

ASSESSMENT AND DIAGNOSIS OF ANXIETY

Assessment

Often patients will be non-specific about anxiety and reluctant to discuss symptoms or their anxiety experiences because discussing them leads to them feeling even more anxious. "I just feel anxious" or "nervous" or other general descriptors are used. We know that avoidance occurs, but it is not only avoidance of situations. Often avoidance occurs with emotions, thoughts and discussing the anxiety itself. GP behaviour can influence the likelihood of anxiety symptoms being talked about. Specific helpful strategies include:

- Routine questioning about mental health or general wellbeing
- Initiating discussion of potential anxiety which becomes evident, but might be avoided
- Active listening and feeding back empathy about distress
- Actively negotiating confidentiality about sensitive areas
- Asking specific questions about the thoughts people are having (fears or worries) and the physical anxiety symptoms
- Assessing: How often? How distressing? How interfering with life? What is not done now that used to be? (avoidance)

Differential diagnosis

Anxiety symptoms may be associated with a number of different psychiatric conditions. There are some of these where a referral for treatment of anxiety may not be indicated. Some differential diagnoses for anxiety symptoms are:

❖ **Drug and alcohol problems.**

Anxiety symptoms commonly occur in substance intoxication and substance withdrawal, for instance alcohol withdrawal. A referral to AOD services may be more appropriate than to mental health services.

❖ **Personality Disorder.**

Anxiety symptoms may be prominent for some personality disorders such as Avoidant, Dependent and Obsessive-Compulsive Personality Disorders. In situations like this treatment will take longer than 12 sessions so referral is more appropriate to other services than the GP Allied Psychological Services Project.

Establishing diagnosis

The most widely used psychiatric diagnostic system is the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association. Patients in primary care settings may often present with mixed, atypical or transient syndromes which do not neatly fit into DSM-IV.

Patients experiencing anxiety symptoms which do not fit neatly into one of the diagnostic categories may still be helped effectively. The following are descriptions of some of the main anxiety classifications according to DSM-IV.

Panic Attacks

As outlined in DSM-IV, patients typically describe **four or more** anxiety symptoms that cause considerable distress and **reach peak intensity** within ten minutes. The anxiety symptoms include:

- Palpitations
- Sweating
- Trembling or shaking
- Feeling short of breath
- Choking or smothering feeling, chest pain, or discomfort
- Nausea
- Dizzy, lightheaded
- Derealisation and depersonalisation, fear of losing control or going crazy, and fear of dying
- Numbness & tingling sensations, chills and hot flushes

Panic Disorder

In DSM-IV Panic disorder is diagnosed when:

- The patient experiences recurring **unexpected** panic attacks.
- There has been at least one month of:
 - a. Ongoing worry about having further panic attacks
 - b. Fear about what will happen if another attack occurs such as "losing control", "going mad", or "having a heart attack".
- There are behavioural changes as a result of the panic attacks such as repeated presentations to the A&E Department.

Agoraphobia

Agoraphobia is diagnosed in DSM-IV when:

- Situations or places are avoided (or endured with difficulty) for fear of experiencing a panic attack.
- The person typically worries that escape could be difficult or that help would not be available.
- It is common for the individual to "need" the presence of another person to negotiate these situations.

Generalised Anxiety Disorder

Generalised anxiety disorder (GAD) is diagnosed in DSM-IV when:

- There is excessive anxiety and worry that occurs most of the time, for more than 6 months, about a number of different concerns.
- The person finds it difficult to stop worrying, and experiences **at least three** of the associated anxiety symptoms listed:
 - Feeling restless and on edge
 - Fatigue
 - Poor concentration
 - Irritability
 - Muscle tension
 - Insomnia

Social Phobia

Social Phobia is diagnosed in DSM-IV when:

- There is a marked and persistent fear of one or more social or performance situations involving possible scrutiny by others.
- The person fears they may act in a way that will be humiliating or embarrassing.
- Exposure to the feared situation results in an elevated level of anxiety, and it can even result in panic attacks.
- The feared situations are either avoided or endured with an elevated level of distress.
- The person recognises that the anxiety (fear) is excessive or unreasonable.

Health Anxiety (Hypochondriasis)

Hypochondriasis is diagnosed in DSM-IV when:

- A person has a preoccupation with fears of having a serious disease, usually based on their misinterpretation of bodily symptoms.
- This fear persists despite medical evaluation and reassurance, often this advice is sought out frequently and possibly from many sources.
- The belief is not of delusional intensity, and is not restricted to a fear about appearance (body dysmorphic disorder).

Obsessive-Compulsive Disorder

In DSM-IV Obsessive-Compulsive Disorder (OCD) is diagnosed when:

- Obsessions are present as defined by:
 - Recurrent and persistent thoughts, impulses or images that are intrusive and cause elevated anxiety or distress.
 - These are not just excessive worries about real life problems/worries.
 - The person usually attempts to ignore or suppress these, or they attempt to neutralise them with another thought or action.
 - The person recognises that these are a product of their own mind (not inserted from outside).
- Compulsions are present as defined by:
 - Repetitive behaviours (eg handwashing, or checking) or mental acts (eg praying or counting) that the person feels driven to perform in response to the obsessions.
 - These behaviours or mental acts are aimed at preventing or reducing distress, or preventing some dreaded event or situation. These are clearly excessive.
- Mostly the person recognises that the obsessions or compulsions are excessive or unreasonable, but a subset have poor insight and do not recognise this.
- The obsessions or compulsions cause marked distress or are time consuming (take more than one hour per day) or interfere significantly with a person's routine.