Treating Anxiety in Primary Care

Council of Community Clinics Webinar

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Outline

• Overview of Anxiety Disorders (with diagnostic criteria)
• Overview of evidence-based treatments for anxiety (with focus on primary care setting)
• Common challenging cases
• Discussion/questions
Anxiety vs Anxiety Disorder

- **What is Anxiety?**
  - Automatic reaction to perception of threat

- **What is an Anxiety Disorder?**
  - Syndrome of anxiety-related symptoms/behaviors that cause significant distress and/or functional impairment
DSM-IV Anxiety Disorders

- Panic disorder
- Agoraphobia
- Generalized anxiety disorder
- Social phobia
- Obsessive-compulsive disorder
- Specific phobia
- Post-traumatic stress disorder
- Acute stress disorder
- Adjustment reaction with anxious mood
- Anxiety disorder due to general medical condition or substance use
- Anxiety Disorder Not Otherwise Specified
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence (%)</th>
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<tr>
<td>Alcohol dependence</td>
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(Kessler RC et al, 1994; Narrow et al, 2002; Ruscio et al, 2007)
Significance of Anxiety Disorders

- Most common psychiatric conditions in the world

- Lead to higher disability, suicidality, and cost: $44 Billion (comparable with stroke and cardiovascular disease)

- Anxiety is best predictor of chronic course and poor response to treatment in depression
Panic Attack

• Sudden onset of extreme fear of dying, losing control, or going crazy, accompanied by physical symptoms, such as tachycardia, palpitations, shortness of breath, nausea, sweating, tremor, dizziness, numbness, and tingling

• Symptoms peak within minutes, then diminish, but after effects can last hours

• Lifetime prevalence:
  – Panic Attacks: 22%
  – Panic Disorder: 4%
  – PD w/ Agoraphobia: 1%
  – PD w/ out Agoraphobia: 3%
Panic Disorder

**DSM-IV Diagnosis**

- Panic attacks must include intense fear or distress, plus at least *4 of the 13 other symptoms*.

- At least some of the panic attacks are *unexpected* or *unpredictable*, occurring in situations where most people would not feel anxious or frightened.

- At least 1 month of *persistent fear* or *anticipation* of another attack or *worry about the consequences* of the attacks, or *significant change in behavior*

- Not better accounted for by another psychiatric or medical disorder or substance use
Agoraphobia

DSM-IV Diagnosis

- Anxiety about being in situations from which escape might be difficult or embarrassing, or in which help might not be available in the event of having a panic attack

- Situations are avoided or endured with marked distress/anxiety or only done with a companion

- Not better accounted for by another mental disorder, such as:
  - Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment)
  - Specific Phobia (e.g., avoidance limited to a single situation like elevators)
  - Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination)
  - Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor)
  - Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives)
Generalized Anxiety Disorder

Chronic Excessive Worry

- Excessive anxiety and *worry* about multiple usual situations – not a single focus
- Present *most days* for over 6 *months*
- *Inability to control* the worry
- Excessive *physical arousal*: insomnia, fatigue, muscle tension, poor concentration, restlessness, irritability, *etc.*
Social Phobia

Excessive Fear of Negative Evaluation

- Marked, persistent fear of *social or performance situations* in which person is exposed to *unfamiliar people or possible scrutiny* - fear of embarrassment or humiliation
- Excessive *anxiety and arousal* in those situations
- *Anticipatory worry* about social situations
- *Avoidance* (or enduring situation with distress)
- The person recognizes that the fear is excessive
- Interference with functioning or causes marked distress
- Specific (Performance Anxiety) and Generalized subtypes
Obsessive Compulsive Disorder

Obsessions

- *Recurrent and persistent thoughts, impulses, or images* that are experienced, at some time, as *intrusive* and *inappropriate* and that *cause marked anxiety or distress*.
- The thoughts, impulses, or images are *not simply* excessive worries about real-life problems.
- The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
- The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind.
Obsessive Compulsive Disorder

Compulsions

- Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

- The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to prevent or are clearly excessive.
Obsessive Compulsive Disorder

DSM-IV Diagnosis

- Obsessions and/or compulsions
- Recognized as excessive or unreasonable
- Causes marked distress, time-consuming (>1 hour/day), or interferes with functioning
- Not due to another Axis I disorder, substance use or general medical condition
- Specify: Poor insight (~10-15% of patients)
Acute Stress Disorder

- Severe trauma and fearful reaction to the trauma
- During or after trauma, 3+ dissociative symptoms: numbing, “in a daze”, derealization, depersonalization, dissociative amnesia
- Re-experiencing (1): recurrent fearful recollection of the trauma, nightmares, flashbacks, triggered by trauma cues
- Numbing and Avoidance: emotional numbing, apathy, detachment, avoidance of situations and affects related to trauma, trouble recalling aspects of trauma
- Hyperarousal: insomnia, irritability, hypervigilance, overactive startle response, poor concentration
- Associated Symptoms: Dissociation, anxiety, depression, anger, guilt, substance abuse, personality changes
- Occurs within 4 weeks of trauma, lasts 2 days – 4 weeks
Post-Traumatic Stress Disorder

- Severe trauma and fearful reaction to the trauma
- **Re-experiencing (at least 1):** recurrent fearful recollection of the trauma, nightmares, flashbacks, triggered by trauma cues
- **Numbing and Avoidance (at least 3):** emotional numbing, apathy, detachment, avoidance of situations and affects related to trauma, trouble recalling aspects of trauma
- **Hyperarousal (at least 2):** insomnia, irritability, hypervigilance, overactive startle response, poor concentration
- Associated Symptoms: Dissociation, anxiety, depression, anger, guilt, substance abuse, personality changes
- Delayed onset – 6 mo.
Specific Phobia

- Excessive unreasonable fear upon confronting a situation, object, or event
  - person recognizes that it is unreasonable
- Avoidance is present
- Types:
  - Blood-injection-injury
  - Natural environment
  - Animal type
  - Situational (driving, transportation, heights)
  - Other
Adjustment Disorder with Anxiety

• Presence of a stressor believed to be causing the reaction

• Symptoms include:
  – Anxiety and worry
  – Autonomic arousal
  – Avoidance

• If symptoms continue for > 6 months, diagnose GAD or PTSD
Treatment of Anxiety Disorders

First-line evidence-based treatments for anxiety disorders

- Cognitive-Behavioral Therapy
- Medications
Cognitive-Behavioral Therapy

- Highly effective
- Involves relaxation training, cognitive restructuring, and/or graded exposure to feared situation/object/sensation
- Hard to access
  - Primary care intervention: Roy-Byrne et al. JABFM March-April 2009
Treatment of Anxiety Disorders

First-line medications

- SSRIs
- SNRIs
- Benzodiazepines
  - Only for panic, GAD, and social phobia (insufficient evidence for PTSD, OCD)
  - Not adequate monotherapy if co-morbid depression
  - Addictive potential
## Treatment of Anxiety Disorders

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<tr>
<th>Drug</th>
<th>SSRI/SNRI dosing</th>
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<tbody>
<tr>
<td></td>
<td>Starting</td>
<td>Daily Dose (mg/day)</td>
<td>Typical Dose</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>Citalopram</td>
<td>10-20</td>
<td>40-80</td>
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</tr>
<tr>
<td>Fluoxetine</td>
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<tr>
<td>Paroxetine</td>
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<tr>
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<tr>
<td>Escitalopram</td>
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<td>20-40</td>
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<tr>
<td>Venlafaxine</td>
<td>37.5-75</td>
<td>150-375</td>
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- For anxiety disorders: may need to start at lower doses and end at higher doses than for depression
- Warn patients that anxiety may *increase* in first couple weeks, but will get better
Treatment of Anxiety Disorders

Benzodiazepines

- **Pros**
  - Work immediately
  - Highly effective anxiolytics

- **Cons**
  - Addictive/abuse potential
  - Sedation/cognitive impairment
  - Not adequate monotherapy if co-morbid depression
  - Rebound anxiety (especially with short acting benzos like alprazolam)
Treatment of Anxiety Disorders

Benzodiazepines

• When to use?
  • When starting an SSRI/SNRI
  • If SSRI/SNRI only partially effective (and have residual anxiety or insomnia)

• When not to use?
  • Missing appointments/no shows
  • Not participating in other parts of treatment (eg -SSRI, therapy)
  • Losing meds
  • Risk of cognitive impairment
Common strategy

- Start long acting benzodiazepine (e.g., clonazepam 0.25 - 1mg BID) when starting SSRI or after partial response to SSRI/SNRI
- Taper off benzodiazepine *gradually* once SSRI/SNRI starts working
Treatment of Anxiety Disorders

Benzodiazepine alternatives

- For anxiety
  - Hydroxyzine 25-50mg TID - QID prn anxiety
    - Pro: FDA approved, Con: sedating
  - Gabapentin (not prn)
    - Evidence is for pregabalin in GAD
  - Buspirone 20-30mg divided BID or TID
    - Pro: FDA approved for GAD; Con: not immediate acting

- For insomnia
  - Trazodone 25 - 300mg QHS prn
  - Benadryl 25 - 50mg QHS prn
Common Challenging Cases

• Already taking benzo (and pt still symptomatic or there is misuse concern)
  • Don’t stop suddenly
  • Consider switching from short acting to long acting
  • Start longer term treatment, explain rationale/plan for eventually tapering off if indicated
  • If effective and no misuse/side effects, consider continuing

• Geriatric or cognitive impairment
  • Avoid benzos
  • Start low and go slow
Discussion

- Questions?
- Challenging cases/situations?