GENERAL MEASURES

Stop all antipsychotics.
Cool patient and hydrate adequately.

REFERRAL

» All patients for urgent medical admission and psychiatric review

16.3 ANXIETY DISORDERS

F40.0-2/F40.8-9/F41.0-3/F41.8-9/F42.0-2 + (F10.0-F19.9/R42/R45.0-8/Z65.0-5/Z65.8-9/Z81.0-4/Z81.8)

DESCRIPTION

Anxiety is an emotional response to an apparent stress. It is diagnosed as a disorder when it is excessive or persistent and impacts daily functioning.
Anxiety disorders are associated with an increase in cigarette smoking, alcohol use, and various medical illnesses.
Anxiety may present in various forms:

» **Physical symptoms:** anxiety may present with medically unexplained symptoms like muscle tension, headache, abdominal cramps, nausea, palpitations, sweating, a choking feeling, shortness of breath, chest pain (non-cardiac), dizziness, numbness, and tingling of the hands and feet.
  - *Panic attacks* are abrupt surges of intense anxiety with prominent physical symptoms. They may occur in anxiety, mood, psychotic, or substance use disorders, and are a marker of increased severity.

» **Psychological symptoms**: panicky feelings, excessive worry, mood changes, irritability, tearfulness, distress, and difficulty concentrating.
  - *Phobias* are diagnosed when the anxiety is caused by a specific situation or object, e.g. social phobia is the fear of social interactions. Thoughts are of negative evaluation by others and usually start in adolescence. Self-medication with alcohol or other substances before and during a social event is common. Substance misuse may be the presenting feature.
  - *Obsessive thoughts and/or compulsive behaviours* are a core feature of Obsessive Compulsive Disorder but may also occur in other anxiety, mood, developmental, and psychotic disorders.
  - *In people with intellectual disability*, anxiety may present with aggression, agitation, and demanding behaviour.

GENERAL MEASURES

» Assess severity of the condition.
» Maintain an empathic and concerned attitude.
» Exclude underlying medical conditions and optimise treatment for comorbid medical conditions (e.g. heart disease, hypertension, COPD, asthma, GORD, inflammatory bowel disease, thyroid disease, epilepsy).
» Screen for, and manage, underlying or co-morbid substance use, e.g. nicotine, alcohol, over the counter analgesics, benzodiazepines.

» Psychoeducate the patient and their family regarding the nature of anxiety, importance of managing the condition, and early signs of recurrence.
» Explore and address psychosocial factors:
  - Stress management/coping skills – refer to registered counsellor or non-governmental organization (NGO) counselling services, e.g. SA Depression and Anxiety Group (https://www.sadag.org/)
  - Social support systems, relationship, and family issues – refer to social worker, registered counsellor, or NGO counselling, e.g., Family and Marriage Society of South Africa (https://famsa.org.za)
  - Abuse – refer to a social worker, social welfare, and/or People Opposing Women Abuse (https://www.powa.co.za/POWA/).

MEDICINE TREATMENT

» Offer a choice of psychotherapy (if available) or medication.
» Review every 2–4 weeks for 3 months, then 3–6 monthly.
» If response to psychotherapy is sub-optimal, medication may be prescribed together with continued psychotherapy (if available).
» If medication is effective, continue for at least 12 months to prevent relapse.
» Patients with severe anxiety should be assessed by a doctor.

- Fluoxetine, oral (Doctor prescribed).
  - Initiate at 20 mg on alternate days for 2-4 weeks.
  - Increase to 20 mg daily after 2–4 weeks.
  - Delay dosage increase if increased agitation or panic symptoms occur.

LoE:Ib[12]

If fluoxetine is poorly tolerated:

- Alternative SSRI, e.g.: (Doctor prescribed)
- Citalopram, oral.
  - Initiate at 10 mg daily for the 1st week.
  - Then increase to 20 mg daily.

LoE:Ib[13]

CAUTION

SSRIs (e.g. fluoxetine, citalopram) may cause agitation initially. This typically resolves within 2-4 weeks.

LoE:Ivb[14]

Ask about suicidal ideation in all patients, particularly adolescents and young adults. (See Section 16.7: Suicide risk assessment).
If suicidal ideation is present, refer before initiating SSRI.
Once started, monitor closely for clinical worsening, suicidality, or unusual changes in behaviour.
Advise families and caregivers of the need for close observation, and refer as required.

Note: If there is a good response to SSRI, continue treatment for a minimum of 12 months after remission of symptoms. Consider stopping after 12 months only if patient has had

no/minimal symptoms and has optimal functioning. Reduce dose gradually over 4 weeks. Prolong treatment if:
» Previous episode/s of anxiety (extend treatment to at least 3 years).
» Any of: severe anxiety, suicidal attempt, sudden onset of symptoms, or family history of bipolar disorder (extend treatment to at least 3 years).
» ≥ 3 episodes of anxiety (advise lifelong treatment). *LoE:Ib*[15]

For severe panic attacks:
- Benzodiazepines, e.g.: (Doctor prescribed)
- Diazepam, oral. *LoE:IIIb*[16]
  - 2.5–5 mg immediately.
  - Continue with 2.5–5 mg at night, for a maximum of 10 days for relief of severe anxiety.
  - Start definitive treatment with psychotherapy/SSRI. *LoE:Ia*[17]

CAUTION - BENZODIAZEPINES
» Associated with cognitive impairment – reversible with short-term use and potentially irreversible with long-term use.
» Elderly are at risk of over-sedation, falls and hip fractures.
» Dependence may occur after only a few weeks of treatment.
» Prescribe for as short a period of time as possible.
» Warn patient not to drive or operate machinery when used short-term.
» Avoid use in people at high risk of addiction: e.g. personality disorders and those with previous or other substance misuse. *LoE:IVb*[18]

REFERRAL
» Any risk of harm to self or others.
» Comorbid severe mental or physical conditions.
» Poor response to treatment.
» Repeated panic attacks.
» Children and adolescents.

16.4 MOOD DISORDERS

DESCRIPTION
The person's thoughts and behaviour are driven by their mood, which may be depressed, sad, angry, happy, elated, manic, or any of these in combination.
Mood disorders may be:
» Due to another medical condition, e.g. HIV, TB, anaemia of any cause, malignancy, hypothyroidism, and chronic pain conditions.
» Comorbid with other medical conditions e.g. epilepsy, diabetes, and cardiovascular disease.
» Due to substance use, e.g. alcohol, cannabis, benzodiazepines.
» Comorbid with substance use.