



SPA Specialty Referral Guideline
Detection, Assessment, and Treatment of Anxiety Disorders in the Primary
Care Setting

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“Detection and Assessment”

I. General Guidelines:

Overview of the Anxiety Spectrum

A) Lifetime Prevalence: 4 of the top 6 most common Psychiatric Disorders

- a) Depression: 17%
- b) Alcohol Use Disorders: 15%
- c) Social Anxiety Disorders: 14%
- d) Post Traumatic Stress Disorder: 5% Males; 10% Females
- e) Generalized Anxiety Disorder: 5%
- f) Panic Disorder: 4 – 5%

B) Psychiatric Disorders are 2 – 3 times more common in:

- a) The chronically ill medical patient: Cardiovascular, Pulmonary, GI, Neurologic
- b) Long Term Care: assisted living, Skilled Nursing Facility (SNF)

C) Early Detection - Promotes effective Treatment and Prevents

- a) Chronicity and refractoriness
- b) Comorbidity cascades
- c) Dysfunction
- d) Inappropriate/excessive Medical Utilization

D) A Psychiatric Anxiety Disorder always has these elements:

- a) Leads to significant internal distress, and/or
- b) Causes significant role dysfunction, and
- c) Is not better accommodated for by another mental disorder and
- d) The symptoms are not due to the direct physiological effects of a substance or general medical condition.

II. Diagnostic Criteria for Anxiety Disorders:

A) **Social Anxiety Disorder:** Lifetime Prevalence (LTP) = 14%

- a) Marked and persistent fear of social or performance situations – fear of “scrutiny,” fear of “performance.”
- b) The exposure to feared situation leads to internal anxiety.
- c) Person recognizes that the fear is excessive, unreasonable.
- d) The Performance situations are avoided or endured with internal distress.
- e) The avoidance and distress interferes significantly with normal functioning and role performance.
 - 1) Examples: Internal anxiety and avoidance of speaking, socializing, working, toileting
 - 2) 90% of persons have this anxiety in multiple areas of performance = Generalized Social Anxiety Disorder
 - 3) Excellent Screen: SPIN

B) **Post Traumatic Stress Disorder:** Characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma; symptoms last for \geq 1 month.

- a) Acute: duration of symptoms less than 3 months

- b) Chronic: symptoms last 3 months or more
- c) Delayed onset: at least 6 months have passed between the traumatic event and the onset of the symptoms

“Criteria”

- 1) Person is exposed to a traumatic event:
 - Experienced, witnessed or confronted with events that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others
 - Response involves intense fear, helplessness or horror
- 2) The traumatic event is persistently re-experienced via one or more:
 - intrusive distressing recollections; thoughts, images, perceptions
 - recurrent distressing dreams of the event
 - acting or feeling as if the traumatic event was occurring – reliving, illusions, hallucinations, dissociative flashbacks
 - intense psychological distress at exposure to internal or external cues that symbolize the event
 - physiological reactivity on exposure to internal or external cues
- 3) Persistent avoidance of stimuli associated with the trauma inducing general responsiveness indicated by three or more:
 - efforts to avoid thoughts, feelings or conversations associated with trauma
 - efforts to avoid activities, places or people that arouse recollections of the trauma
 - inability to recall an important aspect of the trauma
 - markedly diminished interest or participation in activities
 - feeling of detachment or estrangement from others
 - sense of a foreshortened future
- 4) Persistent symptoms of increased arousal indicated by two or more:
 - hard to fall or stay asleep
 - irritability or outbursts or anger
 - difficulty concentrating
 - hypervigilance
 - exaggerated startle response
- 5) The symptoms are greater than one month in duration.
- 6) The disturbance causes significant distress or impairments in social, occupational or other role functioning.
 - Very high rate of suicide attempts: 20%
 - Excessive substance abuse

C) Generalized Anxiety Disorder

- a) Excessive anxiety and worry occurring more days than not for at least 6 months about a number of events or activities.
- b) Finds it difficult to control the worry.
- c) The worry is associated with 3 or more:
 - 1) restlessness – feeling “keyed up”, on edge
 - 2) easily fatigued
 - 3) difficulty concentrating – mind goes blank
 - 4) irritability
 - 5) muscle tension
 - 6) difficulty falling or staying asleep
- d) The focus of worry or concern is not confined to features of another psychological diagnosis.
- e) The worry causes significant distress and role impairment.
- f) The disorder is not due to direct effects of a substance or general medical condition.
 - 1) Screen: WAT
 - 2) Peaks mid-twenties

D) Panic Attack

- a) Discrete period of intense fear or discomfort (sudden, unexpected intense anxiety: “Out of the Blue”)
- b) In which four or more of these symptoms develop abruptly and peak within 10 minutes:
 - 1) Palpitations, pounding heart, accelerated pulse
 - 2) Sweating
 - 3) Trembling or shaking
 - 4) Sensation of shortness of breath or smothering
 - 5) Feeling of choking
 - 6) Chest pain or discomfort
 - 7) Nausea or abdominal distress
 - 8) Feeling dizzy, unsteady, lightheaded, faint
 - 9) Feeling of unreality or feeling detached from oneself
 - 10) Fear of losing contact or going crazy
 - 11) Fear of dying
 - 12) Paresthesias (numbness, tingling)
 - 13) Chills or hot flashes

E) Panic Disorder

- a) recurrent, un-expected panic attacks
- b) at least one of the panic attacks has been followed by at least a month of the following:
 - 1) Persistent concern of having additional attacks (anticipatory anxiety)
 - 2) Worry about the implication of the attack or its consequences
 - 3) A significant change in behavior related to the attacks

F) Panic Disorder with Agoraphobia

- a) Meets the conditions of Panic Disorder, plus

- b) Anxious about being in places or situations from which escape might be difficult or embarrassing or in which help may not be available (in crowds, in movies, on a bridge, on a train), and
- c) The situations are avoided or endured with marked distress about heavy panic
 - 1) Both present very frequently to ER and PCP office
 - 2) Multi-organ system, somatic presentation

G) Obsessive Compulsive Disorder

- a) Characterized by either obsessions or compulsions
 - 1) Obsessions are defined by four criteria:
 - recurrent and persistent thoughts, impulses, or images that are experienced at some time as intrusive and inappropriate and that cause marked anxiety or distress, and
 - the thoughts, impulses or images are not simply excessive worries about real-life problems, and
 - the persons attempts to ignore or suppress the thoughts, impulses, images, or to neutralize them with other thought or actions, and
 - the person recognizes that these obsessional thoughts, impulses, or images are a product of his own mind.
 - 2) Compulsions are defined by two criteria:
 - Repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, repeating words) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly, and
 - These behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event.
- b) At some point during course of disorder, the person recognizes that obsessions or compulsions are excessive or unreasonable.
- c) The obsessions or compulsions cause marked distress; are time consuming (>1hr/day) or significantly interfere with normal routine of life.
 - 1) Onset Teens/Twenties
 - 2) Very Chronic
 - 3) Common Clusters: obsessions; compulsions
 - Cleanliness: washing
 - Obsessional: checking
 - Symmetry: ordering
 - Sinning: Doubting
 - Hoarding: Collecting

H) Acute Stress Disorder

- a) The person has exposure to a traumatic event in which
 - 1) He/she experienced, witnessed or was confronted with an event(s) that involved actual or threatened death or serious injury; or a threat to physical integrity, and
 - 2) The response involves intrusive fear, helplessness, or horror
- b) The person has ≥ 3 of these dissociative symptoms:

- 1) Subjective sense of numbing, detachment or absence of emotional responsiveness
 - 2) A reduction in awareness of surroundings “in a daze”
 - 3) De-Realization
 - 4) De-Personalization
 - 5) Dissociative amnesia (inability to recall important aspects of the trauma)
 - c) The traumatic event is persistently re-experienced; recurrent images, thoughts, dreams, illusions, flashbacks, reliving
 - d) Marked avoidance of stimuli that arouse recollection of the trauma
 - e) Marked anxiety or increased arousal: insomnia, irritability, poor concentration, hypervigilance, startle responses, motor restlessness
 - f) The disturbance lasts a minimum of two days and a maximum of four weeks and occurs within four weeks of the trauma (Differential Diagnosis (DDX) from Post Traumatic Stress Disorder (PTSD))
- I) **General Medical Conditions Which Cause Anxiety**
- a) Endocrine conditions: Hyper/Hypo- thyroid, Pheochromocytoma, Hypoglycemia, Hyperadrenocorticism
 - b) Cardiovascular: Chronic Heart Failure (CHF), Pulmonary Embolism, Arrhythmia
 - c) Respiratory: Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Hyperventilation
 - d) Metabolic: B12 deficiency, Porphyria
 - e) Neurological: Neoplasms, Vestibular dysfunction, Encephalitis
- J) **Substances That Can Induce Clinically Significant Anxiety Disorders**
- a) Substance intoxication: alcohol, amphetamine related, caffeine, cannabis, cocaine, hallucinogens, inhalants, phencyclidine
 - b) Substance Withdrawal: alcohol, cocaine, sedative, hypnotics, anxiolytics
 - c) Medications: analgesics, anesthetics, anticholinergics, anticonvulsants, antihistamines, anti-Parkinsonian meds, corticosteroids, sympathomimetics, thyroid medication
 - d) Toxins: CO₂, CO, Gasoline, Heavy Metals

“Treatment of Anxiety Disorders”

III. General Overview

- A) Many mild/moderate disorders will respond to Cognitive Behavioral Therapy (CBT)
- “It is important that patients understand that the condition and its symptoms are very real; that certain known thoughts and words (cognitions) trigger the symptoms; that the first step to healing is recognition; that there are very clear Behavioral Training Techniques that will be practiced behaviorally; and that this learning will make a big difference.”*
- a) The focus is on attention to distorted thoughts (cognitions) which result in dysfunctional anxiety and emotion.
 - b) Train patient to recognize these distorted thoughts and learn to change thinking constructs to adaptive options via practice in the here and now (Behavior).

- c) The Therapy teaches new cognitions which lead to adaptive emotions and behavioral change.
- d) Central categories of Cognitive Distortions:
 - 1) All or none thinking; black or white, all or none
 - 2) Over-generalization
 - 3) Mental filters – see the bad selectively
 - 4) Disqualifying the positive
 - 5) Jumping to conclusions: maladaptive expectancy
 - 6) Catastrophizing
 - 7) Emotional reasoning
 - 8) Should, have to, must, ought to; obligatory prisons
 - 9) Labeling – automatic sorting
 - 10) Personalization

B) Moderate/Severe Anxiety Disorders:

- a) Some will respond to CBT alone, but
- b) Most require:
 - 1) CBT, plus
 - 2) Pharmacotherapy

C) References for CBT

- a) Feeling Good: The New Mood Therapy, David Burns, M.D.
- b) Anxiety Disorders and Phobias: A Cognitive Perspective, Aaron Beck, M.D.
- c) The Anxiety and Phobia Workbook, 4th Edition. Edmund J. Bourne

IV. Pharmacotherapy:

A) General Principles:

- a) Response to best agents can take 3 – 5 weeks.
 - 1) Educate patient on response, or they do not comply
 - 2) Side effects are early (7 – 10 days) and tend to taper
 - 3) Take medications as ordered; never change or stop without advice
- b) Patients with anxiety disorders:
 - 1) Are more sensitive to initial medication effects
 - 2) Start low and go slowly: taper up slowly
- c) After a positive response to medication:
 - 1) Remain on this agent for 6 – 9 months (on same effective dose) continuation.
 - 2) Some patients need maintenance to prevent relapses (long history of illness; past relapse history)
- d) Do not abuse substances: alcohol, marijuana, narcotics, benzodiazepine's (BZ's)

B) The Best Evidence Supports:

- a) SSRI: Prozac, Paxil, Zoloft, Celexa, Lexapro
- b) SNRI: Effexor, Effexor XR
- c) Duloxetine (Cymbalta)

- 1) Not as dangerous in overdose as other medications
 - 2) Least anti-cholinergic
 - 3) Simple dosing: most are daily
 - 4) Best are long acting, slow release formulations
- E) Some Benefits in Some Cases:
- a) Wellbutrin –SR (SDRI)
 - b) Anti-kindling agents: Tegretol; Depakote XR
 - c) Propranolol for simple Social Anxiety Disorder (SAD) 10 – 30mg (Note: 90% of SAD is Generalized – see SSRI)
 - d) Buspar: For uncomplicated Generalized Anxiety Disorder (GAD) 10 – 15 mg po BID – TID (Note: 90% of GAD is complicated, not simple – see SSRI)
 - e) Luvox for OCD: Requires high doses in most cases up to 300 mg/day
 - f) Tricyclic antidepressants:
 - 1) Nortriptyline 25 –75mg (Pamelor)
 - 2) Desipramine 75 – 100mg (Norpramin)
 - 3) Problems with TCA:
 - anticholinergic (glaucoma, BPH)
 - sedation; orthostatic hypotension
 - arrhythmias, conduction issues
 - Lethal in overdose
 - g) Benzodiazepines
 - 1) Used in first 7 – 10 days at lowest effective dose
 - Helps relieve distress immediately
 - Allows patient to tolerate the early treatment emergent effects of the true therapeutic agent: SSRI; SNRI
 - 2) Do not use for months; dependency problems
 - 3) Caution in comorbid substance abusing patients

“Dosing Guidelines for Anxiety Disorders”

V. SSRI

	<u>Start Dose / D</u>	<u>Max / D</u>
A) Citalopram (Celexa)	10 – 20mg	60mg
B) Escitalopram (Lexapro)	5 – 10mg	40mg
C) Fluoxetine (Prozac)	10 – 20mg	80mg
D) Fluvoxamine (Luvox)	100mg	300mg
E) Paroxetine (Paxil)	5 – 10mg	60mg
Paroxetine – CR	12.5mg	75mg
F) Sertraline (Zoloft)	25 – 50mg	200mg

VI. SNRI

	<u>Start Does / D</u>	<u>Max / D</u>
A) Venlafaxine (Effexor)	25 – 50mg	375mg
Venlafaxine XR	37.5 – 75mg	225mg
Duloxetine (Cymbalta)	20mg	120mg

VII. SDRI

	<u>Start Does / D</u>	<u>Max / D</u>
A) Bupropion (Wellbutrin)	75mg BID	450mg
B) Bupropion SR	100 – 150mg	400mg
C) Bupropion XL	150mg	450mg

VIII. Benzodiazepine*Start: (Caution: short term only)

A) Lorazepam (Ativan)	.5mg po BID – TID PRN
B) Alprazolam (Xanax)	.5mg po BID – TID PRN
C) Clonazepam (Klonopin)	.5mg po BID – TID PRN

*Safe tapering schedule for those on chronic treatment is 10 – 15% q. week

IX. Screens Used for Anxiety Disorders

- A) Panic Disorder: Sheehan Patient Rated Anxiety Scale (SPRAS)
- B) Generalized Anxiety Disorder: W.A.T.
- C) Social Anxiety Disorder (SPIN)
- D) Beck Anxiety Inventory (BAI)
- E) Mini Screening Tool: Panic Disorder, Social Anxiety Disorder
- F) Obsessive Compulsive Disorder: Y-BOCS
- G) Burns Anxiety Inventory – General Screen
- H) Sheehan Disability Scale

Switching Antidepressants			
Switching from		Switching to	Wash-out Period ^(a)
Non-selective cyclic	→	Non-selective Cyclic	No washout – use dose equivalents for switching
	→	SSRI	5 half-lives of cyclic antidepressant (Caution: see Interactions) ^(b)
	→	SDRI	5 half-lives of cyclic antidepressant
	→	Irreversible MAOI	5 half-lives of cyclic antidepressant
	→	RIMA	5 half-lives of cyclic antidepressant
	→	SNRI	5 half-lives of cyclic antidepressant ^(b)
SSRI	→	Non-selective Cyclic	5 half-lives of SSRI (Caution: with Fluoxetine due to long half-life of active metabolite) ^(b)
	→	SDRI	5 half-lives of SSRI (Caution: with Fluoxetine) ^(b)
	→	SNRI	5 half-lives of SSRI (Caution: with Fluoxetine)
	→	Irreversible MAOI	5 half-lives of SSRI (Caution: with Fluoxetine) – DO NOT COMBINE
	→	RIMA	5 half-lives of SSRI (Caution: with Fluoxetine)
	→	SSRI	No washout – taper first drug over 2-5 days then start second drug (use lower doses of second drug if switching from Fluoxetine; longer taper may be necessary if higher doses of Fluoxetine used)
Irreversible MAOI	→	Non-selective Cyclic	10 days – CAUTION
	→	SSRI	10 days – DO NOT COMBINE
	→	SDRI	10 days – DO NOT COMBINE
	→	SNRI	10 days – DO NOT COMBINE
	→	RIMA	10 days – DO NOT COMBINE
	→	Irreversible MAOI	10 days – DO NOT COMBINE
RIMA	→	Non-selective Cyclic	2 days
	→	SSRI	2 days – CAUTION
	→	SDRI	2 days
	→	SNRI	2 days – CAUTION
	→	Irreversible MAOI	2 days – DO NOT COMBINE
SDRI	→	Non-selective Cyclic	2 days
	→	SSRI	2 days – CAUTION
	→	SNRI	2 days
	→	RIMA	2 days – DO NOT COMBINE
	→	Irreversible MAOI	2 days
SNRI	→	Non-selective Cyclic	3 days
	→	SSRI	3 days – CAUTION
	→	SDRI	3 days
	→	Irreversible MAOI	3 days – DO NOT COMBINE
	→	RIMA	3 days – CAUTION

(a) Recommendations pertain to outpatients. More rapid switching may be used in inpatients (except from an irreversible MAOI or RIMA) with proper monitoring of plasma levels and synergistic effects; (b) Taper first drug over 3 to 7 days prior to initiating second antidepressant; consider starting second drug at a reduced dose

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FYI: Only