Anxiety Screening & Treatment:

Basic Principles

Hamilton Family Health Team

Better care, together.

INDEX FOR SUSPICION

Symptoms:

- Excessive anxiety
- Fear
- Worry
- Avoidance
- Multiple somatic complaints
    - Vague pains, headaches, dizziness, GI complaints
- Multiple visits to family physician
- Sleep disturbance
- Fatigue
- Poor concentration
- Substance use

Risk Factors for Anxiety Disorders:

- Family history of anxiety (or other mental disorder)
- Personal history of anxiety in childhood or adolescence, including excessive shyness
- Stressful life event and/or traumatic event including abuse, domestic violence
- Being female
- Comorbid psychiatric disorder, especially depression, ADD/ADHD, substance use

Need to R/O:

- Medical condition
- Depression
- Substance use disorder
- Symptoms secondary to medication
- Somatoform disorder
- ADD/ADHD

SCREENING & ASSESSMENT

Panic Disorder [PD]:

1. Have you ever had a spell or attack where all of a sudden you felt frightened, anxious, or uneasy?
2. Ever had a spell or attack when for no reason your heart began to race, you felt faint or nauseous or could not catch your breath?

Generalized Anxiety Disorder [GAD]

(if answers yes, can follow these questions with GAD-7):

1. Have you been bothered by nerves or feeling anxious or on edge for at least 6 months?
2. Do you worry excessively and have trouble stopping or controlling the worry?
3. Would people describe you as "a worrier"?

Social Anxiety Disorder [SAD]:

1. Have you had a problem being anxious or uncomfortable around people?
2. Does fear of embarrassment cause you to avoid doing things or speaking to people?
3. Is being embarrassed or looking stupid among your worst fears?

Obsessive Compulsive Disorder [OCD]:

1. Do you experience unwanted recurrent and intrusive thoughts that cause anxiety but you cannot control? (e.g., thoughts about contamination, doubts about your actions, aggressive thoughts, etc.)
2. Do you perform repetitive behaviours (or mental acts) in order to decrease the anxiety generated by the obsessions? (e.g., checking, washing, counting, or repeating)

Post-Traumatic Stress Disorder [PTSD]:

1. Have you had recurrent dreams or nightmares of trauma, or avoidance of trauma reminders?

Depression: "Over the past <u>month</u>, have you . . ."

1. Have you often been bothered by feeling down, depressed, or hopeless?
2. Have you often been bothered by little interest or pleasure in doing things?

Substance Screen [HFHT]: "In the last <u>three months</u>, have you. . ."

1. Had 5 or more drinks on any one occasion?
2. Used an illegal drug (including marijuana)?
3. Used a prescription medication for non-medical reasons?

Pain:

1. On a scale of 0 to 10, where 0 means no pain and 10 means the worst pain imaginable, how would you rate your pain?

Suicide Evaluation

1. Current thoughts of active self-harm**,** or passive thoughts of being "better off dead"
   - **a.** Plan and access to means
   - **b.** "Reasons for living" that would stop them from acting
   - **c.** History of suicide attempt
   - **d.** Substance abuse increases risk for suicide

2. Contract for safety; give crisis information

SCALES THAT CAN ASSIST WITH ASSESSMENT

Severity of Anxiety: **GAD-7** [7 items]

Adult ADHD Self Report Scale Symptom Checklist [6 + 12 items]

Patient Health Questionnaire - Somatic, Anxiety, Depression Scales: **PHQ-SADS**
[includes PHQ-9 for depression, GAD-7 for anxiety plus questions for panic, PHQ-15 for physical symptoms]

WHEN DOES ANXIETY BECOME A DISORDER?

Anxiety becomes a problem, and a disorder should be considered when:

- It is of greater intensity and (or) duration than usually expected, given the circumstances of its onset (consider context of family, societal, and cultural behavior and expectations
- It leads to impairment or disability in occupational, social, or interpersonal functioning
- Daily activities are disrupted by the avoidance of certain situations or objects in an attempt to diminish the anxiety
- It includes clinically significant, unexplained physical symptoms and (or) obsessions, compulsions, and intrusive recollections or memories of trauma (unexplained physical symptoms, intrusive thoughts, and compulsion-like behaviours are very common among people who do not have an anxiety disorder)

The Canadian Journal of Psychiatry – Clinical Practice Guidelines for the Management of Anxiety Disorders. Cdn J Psychiatry 2006,51 (Suppl 2): 1S-90S.

DISORDER	KEY FEATURES OF SPECIFIC ANXIETY DISORDER
PD with or without Agoraphobia	• Recurrent unexpected panic attacks without any obvious situational trigger • Patient may actively avoid situations in which panic attacks are predicted to occur • Intolerance of physical symptoms of anxiety
SAD (or Social Phobia)	• Excessive or unrealistic fear of social or performance situations • Intolerance of embarrassment or scrutiny by others
Specific Phobia	• Excessive or unreasonable fear of a circumscribed object or situation, usually associated with avoidance of the feared object (for example, an animal, blood, injections, heights, storms, driving, flying, or enclosed places)
OCD	• Presence or obsessions; recurrent, unwanted, and intrusive thoughts, images or urges that cause marked anxiety (for example, thoughts about contamination, doubts about actions, distressing religious, aggressive, or sexual thoughts) • Compulsions; repetitive behaviours or mental acts that are performed to reduce the anxiety generated by the obsessions (for example, checking, washing, counting, or repeating)
GAD	• Uncontrollable and excessive worry occurring more days than not, about a number of everyday, ordinary experiences or activities. Often accompanied by physical symptoms (for example, headaches or upset stomach) • Intolerance of uncertainty
PTSD	• Occurs after a traumatic event to which patient responds with intense fear, helplessness, or horror; patients relive the event in memory, avoid reminders of the event, and experience emotional numbing and symptoms of increased arousal • Intolerance of re-experiencing trauma

Cdn J Psychiatry 2006,51 (Suppl 2): 1S-90S. Clinical Practice Guidelines [Adapted from DSM-IV-TR]

TREATMENT HISTORY & EXPECTATIONS FOR TREATMENT

Reflect how anxiety has adversely affected them (negatives of being anxious).

Has the patient had prescribed medication or psychotherapy treatment in the past for their anxiety or depression?

- If yes, review their health record
- How helpful was the previous treatment? (a little, moderately, a lot)

Was treatment stopped because of side effects or another reason?

- If yes, document the reason(s) for stopping previous treatment

Is the patient using alternative/complementary medicine for their anxiety, e.g., chamomile, St John's Wort, valerian, lavender, kava, or other?

- Also inquire about prayer, exercise, meditation or other.

TREATMENT

1. Psycho-Education & Self-Care

- "Cycle of Anxiety" → cognitive (thoughts)
  → physical symptoms
  → behaviour – avoidance, freezing

- Anxiety is normal and adaptive because it helps us prepare for danger (for instance, our heart beats faster to pump blood to our muscles so we have the energy to run away or fight off danger). Therefore, the goal is to learn to manage anxiety, not eliminate it.

- Anxiety can become a real problem when our body tells us that there is danger when there is <u>no real</u> danger.

- Lifestyle & Self-Care
  - Improve sleep hygiene
  - Reduce caffeine, alcohol, sweets
  - Include diaphragmatic breathing
  - Add exercise

2. Psychotherapy: CBT Basic Principles

- CBT is used to break the cycle of anxiety

- **Focus on <u>avoidance</u>**
  - <u>gradual exposure to feared objects or situations</u>
  - make a list of avoided activities or most feared situations from least to worst
  - gradually try to face these situations, starting with easiest first
  - each situation may need to be broken down further (eg., driving a car may need to be broken down into several steps)
  - practice needs to be regular (5 times per week) for a long enough duration that anxiety starts to decrease

- **Cognitive restructuring to help with exposure**
  - identify automatic thoughts
  - identify thinking errors (e.g., jumping to conclusions or catastrophizing)
  - challenge unrealistic thoughts with questions such as "what is the evidence", "so what if it happens", "what is another way of looking at the situation".

- **Reduce physical symptoms**
  - regular exercise
  - breathing retraining
  - progressive muscle relaxation

3. Psychopharmacology

- SSRI's/SNRI's treat many of most common anxiety disorders including PD, GAD, SAD, PTSD and OCD (SSRI's better than SNRI's)
- If never treated before, start with an SSRI
- Start with a low dose (1/4 to 1/2 of usual starting dose for depression)
- Increase antidepressant slowly → over 4-6 weeks
- If patient is on a benzodiazepine, continue for 12 weeks, while beginning the antidepressant and then taper slowly
- Don't use as needed (prn) benzodiazepines
- Benzodiazepines may be used as monotherapy in very selected cases

SSRI ANTIDEPRESSANT OPTIONS

MEDICATION	ANXIOLYTIC EFFICACY	ADVANTAGES	DISADVANTAGES
Fluoxetine	Panic PTSD OCD	Long ½ life (no withdrawal)	Most stimulating; Longer ½ life
Paroxetine	Panic GAD SAD PTSD OCD	Most extensively studied across anxiety disorders; Least stimulating; P4502D6 effects; No P4503A4 effects	Most sedating; Shorter ½ life & worse withdrawal Most weight gain
Sertraline	Panic GAD SAD PTSD	Well-studied across the anxiety disorders; Least P4502D6 effects; Minimal P4503A4 effects; Intermediate ½ life (Less withdrawal)	Most diarrhea
Citalopram	Panic GAD (level 3) SAD (level 2) OCD (level 2)	No P450 effects	
Escitalopram	Panic GAD SAD OCD (level 4) PTSD (level 4)	No P450 effects	
Venlafaxine ER	Panic GAD SAD PTSD OCD (level 2)	No P450 effects	Short ½ life Withdrawal with missed dose or sudden discontinuation; Increased BP at >225 mg
Fluvoxamine	Panic SAD OCD PTSD (level 3)	Less P4502D6 effects P4501A2 effects	Short ½ life

Levels of Evidence:

1. Meta-analysis or replicated RCT that includes a placebo condition
2. At least one RCT with placebo or active comparison condition
3. Uncontrolled trial with at least 10 or more subjects
4. Anecdotal reports or expert opinion

ANXIETY RESISTANT TO FIRST-LINE TREATMENT

- Failure to respond should always prompt reconsideration of diagnosis
  - Other syndromes, e.g., ADD/ADHD
  - New life stressors or changes (e.g., changes with age; females: postpartum or perimenopause)
  - Concealed substance abuse
  - Functional status, in particular Avoidance
  - Depression is more prominent
  - Chronic pain / pain with opioid use

HELP PATIENT WEIGH POSITIVES & NEGATIVES OF TREATMENT

Discern possible barriers to treatment (e.g., logistical issues, concerns about taking medication, belief that treatment will not work).

How much does the patient think treatment might work? (Outcome Expectancy)

- Scale 0-10

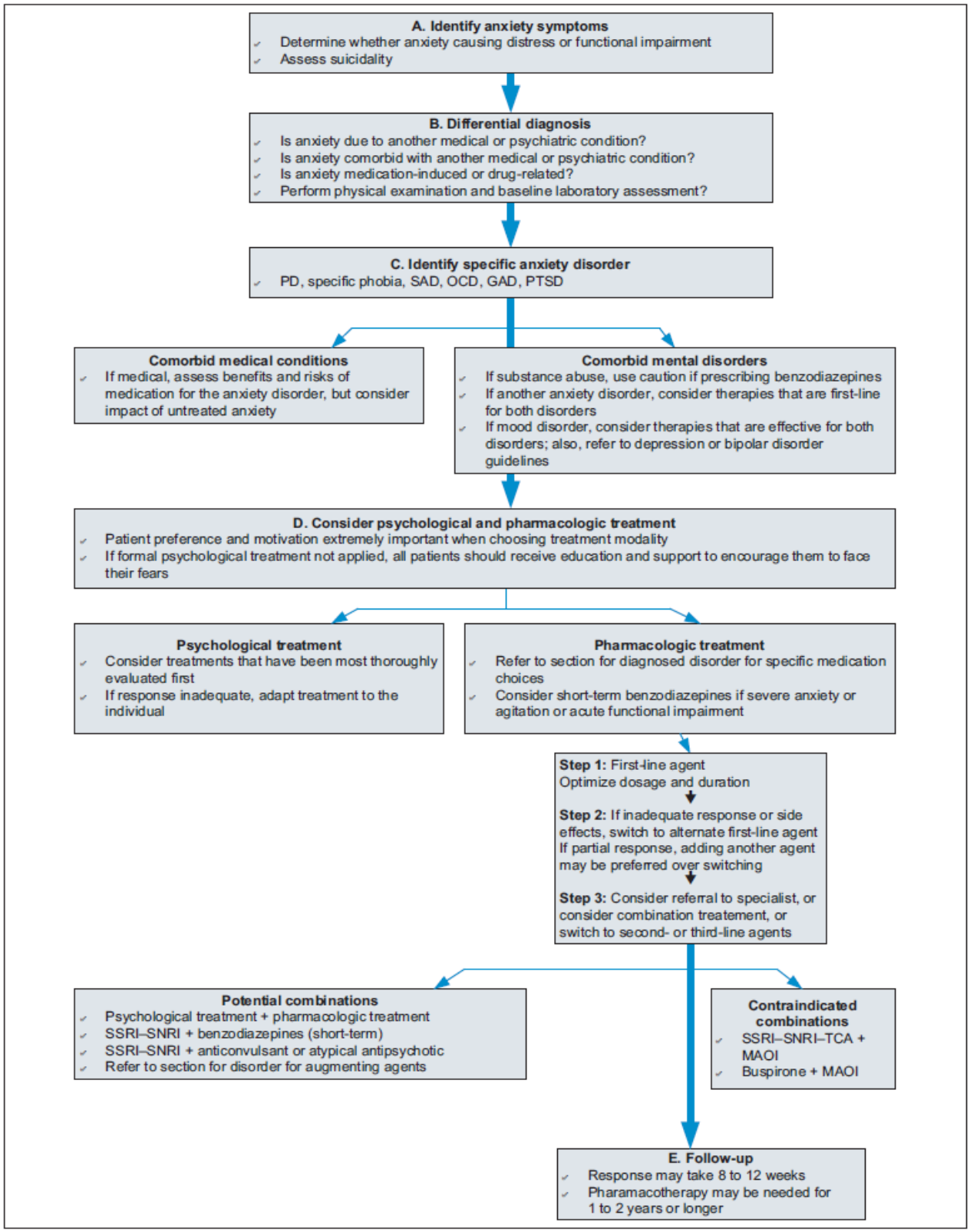
How confident is the patient that he/she can help the treatment along? (Self-Efficacy Expectancy)

- Scale 0-10

Ask what could improve Outcome Expectancy and Self-Efficacy Expectancy.

Reinforce patient strengths.

APPENDIX I: KEY DECISION POINTS IN THE MANAGEMENT OF ANXIETY DISORDERS



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