ABC of Anxiety and Depression

Edited by Linda Gask and Carolyn Chew-Graham

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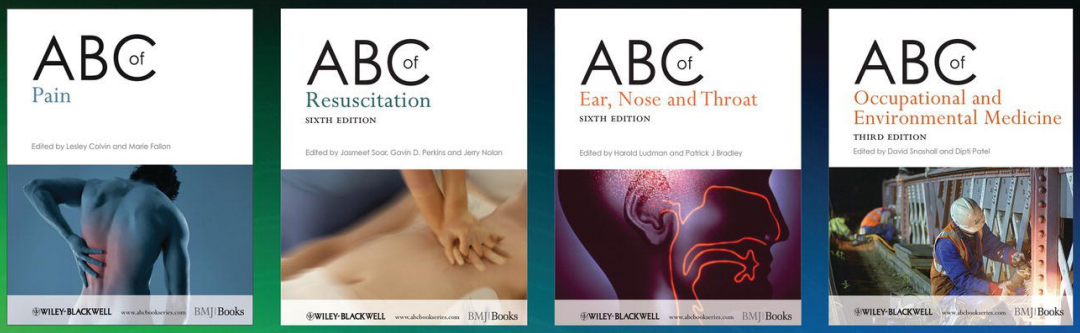

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Preface

We hope this book will be a useful resource for anyone who is interested in the management of common mental health problems in the primary care setting. Anxiety and depression are common and often overlap, and patients who suffer from these symptoms are usually managed in primary care.

We have drawn on our clinical experience, working in primary and secondary care, and across the interface. We have used ‘cases’ of fictitious characters interlinked by living in one street to illustrate the breadth of problems under the umbrella of ‘anxiety and depression’, reflecting our professional experiences. We hope that this makes the book appealing to a broad range of readers, including students of health and social care professions, general practitioners and primary care nurses, and practitioners working in specialist care and the voluntary (or ‘third’) sector.

Above all, we would like this text to contribute to an improvement in the care of people with anxiety and depression in the future.

Linda Gask
Carolyn Chew-Graham

Acknowledgements

We thank our husbands for their patience and support, our colleagues who have contributed the chapters, and our patients whose problems inspired the ‘cases’.

List of Abbreviations

ACE
Addenbrooke’s Cognitive Examination

AMTS
Abbreviated Mental Test Score

BA
behavioural activation

BDI
Beck Depression Inventory

BME
British Minority Ethnic

CAMHS
Child and Adolescent Mental Health Services

CBT
cognitive-behavioural therapy

cCBT
computerised CBT

CEMD
Confidential Enquiry into Maternal Deaths

COPD
chronic obstructive pulmonary disease

DBT
dialectical behaviour therapy

DSM
Diagnostic and Statistical Manual

ECT
electroconvulsive therapy

ED
Emergency Department

EMDR
eye movement desensitisation reprocessing

EPDS
Edinburgh Postnatal Depression Scale

ESA
Employment Support Allowance

FBC
full blood count

GAD
generalised anxiety disorder

GP
General Practitioner

HADS
Hospital Depression and Anxiety Scale

HPA
hypothalamic-pituitary-adrenal

5-HT
5-hydroxytryptamine (serotonin)

IAPT
Improving Access to Psychological Therapies

ICD
International Classification of Diseases

‘IP’
‘in possession’

LTC
long-term condition

MI
myocardial infarction

MOCA
Montreal Cognitive Assessment

NaSSA
noradrenergic and specific serotonergic antagonist

NCT
National Childbirth Trust

NHA
National Health Service

NSAID
non-steroidal anti-inflammatory drug

OCD
obsessive-compulsive disorder

PHQ-9
Patient Health Questionnaire 9

PTSD
post-traumatic stress disorder

PWP
psychological wellbeing practitioner

QoF
Quality and Outcomes Framework

RCT
randomised controlled trial

SNRI
serotonin and noradrenaline reuptake inhibitor

SSRI
selective serotonin reuptake inhibitor

TCA
tricyclic antidepressant

U&E
urea and electrolytes

WHO
World Health Organization

Chapter 1
Introduction: Anxiety and Depression

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Anxiety and depression are both *common mental health disorders.* They are the commonest mental health problems in the community, and the great majority of people who experience these problems will be treated in primary care.

In the UK, primary care services are an integral part of the National Health Service (NHS) in which general practitioners (GPs) work as independent contractors. The GP works as a generalist and a provider of personal, primary and continuing care to individuals, families and a practice population, irrespective of age, gender, ethnicity and problems presented.

In this book we will consider both depression and anxiety with reference to specific case histories: the O'Sullivan family and their neighbours (see Box 1.1). We will be adopting a life cycle perspective, considering depression and anxiety at different ages and times of life and in different settings although primarily taking a primary care perspective.

Box 1.1 Broad Street

The O'Sullivans live in a three-storey Victorian house in need of repair, in a northern English city. The extended family consists of Maria, 53, who is married to Ged; her parents, Bridie and Anthony; and Maria and Ged's sons, Patrick, 18, Francis, 20, and John-Paul, 23. Maria's brother, Frank, killed himself 10 years ago, and Bridie says she has 'never recovered'. Maria's other siblings live in Dublin, Cork and Australia.

Next door, at number 64, live the Jairaths, who also fill their house. Imran and Shabila are second-generation Pakistanis, who speak good English and both work: Imran is a businessman, importing textiles, and Shabila is a teaching assistant. Imran's parents, Hanif and Robina are in their late 70s and go out very little. Both have diabetes and Hanif had a heart attack 3 years ago, which left him anxious about his health. Shabila's four sons and one daughter, Humah, all attend the local school and seem to be doing well. The eldest son, Shochin, aged 17, is hoping to apply to study medicine. All the children attend the mosque for weekly instruction in Islam.

Number 60 is a multi-occupancy house with students who attend the local University. Jess is 19 and lives with her boyfriend, Oliver. Jess is friendly with Shabila and often looks after the younger children. She feels she has got to know Humah, Shabila's 15-year-old daughter, quite well. Hannah has lived in the house for 2 years, and recently separated from a boyfriend. Mark and George share the top flat, and are accused by their housemates and Ged of being noisy and 'drunk'. Maria

thinks they use drugs and worries about their influence on her sons.

John lives alone at number 63. He took voluntary redundancy as a supermarket manager 18 months ago. He has little to do with his neighbours. Two months after finishing work his widowed father, who lives a couple of miles away, had a stroke and John spent the next 6 months supporting his father in his recovery. John now finds himself feeling depressed, without motivation and reluctant to leave his house. He is finding it difficult to sleep. He lays awake and worries. He has stopped seeing friends, and is reluctant to talk to anyone as he thinks he has no right to feel depressed and he is a failure.

Nirma and Naeem live at number 65. Nirma is British born, 23 years old and works part time in a bank. She first saw her husband, Naeem, when she was aged 17 and on the day of her marriage (which her father had told her would be her engagement party). Her husband arrived from Bangladesh and there were no problems in the first 2 years of marriage. Then Nirma was devastated to discover that Naeem was having an affair and decided that she would leave him, although she was frightened and unsure how she would look after her two young children. Her family, who live in the next street, were not supportive of this decision, saying that this could hinder the marriage prospects of her three younger sisters. So, she remains with him, but feels her husband criticises her appearance and behaviour. She knows that he discloses their personal problems to others, which is humiliating for Nirma. Naeem is also unpredictably violent and has started to hit her in front of the children.

What is depression?

Some people may describe themselves as ‘depressed’ when they are unhappy. ‘Depression’ is more than unhappiness: A person who is depressed will experience *low mood*, which is lower than simply being ‘sad’ or ‘unhappy’, and crucially is associated with difficulty in being able to function as effectively as is usual for them in their everyday life. The severity of this mood disturbance can vary between a mild degree of difference from the norm, through moderate levels of depression to severe depression, which may be then associated with abnormal or ‘psychotic’ experiences such as delusions and hallucinations. Low mood is accompanied by a wide range of other symptoms, which also need to be present in order to make the diagnosis of depression (see diagnostic criteria, Appendix 2). In bipolar disorder, episodes of depression and mania are both experienced. We will not be focusing specifically on bipolar disorder in this book but will highlight how, where and why it is important to distinguish bipolar from unipolar depression.

What is anxiety?

Similarly, ‘anxiety’ is a term in common usage to describe feeling worried and fearful. People who are suffering with one or more of the anxiety disorders also experience symptoms of anxiety to a degree that it interferes with their ability to function. The central emotions at the heart of anxiety are fear and worry. You may be worried and fearful because you feel unsafe and have a sense of foreboding and uncertainty, as in generalised anxiety, or you may have a specific fear or phobia, or experience sudden crescendos of anxiety associated with physical symptoms, which are known as panic. Obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) are also included among the anxiety disorders (see Box 1.2).

Box 1.2 The spectrum of anxiety and depression[a]

	Key symptoms
Depression[b]	Low mood Loss of interest or pleasure
Generalised anxiety disorder	Excessive anxiety and worry
Phobia	Fear of a specific object or situation that is out of proportion to the actual danger or threat
Panic disorder	Panic attacks (sudden, short-lived anxiety)
Obsessive-compulsive disorder	Presence of obsessions (unwanted intrusive thought, image or urge that repeatedly enters one's mind but is recognised as one's own thoughts) and/or compulsions (repetitive behaviours or acts that one feels driven to perform)
Post-traumatic stress disorder	Re-experiencing symptoms and aspects of a traumatic event

[a] May occur separately or together in differing combinations.

[b] Depression can be unipolar or bipolar, and in severe depression psychotic symptoms may be present, which are mood-syntonic or consistent with depressed mood.

How are anxiety and depression related?

Although they have traditionally been classified as separate disorders, there is a considerable overlap between anxiety and depression. The majority of people who are seen in primary care settings will have a mixture of symptoms of anxiety (with often symptoms of different anxiety disorders present) and depression, and often also physical symptoms that may be related to either or both of these, or for which there is no apparent physical cause (and also other health problems too). People with more severe disorders who are seen in specialist settings may have a more distinct presentation of depression or one of the anxiety disorders, but even here they often coexist (see both Maria's and Francis's stories in Box 1.3 and Chapter 2). Anxiety may precede the development of depression and vice versa. The coexistence of symptoms had led some to question whether these are indeed distinct disorders.

Box 1.3

Maria's story

'I've always been a worrier, I know that. My husband Ged says I'm always needing someone to tell me everything is going to be OK. He gets annoyed with me sometimes. I do worry about everything, especially my family. Sometimes I sit here in the armchair and it just feels as though something else awful is going to happen and I've no idea what it is. I just feel sweaty and shaky and my heart starts beating really fast. Then the other day in the supermarket, I just suddenly felt really dreadful, I suddenly started shaking and sweating, and I felt faint and I thought I was going to pass out. It was really scary. I felt awful when my brother killed himself, and I suppose I've been feeling worse since the problems started next door. I wish those boys would move out. I don't know what's happening to me. It's all really getting me down.'

Francis's story

'I had my first drink when I was 14. I used to get really anxious when I was out, so it gave me a bit of Dutch courage. I couldn't chat up girls if I hadn't had a drink. I was the life and soul of the party when I'd had a drink. Then it started to get a bit out of hand, and I carried on drinking when everyone else moved on, went to college and left town. I don't get out much at the moment. I have to go out to get my cider otherwise I get a bit shaky in the morning. It calms me down. I feel very stuck now. I can't seem to move on. I've started to feel really wound up and sometimes I'm *really* low. I don't tell anyone about that. I don't want to worry my mother.'

Diagnosis and multimorbidity

The two major diagnostic systems in use for mental disorders are the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM), which has recently been published in its fifth edition, and the *International Classification of Diseases* (now ICD-10 with edition 11 in preparation). These differ slightly in the criteria used for diagnosis of depressive and anxiety disorders. We will describe the specific symptoms associated with each way in which they can present across the life cycle in different chapters of this book.

There has been criticism about the applicability of diagnostic criteria developed in the population of people seen in specialist settings to the way in which anxiety and depression present in the wider community and in primary care. In general, presentations in primary care are less severe, though there is considerable overlap in terms of severity with those people who present to mental health services. Primary care patients frequently present a mixture of psychological, physical and social problems, and the context of life events and medical comorbidity plays an important role in how patients experience their mental health symptoms. What is clear is that overlapping degrees of psychopathology exist along a spectrum of anxiety, depression, somatisation and substance misuse. Thus, Francis (Boxes 1.1 and 1.3) has a number of problems including anxiety, depression and alcohol dependence. This coexistence may be cross-sectional in that all these symptoms appear together at the same time, or it may be longitudinal, as one set of symptoms is followed closely in time by another. All of these may occur against a background of personality difficulty or disorder. Physical

health problems, especially long-term conditions such as diabetes, coronary heart disease, chronic obstructive pulmonary disease and pain (see Chapter 6) may be complicated by depression and anxiety, which will both exacerbate the distress, pain and disability associated with physical illness and adversely affect health outcomes.

Epidemiology of depression and anxiety

Depression is a considerable contributor to the global burden of disease, and according to the World Health Organization unipolar depression alone (not associated with episodes of mania) will be the most important cause by 2030.

Estimates of prevalence vary considerably depending on the methods used to carry out the research, and the diagnostic criteria employed. In the UK the household survey of adult psychiatric morbidity in England carried out in 2007 found that 16.2% of adults aged 16 to 64 met diagnostic criteria for at least one of the common mental health disorders in the week prior to the interview. More than half of these presented with a mixed anxiety and depressive disorder (9% of the population in the last week). The 1-week prevalence for the other common mental health disorders were 4.4% for Generalised Anxiety Disorder (GAD), 2.3% for a depressive episode, 1.4% for phobia, 1.1% for Obsessive-Compulsive Disorder (OCD) and 1.1% for Panic Disorder.

Both anxiety and depression are more common in women, with a prevalence of depression around 1.5–2.5 times greater than in men. The gender difference is even greater in the South Asian population in the UK (see Chapter 8). Depression and anxiety occur in children and young people