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

Epidemiology

Disorder	Prevalence (%) Lifetime	12-Month
Any psychiatric disorder	48.0	29.5
Any affective disorder	19.3	11.3
Major depressive disorder	17.1	10.3
Dysthymia	6.4	2.5
Manic episode	1.6	1.3
Any anxiety disorder	*24.9*	*17.2*
Social phobia	12.1	7.1
Simple phobia	11.3	8.8
Generalized anxiety disorder	5.1	3.1
Panic disorder	4.0	2.3
Obsessive-Compulsive Disorder	2.5	2.1
Post-Traumatic Stress Disorder	7.8	3.6
Any substance abuse/dependence	26.6	11.3
Alcohol abuse w/o dependence	9.4	2.5
Alcohol dependence	14.1	7.2

(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

Treatment of Anxiety Disorders

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

SSRI/SNRI dosing

Drug	Starting Daily Dose (mg/day)	Typical Dose
Citalopram	10-20	40-80
Fluoxetine	10-20	40-80
Paroxetine	10-20	40-80
Sertraline	25-50	150-300
Escitalopram	5-10	20-40
Venlafaxine	37.5-75	150-375

- 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

Treatment of Anxiety Disorders

Benzodiazepines

Common strategy

- Start long acting benzodiazepine (eg - 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?