# Identifying and Managing Anxiety Disorders

"Anxiety" is not a diagnosis itself, but rather a symptom that can be a part of several diagnoses found in the Diagnostic and Statistical Manual 5 (DSM 5). Additionally, anxiety could also be a presenting symptom for other diagnoses such as eating disorders, personality disorders, disorders with associated paranoia, or other categories of psychiatric illness. This document is meant as an introduction to some of the more commonly seen anxiety disorders. Further exploration of the nuances of reported "anxiety" is crucial for appropriate diagnosis.

## IMPORTANCE OF FOCUS

Many patients with anxiety will be initially seen and treated by primary care providers. Making the correct diagnosis and initiating appropriate evidence-based treatment is important in treating anxiety disorders. Anxiety Disorders share the underlying theme of having excessive fear and anxiety in combination with a behavioral disturbance. Anxiety disorders are also commonly co-morbid with other psychiatric illnesses. Anxiety can also be caused by medications and/or substance use. Clarifying the symptoms and making an accurate diagnosis are imperative.

## GOALS

The overall goal of this Care Map is to improve the care of adults entering the primary care setting with anxiety disorders, by making the appropriate diagnosis and increasing compliance with evidence-based practice guidelines.
The ultimate treatment goal for the patient is to receive the appropriate diagnosis(es), achieve remission of symptoms, return to the optimal level of psychosocial functioning and to prevent the relapse and recurrence of the anxiety symptoms.

## KEY RECOMMENDATIONS

- The most common categories of illness related to anxiety listed in the DSM 5 are Anxiety Disorders, Obsessive-Compulsive and Related Disorders, and Trauma and Stressor- Related Disorders. The differential diagnosis for a chief compliant of anxiety should at least include Generalized Anxiety Disorder, Posttraumatic Stress Disorder or Acute Stress Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Social Anxiety Disorder, Adjustment Disorder with Anxious Mood, Substance/Medication-Induced Anxiety Disorder and Anxiety Disorder Due to Another Medical Condition.
- Assessment:
  - Initial assessment should include a thorough diagnostic evaluation and work up, including consideration of medical conditions or substance use disorders that can mimic anxiety.
  - Utilize the Biological-Psychological-Social method for assessment and treatment.
  - Utilize standardized measures to screen for symptoms and monitor response to treatment.
  - Assess for suicide risk at each visit and counsel the patient on how to access emergency care.
- Treatment:
  - Referral for psychotherapy or counseling is appropriate at any stage of treatment. In many cases the combination of medications and psychotherapy are indicated.
  - The therapeutic benefits of most medications used for anxiety (SSRI, SNRI, Buspar) are often not apparent for several weeks and full benefits may not be realized for up to 12 weeks. It is important to educate the patients about this and encourage continued compliance if the patient is without side effects.
  - If the anxiety is likely due to a substance, medication or general medical condition, treatment of the underlying cause is considered the primary treatment. If symptoms persist following the removal of the medical problem, medication or substance, follow the

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treatment outline for the appropriate anxiety disorder.

- Anxiety disorders may require higher doses of SSRIs to achieve remission of symptoms.
- Would not recommend using TCA's in patients who have arrhythmias or have had suicidal thoughts. TCA's can be toxic in overdose.
- Utilize an interaction checker for all medications when starting a new SSRI. Some medications used for other illnesses can increase the risk of serotonin syndrome. Some medications used in the treatment of anxiety, like TCA's, are used for other indications.
- Some medications can potentially worsen anxiety.
  - Bupropion (Wellbutrin) is not indicated for anxiety disorders, and could potentially worsen anxiety.
  - Stimulants can potentially worsen anxiety.

## CARE PATHWAY COMPONENTS

**Table 1: General Overview of Disorders in the DSM 5 that present with anxiety.**
*All of these disorders include the following specifiers: 1) the symptoms cause significant impairment in functioning. 2) the symptoms are not better accounted for by other medical/mental conditions or substances (including delirium).

| | |
|---|---|
| **Generalized Anxiety Disorder (GAD)** | *Excessive worries that are difficult to control and are about number of events/activities. These worries typically occur more often than not for months. The worry causes at least 3 of the following: worsening sleep irritability, muscle tension, trouble with concentration, feeling on edge restless.* |
| **Panic Disorder (PD)** | *Recurrent and unexpected panic attacks with fear of having future pan or fear of consequences (heart attack). This concern may cause behav changes. Some may have other anxiety disorders with panic attacks. H panic attacks alone does not meet the criteria for panic disorder.* |
| **Social Anxiety Disorder (SAD)** | *Fear and anxiety about social situations where they perceive there is t possibility that they can be scrutinized, embarrassed, humiliated, or re others.* |
| **PTSD/Acute Stress Disorder** | *Exposure to or actual threatened death, serious injury or violence. Syn develop in response to this trauma. Symptom clusters: 1) re-experienc hyperarousal 3)avoidance 4)negative mood/cognitions. Symptoms < is acute stress disorder. Symptoms > 1 month is considered PTSD.* |
| **Obsessive Compulsive Disorder (OCD)** | *The patient has Obsessions and/or Compulsions. These obsessions a compulsions are time consuming and cause distress. Obsessions are distressing, intrusive, unwanted recurrent thoughts, urges or images. Compulsions are behaviors or mental acts that one feels they must co response to an obsession or as a "rule", to decrease anxiety/distress.* |
| **Anxiety Disorder Due to Another Medical Condition** | *Anxiety is the direct physiological result of a medical condition.* |
| **Substance/Medication-Induced Anxiety Disorder** | *Anxiety develops either after being exposed to a medication or during/ after intoxication or withdrawal from a substance.* |
| **Adjustment Disorder with Anxiety** | *Symptoms develop within 3 months of a stressor. The distress is out o proportion to the severity of the stressor. Worries, nervousness and jitt are prominent symptoms.* |

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**Initial Visit**

- Diagnostic Evaluation
  - Establish diagnosis by utilizing DSM 5 Criteria
    - Free online access to the DSM 5 through Palmetto Health Digital Library.
  - Utilize general screening tools (GAD-7 and OASIS)
  - Work up and rule out medical conditions that could mimic or contribute to anxiety
    - CMP, CBC, TSH with reflex, UPT ,UDS, U/A
  - Review medication list for possible pharmacological causes of increased or worsened anxiety
  - Consider co-morbid illnesses like depression, substance use disorders, personality disorders, bipolar disorder, etc.
    - Carefully screen for history of mania*. (Please note that mania is a sustained period of elevated or irritable mood lasting days, weeks, or even months. Sudden, brief "mood swings" or a situational irritability are <u>not</u> suggestive of bipolar disorder.)*
  - Suicide risk assessment
    - Screen for suicidal thoughts, intentions, or plan. Screen for thoughts of being "better off dead" or "wishing I wouldn't wake up". Include information about past suicide attempts, family history of suicide, history of self-harm behaviors and access to weapons.
    - Administer Columbia Suicide Scale
- Initial Treatment Plan for Anxiety Disorders:
  - Consider referral for psychotherapy
    - www.psychologytoday.com to help find a local therapist.
  - Start pharmacotherapy
    - SSRI's are first line treatment for most anxiety disorders.
    - Consider specific diagnosis, co-morbid diagnoses, patient's preference and prior response to medication when selecting a medication.
    - Be cautious and consider referral to psychiatry if the history is suggestive of mania, as serotonergic agents could potentiate mania in bipolar disorder.
    - FDA approved medications will vary based on diagnosis. Micromedex is a useful resource for FDA approved indications.
      - Free online access to Micromedex is available through Palmetto Health Digital library.
    - Consider starting SSRI at a low, sub-therapeutic dose to assess for tolerability and attempt to minimize side effects (including worsening anxiety).
      - For example: fluoxetine 10mg, sertraline 25mg, citalopram 10mg
    - Consider use of PRN Vistaril if needed for times of overwhelming/breakthrough anxiety. Vistaril is an antihistamine that is FDA approved for anxiety.
    - Given the potential for abuse, physiological dependence and other risks described in this document, benzodiazepines are typically not utilized as first line treatment for anxiety.
      - Could consider a benzodiazepine if the anxiety is acute and severe enough to warrant immediate intervention and there is significant impairment in functioning. This requires weighing the risks versus benefits. Please reference "medication class" section for more

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information.

- Counsel patient on expected time to onset of action for medication and the importance of taking the medication every day as prescribed.
- Provide suicide hotline number, educational resources, and instructions on how to access emergency services.
- Schedule follow up appointment in 1-2 weeks

**Follow Up Visit #1**

- Assessment
  - Screening tool (GAD 7, OASIS or tool specific to diagnosis made at initial visit).
  - Suicide Risk Assessment
  - Follow up on psychotherapy referral (if made at initial visit). Obtain consent to collaborate with therapist.
  - Check for medication side effects: GI upset, headaches, sexual dysfunction, sweating, sedation, activation/increased anxiety, sleep disturbance.
- Counsel
  - There may not be much symptom response until 4-12 weeks of treatment. Continue to encourage compliance if they are tolerating the medication.
- Treatment Plan
  - Continue the medication if tolerated. Do not stop the medication due to lack of efficacy at this point in treatment.
  - If the medication started at initial visit is not tolerated, consider switch to a different SSRI.
  - Increase the dose if the initial dose was started sub-therapeutically and the patient has tolerated the medication.
- Return to clinic in 2-4 weeks.
  - If the patient has severe symptoms or possible safety concerns, follow closely.

**Follow Up Visit #2**

- Assessment
  - Screening tool (GAD 7, OASIS or tool specific to diagnosis made at initial visit).
  - Suicide Risk Assessment
  - Inquire about psychotherapy or consider referral.
  - Check for medication side effects.
  - Check for the patient's perception of symptom improvement.
- Counsel
  - There may not be much symptom response until 4-12 weeks of treatment. Continue to encourage compliance if they are tolerating the medication.
- Treatment Plan
  - If no response
    - Consider switch to a different SSRI, SNRI, or Buspar.
  - If partial response
    - Maximize dose as tolerated.
    - Refer for therapy if patient is not already engaged in therapy.
    - Consider referral to psychiatrist to re-evaluate medication regimen and diagnosis.

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- Return to clinic in 2- 4 weeks
    - If the patient has severe symptoms or possible safety concerns, follow closely

**Subsequent Follow Up Visits**

- Assessment
    - Screening tool (GAD 7, OASIS or tool specific to diagnosis made at initial visit).
    - Suicide Risk Assessment.
    - Inquire about psychotherapy or consider referral .
    - Check for medication side effects.
    - Check for patient's perception of symptom improvement.
- Treatment Plan
    - If no response or partial response
        - Consider switch to another SSRI, SNRI or Buspar.
        - Consider referral to psychiatry.
        - Consider other reasons if there is a failure to respond to multiple medications with an adequate trials:
            - Adherence
            - Psychosocial stressors
            - Co-occurring disorders (depression, substances, etc.)
            - Incorrect diagnosis
    - If remission of symptoms
        - Continue medications
        - Continue follow up visits and assessments
        - If a benzodiazepine was started, consider beginning benzodiazepine taper with monitoring for withdrawal.
    - Schedule follow up in 2-4 week increments until the patient has resolution of symptoms and the medications doses are stable. After that, the time between appointments can be increased as clinically appropriate.

**Medication Classes:**

- **SSRI**: fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram
- **SNRI**: venlafaxine, duloxetine, *desvenlafaxine (not FDA approval for anxiety disorders*)
- **Other:**
    - **Buspar:** FDA approved for anxiety. It is anxiolytic that takes 2-3 weeks for full efficacy. It is not a benzodiazepine or controlled substance. Works as a selective serotonin 1A receptor partial agonist.
    - **Mirtazapine** : not first line, but would consider after SSRI, SNRI and Buspar trials; not FDA approved for anxiety.
- **Tricyclic Antidepressants (TCS's):** would not consider first line; side effects are common; can be toxic in overdose.
- **Monoamine Oxidase Inhibitors (MAOI's)**: Given the significant risk of major drug and diet interactions with MAOIs, would consider referral to psychiatry instead of prescribing MAOIs for anxiety disorders.
- **Benzodiazepines:**
    - Benzodiazepines are not always indicated when initiating a SSRI or SNRI. Would

recommend utilizing benzodiazepines only in severe anxiety when rapid symptom control is needed. Many patients are functioning and do well with initiation of SSRI and psychotherapy, without addition of a benzodiazepine.

- Although benzodiazepines provide short-term relief of anxiety, they are poor long term options.
- Anxiety should not be treated with monotherapy benzodiazepines.
- Avoid using in patients with alcohol use or current or history of other substance use disorders.
    - Use of benzodiazepines in combination with opioid pain medications or alcohol is associated with **potentially fatal side effects** and should be avoided whenever possible.
- Once tolerance and physiologic dependence develop, withdrawal symptoms can be mistaken for anxiety.
- Deciding to use a benzodiazepine must be a thoughtful decision of balancing the risks versus benefits.
    - *Potential Risks:*
    - Benzodiazepines are associated with physiological dependence, psychological dependence, rebound anxiety, sedation and physiological withdrawal. In the elderly they are associated with cognitive impairment, disinhibition and increase risk of falls.
    - Benzodiazepines can sometimes be psychotherapy-interfering, where patients will utilize medications instead of coping skills.
        - May decrease the patient's ability to cope with anxiety.
        - Cognitive Behavioral Therapy is less likely to be effective if the patient is treated with benzodiazepines.
    - *Potential Benefits:*
    - Benzodiazepines can provide relief quickly and do not require 4-12 weeks to start working, like the SSRI/SNRIs.
- The clinical decision to start a benzodiazepine should be thoughtful and result in the creation of a specific plan for use. The diagnosis, targeted symptoms and length of treatment should be specifically outlined and discussed with the patient.
    - Review prescribing information. Benzodiazepines are dosed at different frequencies and have different half-lives.
    - Educate the patient on the short term use of the medication and the potential risks.
    - Advise the patient of the risks of withdrawal with abrupt cessation, not to utilize benzodiazepines with alcohol, not to take with other sedating medications and not to drive while taking the medication.
    - If a benzodiazepine is going to be prescribed, would recommend using a longer acting benzodiazepine, like clonazepam. Short-acting benzodiazepines, like alprazolam, should be avoided.
        - For anxiety, clonazepam is typically not dosed more frequently than twice daily.
        - Could consider a one time dose of Xanax for infrequent, specific situational anxiety, like panic attacks as an airplane passenger.
    - Monitor urine drug screens and the state prescription monitoring program.

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- Will need to taper the benzodiazepine when discontinuing the medication, given risk for withdrawal.

**WHEN TO REFER**

- The patient has not responded to an evidence-based treatment approach (as outlined above).
- Diagnostic clarification is needed.
- Severe, treatment resistant illness may require inpatient hospitalization or partial hospitalization.
- Patients who are an imminent risk to themselves or others and warrant emergent admission for safety should be hospitalized. Suicide risk assessments should be done at each visit.

**Table 2: Key Points for Treatment**

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|---|
| **First Line:**<br>• **SSRI**<br>*Increase dose to remission of symptoms if tolerated.* |
| **Second & Third Lines (No Response):**<br>• **Switch**<br>*Switch to another SSRI*<br>*Consider SNRI*<br>*Consider Buspar* |
| **Additional Strategies:**<br>• **Consider psychotherapy referral.**<br>*Can refer at initial visit. Strong evidence for psychotherapy in anxiety disorders.*<br>• **Start treatment with a medication (SSRI) that has worked for the patient in the past and was well tolerated, if possible.**<br>• **Consider re-examining diagnosis if poor response.**<br>• **Rule out medical illnesses or substances that can present with anxiety.**<br>• **Complete suicide risk assessments regularly .**<br>• **Consider appropriate level of care (outpatient, partial hospitalization, inpatient hospitalization).** |
| **Referral Indicated:**<br>• **Treatment-resistant illness.**<br>• **Diagnosis is unclear.**<br>• **No/Little response to medications or psychotherapy as advised above.**<br>• **Severe illness (especially with possible safety concerns).** |

## RESOURCES

**References:**

1. DSM 5
2. APA Practice Guidelines
    a. OCD
    b. PTSD and Acute Stress Disorder
    c. Panic Disorder
3. Sadock, B.J., Sadock, V.A., Ruiz, P. (2015). *Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry (11th Edition).* Wolters Kluwer.
4. Micromedex online

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5. Byrne, et al. Brief Intervention for Anxiety in Primary Care Patients. J Am Board Fam Med 2009 Mar-Apr, 22(2): 175-86.

## For Additional Information

**[List Clinical team leads contact information]**

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This Care Map presents a model of best care based on the best evidence available at the time of publication. It is not a prescription for every patient, and it is not meant to replace clinical judgment. Although physicians are encouraged to follow the Care Map to help focus on and measure quality, variation from the pathway may occur as clinical freedom is exercised to meet the needs of the individual patient. Send feedback to Elizabeth Sheridan, Manager of Clinical Integration for the Palmetto Health Quality Collaborative (PHQC) at Elizabeth.sheridan@palmettohealth.org or 803 296-2384