Clinician Guide:
Management of Anxiety in Adults in Primary Care

Overview

Behavioral Health disorders are common in the primary care setting, and frequently co-exist with and worsen the outcomes of chronic diseases. These disorders are undertreated due to inadequate recognition, a shortage of behavioral health clinicians, stigma, and challenges navigating complex healthcare systems. Integrating behavioral health care into primary care provides a holistic care approach that reduces fragmentation, reduces time to treatment, destigmatizes behavioral health disorders, lowers care costs, increases patient and provider satisfaction, and improves both behavioral and physical health outcomes. Dartmouth-Hitchcock is in the process of implementing behavioral health integration at its primary care clinics, utilizing the Collaborative Care Model- a team approach in which the patient and primary care provider (PCP) are supported by a Behavioral Health Clinician (BHC, usually a licensed clinical social worker) and a consulting psychiatrist. This process includes screening with a standardized questionnaire, eDH decision support triggered by positive screens, Knowledge Map guidelines, and training to address depression, anxiety, and unhealthy alcohol and drug use.

Anxiety disorders are prevalent and are a leading cause of disability. The most commonly encountered anxiety disorders in primary care are generalized anxiety disorder (GAD), panic disorder and social anxiety disorder. In addition, anxiety is often present in post-traumatic stress disorder (PTSD). These disorders commonly co-occur, share much in common, and have similar treatments- arguing for a unified approach to screening, diagnosis and treatment in primary care.[1]

Screening and Diagnostic Evaluation

Population screening for anxiety disorders is not routinely recommended, but may be beneficial if systems are in place to care for patients who screen positive.[2] The DH behavioral health questionnaire includes the GAD-2, which triggers the remaining questions of the GAD-7[3] for a score over 3 (see appendix 1). Although the GAD-7 was designed to detect generalized anxiety disorder, it is also fairly accurate for panic, social anxiety, and PTSD.[4] It should be used for screening and monitoring symptom severity, but should not replace a clinical assessment and diagnosis.

In primary care, patients are as likely to present with physical symptoms such as headaches, gastrointestinal symptoms, musculoskeletal pain and insomnia as they are to have a chief complaint of anxiety- which may lead to misdiagnoses. Symptoms that are multiple, vague, or

medically unexplained should raise suspicion for an anxiety or depressive disorder.[5] It is important to distinguish normal anxiety from an anxiety disorder, as fear and anxiety are common in everyday life. Features of anxiety disorder include the presence of anxiety (often with physical symptoms such as tachycardia, dyspnea, or gastrointestinal distress), worry, or avoidance that are excessive or out of proportion to the situation, persistent, and associated with impairments in social, occupational, or other important areas of functioning. Anxiety disorders may occur with no clear precipitating factors. However, most individuals live stressful lives, and anxiety typically emerges during periods of stress. It is reasonable to watchfully wait and reevaluate the patient's symptoms once the stress has subsided. However, if anxiety persists or regularly recurs during subsequent periods of stress, then an anxiety disorder is likely, and it is time to intervene. Although evaluation and management of the different anxiety disorders is similar, an awareness of the different diagnoses remains useful (see appendix 2).

Anxiety disorders often co-occur with depression, substance-use disorders (including alcohol), and personality disorders. Patients with anxiety should be asked if they use alcohol or drugs to reduce anxiety or tension, and screened for depression and risk of suicide. Medical conditions and medications/substances can cause or exacerbate anxiety. Inquire about the use of caffeine, other stimulants (including illicit), beta agonists, and steroids. It should be determined that the physical symptoms of anxiety are not from cardiac, pulmonary, or endocrine causes. Unless there are suggestive signs or symptoms, TSH is the only lab to get routinely. The severity of anxiety should be measured with the GAD-7 initially and at each follow-up visit to assess response to treatment.

Treatment

Treatment for anxiety is determined by severity, co-morbidity, patient preference, and available resources, stepping up care when needed. Initial treatment of milder symptoms can start with lifestyle interventions that are accessible, low cost, and safe: physical exercise, yoga, mindfulness based stress reduction (available through apps or web-based programs), and education. For more bothersome or persistent symptoms, cognitive behavioral therapy (CBT) or pharmacotherapy are equally effective (~50-60% response), and the initial treatment should be based on patient preference. Combination treatment works better in severe or treatment-resistant cases. Occult substance use or bipolar disorder should be considered in patients not responding to treatment. Appendix 3 provides a graphic overview of treatment.

Non-pharmacological

The most validated non-pharmacological treatment for anxiety is CBT. CBT is a goal oriented short-term therapy designed to reduce overly negative interpretations of situations (cognitive restructuring), replace avoidant behaviors with approach and coping behaviors (exposure therapy), and reduce levels of tension and autonomic arousal (relaxation training). Techniques vary with the different anxiety disorders. Online programs can be effective (on their own or as an adjunct to in-person counseling), and have advantages of cost, convenience and anonymity.[6-8]

Pharmacological

Selective serotonin receptor inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are the clear first-line agents due to a combination of efficacy and safety, and also treating co-morbid depression. Patients with anxiety tend to be sensitive to side effects, so start at a low dose. Gradually titrate to upper end of the dose range for at least 4 weeks before expecting significant symptom relief.[9] Despite varying FDA indications, all SSRIs are thought to have similar efficacy.[10] If the first medication is ineffective or not tolerated, try another SSRI or SNRI, or change to CBT (or add CBT if antidepressant is partially effective).[11]

Second line medications should be used in combination with SSRI/SNRIs if response is incomplete, or as monotherapy when SSRI/SNRIs are not tolerated or minimally effective. ***Benzodiazepines*** can speed symptoms resolution, but cause sedation, impair cognition and reaction time, and don't improve longer term outcomes.[12] Like opioids for pain, benzodiazepines for anxiety are highly effective in the short term, liable to be abused by some patients, and generally discouraged for chronic use.[13] Their use should be limited to patients without histories of alcohol or other substance use who have not responded to antidepressants and CBT, or as short-term bridging for severe symptoms. Long acting agents, such as clonazepam, are preferred and should be taken on a scheduled basis (bedtime or twice a day). Low dose dependency with rebound anxiety is common after 2 or more weeks of continuous treatment, especially with shorter acting, rapid onset agents such as alprazolam.[14] ***Pregabalin*** is effective for GAD, SAD, and panic and considered a first line treatment in Europe.[14] Although side effects include sedation and dizziness, it is generally better tolerated and less addictive than benzodiazepines. It is expensive, and use for anxiety is off-label in the US. ***Gabapentin*** has less robust data, and may not be as effective.[15] ***Buspirone*** is effective for GAD as an adjunct to SSRI/SNRI or as monotherapy, but probably ineffective for other anxiety disorders. ***Hydroxyzine*** is FDA approved to use as needed for anxiety, but can cause sedation and anticholinergic side effects.

Herbal treatments are generally not supported by high quality evidence.[16] ***Marijuana*** use to self-treat mood and anxiety disorders may temporarily relieve symptoms, but is associated with worse outcomes in the long term.[17] ***Lavender oil*** gel caps (Silexan 80-160 mg/day) have been shown to be effective in multiple RCTs (superior to paroxetine or placebo, comparable to lorazepam).[18] ***Kava*** is probably effective, but there are concerns for hepatotoxicity and drug interactions.[16]

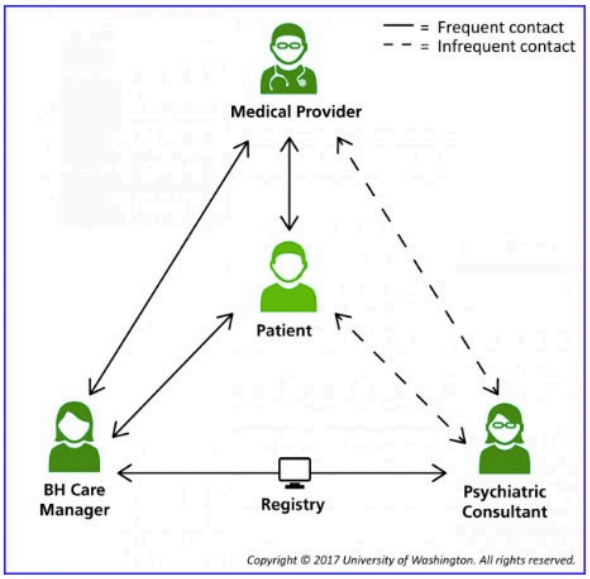
Monitoring and Follow-up

Response to treatment should be assessed with the GAD-7 (measurement based care) at each visit and/or through between-visit telephone outreach by the BHC.[19] Treatment should be stepped up as described above until there is satisfactory relief of symptoms. Pharmacological treatment at the therapeutic dose should be maintained for 9-12 months, after which a slow taper may be considered.[11]

DH Resources

The Collaborative Care Team

The **Behavioral Health Clinician** (BH care manager in figure) supports the PCP and patient by increasing patient engagement in their care, assessing treatment adherence and side effects, providing brief counseling, exploring treatment preferences, facilitating referrals outside primary care, and collecting clinical outcome metrics. The BHC uses a registry to track patient follow-up and outcomes, and prioritize patients for case review with the consulting psychiatrist. The **consulting psychiatrist** can give management recommendations through the case review, eDH messaging (including e-consults for new cases), or direct evaluation of the patient (on site or through telemedicine). To involve the BHC, order "Referral to Behavioral Health Clinician" in eDH, after asking your patient's permission.



eDH Tools

- Screening questionnaire (as part of behavioral health bundle) administered pre-visit through myDH (home) and tablets (in clinic)
- Best Practice Advisory, triggered by GAD-7 score ≥10.
- Smartset attached to BPA, with clinical decision support and ordering efficiency
- e-Consults: an efficient way to get input from a psychiatrist, delivered and recorded in the patient's chart

Clinician Education

- Archived talk available for CME, recorded 10/18/18: https://ce.dartmouth-hitchcock.org/Activity/6615505/Detail.aspx
- On-site talks, ECHO

Patient Education and Shared Decision Making

- List of self-management books, websites, and apps (available through smartset: patient information, smartphrase ".BHAPPS", and on SUMHI website)

This Clinician Guide is a companion to the guideline:
http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/anxiety-guideline-final-010919.pdf?sfvrsn=36425c1c_2

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Appendices

Appendix 1: GAD-7 Screening Instrument

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Score	Symptom Severity	Comments
5-9	Mild	Monitor
10*-14	Moderate	Possible clinically significant condition
>15	Severe	Active treatment probably warranted

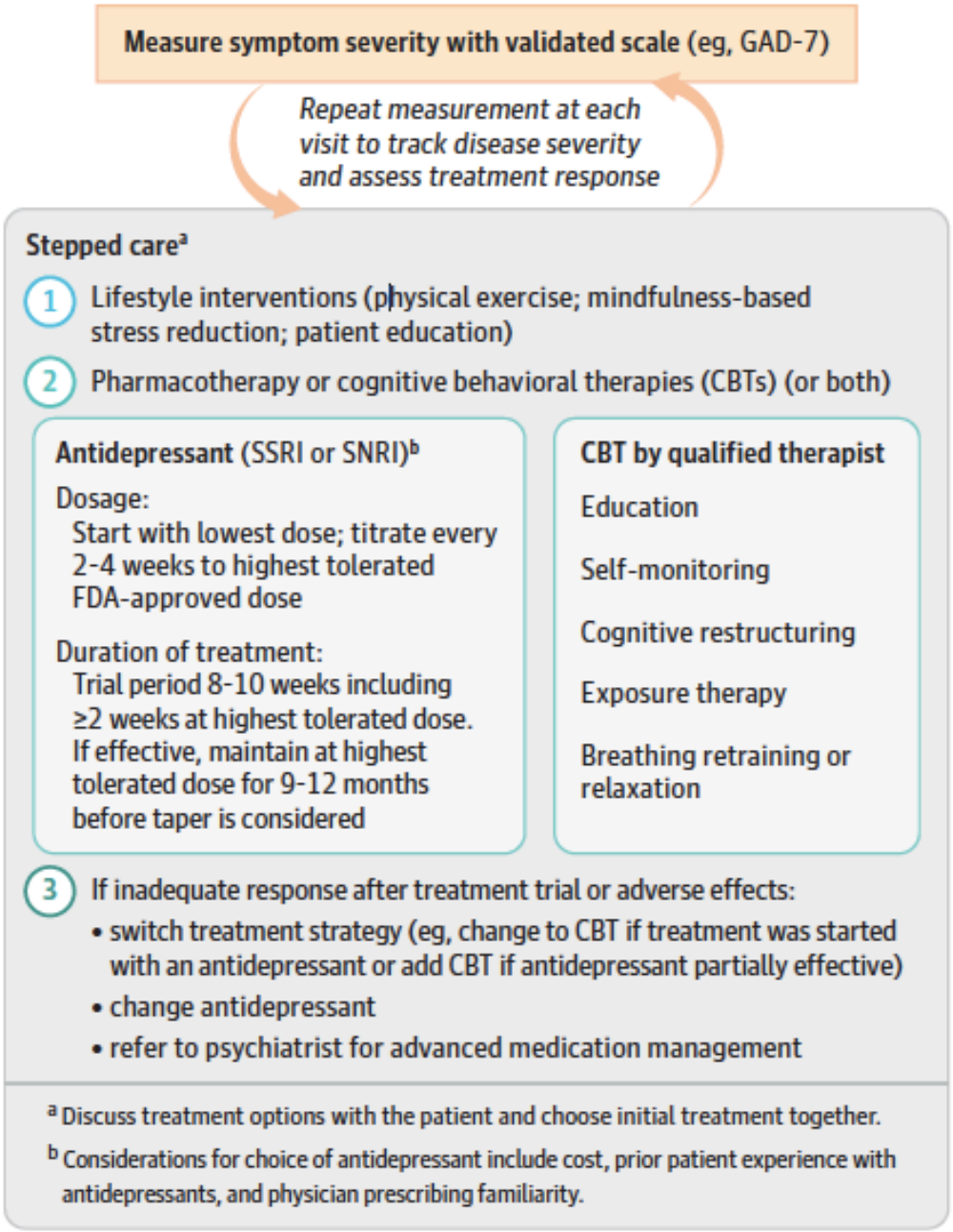
*For Panic Disorder, Social Phobia, & PTSD, cutoff score of 8 may be used for optimal sensitivity/specificity (see EBM section).

Appendix 2: Anxiety and Related Disorders (PTSD and OCD are categorized separately in DSM5)

Disorder	Prevalence	Key Features
GAD	9% lifetime 2% 12 mo	Marked anxiety and worry about multiple domains, more days than not for at least 6 mo. Accompanied by symptoms such as restlessness/feeling on edge/muscle tension
SAD	13/7.4	Marked, excessive or unrealistic fear or anxiety about social situations in which there is possible exposure to scrutiny by others. Active avoidance of feared situation
Panic	6.8/2.4	Recurrent unexpected panic attacks in the absence of triggers. Persistent concern about additional attacks +/or maladaptive change in behavior related to the attacks
Agora-phobia		Marked, unreasonable fear or anxiety about a situation. Active avoidance of feared situation due to thoughts that escape might be difficult or help unavailable if panic-like symptoms occur.
Specific Phobia	18.4/12.1	Marked, unreasonable fear or anxiety about a specific object or situation, which is actively avoided (flying, heights, animals…)
PTSD	10.1/3.7	Exposure to actual or threatened death, serious injury, or sexual violation. Intrusive symptoms and avoidance of stimuli associated with the event. Negative alterations in cognition and mood as well as marked alterations of arousal and reactivity
OCD	2.7/1.2	Obsessions: recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted and that cause marked anxiety or distress. Compulsions: repetitive behaviors or mental acts that the individual feels driven to perform to reduce the anxiety generated by the obsessions.

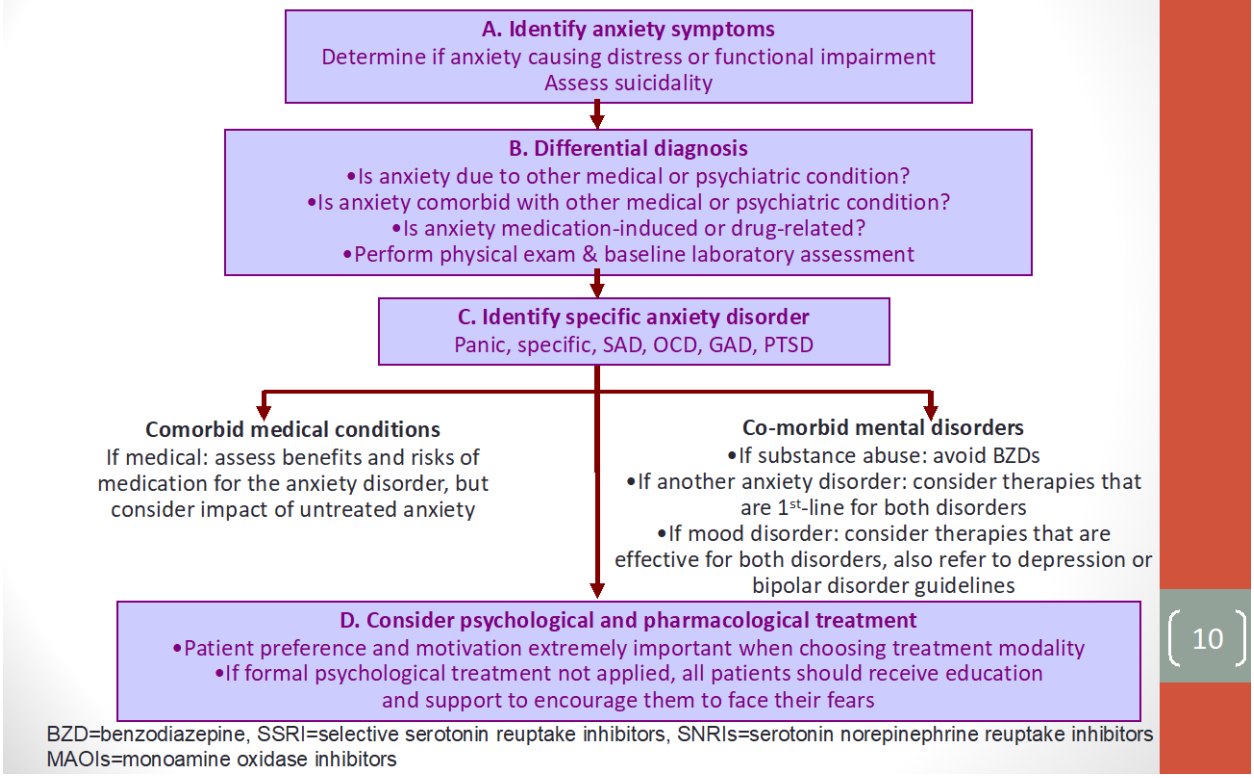
Appendix 3: Management of Anxiety Disorders

Figure. Treatment of Persistent or Recurrent Anxiety Disorder



FDA indicates US Food and Drug Administration; GAD-7, Generalized Anxiety Disorder 7-Item Scale; SNRI, serotonin and norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor.

Key Decision Points in the Management of Anxiety Disorders



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BZD=benzodiazepine, SSRI=selective serotonin reuptake inhibitors, SNRIs=serotonin norepinephrine reuptake inhibitors
MAOIs=monoamine oxidase inhibitors

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