

10.7 Anxiety Disorders in Adults in Primary Care

Clinical Practice Guideline

This guideline is intended to assist the practitioner in clinical decision-making and attempt to define clinical practices that apply to most patients in most circumstances. The treating practitioner should make the ultimate decision regarding the care of a particular patient.

Goals of Treatment

Key priorities for implementation of a successful treatment plan for anxiety disorders include:

- Recognition and diagnosis of appropriate type of anxiety disorder.
- Utilization of diagnostic tools for anxiety symptom identification.
- Incorporating shared decision making between patient/caregiver and provider.
- Providing pharmacological management specific for anxiety type.
- Monitoring the patients' response to treatment and stabilization of symptoms.
- Reviewing and offering alternative treatments to include referral to mental health services.

Clinical Highlights and Some Common Recommendations

I. Diagnosing and Defining Anxiety Disorders

Everyone experiences anxiety at one time or another – “butterflies in the stomach” before giving a speech or sweaty palms during a job interview are common symptoms. Other symptoms include irritability, uneasiness, jumpiness, feelings of apprehension, rapid or irregular heartbeat, stomachache, nausea, faintness, and breathing problems. Anxiety is often manageable and mild, but sometimes it can present serious problems. A high level or prolonged state of anxiety can make the activities of daily life difficult or impossible. The diagnostic process should elicit necessary relevant information such as symptoms, personal history, self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. Patients may have generalized anxiety disorder (GAD) or more specific anxiety disorders such as panic, phobias, obsessive-compulsive disorder (OCD), or post-traumatic stress disorder (PTSD).

- **Generalized Anxiety Disorder (GAD)** is ongoing, excessive worry or fear that is not related to a particular event or situation. It is out of proportion to what would be expected. If a patient has GAD, they worry so much that it interferes with day-to-day life, and is accompanied by tense feelings and worrying more days than not.

Symptoms

- Exaggerated worry
- Tension
- Anticipating disaster
- Irritability
- Trouble concentrating
- Restlessness, or feeling keyed up or on edge
- Physical symptoms
 - Fatigue
 - Headaches
 - Muscle tension
 - Muscle aches
 - Difficulty swallowing
 - Trembling and/or twitching

- Shortness of breath (SOB)
- Pounding heartbeat
- **Panic Disorder** is characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms.

Symptoms

- Feelings of terror that strike suddenly and repeatedly with no warning
- Heart pounding with palpitations
- Sweating
- Feeling weak, faint, or dizzy
- Tingling or numbness in hands
- Feeling flushed or chilled
- Chest pain or smothering sensation
- Sense of unreality
- Fear of impending doom or loss of control
- **Obsessive Compulsive Disorder (OCD)** is characterized by the presence of obsessions (unwanted compulsive thoughts, images, or urges, which repeatedly enter the person's mind) and/or compulsions (unwanted, unnecessary behaviors such as repeated hand washing or cleaning, counting, checking electrical appliances or locks, etc.).

Symptoms

- Recurrent, unwanted, anxious thoughts
- Persistent, unwelcome thoughts or images
- Urgent need to engage in certain rituals that provide temporary relief, and not performing them markedly increases anxiety
- Rituals that cannot be controlled
- **Post Traumatic Stress Disorder (PTSD)** can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat.

Symptoms

- Persistent frightening thoughts
- Memories of tragic, violent acts or trauma
- Feeling emotionally numb or detached
- Easily startled
- May experience sleep problems
- **Social Anxiety Disorder**, also known as **Social Phobia**, refers to excessive long-lasting social anxiety causing relatively extreme distress and impaired ability to function in at least some areas of daily life. The diagnosis can be a 'specific' disorder (when only some particular situations are feared) or a generalized disorder.

Symptoms

- Excessive self-consciousness
- Persistent, intense, and chronic fear of being watched and judged by others
- Being embarrassed or humiliated by one's own actions
- Physical symptoms

- Excessive blushing
- Sweating (hyperhidrosis)
- Trembling
- Nausea
- Difficulty talking or stammering

Hamilton Rating Scale for Anxiety (HAMA) is a rating scale developed to quantify the severity of anxiety symptomatology. It consists of 14 items, each defined by a series of symptoms. Each item is rated on a 5-point scale, ranging from 0 (not present) to 4 (incapacitating). *(See attachment)*

II. **Shared Decision Making**

Shared decision-making between the individual/caregiver and healthcare professionals should take place during the process of diagnosis and in all phases of care. There should be accurate and effective communication between all healthcare professions involved in the care of the patient.

- Provide information on the nature, course and treatment of anxiety disorder
- Present information in clear and understandable language
- Discuss possible options of treatment
- Consider patient preference and the outcomes of previous experiences
- Encourage patient to take medication as prescribed
- Provide information on psychopharmacology
- Provide phone numbers for support and self-help groups
- Make appointments with mental health professionals before patient leaves the office

III. **Psychotherapy Treatment Options**

Psychotherapy involves talking with a trained mental health professional, such as a psychiatrist, licensed clinical psychologist, licensed clinical social worker (LCSW), or advanced practice psychiatric nurse (APPN), to discover what caused an anxiety disorder and how to deal with its symptoms. Patients much learn new ways to cope with anxiety and worry.

- **Cognitive Behavioral Therapy (CBT)** is very useful in treating anxiety disorders. The cognitive part helps patients change the thinking patterns that support their fears, and the behavioral part help patients change the way they react to anxiety-provoking situations. When patients are ready to confront their fears, they are shown how to use exposure techniques to desensitize themselves to situations that trigger their anxieties.
- **Exposure Based Behavioral Therapy** has been used for many years to treat specific phobias. The person gradually encounters the object or situation that is feared, perhaps at first only through pictures or tapes, then later face-to-face. Often the therapist will accompany the patient to a feared situation to provide support and guidance.
- **Self-help (bibliotherapy)** consists of the selection of reading material with special relevance to that patient's life situation. The use of written material is to help the patient understand their psychological problems and identify with ways to overcome them by changing their behavior.
- **Support group** information should be available and offered to all patients. Support groups may provide face-to-face meetings, telephone conference support groups, or additional information on all aspects of anxiety disorders plus other source help.

IV. **Medication Treatment Options**

Although medications cannot cure an anxiety disorder, they can keep the symptoms under

control and enable the patient to lead a normal, fulfilling life. Medication must be prescribed by physicians, usually psychiatrists, who can either offer psychotherapy themselves, or work as a team with psychologists, social workers, or counselors who can provide psychotherapy. The principal medications used for anxiety disorders are antidepressants, anti-anxiety drugs, and beta-blockers to control some of the physical symptoms.

- **Antidepressants** were developed to treat depression but are also effective for anxiety disorders. Although these medications begin to alter brain chemistry after the very first dose, their full effect requires a series of changes to occur; it is usually 4 to 6 weeks before symptoms start to fade. It is important to continue taking these medications long enough to let them work.

Selective Serotonin Reuptake Inhibitors (SSRIs) alter the levels of the neurotransmitter serotonin in the brain, which, like other neurotransmitters, helps brain cells communicate with one another. Fluoxetine, sertraline, escitalopram, paroxetine, and citalopram are some of the SSRIs commonly prescribed for panic disorder, OCD, PTSD, and social phobia. SSRIs are also used to treat panic disorder when it occurs in combination with OCD, social phobia, or depression. These medications are started at low doses and gradually increased until they have a beneficial effect. SSRIs have fewer side effects than older antidepressants, but they sometimes produce slight nausea or jitters when people first start to take them. These symptoms fade with time. Some patients experience sexual dysfunction with SSRIs, which may be helped by adjusting the dosage or switching to another SSRI.

Tricyclics are older than SSRIs and work as well for anxiety disorders other than OCD. They are also started at low doses that are gradually increased. They sometimes cause dizziness, drowsiness, dry mouth, and weight gain, which can usually be corrected by changing the dosage or switching to another tricyclic medication. Tricyclics include imipramine, which is prescribed for panic disorder and GAD, and clomipramine, which is the only tricyclic antidepressant useful in treating OCD.

- **Monoamine Oxidase Inhibitors (MAOIs)** are the oldest class of antidepressant medications. The MAOIs most commonly prescribed for anxiety disorders are phenelzine, followed by tranylcypromine, and isocarboxazid, which are useful in treating panic disorder and social phobia. Patients who take MAOIs cannot eat a variety of foods and beverages (including cheese and red wine) that contain tyramine or take certain medications, including some types of birth control pills, over the counter (OTC) pain relievers, cold and allergy medications, and herbal supplements. These substances can interact with MAOIs to cause dangerous increases in blood pressure. The development of a new MAOI skin patch may help lessen these risks. MAOIs can also interact with SSRIs to produce a serious condition called “serotonin syndrome”, which can cause confusion, hallucinations, increased sweating, muscle stiffness, seizures, changes in blood pressure or heart rhythm, and other potentially life-threatening conditions.
- **Anti-Anxiety Drugs**
High-potency benzodiazepines combat anxiety and have few side effects other than drowsiness.

Benzodiazepines can relieve symptoms within a short time and vary in duration of action in different patients. They may be taken two or three times a day, sometimes only once a day, or just on an as needed (PRN) basis. Dosage is generally started at a low level and gradually raised until symptoms are diminished or removed. The dosage will vary a great deal depending on the symptoms and the individual’s body chemistry. It is wise to abstain from alcohol when taking benzodiazepines, because the interaction between benzodiazepines and alcohol can lead to serious and possibly life threatening complications. It is also

important that the physician is informed of other medications being taken. Patients taking benzodiazepines for weeks or months may develop tolerance for and dependence on these drugs. Abuse and withdrawal reactions are also possible. **For these reasons, the medications are generally prescribed for brief periods of time - days or weeks – and sometimes just for stressful situations or anxiety attacks.** However, some patients may need long-term treatment. Clonazepam is used for social phobia and GAD, lorazepam is helpful for panic disorder, and alprazolam is useful for both panic disorder and GAD. Some patients may experience withdrawal symptoms if they stop taking benzodiazepines abruptly instead of tapering off, and anxiety can return once the medication is stopped. These potential problems have led some physicians to shy away from using these drugs or to use them in inadequate doses.

Bupirone, an azapirone, is a newer anti-anxiety medication used to treat GAD. Possible side effects include dizziness, headaches, and nausea. Unlike benzodiazepines, bupirone must be taken consistently for at least 2 weeks to achieve an anti-anxiety effect.

- **Beta-Blockers** are medications often used to treat heart conditions and high blood pressure but are also used to control “performance anxiety” when the individual must face a specific stressful situation.

Propranolol, which is used to treat heart conditions, can prevent the physical symptoms that accompany certain anxiety disorders, particularly social phobia. When a feared situation can be predicted (such as public speaking), a doctor may prescribe a beta-blocker to keep physical symptoms of anxiety under control.

V. **Monitoring and Follow Up**

Contact with the PCP is essential during treatment so that progress can be monitored and alternative interventions considered. In general, anxiety disorders are treated with medication, psychotherapy, or both. Communication between all healthcare professionals involved in the care of the patient is essential, especially if there exist physical health conditions that also require active management.

- **In some instances, referral is indicated upon identification of anxiety disorder regardless of severity level, but only after all medical issues and/or etiology are resolved.**
- Follow up within 2 weeks after new medications are started and again on 4, 6, and 8 weeks.
- At 8 weeks assess the efficacy of treatment and decide if continuation of treatment is warranted or if alternative interventions are needed.
- Benzodiazepines should not be used beyond 2-4 weeks.
- Consider referral/hospitalization for the following:
 - Comorbid depression
 - Comorbid substance abuse
 - Member requests specialized care
 - Member unresponsive to treatment

Based on National Institute of Clinical Excellence, Anxiety, management of anxiety (panic disorder, with or without agoraphobia, and generalized anxiety disorder) in adults in primary, secondary, and community care, Clinical Guideline 22, December 2004; National Institute of Mental Health, Anxiety Disorders, NIH Publication No. 02-3879, Reprinted 2002; Va/Dod Clinical Practice Guideline for the Management of Post Traumatic Stress, December 2003; National Institute of Mental Health (NIMH) Anxiety Disorders, website www.nimh.nih.gov; and Hamilton Anxiety Rating Scale (HAM-A) at www.cnsforum.com.

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HAMILTON ANXIETY RATING SCALE (HAM-A)

Classification of Symptoms: 0 - absent; 1 - mild; 2 - moderate; 3 - severe; 4 - incapacitating
 HAM-A score level of Anxiety: < 17 mild; 18-24 mild to moderate; 25-30 moderate to severe

Patient: _____

Date : _____

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. Anxious mood 0 1 2 3 4</p> <ul style="list-style-type: none"> • worries • anticipates worst | | <p>10. Respiratory Symptoms 0 1 2 3 4</p> <ul style="list-style-type: none"> • chest pressure • choking sensation • shortness of breath |
| <p>2. Tension 0 1 2 3 4</p> <ul style="list-style-type: none"> • startles • cries easily • restless • trembling | | <p>11. Gastrointestinal Symptoms 0 1 2 3 4</p> <ul style="list-style-type: none"> • dysphagia • nausea or vomiting • constipation • weight loss |
| <p>3. Fears 0 1 2 3 4</p> <ul style="list-style-type: none"> • fear of the dark • fear of strangers • fear of being alone • fear of animal | | <p>12. Genitourinary Symptoms 0 1 2 3 4</p> <ul style="list-style-type: none"> • urinary frequency or urgency • dysmenorrhea • impotence |
| <p>4. Insomnia 0 1 2 3 4</p> <ul style="list-style-type: none"> • difficulty falling asleep or staying asleep • difficulty with nightmares | | <p>13. Autonomic Symptoms 0 1 2 3 4</p> <ul style="list-style-type: none"> • dry mouth • flushing • pallor • sweating |
| <p>5. Intellectual 0 1 2 3 4</p> <ul style="list-style-type: none"> • poor concentration • memory impairment | | <p>14. Behavior at Interview 0 1 2 3 4</p> <ul style="list-style-type: none"> • fidgets • tremor • paces |
| <p>6. Depressed Mood 0 1 2 3 4</p> <ul style="list-style-type: none"> • decreased interest in activities • anhedonia • insomnia | | |
| <p>7. Somatic complaints - Muscular 0 1 2 3 4</p> <ul style="list-style-type: none"> • muscle aches or pains • bruxism | | |
| <p>8. Somatic complaints - Sensory 0 1 2 3 4</p> <ul style="list-style-type: none"> • tinnitus • blurred vision | | |
| <p>9. Cardiovascular Symptoms 0 1 2 3 4</p> <ul style="list-style-type: none"> • tachycardia • palpitations • chest pain • sensory of feeling faint | | |

Column 1 Totals

Column 2 Totals

Total Score

Rater's Signature _____