MHPN
WEBINAR

Monday, 06 December 2021

An interdisciplinary approach to caring for people living with Generalised Anxiety Disorder

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Mental Health Professionals' Network

Tonight's panel

Dr Cathy Andronis
General Practitioner

Associate Professor Lisa Lampe
Psychiatrist

Natasha Davis
Clinical Psychologist

Facilitator:
Prof Stephen Trumble
General Practitioner

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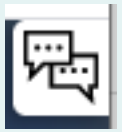

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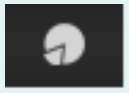

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Learning outcomes

Through an exploration of generalised anxiety disorder (GAD) the webinar will provide participants with the opportunity to:

- Identify biological and environmental factors that increase the risk of developing GAD along with comorbidities.
- Discuss the identification, assessment and diagnosis of GAD.
- Evaluate therapeutic approaches that have proven successful in the treatment of GAD.
- Elaborate on the importance of collaboration and appropriate referrals when providing care to people living with GAD.

A General Practitioner's perspective

GAD in general practice

- Common (majority of GP consultations include a mental health issue, especially anxiety).
- Typically present frequently, multiple and varied problems, over many years.
- Difficult to reassure.
- Problems with work, study, ADLs requiring medical certificates.
- Concentration difficulties (e.g. ADHD).
- Tiredness ("something wrong with me").
- Muscle tension, chronic pain.
- Insomnia.
- Irritable bowel syndrome / food issues.
- Difficulties accepting diagnoses, management options offered or prescribed.

Dr Cathy Andronis

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A General Practitioner's perspective

GAD diagnosis

- History - long standing anxiety: "I'm a worrier".
- Exclude physical cause.
- Screening - DSM 5, DASS, GAD7.
- 3% prevalence; 6% incidence.
- Women > men; aged 30 on average.
- Frequent co-morbidities - chronic diseases.
- Family history.
- Past history- trauma, ACEs.
- Personality factors.

Dr Cathy Andronis

A General Practitioner's perspective

GAD management - non prescription

- Biopsychosocial and patient centred approach.
- Assess and manage physical co-morbidities, diet, exercise, medication side effects.
- Sleep hygiene.
- Identify associated relationship, work and domestic issues, demographic and cultural factors, disabilities, financial problems etc.
- Assessment and management of psychological co-morbidities.
- FPS: CBT, behavioural treatments, relaxation, mindfulness, psycho education.
- Self- compassion, yoga, walking, social prescribing.
- E- health options, "head to health" website, BB, BDI, apps.
- Empower to self manage or refer for psychological or psychiatric assessment and management- discuss risk/benefits.
- PERMA.

Dr Cathy Andronis

A General Practitioner's perspective

GAD management - medication

- SSRIs usually, other antidepressants.
- Limited use of benzodiazepines - "special occasions".
- Increasing use of "off label" treatments - quetiapine; propranolol, hypnotics, vitamins etc.
- Australian prescription rates well above average.
- Risks and benefits discussion, often "reluctant" or fixed mindset/opinions.

Dr Cathy Andronis

A General Practitioner's perspective

Self (care) of the GP - transference issues

1. Rule out physical causes of anxiety in particular physical illness, identify red flags.
2. Plan a Review schedule -including screening - in collaboration with the patient.
3. "Broken Record" approach of reassurance that is "just right" (Goldilocks approach) and confident and rational.
4. Be a Mindful GP - self awareness, transference and counter-transference, compassion. Avoid "difficult patient" attitude.
    - Model mindfulness in sessions - benefits to GP and patient.
5. Honest and realistic discussion of risks and benefits, aim to empower patients to take responsibility, set clear boundaries.
6. Refer - "shared care", team care approach with established parameters and boundaries regarding responsibilities- in collaboration with the patient.

Dr Cathy Andronis

A Psychiatrist's perspective

Diagnostic Assessment

- Excessive worry raises DDx of GAD.
  - Note GAD not just "very anxious".
  - Distinguish from other anxiety disorders.
- DSM-5:
  - Excessive anxiety and worry.
  - Difficulty controlling worry.
  - Anxiety & worry assoc. with ≥3 of:
    - Restlessness or feeling keyed up/on edge.
    - Easily fatigued.
    - Difficulty concentrating or mind going blank.
    - Irritability.
    - Muscle tension.
    - Sleep disturbance.

Associate Professor Lisa Lampe

GAD-7 Screener

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

Cut point of 10 max sensitivity; 15 max specificity

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097.

A Psychiatrist's perspective

Other assessment tools

Severity of GAD (frequency of worries)

- PSWQ - Penn State Worry Questionnaire (PSWQ) 16 items

  https://novopsych.com.au/assessments/diagnosis/penn-state-worry-questionnaire-pswq/

Depression screener

- *e*.g. Hospital Anxiety and Depression Scale, Patient Health Questionnaire-9

  OR ask[1]:

  "Over the past two weeks, have you felt down, depressed or hopeless"?

  "Over the past two weeks, have you felt little interest or pleasure in doing things"?

  [Ask whether just since very anxious]

[1]https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/psychosocial/depression

Associate Professor Lisa Lampe

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A Psychiatrist's perspective

GAD and Depression: close relatives

- Approx 43% lifetime comorbidity with depression[1].
- Moderately heritable (≈ 40%) [1].
- Highest level of shared genetic risk among internalizing disorders[1].
  - Temperamental risk factor of negative emotionality.
  - NZ longitudinal study: by age 32 years 75% of F and 50% of M with GAD had had MDD [2].
- Concurrent comorbidity 12% in NZ longitudinal study & assoc. with higher health burden [2].

1.Kalin NH. Am. J. Psychiatry 2020 177:5, 365-367;

2.Moffitt TE, et al. Arch Gen Psychiatry. 2007 Jun;64(6):651-60.

Associate Professor Lisa Lampe

A Psychiatrist's perspective

Other diagnostic considerations

- Separation anxiety disorder.
- Personality.
  - Obsessive compulsive.
  - Dependent.
- Self-esteem.
- Lack of assertiveness.
- Domestic violence (coercive control).

Associate Professor Lisa Lampe

A Psychiatrist's perspective

Treatment

- First line psychological Rx.
- Consider antidepressant if comorbid depression.
  - SSRI
  - SNRI
- All antidepressants have anxiolytic action; takes time.
- Choose on long term tolerability.
- "Start low and go slow".
- No evidence of need for high doses in GAD.

Associate Professor Lisa Lampe

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A Psychiatrist's perspective

Other medications

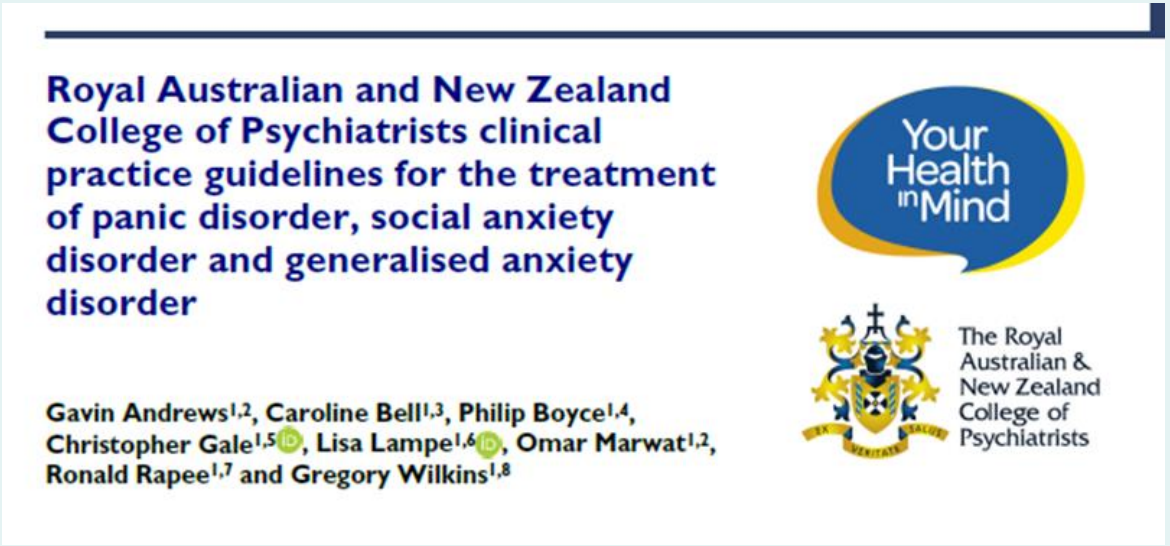
- Mirtazapine – not as much evidence as SSRI; immediate anxiolytic action may be outweighed by longer term tolerability issues.
- Pregabalin – some evidence in GAD; not first line; not TGA approved; dangerous in OD.
- Buspirone – evidence in GAD; not on PBS;
- Quetiapine – moderately effective at 150-300mg day; beware metabolic effects; ?TD.
- Agomelatine – some evidence.
- Tricyclic antidepressants – high AE burden; dangerous in OD.

Associate Professor Lisa Lampe

A Psychiatrist's perspective

Not recommended

- Symptomatic prescribing e.g. sleep
- Polypharmacy
- Routinely starting benzodiazepine with SSRI
- Beta blockers



ANZJP 2018, Vol. 52(12) 1109-1172.

Associate Professor Lisa Lampe

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A Clinical Psychologist's perspective

Steps to providing good clinical care – Diagnosis, Formulation, Treatment

Step 1: Identification, assessment and diagnosis.

- Key component of GAD is worry. We need to differentiate this from rumination linked to depression.
- Worry – danger.
- Rumination - loss, hopelessness and failure.
- We would also want to rule out comorbidities of other anxiety disorders or personality disorders (e.g. Social Anxiety Disorder and Dependent Personality Disorder).

A Clinical Psychologist's perspective

Use of interview schedules and measures to aid diagnosis and formulation

Measures to assess GAD*

- Some available in NovoPsych e.g. GAD-7 and PSWQ
- The Metacognitions Questionnaire 30 (MCQ-30; Wells & Cartwright-Hatton, 2004)

5 factors in MCQ: POS = positive beliefs about worry; NEG = negative beliefs about uncontrollability and danger of worry; CC = cognitive confidence; NC = need for control; and CSC = cognitive self-consciousness.

Broad measures to assess comorbidities or other areas of focus

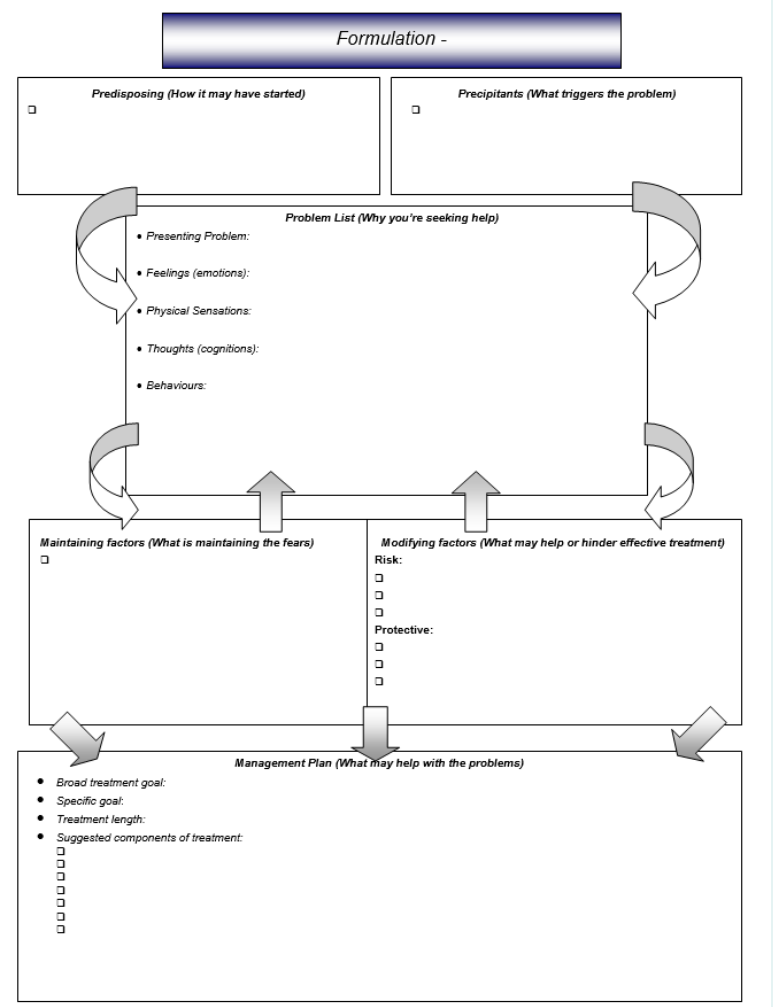
- DASS-21, AUDIT (NovoPsych); Pittsburgh Sleep Quality Index (PSQI); Young Schema Questionnaire (YSQ)

*See resources for full list

A Clinical Psychologist's perspective

Step 2: Formulation

- Predisposing
- Precipitating
- Perpetuating
- Prognostic



Natasha Davis

A Clinical Psychologist's perspective

Step 3: Treatment planning and implementation

Goals

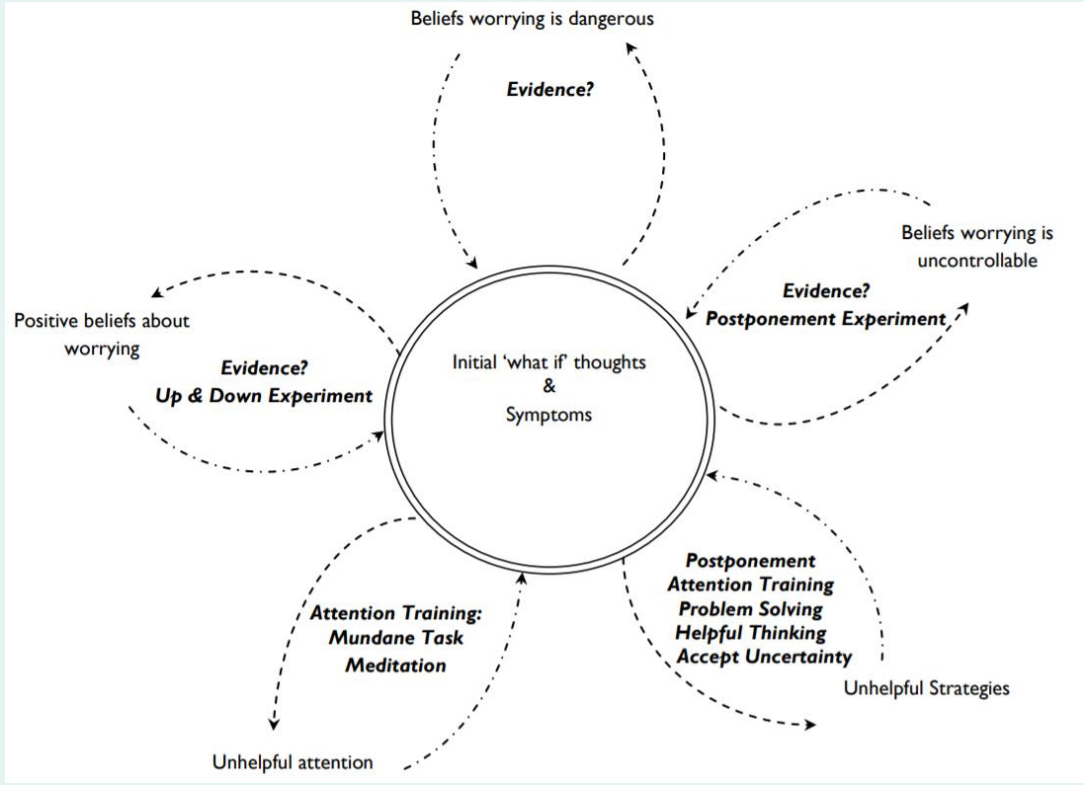
Motivational interviewing may be needed to determine goals and specific targets for change.

Treatment options

- CBT – gold standard, most popular. Addresses content and processes.
- Metacognitive Therapy (MCT) – modified CBT, focusses on processes. May be more effective than CBT[1].
- ACT – some evidence to support.

[1]Normann, N., & Morina, N. (2018). Frontiers in Psychology, 9

MCT targets "vicious" worry cycle



Saulsman, L., Nathan, P., Lim, L., Correia, H., Anderson, R., & Campbell, B. (2015). What? Me Worry!?! Mastering Your Worries. Perth, Western Australia: Centre for Clinical Interventions.

Natasha Davis

A Clinical Psychologist's perspective

Typical CBT treatment for GAD

Phase 1: CBT / MCT for GAD (10-15 sessions; may include some or all of below)

- Develop and discuss formulation.
- Psychoeducation anxiety, mood, sleep and worry.
- Behavioural experiments:
  - Uncontrollability Beliefs (e.g. I can't stop worrying).
  - Understanding role of attention in anxiety and attention training.
  - Danger Beliefs (e.g. worrying can cause IBS or cancer)
  - Positive Beliefs. (e.g. it helps because I come up with ideas to on how to fix [things]).
- Structured Problem-Solving.
- Imaginal exposure and/or cognitive challenging for worst case scenario and catastrophic thinking (e.g. I could have cancer).
- Reducing excessive checking and reassurance seeking (esp for health anxiety).
- Accepting Uncertainty.
- Maintaining gains and relapse prevention.

Natasha Davis

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A Clinical Psychologist's perspective

Typical treatment for GAD

Using the information taken from the developmental and relationship history, we may look to plan for a second phase of treatment.

Goal: to address long term unhelpful patterns which were identified in assessment.

Phase 2: Managing self in relationships (2- 4 weekly for 12 -18 months)

- Patterns of overfunctioning and underfunctioning.
- Interpersonal effectiveness skills.
- Identifying and modifying maladaptive schemas (e.g. Unrelenting standards, subjugation, self sacrifice, pessimism, approval seeking, functional dependence, enmeshment).

An important part of all treatments is collaborating with the client and other team members.

Natasha Davis

A Clinical Psychologist's perspective

Collaboration and appropriate referrals are key to helping patients with GAD.

- General practitioners who have a long-term relationship with the patient can assist with providing a good medical history.
- A shared understanding of the nature of the concerns (i.e. diagnosis if GAD or health anxiety) amongst the treatment team is important for the successful treatment of GAD.
- Patients can otherwise engage health professionals in their safety behaviours, such as checking and reassurance seeking. For example, running multiple tests might reduce distress in short term, but doesn't address the underlying long-term beliefs (e.g. I really have something wrong with me; worrying helps me to solve problems).
- GP's and/or Psychiatrists can assist with prescribing medication for comorbid factors such as mood difficulties and managing patient expectations as therapy will not provide a quick fix.

Natasha Davis

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Q&A Session

Dr Cathy Andronis
General Practitioner

Associate Professor Lisa Lampe
Psychiatrist

Natasha Davis
Clinical Psychologist

Facilitator:
Prof Stephen Trumble
General Practitioner

Thank you for your participation

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We have 373 networks around the country. Visit our online map to find out which networks are close to you at mhpn.org.au or contact the Networks Team at networks@mhpn.org.au for further information.

Thank you for your contribution and participation.

Good evening.