsychotics, and Antioxidants. Role of vitamin A, C and E has been evaluated and recommended in adequate doses for patients suffering from GAD.

Dosing

Majority of patients respond to the low dose of antidepressants (with the exception of OCD). In the elderly,

treatment should be started with half the recommended dose or less in order to minimize initial adverse drug events. The antidepressant dose should be increased to the highest recommended therapeutic level if the initial treatment with a low or medium dose fails.

For patients who do not improve with standard treatments, a number of alternative options should be tried including augmentation with small dose of antipsychotics or adding another anxiolytic agent or addition of non-pharmacological therapy like cognitive behavioral therapy (CBT) or Yoga, Meditation and increased physical activity as described below.

4. Non-pharmacological treatment

Non pharmacological treatment found useful in treatment of anxiety disorders include **supportive therapy**, **Exposure therapy** (e.g. gradual exposure *in vivo*, "flooding") and **response prevention**. Psychoeducational advice, and suggestions to not to avoid feared situations are helpful in management.

Cognitive Behavioural Therapy: Adequate strength of evidence is available for Individual CBT, Group CBT and Self-directed CBT. Choosing between medications and CBT is determined by a number of factors, particularly the patient's preference, treatment options at hand, adverse drug effects, onset of efficacy, comorbidity (e.g. with depression), financial considerations, time availability, accessibility of psychiatric and psychological treatment resources, and experience of the clinician.

Steps of CBT shall include:

1. Psychoeducation
2. Self-monitoring
3. Systemic exposure to panic inducing cues
4. Countering anxious beliefs
5. Exposure to fear cues
6. Modify [mal-adaptive behaviors
7. Relapse prevention
8. Dealing with transference issues
9. Resolving interpersonal and other emotional issues.

Initial expectations and anticipation favoring CBT

- Accept that the worrying is out of control
- Perhaps, worrying offers some protective value.
- CBT will facilitate future adversities, despite the worrying.

During the course of the treatment, revised understanding:

- The reasons for worrying and fears cannot be controlled
- Subjectively learn to control response to the fears and worries
- Learn to obviate the behaviour of worrying
- Worrying does not have a protective value
- Actually, worrying reinforces negative thinking

Excessive worrying increases likely hood or more anxieties in the future
 CBT does not alter the method of managing source of the worries
 CBT helps to be better equipped to handle the future stress.

Indian modules of psychotherapy

Several therapists have talked about Search of Indian module of psychotherapy and it is a felt need to have such a module, which is socially and culturally relevant.

Ancient Indian thought has provided very rich knowledge regarding mind and its functioning. From the Vedic period issues relating to mind, consciousness, understanding of human life, its existence and the concept of Atman have been widely studied and several explanations to improve the quality of human life are available in Vedic and Post Vedic literature. The Bhagvad Gita contains in condensed form all the philosophical and psycholoical wisdom of the Upanishads. Bhagwad Gita describes all aspects of yoga, psychology and is unique among the psychological and philosophical teachings for a student of psychotherapy, various aspects of psychotherapeutic techniques are described in it.

In this excellent module of Psychotherapy through 18 chapters way of self knowledge, the Yoga of action (karma) knowledge of renunciation and action, the path of meditation, knowledge of the absolute and eternal, yogic vision, yoga of devotion, profound knowledge of three Gunas and the wisdom of renunciation and liberation have been described at length, which leads to personality transformation of Arjuna. In the modern psychotherapy, cognitive restructuring is the goal of psychotherapy, which has been accomplished a great deal through Bhagwad Gita.

Prekshadhayan

A Jain Meditational technique propounded by Acharya Mahapragya, which includes relaxation, meditation, yoga, asanas and pranayam, a comprehensive capsule of behavioural management has been tried in management of GAD. On mental level, it proves to be an applied method to train the mind to concentrate. It offers a way to treat serious anxiety disorders with or without drugs. Large trials of this technique are still awaited. At present, few scientific studies are available.

5. Providing Education To The Patient And Family

This seemingly unimportant aspect is most relevant to Indian settings where awareness of psychiatric illness and its realization and need for treatment with compliance is little. Many feel dejected, angry, isolated and may have suicidal ideas. Family and the patient need to be told that this is like any other illness that needs treatment and success depends on compliance.

6. Addressing early signs of relapse

The education that the illness is a chronic relapsing illness is essential and emergence of anxiety with or without treatment should be promptly treated. Sudden discontinuation may lead to emergence of withdrawal symptoms thus early recognition by the patient and the family helps in prompt treatment.

MANAGEMENT AS PER THE DIFFERENT STAGES OF THE ILLNESS

The treatment recommendations for the different anxiety disorders are summarized in Table I. Some antianxiety drugs are effective in all anxiety disorders, whereas some drugs have only been studied in specific anxiety disorders and thus should be reserved for use in these particular disorders.

Panic disorder and agoraphobia. In acute panic attacks, mouth desolving short-acting benzodiazepines and reassurance to the patient may be sufficient. SSRIs SNRIs are first-line treatments for longterm management. Patients should be treated for atleast six to eight months or longer to prevent relapses.

A combination of CBT and anxiolytic medication has been shown to have the best treatment outcomes.

In GAD and Social anxiety disorder (SAD): Choice of Drugs for Management are SSRIs, SNRIs and pregabalin. Buspirone and hydroxyzine are second line treatment. Benzodiazepines should only be used for long-term treatment when other drugs or CBT have not shown results.

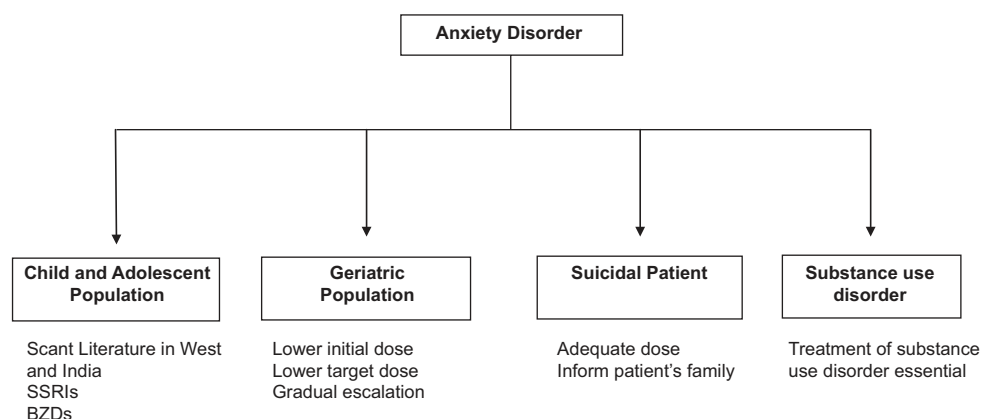
Specific phobia: Specific phobia should be treated with behaviour therapy including systematic desensatisation. SSRIs or short acting benzodiazepines should be tried in cases not responding to behaviour therapy.

OCD: Choice of treatments is the SSRIs and the TCA clomipramine. Cognitive behaviour therapy (CBT) and exposure and response prevention are other proven techniques of management.

PTSD: Choice of treatments includes the SSRIs and venlafaxine. Therapeutic conversation, psychoeducation and regrief therapy are non-pharmacological treatment techniques advocated.

TREATMENT UNDER SPECIAL CONDITIONS (FLOW CHART-3)

Pregnancy. The use of SSRIs and TCAs in pregnancy does not have increased risk for malformations. It is recommended to avoid paroxetine alprazolam use among pregnant women or women planning to become pregnant.



Flowchart 3: Management of Anxiety Disorders in Special Population

Breast-feeding. SSRIs and TCAs are excreted into breast milk, they do not cause any harm to the new born because the concentration in breast milk is very small however infants of mothers on benzodiazepines, should be observed for signs of sedation, lethargy, poor suckling, and weight loss, and if high doses have to be used and long-term administration is required, breast feeding should probably be discontinued.

Treating children and adolescents. Choice of treatment should be SSRIs concerns about increased risk of suicidal ideation and behavior have been reported therefore careful monitoring is advisable, presence of comorbid depression should be looked fore.

Treating the elderly. Elderly have increased sensitivity for anticholinergic properties, an increased risk for orthostatic hypotension, and ECG changes during treatment with TCAs, and possible paradoxical reactions to benzodiazepines, which include depression, with or without suicidal tendencies, phobias, aggressiveness, or violent behavior. Thus, treatment with TCAs or benzodiazepines is less favorable, while SSRIs appear to be safe.

Treatment of patients with severe Physical disease. Patients with cardiovascular, cerebrovascular and endocrine disease, irritable bowel syndrome, malignency, stroke, chronic obstructive pulmonary disease (COPD) hyperthyroidism may have associated anxiety reactions with their somatic disease state. Such anxiety disorders may compound the management and the prognosis of these primary conditions. Advocated pharmacological agents in such conditions include SSRIs and Venlafaxine.

WHEN TO STOP TREATMENT

Decesion to stop treatment will depend on clinical response of the patients. Usually the treatment is stopped in a tapering manner after atleast 6 months stability of clinical improvement and asymptomatic status of the patient. Before stopping the treatment, the nature of illness

possibilities of recurrence, response to triggers and his/her ability to cope with the situation should be discussed at length. Patient's personal view should be included in decesion making of stopping the treatment. Patient should be encouraged to adapt alternative methods of anxiety reduction like yoga, pranayam, relaxation techniques including progressive muscular relaxation (PMR)/Shavasan etc. which can be mastered by him before weaning off the smallest dose of antianxiety medication. Mindfulness-Based Cognitive Behavior Therapy (MBCBT) for reducing cognitive and somatic anxiety and modifying dysfunctional cognitions in patients with anxiety disorders has been tried where in different versions of mindfulness meditation, cognitive restructuring, and strategies to handle worry, such as, worry postponement, worry exposure, and problem solving have been employed. However, these studies are on small number of patients and need carefull review for further application.

MANAGEMENT OF SIDE EFFECTS OF MEDICATION

Diffrent side effects will emerge with different category of antianxiety medication. They should be carefully observed and addressed to. Side effects of medication can be drug related or dose related. If it is drug, related, alternative class of drug should be tried for adequate length of time. If it is dose related then the dose of the drug has to be reduced.

Things to remember for GAD:

1. Anticholinergic and cardiovascular side effects to be kept in mind when using tricyclic and Tetra cyclic for side effects. Precaution in suicidal patients.
2. Long-term treatment may be required.
3. Psychopharmacological therapy combined with psychotherapy works better.

SUGGESTED READING

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