A new classification for depression and anxiety in primary care and the general hospital population

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Annual Meeting of the Northern Netherlands Network for Mood and Anxiety Disorders
Friday 24th January 2014

Institute of Psychiatry
at The Maudsley

World Health Organisation
Collaborating Centre

University of London

Disclosure slide

Conflict of interests	None / see below
Relevant relationship with companies	Companies
• Sponsoring or research money • Fee or other reimbursement • Shareholder • Other relationship, namely … • Consultant adviser	• None • See below • Not applicable Janssen Pharmaceuticals

PLAN OF LECTURE

1) Criminally brief statement of the problem
2) The revised ICD11-PHC
3) What co-morbidity should mean in general medical practice
4) Focus Groups, Expert opinions and Field Trials
5) Future developments

In my lecture yesterday in honour of Hans Ormel I said:

The commonest diagnosis in primary care is anxious depression. However, this is not recognised by either the ICD-11 or the DSM5. Only "co-morbid MDD + GAD" can be diagnosed - our present criteria for MDD do not encourage clinicians to ask about anxiety

Non-anxious depression is recognised by all clinicians, but is by no means the same as "MDD only", which may have had anxious symptoms up to 6/12!

	Non-anxious depression	Anxious depression
Parental pathology	Double rates of MDD only cf'd controls	Higher rates of MDD only, MDD+GAD, GAD only & mania
Early Adversity	Low parental warmth	Most severe early adversity, high maternal internalising Childhood separation, parental rejection & over-protection
Personality	Normal harm avoidance cf controls	High harm avoidance / neuroticism / negative affect
Episodes of illness	Shorter length episode Better response to Rx	Most severe depressive symptoms Higher risk of suicide. Outlook worse if anxious symptoms

I went on to say:

- these two forms of depression should not be thought of as two quite different disorders, but the pathoplastic effects of negative affect (neuroticism) on the experience of depression

- other personality characteristics appear to also have an effect on the depressive experience, and these call for special forms of psychotherapeutic intervention

- the requirement in DSM5 that clinicians use an "anxiety specifier" whenever major depression is diagnosed using DSM5 is likely to lead to research focused on non-anxious depression as well as anxious depression.

DO INTERNISTS & GENERAL PRACTITIONERS FOLLOW OUR DIAGNOSTIC RULES?

- some do, but most don't

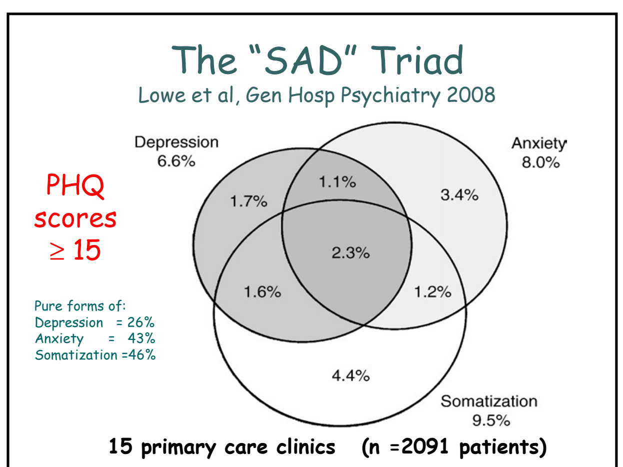
- in general medical settings, patients present with untidy combinations of anxious, depressive & somatic symptoms

"co-morbidity" is the rule, not the exception

The "SAD" Triad

Lowe et al, Gen Hosp Psychiatry 2008

PHQ scores ≥ 15



Pure forms of:
Depression = 26%
Anxiety = 43%
Somatization =46%

15 primary care clinics (n =2091 patients)

WHO published ICD10-PHC

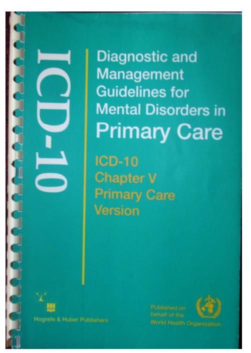
Hogrefe Huber 1996

✓ Only 26 disorders

✓ many modifications introduced after field trials

✓ sexual disorders divided (male and female)

✓ brief version released for health workers (6 conditions only)



Aims of the PCC Group

- To produce a classification system that **corresponds more closely** to the common mental disorders that present in general medical practice
- To eliminate **specious co-morbidity**: the co-morbidity we want practitioners to recognise is that between physical and psychological disorders
- To allow **dimensions of severity** of some common disorders to be recognised, rather than case / non-case distinctions. This is important where the managements are different.

ICD11-PHC First draft

28 possible categories for Field Testing

- Intellectual disability
- Autism spectrum disorder
- Specific learning disorder
- ADHD
- Conduct disorder
- Enuresis, encopresis
- Acute psychotic disorder
- Persistent psychotic disorders
- Bipolar disorder
- Anxious depression
- Depression
- Anxiety
- Health anxiety
- PTSD
- Bodily Stress disorder
- Dissociative disorder
- Self harm
- Personality disorder
- Acute stress reaction
- Eating disorders
- Sleep problems
- Male sexual problems
- Female sexual problems
- Alcohol use disorder
- Drug use disorder
- Tobacco use problems
- Dementia
- Delirium

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Clinical states with combinations of anxious and depressive symptoms:

Anxious Depression

Depression, and

Current Anxiety

The Screening Questions

D1 Persistent depressed mood (S)

D2 Diminished interest or pleasure (S)

A1 Feeling nervous or anxious (S)

A2 Not able to control worrying (S)

We are arguing that adequate diagnostic assessments can be made with only THREE additional questions for each

Required symptoms: There must be no previous history of manic episodes, and they must have **at least 3 anxious and at least 3 depressive symptoms from the following list** for, at least two weeks:

D1 Persistent depressed mood (S)
D2 Diminished interest or pleasure (S)
D3 Poor concentration
D4 Feelings of worthlessness
D5 Felt you wanted to die, thoughts of death
A1 Feeling nervous or anxious (S)
A2 Not able to control worrying (S)
A3 having trouble relaxing
A4 so restless, hard to keep still
A5 afraid that something awful might happen

ANXIOUS DEPRESSION

- **Presenting symptoms:** The patients commonly present with **somatic symptoms**, but will be found to have both anxious and depressive symptoms accompanying these symptoms.
- **Clinical description**: This is a disorder in which mixed anxious and depressive symptoms cause significant distress or dysfunction and lead to functional impairment and care-seeking. Their **symptoms are at "case" level for both anxiety and depression**, using DSM-5 full definitions

ANXIOUS DEPRESSION

Associated symptoms:

weight / appetite - loss or gain
Poor sleep
loss of libido
fatigue / low energy
panic attacks
obsessional ruminations
excessive concern with their health

DISORDERS SHARING SYMPTOMS OF ANXIETY & DEPRESSION

If both the DEP5 and the ANX5 are above "case" level this disorder is now "anxious depression"

If one disorder is at "case" level, but the other sub-threshold, these are "Anxiety Disorder" and "Depression"

If both are present, but at sub-threshold level, these are now termed "sub-threshold anxious depression"

How might the 5-item scales work?

A secondary analysis of PC data

WHO's "Psychological Disorders in Primary Care Settings" was carried out in 15 centres in 14 countries in 1992

It involved 5,500 primary care patients being administered the "CIDI-PC" interview

This constitutes a preliminary Field Trial

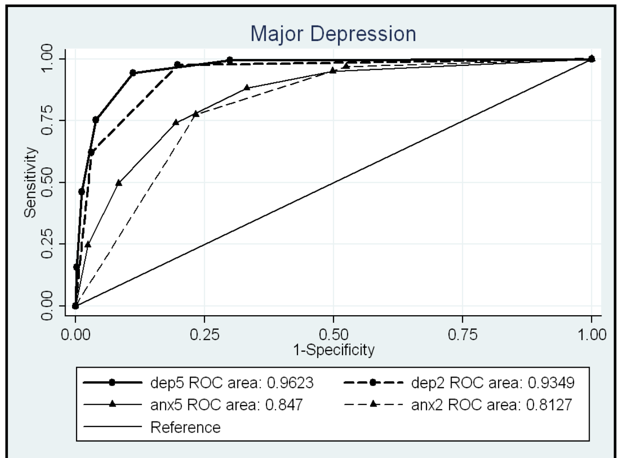
Goldberg et al; General Hospital Psychiatry 2012

Core symptoms of anxiety and depression

In 5.500 Primary Care patients

	DEP5 Threshold 2/3	ANX5 Threshold 3/4
Major depression	Sens 95% Spec 89%	Sens 90% Spec 73%
Generalised Anxiety dis.	Sens 82% Spec 98%	Sens 90% Spec 74%

Goldberg et al; General Hospital Psychiatry 2012



Bodily Stress Disorder

was "unexplained Somatic symptoms"

BODILY STRESS SYNDROME (BSS)

- ✓ ≥3 concurrent physical symptoms
- ✓ Autonomic arousal symptoms or general exhaustion
- ✓ Concern about their health or spend much time and energy devoted to their symptoms.
- ✓ The symptoms are distressing and result in significant disability
- ✓ Both exclude case anxiety or case depression

ALTERNATIVE VERSION

Required symptoms:
The patient must have
3 or more concurrent and persistent symptoms from one of three bodily systems attributable to over-arousal (cardio-respiratory, gastrointestinal, musculoskeletal) or as general symptoms of exhaustion and fatigue. .
Symptom patterns:
Examples of *cardio-respiratory arousal*: palpitations, precordial discomfort, breathlessness without exertion, hyperventilation, hot or cold sweats, dry mouth
Examples of *gastrointestinal arousal*: abdominal pains, frequent loose bowel movements, feeling bloated, regurgitations, diarrhoea, nausea, burning sensation in chest or epigastrium
Examples of *musculoskeletal tension*: pains in arms or legs, muscular aches or pains, pains in the joints, feelings of paresis or localized weakness, back ache, pain moving from one place to another, unpleasant numbness or tingling sensations
Examples of *general, non-specific symptoms*: concentration difficulties, impairment of memory, excessive fatigue, headache, dizziness

HEALTH ANXIETY

Required symptoms:
One (or both) of the following two phenomena:

Either worrying about or preoccupation with fears of harbouring a severe physical disease or the idea that disease will be contracted in the future

Or attention and intense awareness on bodily functions, physical sensations, physiological reactions or minor bodily problems that are misinterpreted as serious disease.

Focus Groups of GPs

in the following countries

Austria

Brazil

Hong Kong

New Zealand

India

Pakistan

Tanzania

United Kingdom

Lam, Goldberg et al, Family Practice, 2013, 30, pp76-87

Results of the Focus Groups

Anxious depression received enthusiastic support in all countries

While most GPs in high income countries preferred the "3 or more symptoms" version, in low income countries favoured four lists in different bodily systems

New Zealand GP: *We have been operating very successfully in primary care as if this condition exists*
Hong Kong GP: *I think anxious depression is something like 'bread and butter'. … As a frontline clinician, I think it allows me to write something down comfortably after seeing the patients, as it portrays something really difficult to describe in the past.*
Tanzania, primary Assistant Medical Officer: *…depression without anxiety is rare… over 90% of times we see mixed anxiety/depression symptoms in our patients*.
Brazil, primary care nurse: *It's the commonest that there is*

Clinical Field Trials

We have had provisional agreement from 6 countries

High income countries:

Spain, (Japan)

Middle income countries:

Brazil, China, Mexico,

Low income countries:

Pakistan, Tanzania

2. TESTS OF CLINICAL VALIDITY

This will be done with patients rated by GPs who are then interviewed with a structured, computerised interview (the PROQSY) capable of making diagnoses using DSM-5 and ICD-11 criteria, and assessing these against

- the patient's complaints, and
- The GP's assessments

The computer-assisted interview, the PROQSY

The interview elicits responses to 14 areas of symptoms including *somatic symptoms, health worries, panic, compulsions, obsessions, phobias, irritability, worry, anxiety, concentration, fatigue, sleep, depression, and depressive thoughts*

8 somatic symptoms common in PHC are each rated on a severity score from 0 to 3, providing a *total somatic symptom score* ("SOMA") between 0 and 24 for each patient. These symptoms are *also* rated for *duration* and *consistency*

Output of the original interview

In addition to the profile of 14 symptom scores, the interview provides a total severity score, and also gives *one or two ICD-10 diagnoses*, in the following hierarchy:

- depression (mild, moderate, severe),
- panic disorder,
- GAD case level,
- mixed anxiety depression,
- phobias (agora-, social and specific),
- OCD,
- mild current anxiety
- mild neurosis

Modifications necessary to the computerised interview (PROQSY)

1. The short WHO-Disability Assessment Scale has been added
2. A modification to the output allows the five item depression and the 5 item anxiety symptoms to be counted and printed out – the symptoms are already included
3. Questions that would allow a diagnosis of Health Anxiety have been included
4. ICD11 and DSM5 criteria now exist, and we have adapted the diagnostic algorithm to them

TESTS OF CLINICAL VALIDITY

- This will be done with groups of GPs in several countries, and will involve each GP in rating 30 patients who appear distressed, using the 10 questions that detect anxious depression, depression and current anxiety.
- They must also rate patients who appear to have somatic symptoms without anxiety/depression
- These patients are interviewed by a research assistant using a research interview that gives the diagnoses above, as well as the WHO disability assessment scale

TESTS OF CLINICAL VALIDITY
ANXIOUS DEPRESSION

- What is the ***best threshold*** to adopt with the 5 item scales in each country in order to detect anxious depression in an optimal manner?
- Are clinicians comfortable with ***dimensional rather than "case/non-case"*** decisions?
- Are clinicians able to assess ***associated disability***, and to use these to make assessments of severity?

TESTS OF CLINICAL VALIDITY
BODILY STRESS SYNDROME

- Is the syndrome ***recognised*** in all countries?
- To assess the ***agreement*** between assessments of BSS made by the clinicians and assessments made by the research interview.
- Is the ***association between symptoms of anxious depression and persistent somatic symptoms*** equally strong in all countries?
- To determine whether ***modifications need to be made to*** our description of bodily stress syndrome as a result of the field trial

FUTURE PLANS

- The Field Trials should be completed by Autumn 2014.
- We will adapt our final classification, taking into account comments made by GPs participating in our Field Trials, and remove or modify any descriptions.
- The Group will then have to negotiate with the Advisory Group for ICD-11 to establish the equivalent ICD-11 diagnoses for each of our constructs
- Finally, we will add advice on best management of each disorder, and publish our final scheme on the internet