Anxiety in the office

Anxiety disorders in family practice

introduction

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Disclosures

- I have not received any payments nor support from any for profit nor not for profit organizations within last 5 yrs .
- I will be making some suggestions for treatment in the absence of any current treatment guidelines
- My main areas of expertise are with teenagers and young adults

Objectives

- Recognition of Anxiety disorders
- Reasoned approach to treatment
- 2 Case illustrations

Family Practice treatment of anxiety disorders

1. Diagnosis
   - symptoms are a reaction to a distressing situation OR indications of an anxiety disorder OR other psychiatric disorder such as depression OR signs of a non-psychiatric condition.
   - Screen for and establish the specific anxiety disorder diagnosis.

2. Develop a treatment plan using an array of options depending on need
   - Provide education as needed
   - Self help resources and guided self help resources
   - Counselling
     - Be familiar with resources in your community
   - pharmacology
     - Be familiar with antidepressants and anxiolytics used to treat anxiety disorders

3. Monitor response and change treatment as necessary

4. Know when to refer on to specialized mental health resources and the referral pathways for those resources.

Presentation of anxiety disorders

- Somatic symptoms
  - Pain/GI symptoms/headaches/nausea/palpitations/Sleep issues
- Psychiatric presentation
  - Overt anxiety symptoms – PD + GAD + PTSD
  - Concurrent with other problems – SAD/OCD with depression OR substance use issues.
- High service users
  - Present with relatively minor symptoms
  - Limited coping skills. Complain when most others would not
  - Limited social networks

Identification of anxiety disorders

- GAD 7
  - question scored from 0 to 21.
  - 10 + typical cut off for further inquiry; 15 + = “severe” and may need treatment and referral
  - False positive rate = 20% at score of 10 up to 50% if high concurrent diagnoses
  - Response if reduction of < 5 over 4 weeks

Identification of anxiety disorders
5 Quick questions…

- **Anxiety: "Have you …"**
  - Had a spell or attack where all of a sudden you felt frightened, anxious, or uneasy? (Panic)
  - Been bothered by nerves or feeling anxious or on edge for 6 months? (GAD)
  - Had a problem being anxious or uncomfortable around people? (SAD)
  - Had recurrent dreams or nightmares/flashbacks of trauma or avoidance of trauma reminders? (PTSD)
  - Unusual and unwanted intrusive thoughts you cannot stop that are (OCD)

Types of anxiety disorders

- Anxiety disorders are defined by the content of 2 key thoughts – what is the person fearful/worried about/anxious about + what will the outcome be if it comes true
- *Social anxiety disorder* = Fearful of negative social evaluation + it will be terrible and I will not be able to cope with it
- *Generalized anxiety disorder* = Fearful of not knowing what is going to happen next + it will be terrible and I will not be able to cope with it
- *Panic Disorder* = Fearful of Panic attacks + there will be a physical or social catastrophe and I will not be able to cope with it.
- *PTSD* = Fearful of the memories + they will overwhelm me and I will not be able to cope
- *OCD* = Fearful of my thoughts being true or me acting on them + what happens if they are true or I act on them
- *Separation Anxiety Disorder* = Will my parents be safe without me or me without them + I will not survive
- *Health anxiety* = I have a health issues all the MDs have missed + it will be terrible

Non-medication approaches: talking therapy community resources

- Counselling - for reactions to life situations (adjustment reactions)
  - Bounce back – needs referral (free)
  - Citizens counselling (modest sliding scale)
  - Beacon Counselling (modest sliding scale)
  - Esquimalt neighbourhood house (modest sliding scale)
  - South island centre for counselling and training (modest sliding scale)
  - ALL = trained lay counsellor OR trainee counsellor under supervision
- Bcalm.ca – mindfulness for general stress management and mild GAD
  - Dr Mark Shearman and other MD'S
  - Various iterations of mindfulness – mindfulness groups 8x90 min (free) or mindfulness CBT up to $400 Referral forms online.

Non medication approaches : talking therapy community resources

- CBT skills groups – Division of Fam Practice. FP + Psych
  - LEVEL 1 + 2 minimal cost. Group format. Low barrier of entry
  - Good general CBT skills.
  - Coping skills + cognitive therapy but little exposure therapy for avoidance.
  - Referral through CBT skills group website
  - Good for “ stressed” mildly anxious, PHQ < 18
- Private Psychotherapy/Therapists. Life stressors/specific anxiety disorders
  - Private - $150-220 / hr
  - Many options. Psychologists best for more serious dysfunction

Talking therapy Government resources

- Island Health > 19
  - For those with significant anxiety symptoms and a degree of complexity or clear ongoing dysfunction
  - Central intake (IH) referral
  - Anxiety disorder Clinic specialized group treatment for individuals with GAD/SAD/OCD

- MCFD < 19
  - MCFD offices. Catchment based
  - regions – Victoria/Saanich/West Shore/Sooke.
  - Some group mainly 1:1

Good self help resources

- Information plus enough guided-self help
  - mobile + teen friendly versions
  - GSH can work for mild conditions for motivated persons.
  - Anxiety Canada - big website. Information + self guided treatment
  - Mind shift CBT mainly anxiety disorders by Anxiety BC. Free
  - Mood gym – CBT for depression/anxiety by Australian organization $40/yr

Pharmacological approaches to treatment Adults

1. SSRI
   - mid dose range e.g. sertraline 100 – 150 mg (fluoxetine 30-40 mg) + Longer to respond (depression 2-4 weeks; GAD/PD/SAD = 6-8 weeks ; OCD 10-12 weeks).
   - NNT = 5 vs 6 for CBT and 3.6 for CBT for OCD

2. Then Second SSRI or SNRI (Duloxetine 60-90 mg x 6-8 weeks)

3. Then Augment the SSRI/SNRI – gabapentin 75 mg x bid x 14 days then 150 mg x bid, up to 600 mg in 2-3 times per day doses.

Pharmacological approaches to treatment Adults

4. Then change to Buspirone (for GAD/SAD) 7.5 bid. Can increase by 5 mg per day per 7 days and typical dose is 15-30 mg in divided doses.

5. Then add Quetiapine XR 50 mg

6. Panic disorder
   - ½ usual dose = 25 mg sertraline OR 2.5 mg of escitalopram
   - Increase dose by 25 mg sertraline OR 2.5 mg escitalopram every 10 days.
   - Clonazepam 0.25 – 0.5 mg bid x 21 days

Pharmacological treatment teens

1. Talking therapy is first line approach. CBT + Exposure
2. Fluoxetine – 10 mg q am x 10 days then 20 mg q am then wait x 6 weeks. If no response (< 35 % reduction of symptoms) then increase to 30 mg q am x 10 days then 40 mg.
3. Sertraline – start 25 mg and increase by 25 mg per 10 days to 100 mg. Wait 6 weeks. Then increase by 25 mg per 10 days to 150 mg to 200 mg.
4. Avoid BDZ; use low doses of quetiapine IR 12.5 – 25 mg or XR 50 mg q 1800 if needed. Aim to stop quetiapine in short time frame 4-8 weeks.
5. Considerations : development of suicidal thoughts 4% with AD vs 2 % placebo; worsening of anxiety and development of akathisia

Suggested treatment approach

1. Life event anxiety – counselling services + self help (anxiety BC)

2. Mild anxiety disorder/ “stress” / coping problems
   - Counselling/BCalm/CBT groups + self help resources

3.Moderate
   - Counselling/BCalm/CBT groups + self help + medication

<u>Medications don’t address avoidance – need exposure therapy</u>

When to Refer to Specialised mental health services

1. Treatment has not worked or if the patient or earlier if the patient is severely affected by the anxiety disorder

2. Significant avoidance behaviour

- When an anxious child/young adult is too fearful to attend school or socialize
- a patient cannot get to work or maintain usual activities of daily living (e.g., child care, going shopping, hygiene)
- Typically SAD + OCD sometimes PD + agoraphobia

3. When a patient has multiple comorbid mental disorders (e.g., depression, substance use, suicidality)

4. When a patient is being prescribed multiple psychiatric medications

5. When a patient is using recreational substances, or over-the-counter medications to alleviate anxiety

Melissa

- Melissa 25 anxious her whole life lots of somatic symptoms as child. Her mother recently died and Melissa has been getting panic attacks and cannot work, and has lost her appetite . Her partner comes with her as he is worried that she is losing wt. and is not herself.

- Fearful of leaving her house and cannot go her work as hair stylist

Melissa

- Your Primary Diagnosis?
- Comorbidity?
- Distress/dysfunction?
- Normal Vs abnormal symptoms?

Melissa

- Interventions?
  - Refer to specialist services as dysfunctional + co morbidity
  - CBT – Because of significant avoidance second to PA's. She was waiting to start a CBT group for PD

- Self help
  - Anxiety BC web site
  - Mind Shift

Melissa

- Sertraline 25 mg q hs
  - Phone call from partner – worse “more panic attacks!”
  - Added clonazepam 0.5 mg bid + kept going with sertraline
  - Call back – doing better
  - Slowly increased sertraline to 150 mg q daily
  - PA subsided over 6 weeks
- BUT still avoiding work
  - CBT group started and started to address avoidance
- Sertraline 150 mg clonazepam 0.5 mg bid
- Scared to stop clonazepam!
  - 3 months and had to taper dose

BDZs a cautionary tale

- BZD long acting –
    - maybe short term for rapid control of severe PAs
        - But Substance abuse – Alcohol/cannabis/other
        - Clonazepam
        - Avoid alprazolam
        - 4 weeks and then need to taper
    - Specialized settings if other therapies not working
- Short acting
    - Not for clinical anxiety disorders such as PD/GAD
    - Lorazepam prn for isolated anxiety producing situations e.g. surgical procedures.
    - Use cautiously
- Informed consent to benefits and problems

Patrick

- 19 yr old male attending post secondary school presents with depression
  - Always shy. Same friends since he was in middle school.
  - Concerned he is going to fail. Feels different to other students. Not going anywhere in life. No significant romantic relationships
  - Cannot focus in class. Sometimes doesn’t go to classes.
  - Smokes cannabis daily to help with his anxiety. Started smoking age 14 because he was anxious at school
  - Primary diagnosis?
  - Concurrent diagnoses?

Patrick

- You make a diagnosis of SAD with secondary depression and CUD
- What do you do?
  - Psychoeducation
  - Self help information about cannabis use + Anxiety Canada.
  - Mental health referrals?
  - Medication?

Patrick

- Commence on sertraline 50 mg increasing to 100 mg in 7 days
- Returns 2 weeks later
  - He is having a hard time stopping cannabis – he thinks it really helps anxiety. He has read on social media that it is safer than ADs
  - He also read that CBD might help his anxiety and he asks for your opinion.

Patrick

- I found it hard to locate firm guidelines on use of Cannabis from medical sources to treat anxiety disorders

- I am much better informed after reading Forbes Health.
  - " Experts suggest starting small (with CBD) and working your way up depending on how your body reacts."
  - 600 milligrams in patients with SAD in a speech simulation[10]
  - 300 milligrams in male patients in a speech simulation[11]
  - 25 to 75 milligrams for generalized anxiety and/or sleep problems[12]
  - 33 to 49 milligrams a day for PTSD, in addition to routine psychiatric treatment[13]

PATRICK

- Increase sertraline to 150 mg q am.
  - Mood improves and he feels less anxious
  - Going to more classes
  - Still has few friends and is avoidant of most social situations.
- Suggest he have CBT and explain rationale for exposure
- Refer to Anxiety disorders clinic via Island Health Central intake.
- Thanks you for your advise about cannabis and continues to smoke 4 days per week