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Tips in Managing Anxiety Disorders in Primary Care

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Anxiety

- Normal anxiety is adaptive
- An internal response to perceived threat
  or
  to absence of people/objects that signify safety
  and
  can result in cognitive and somatic symptoms

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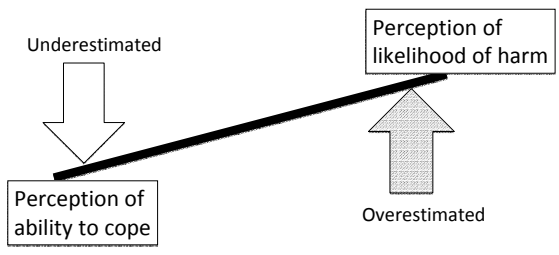
Anxiety



Beck et al (1985) Anxiety Disorders and Phobias: A Cognitive Perspective

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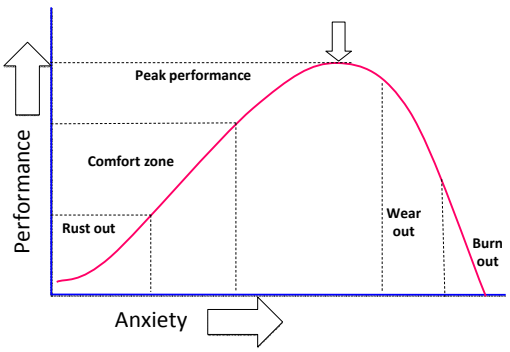
Yerkes Dodson Curve (1908)



Yerkes RM, Dodson JD (1908). J Compar Neurol Psycho 18: 459–482

People can often try to alleviate the unpleasant feeling of anxiety by:

1. Avoiding the trigger
2. Developing a "safety behaviour" (e.g. having someone else accompany them)
3. Using a substance or "as needed" medication

Anxiety as a Disorder

- Severity of symptoms
- Significant subjective distress or disability

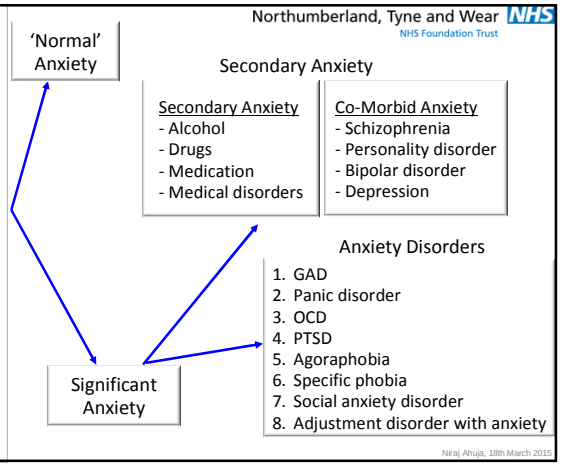
- NICE 2011: Do not rely solely on the number, severity and duration of symptoms, but **also considers the degree of distress and functional impairment**

Anxiety Disorders

- NICE 2011 CMHD
  - Consider GAD in those with anxiety/significant worry, and in frequent attendees in primary care who:
    - have a chronic physical health problem, or
    - are seeking reassurance about somatic symptoms, or
    - are repeatedly worrying about a wide range of different issues

- Differentiate between types of anxiety disorders and note any co-morbidities

Anxiety Disorders



Anxiety Disorders

- GAD (Generalised anxiety disorder)
- Panic disorder
- Agoraphobia
- Specific phobia
- SAD (Social anxiety disorder)
- OCD (Obsessive compulsive disorder)
- PTSD (Post traumatic stress disorder)
- Adjustment disorder with anxiety

- Organic anxiety disorder
- Substance induced anxiety disorder

Separated from Anxiety Disorders in DSM-5

GAD: DSM-5 (2013)

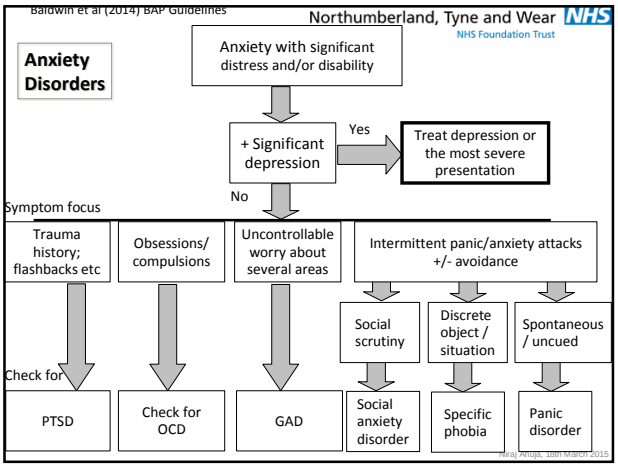
A. Excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities
B. The individual finds it difficult to control the worry
C. The anxiety and worry are associated with ≥3 of the following 6 symptoms: (Note: Only 1 item is required in children)
   1. Restlessness or feeling keyed up or on edge
   2. Being easily fatigued
   3. Difficulty concentrating or mind going blank
   4. Irritability
   5. Muscle tension
   6. Sleep disturbance
D. Clinically significant distress or impairment in functioning
E. Not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism)
F. Not better explained by panic disorder, social anxiety disorder, social phobia, OCD, PTSD, anorexia nervosa, somatic symptom disorder, body dysmorphic disorder, illness anxiety disorder, schizophrenia or delusional disorder

Anxiety Disorders

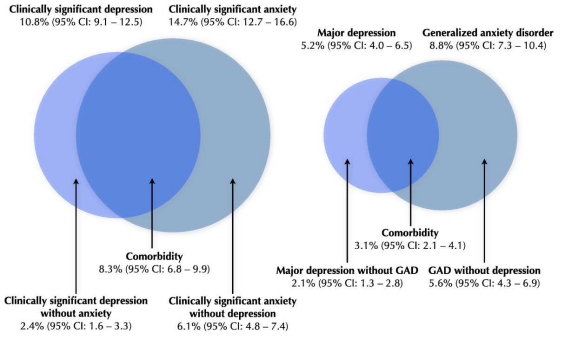
- Organic anxiety disorder

- o Hypoglycaemia
- o Hyperthyroidism, e.g. tachycardia, irritability, restlessness, and tremor
- o Phaeochromocytoma
- o Medications, e.g. thyroxine, caffeine and other stimulants, long term benzodiazepines

Baldwin et al (2014) BAP Guidelines



Co-morbid Depression and Anxiety



Patients with GAD have a 67% life time prevalence of co-morbid depression

Johansson et al (2013) https://peerj.com/articles/98/

Judd et al (1998) Acta Psychiatr Scand Suppl 393:6-11

Common Mental Health Disorders

- Affect ~15% of population at any time
- GAD 4.4%
- OCD 1.1%
- Panic disorder 1.1%
- Phobias 1.4%
- Mod-severe depression 2.3%
- PTSD 3%

*One week prevalence from the Office of National Statistics 2007 National Survey

Focus of the intervention	Nature of the intervention
Step 3: Persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention, initial presentation of moderate or severe depression; GAD with marked functional impairment or that has not responded to a low-intensity intervention; moderate to severe panic disorder; OCD with moderate or severe functional impairment; PTSD.	**Depression:** CBT, IPT, behavioural activation, behavioural couples therapy, counselling[1], short-term psychodynamic psychotherapy[2], antidepressants, combined interventions, collaborative care[3], self-help groups. **GAD:** CBT, applied relaxation, drug treatment, combined interventions, self-help groups. **Panic disorder:** CBT, antidepressants, self-help groups. **OCD:** CBT (including ERP), antidepressants, combined interventions and case management, self-help groups. **PTSD:** Trauma-focused CBT, EMDR, drug treatment. **All disorders:** Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.
Step 2: Persistent subthreshold depressive symptoms or mild to moderate depression; GAD; mild to moderate panic disorder; mild to moderate OCD; PTSD (including people with mild to moderate PTSD).	**Depression:** Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes[3], non-directive counselling delivered at home[4], antidepressants, self-help groups. **GAD and panic disorder:** Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups. **OCD:** Individual or group CBT (including ERP), self-help groups. **PTSD:** Trauma-focused CBT or EMDR. **All disorders:** Support groups, educational and employment support services; referral for further assessment and interventions.
Step 1: All known and suspected presentations of common mental health disorders.	**All disorders:** Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions.

When a person presents with a common MH disorder **AND** harmful drinking or alcohol dependence, refer them for treatment of the alcohol misuse **FIRST**

BAP Guidelines

Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology

Psychopharm

Journal of Psychopharmacology
1–37

DOI: 10.1177/0269881114525674
jop.sagepub.com
SAGE

David S Baldwin[1,2], Ian M Anderson[3], David J Nutt[4], Christer Allgulander[5], Borwin Bandelow[6], Johan A den Boer[7,8], David M Christmas[9], Simon Davies[10], Naomi Fineberg[11], Nicky Lidbetter[12], Andrea Malizia[13], Paul McCrone[14], Daniel Nabarro[15], Catherine O'Neill[12], Jan Scott[16], Nic van der Wee[17] and Hans-Ulrich Wittchen[18]

Baldwin et al (2014) BAP Guidelines

Anxiety Disorders

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Generalised Anxiety Disorder

- Detection:
  - In GAD, look for co-morbid depression and excess alcohol consumptions
  - In patients with medically unexplained physical symptoms and depression, look for anxiety
- Psychological treatment: CBT, Applied Relaxation
- *Do NOT initially combine CBT and drug treatment*
- Drug treatment
  - SSRIs
  - SNRIs
  - Pregabalin
  - Buspirone, Trazodone, Agomelatine, Benzodiazepines (AZM, DZM, LZM), Imipramine, Quetiapine, Hydroxyzine

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Cut off Scores = 5 (mild), **10 (moderate), and 15 (severe)**

Sensitivity = 89%; Specificity = 82% for GAD (score 10)

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CBT

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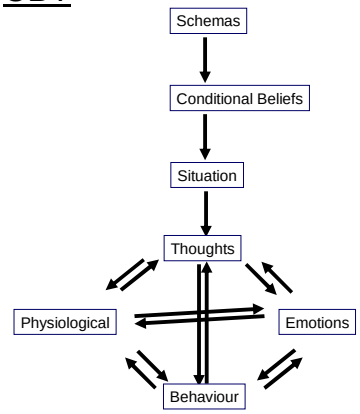

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Anxiety Disorders

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CBT Resources

- Overcoming Anxiety - by Chris Williams
- Mind over Mood - by Dennis Greenberger and Christine Padesky
- Living Life to the Full

  www.llttf.com

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Licensed antidepressant indications in anxiety disorders

	GAD	Panic	OCD	PTSD	SAD
Fluoxetine			YES		
Citalopram		YES			
Escitalopram	YES	YES	YES		YES
Sertraline			YES	YES	
Paroxetine	YES	YES	YES	YES	YES
Fluvoxamine			YES		
Venlafaxine	YES				YES (XL)
Duloxetine					
Clomipramine			YES		YES
Trazodone	YES				
Moclobemide					YES

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Generalised Anxiety Disorder

	Licensed (BNF)	BAP Guidance
Fluoxetine		
Citalopram		YES
Escitalopram	**YES**	**YES**
Sertraline		YES
Paroxetine	**YES**	**YES**
Venlafaxine	**YES (MR)**	**YES**
Duloxetine	**YES**	**YES**
Trazodone	**YES**	**YES**
Buspirone		YES
Agomelatine		YES
Imipramine		YES
Benzodiazepines	**AZM, DZM, LZM**, CDP, OZM	**AZM, DZM, LZM**
Quetiapine		YES
Hydoxyzine		YES

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Antidepressants – start slow

- Patients with anxiety (and especially panic) are particularly prone to side-effects with SSRIs/SNRIs
- Advise the patient that anxiety may get worse before it gets better
- **Almost always start low, e.g. 5mg of Fluoxetine, with slow further increases**
- May need to use a benzodiazepine while initiating and titrating the antidepressant
- Advise the patient that **treatment of up to 12 weeks** may be needed to assess efficacy though non-response in 4 weeks in anxiety is informative

Baldwin et al (2014) BAP Guidelines

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β blockers

- Propranolol
  - Useful for anticipatory (performance) anxiety
  - Does not treat the underlying condition of anxiety disorder
  - Do **NOT** prescribe for panic disorder

Benzodiazepines

- Efficacy in anxiety, panic and social anxiety disorders
- For those not responding to at least 3 previous treatments, with persistent, severe, distressing and impairing anxiety symptoms
- Risks
  - Sedation
  - Amnesia / cognitive impairment
  - Disinhibition / increase in aggression
  - Dependence / Tolerance
  - Under-treatment and worsening of depression
- Recent DVLA guidance (March 2015)

www.benzo.org.uk
The Ashton Manual

Baldwin et al (2014) BAP Guidelines

Buspirone

- A 5-HT_{1A} partial agonist
- Licensed for GAD
  - 15-45mg daily
  - Can not be used PRN
  - Side-effects
  - Especially useful in benzodiazepine naïve
- Do **NOT** prescribe in panic disorder (can make it worse)

Antipsychotics

- Quetiapine
  - Evidence in GAD but not licensed
- Risperidone
- Olanzapine
- Older drugs (not recommended)
  - Flupentixol
  - Trifluperazine

Pregabalin

- Binds to the α2δ subunit of voltage-sensitive calcium channels (VSCCs)
- Licensed for GAD
  - 2nd or 3rd choice after SSRIs and SNRIs
- Also helps with co-morbid depressive symptoms
- 150-450mg daily (max 600mg daily)
- Higher doses may be associated with higher response rates (Baldwin et al 2014)

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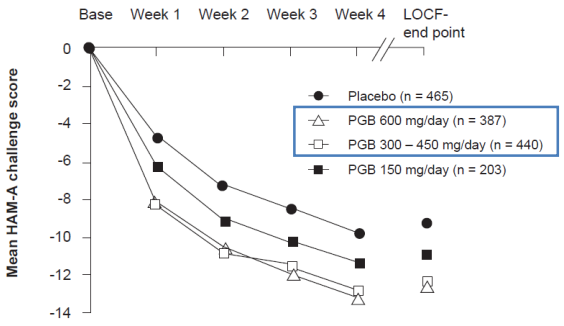
Pregabalin in GAD: Dose-response relationships



Montgomery SA (2006). Exp Opin Pharmacother 7: 2139-2154

Anxiety Disorders

Panic disorder

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- Detection:
  - In panic disorder, look for co-morbid depression and agoraphobia
  - In patients with medically unexplained physical symptoms, look for panic/agoraphobia
- Psychological treatment: CBT
- Drug treatment
  - SSRIs (All)
  - Some TCAs (e.g. Clomipramine, Lofepramine)
  - Venlafaxine, Reboxetine
  - Benzodiazepines (e.g. Diazepam, Lorazepam)
  - Valproate, Gabapentin
  - Do NOT prescribe Propranolol, Buspirone, Bupropion

Baldwin et al (2014) BAP Guidelines

Anxiety Disorders

Panic Disorder

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	Licensed (BNF)	BAP Guidance
Fluoxetine		YES
Citalopram	**YES**	**YES**
Escitalopram	**YES**	**YES**
Fluvoxamine		YES
Sertraline		YES
Paroxetine	**YES**	**YES**
Venlafaxine		YES
Reboxetine		YES
Valproate		YES
Gabapentin		YES
Tricyclic Antidepressants		YES (Clomipramine, Desipramine, Imipramine, Lofepramine)
Benzodiazepines		YES (Diazepam, Lorazepam, Alprazolam, Clonazepam)

Anxiety Disorders

Specific (Simple) Phobia

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- Detection: Look for
  - Number of fears and degree of impairment/severity
  - Co-morbid disorders
- Psychological treatment: Exposure, CBT
- Drug treatment
  - SSRIs (e.g. Paroxetine)
  - Benzodiazepines – contradictory evidence (may both increase and decrease the effectiveness of exposure treatment)

Baldwin et al (2014) BAP Guidelines

Anxiety Disorders

Specific (Simple) Phobia

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	Licensed (BNF)	BAP Guidance
Fluoxetine		
Citalopram		
Escitalopram		YES
Sertraline		
Paroxetine		YES

Anxiety Disorders

Social anxiety disorder

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- Detection:
  - Assess degree of impairment/severity (vs. shyness)
  - Co-morbid depression
  - Ask for social anxiety in depression, panic restricted to social situations, alcohol/cannabis misuse
- Psychological treatment: CBT
- Drug treatment
  - 1st line – SSRIs
  - Venlafaxine, Phenelzine, Moclobemide, Benzodiazepines, Gabapentin, Pregabalin, and Olanzapine
- Routine prescription of higher doses NOT recommended but individual patients may benefit from higher doses
- Avoid prescribing Atenolol or Buspirone

Baldwin et al (2014) BAP Guidelines

Anxiety Disorders

Social Anxiety Disorder

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	Licensed (BNF)	BAP Guidance
Fluoxetine		YES
Citalopram		
Escitalopram	**YES**	**YES**
Fluvoxamine		YES
Sertraline		YES
Paroxetine	**YES**	**YES**
Venlafaxine	**YES (XL)**	**YES**
Clomipramine	**YES**	**YES**
Moclobemide	**YES**	**YES**
Phenelzine		YES
Benzodiazepines		YES (Bromazepam, Clonazepam)
Olanzapine		YES
Gabapentin		YES
Pregabalin		YES

Anxiety Disorders

PTSD

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- Detection:
  - Ask for trauma in mental health presentations
  - Co-morbid depression
- Psychological treatment:
  - Trauma focused CBT, EMDR
- Drug treatment:
  - 1st line - SSRIs (Paroxetine, Sertraline)
    - Do not routinely prescribe high doses of SSRIs
  - Venlafaxine
  - If no response, augment with Olanzapine, Risperidone or Prazosin

Baldwin et al (2014) BAP Guidelines

Anxiety Disorders

PTSD

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	Licensed (BNF)	BAP Guidance
Fluoxetine		+/-
Citalopram		-
Escitalopram		-
Sertraline		YES
Paroxetine		YES
Mirtazapine		+/-
Venlafaxine		YES

Anxiety Disorders

OCD

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- Detection:
  - Assess time spent in OC behaviour, distress, impairment and attempted resistance
  - Ask for OC symptoms in depression and vice versa
- Psychological treatment: CBT, Exposure
- Drug treatment:
  - 1st line: SSRIs
  - Clomipramine may be slightly more efficacious than SSRIs but has more side effects (also supply problems)
  - Increase SSRI dose if insufficient response at lower dosage; may need higher dose
  - SSRI augmentation with an antipsychotic (e.g. Risperidone) or other drugs
  - Combine SSRI/Clomipramine with CBT to maximise efficacy

Baldwin et al (2014) BAP Guidelines

Anxiety Disorders

OCD

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	Licensed (BNF)	BAP Guidance
Fluoxetine	**YES**	**YES**
Citalopram		YES
Escitalopram	**YES**	**YES**
Sertraline	**YES**	**YES**
Paroxetine	**YES**	**YES**
Fluvoxamine	**YES**	**YES**
Venlafaxine		+/-
Clomipramine	**YES**	**YES**

SNRIs (Venlafaxine and Duloxetine) – available data not robust enough

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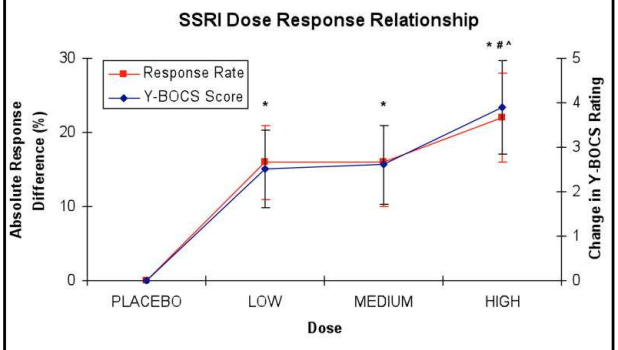


Bloch et al (2010) Meta-analysis of dose-response relationship of SSRI in OCD. Mol Psychiatry 15: 850-5

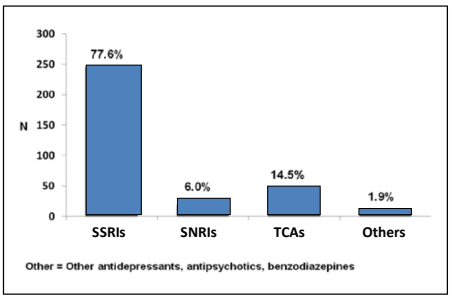
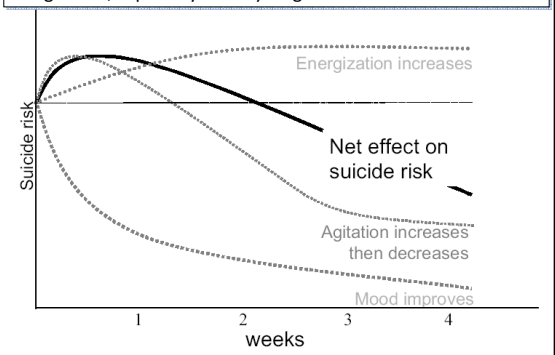


Figure 1. Frequency of prescribed baseline agents (*n*=317).

Ameringen et al (2014). JoP. A view from 9 international centres

Antidepressants and Risk of Suicide

Monitor for akathisia, suicidal ideas, increased anxiety and agitation, especially in early stages of treatment with an SSRI



Nutt DL (2003) J Psychopharm

Risk of Suicide

- Actively ask for ideas/plan/intent of suicide
- Ensure knowledge of how to seek help promptly e.g. Samaritans, Crisis Resolution and Home Treatment (CRHT) Team
- If no suicidal risk, review in 2 weeks
- If suicidal risk or age <30, *weekly review* till risk no longer clinically important

Anxiety Disorders

GAD	At least 18 Months
Panic disorder	At least 6 Months
Agoraphobia	
Specific phobia	
Social anxiety	At least 6 Months
OCD	At least 12 Months
PTSD	At least 12 Months
Adjustment disorder	

Duration of Treatment in those who have responded to treatment is uncertain

- When stopping treatment, taper the dose gradually over an extended period (usually up to 3 months) to avoid discontinuation symptoms

Baldwin et al (2014) BAP Guidelines

Serotonin Syndrome

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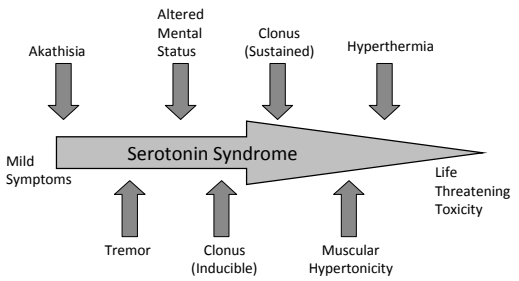

Drugs causing SS

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- ⇧ Serotonin
  - L-Tryptophan, Amphetamines (e.g. Ecstasy), Cocaine, L-Dopa, Meperidine (Pethidine), Sibutramine, Buspirone, Triptans, Ergot Alkaloids, Fentanyl, LSD
- ⇧ Postsynaptic Receptor Sensitivity
  - Lithium, Valproate
- ⇩ Metabolism
  - MAOIs, Linezolide (Antibiotic), Ritonavir
- ⇩ Reuptake
  - Cocaine, Ecstasy, Meperidine (Pethidine), Tramadol, Pentazocine, SSRIs, SNRIs, TCAs, Trazodone, Bromocriptine, St John's Wort, Ondansetron, Granisetron, Panax Ginseng, Dextromethorphan

Anxiety Disorders

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When to Refer to….

- Secondary care MH services
  - Insufficient experience to manage the condition
  - ≥2 treatments have not resulted in improvement
  - Severe co-existing depression, risk of suicide or self neglect
  - Medical co-morbidity or drug interaction issues
  - Interventions not available in primary care
- Tertiary care specialist MH services
  - Complex, severe, enduring and treatment-resistant anxiety disorders not responding to treatment options in secondary care

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Thank You