From Diagnosis to Treatment: Effective Management of Anxiety Disorders

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Introduction

Agenda

- Introduction to Anxiety Disorders
- Types of Anxiety Disorders in DSM-5-TR
- Case Example
- Treatment and Management Approaches
- Risks of Benzodiazepines and Prescription Misuse
- Interprofessional Collaboration and Conclusion

Objectives

Identify	Identify the primary types of anxiety disorders and their impact on individuals and society.
Apply	Apply DSM-5-TR criteria to evaluate symptoms and diagnose anxiety disorders in clinical practice.
Discuss	Discuss both pharmacological and non-pharmacological treatment approaches, including first-line medications, cognitive behavioral therapy, and relaxation techniques.
Explain	Explain the risks of benzodiazepine use, best practices for short-term prescribing, and strategies to avoid prescription misuse.
Collaborate	Collaborate with interprofessional teams to develop individualized treatment plans that optimize patient outcomes.

Understanding Anxiety

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than 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 is 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

Total Score ___ = Add Columns ___ + ___ + ___

If you checked off any problems, how difficult have these problems 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
☐	☐	☐	☐

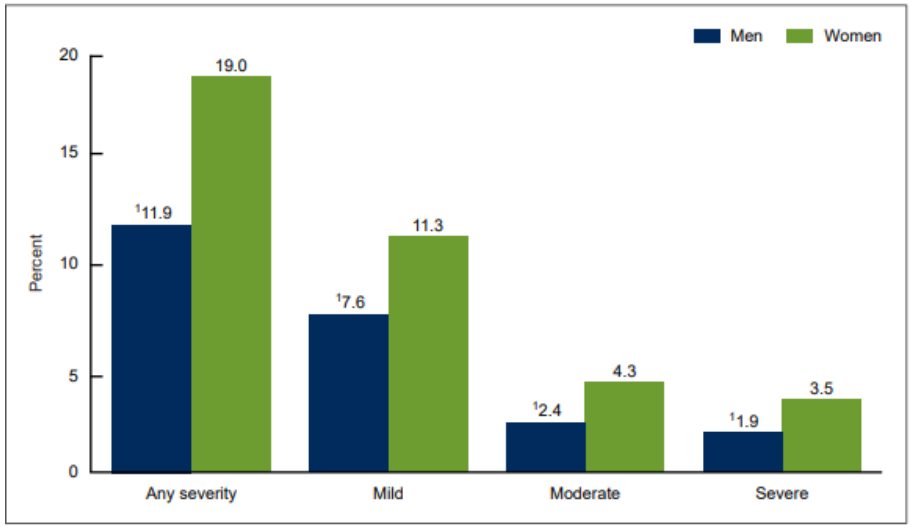
Definition of Anxiety

- Normal anxiety vs anxiety disorders
  - Anxiety as a protective response
    - Protective mechanism: fight or flight response
    - Necessary for survival
  - Disproportionate or chronic worry in anxiety disorders
  - When excessive or persistent→problematic

Importance of Recognizing and Treating Anxiety Disorders

- High prevalence
- Affects millions worldwide
- Often underdiagnosed
- Impact on quality of life
- Emotional and physical strain
- Missed workdays, impaired functioning

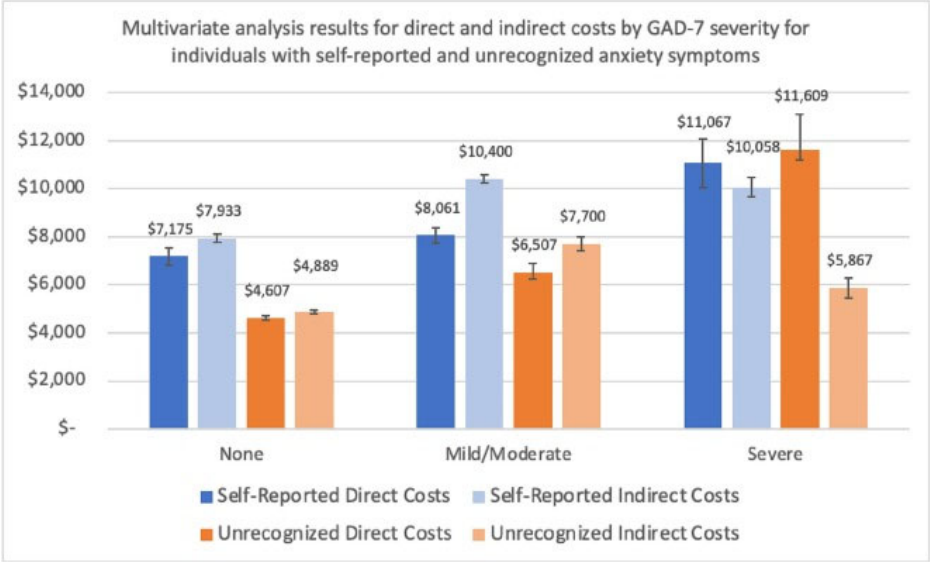
Figure 3. Percentage of adults aged 18 and over who experienced symptoms of anxiety in the past 2 weeks, by symptom severity and sex: United States, 2019



[1]Significantly different from women ($p < 0.05$).
NOTES: Severity of anxiety symptoms was based on the seven-item Generalized Anxiety Disorder scale (GAD–7) and summarized into none or minimal (values 0–4), mild (values 5–9), moderate (values 10–14), and severe (values 15–21). Those categorized as having no or minimal symptoms of anxiety are not shown in this figure. Any severity includes those categorized as having either mild, moderate, or severe symptoms of anxiety in the past 2 weeks. Estimates are based on household interviews of a sample of the civilian noninstitutionalized population. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db378-tables-508.pdf#3.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

Impact of Anxiety on Individuals and Society

- Effects on health and relationships
- Physical symptoms: headaches, fatigue
- Personal and work relationships
- Economic burden
- Healthcare costs
- Lost productivity
- Disability claims



DSM-5-TR: Anxiety Disorders

Generalized Anxiety Disorder (GAD)

Excessive worry

Uncontrollable, daily worry about multiple areas (work, health, etc.)

Physical symptoms

Restlessness

Fatigue

Sleep issues

Difficulty concentrating

Panic Disorder

Sudden panic attacks

Unexpected episodes of intense fear

Physical symptoms: heart palpitations, dizziness

Fear of future attacks

Avoidance behaviors

Disruption to daily life

Social Anxiety Disorder

Fear of social situations

Fear of judgment or embarrassment

Common situations: public speaking, meeting new people

Avoidance behaviors

Limits social and professional opportunities

Impacts daily functioning

Specific Phobia

Intense fear of specific objects or situations

Common examples: heights, flying, needles

Avoidance behavior

Immediate anxiety response

Disrupts normal activities

Obsessive-Compulsive Disorder (OCD)

Obsessions: intrusive thoughts

Unwanted thoughts (contamination, safety concerns)

Recurrent and distressing

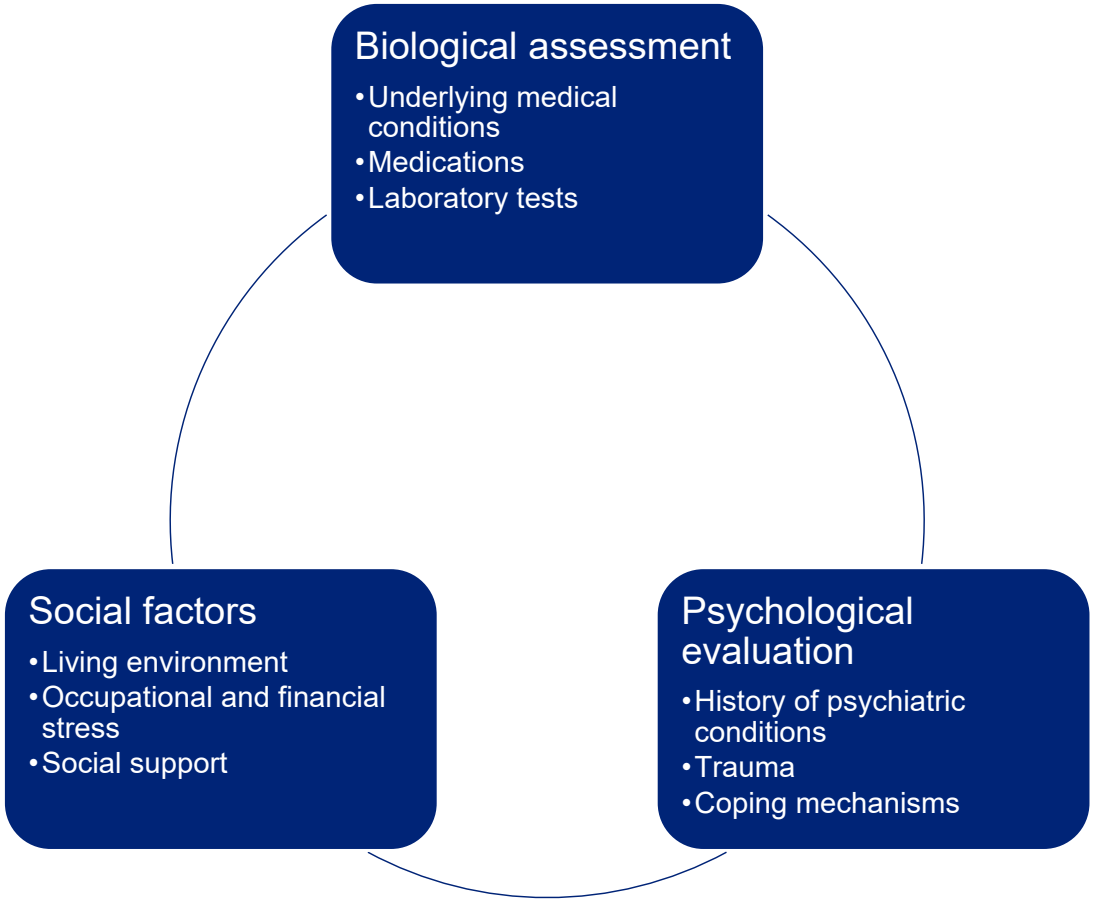
Compulsions: repetitive behaviors

Handwashing, checking, counting

Performed to reduce anxiety

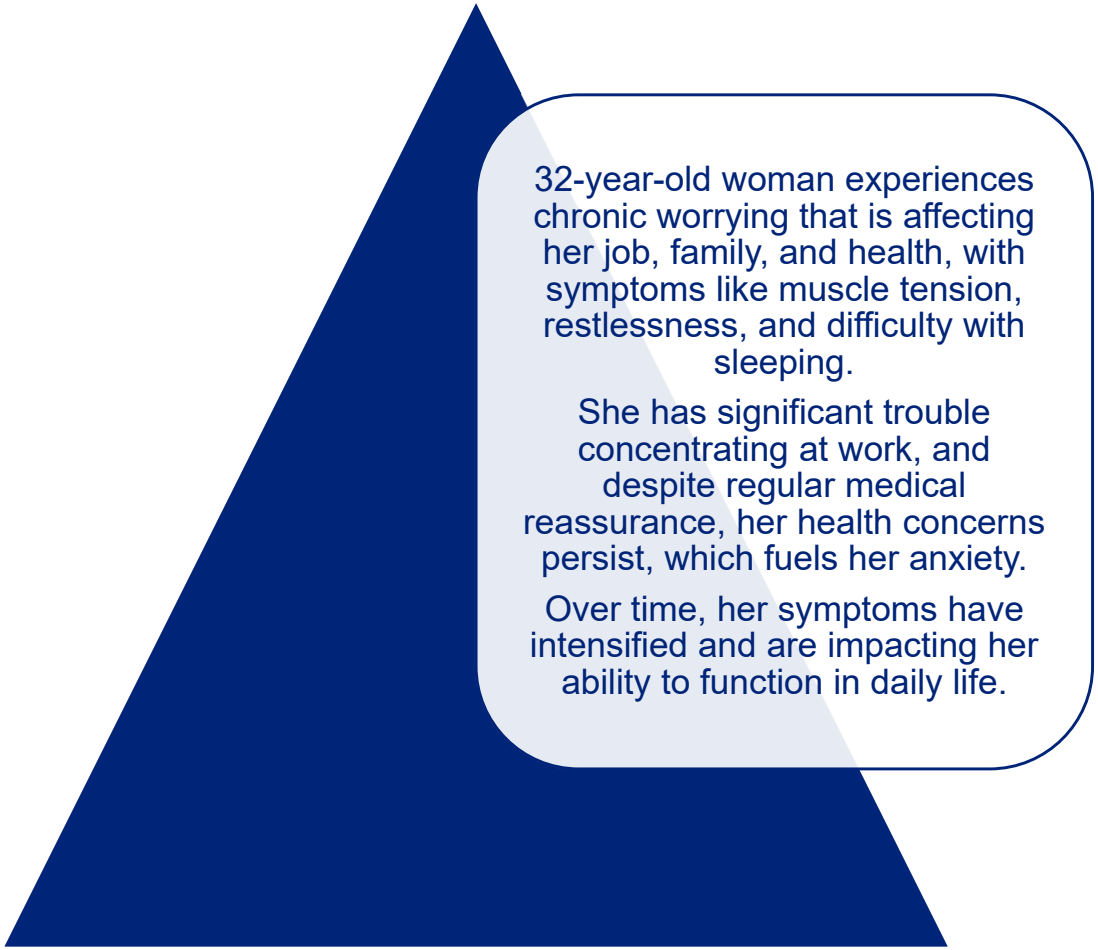
Evaluation of Anxiety

Evaluation of Anxiety



Case Example

Case Example: Anxiety Disorder



Non-Pharmacological Treatments

Cognitive Behavioral Therapy (CBT)

Evidence-based approach

Focus on thought patterns and behaviors

Restructuring thoughts and behaviors

Replacing distorted thinking

Exposure techniques to manage avoidance

Relaxation Techniques and Mindfulness

Deep breathing and progressive muscle relaxation

- Activates relaxation response
- Reduces muscle tension

Mindfulness and stress reduction

- Being present in the moment
- Reduces emotional reactivity

Pharmacological Treatments

Choice of Initial Medication for GAD

- Selective Serotonin Reuptake Inhibitors (SSRI) and Serotonin and Norepinephrine Reuptake Inhibitors (SNRI) are generally the preferred initial therapy.
- Serotonin Reuptake Inhibitors (SRIs) have similar response rates for treatment of anxiety: 60-70% vs 40% placebo.
- Only four SRIs have FDA approval for treatment of GAD but all SSRIs are generally accepted as effective treatment for GAD.

Medication	Class
Escitalopram (Lexapro®)	SSRI
Paroxetine (Paxil®)	SSRI
Duloxetine (Cymbalta®)	SNRI
Venlafaxine XR (Effexor XR®)	SNRI

Craske, M., Bystritsky, A. Generalized anxiety disorder in adults: Management. In: *UpToDate*, Post TW (ed), UpToDate, Waltham, MA. (Accessed on October 22, 2024)

Selective Serotonin Reuptake Inhibitors (SSRIs)

Commonly used first-line due to efficacy, tolerability, safety in overdose, lower cost, years of experience

- citalopram (Celexa®)
- escitalopram (Lexapro®)
- fluoxetine (Prozac®)
- fluvoxamine (Luvox®)
- paroxetine (Paxil®)
- sertraline (Zoloft®)

Comparable tolerability and efficacy within the class

- Common side effects: nausea, GI upset, sexual side effects, dry mouth, headache
- Side effects tend to be dose dependent and often improve after first few weeks

Considerations when choosing an SSRI

- Differences in side effects may guide treatment decision
  - **Constipation**: avoid paroxetine (highly anticholinergic) favor sertraline
  - **History of QT prolongation**: avoid citalopram, escitalopram and fluoxetine
  - **Insomnia**: avoid fluoxetine
  - **Overweight/obese**: avoid paroxetine
  - **Polypharmacy**: fluoxetine, fluvoxamine and paroxetine have higher propensity for drug interactions
- Initial selection will be based on other factors such as:
  - Patient preference
  - Prior response to medication
  - Safety, tolerability and anticipated side effects
  - Co-occurring psychiatric or medical conditions
  - Drug interactions, half life
  - Cost

Considerations when choosing SNRI

- Differ from SSRIs as they also inhibit reuptake of norepinephrine
  - **Duloxetine (Cymbalta®)**
  - **Venlafaxine (Effexor®)**
- Considerations: Co-morbid pain, possible “activating” effect might be useful in those with low energy/hypersomnia
- Common side effects: nausea, dizziness, drowsiness, insomnia and diaphoresis
- Sexual dysfunction can be a concern
- Monitor blood pressure
  - venlafaxine may elevate BP (dose related); duloxetine may cause hypotension or dizziness

Partial or No Response to Initial SRI therapy

No response: Taper off first agent and try another agent within SRIs

- Inadequate response to initial agent does not predict failure to second SRI in treatment of GAD

Partial Response: Augment with another therapy with consideration of patient specific factors

-Buspirone (Buspar®):

- FDA approved for treatment of GAD
- May take 4-6 weeks to improve symptoms
- Generally well tolerated; may cause dizziness and drowsiness with higher doses
- No physiological or physical dependence
- Needs to be given 2-3 times a day for optimal effectiveness

-Gabapentin (Neurontin®)

- Not FDA approved for treatment of GAD; limited data of effectiveness in treatment of anxiety disorders
- Has been used off label for GAD, panic disorder and social phobia
- Onset of action can be within a few days
- Side effects include ataxia, dizziness, drowsiness/fatigue and may develop tolerance
- Withdrawal and dependence possible

Patient Specific Considerations for Augmentation Strategy

- **Mood Stabilizers**
  - Mood instability in conjunction with anxiety/no response to initial treatment
  - Valproate or lamotrigine; limited data to support use in anxiety disorders
- **Second Generation Antipsychotics (SGAs)**
  - Might be considered in treatment resistant anxiety
  - Side effects limit use
    - adverse metabolic effects, extrapyramidal symptoms and tardive dyskinesia

Patient Specific Considerations for Augmentation Strategy

- Insomnia:
  - **Hydroxyzine (Vistaril®)**: FDA approved for the short-term treatment of anxiety in conditions of emotional stress; sedating antihistamine with anticholinergic related side effects (constipation, dry mouth, etc.)
  - **Mirtazapine (Remeron®):** not approved for GAD; associated with sedation and weight gain
  - **Benzodiazepines:** only recommended for short-term augmentation; monotherapy reserved for those refractory to multiple medications
    - Avoid use in those with substance abuse history or comorbid depression due to risk of dependence and potential for worsening of mood symptoms

Duration of Treatment

- If effective and tolerated, continue at least 12 months
- If relapse occurs upon medication taper, resume and extend treatment
- Maintenance (indefinite) treatment should be considered if two relapses occur after termination of effective medication

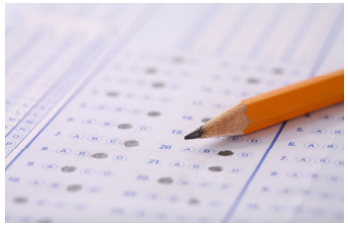
Medications for Panic Disorder and Obsessive Compulsive Disorder

- **Panic Disorder**
  - SSRIs considered first line. FDA approved medications for panic disorder include fluoxetine, paroxetine, sertraline and venlafaxine.
  - Alprazolam and clonazepam (benzodiazepines) FDA approved for panic disorder; guidelines only recommend short term use.

- **Obsessive Compulsive Disorder (OCD)**
  - Clomipramine, fluoxetine, fluvoxamine, paroxetine and sertraline FDA approved for use in OCD.
  - SSRIs are preferred over clomipramine (tricyclic antidepressant) due to more favorable side effect profile.

Medications for Social Phobia and Specific Phobias

- **Social Phobia**
  - SSRI or SNRI first line; no evidence indicating superiority of one SSRI or SNRI over another
- **Specific Phobias**
  - Performance or test anxiety – some may respond to beta blocker therapy such as propranolol; data on effectiveness is limited
  - Benzodiazepines may be considered for acute/short term use (flight anxiety, fear of medical procedures, etc.)



Risks of Benzodiazepines and Prescription Misuse

What are Benzodiazepines?

- Class of medication with anxiolytic, anticonvulsive, hypnotic and muscle relaxing effects
- Various FDA approved indications within the class: anxiety, insomnia, seizure disorders, anesthesia and peri-procedural sedation, skeletal muscle relaxation and alcohol withdrawal
- Medications differentiated by significant variances in half life, onset of action, presence of metabolites
- Commonly prescribed benzodiazepines for anxiety:
  - Lorazepam (Ativan®)
  - Alprazolam (Xanax®)
  - Clonazepam (Klonopin®)
  - Diazepam (Valium®)

Benzodiazepine Use in Anxiety Disorders

- Acute treatment – when rapid anxiolytic/sedative effect needed
- Short-term treatment as a “bridge” when waiting for the effects of initial medication to be realized
- Recommended to taper off the benzodiazepine once the therapeutic effects of maintenance treatment have emerged
- Should not be considered for long term use (≥ 2 months at therapeutic dose)

Side Effects of Benzodiazepines

- Impaired thinking: difficulty with short term memory, easily confused, cognition slowed
- Fatigue/drowsiness
- Balance or coordination issues
- Slurred Speech and slow reactions
- Irritability or changes to mood
- Slowed breathing (respiratory depression)
- Dizziness
- Hypotension

**Side effects can be worsened with use of other CNS depressants including alcohol

Black Box Warnings for Benzodiazepines

FDA's most prominent warning to alert users regarding serious and life-threatening side effects

Potential for dependence and withdrawal

- In 2020, the FDA issued an update to the Boxed Warning on all benzodiazepines regarding risk of abuse, misuse, addiction, physical dependence and withdrawal reactions
- Should be avoided in patients with history of substance abuse due to increased risk of addiction and abuse/misuse
- Abrupt withdrawal can cause serious or fatal convulsive seizures
  - Psychological symptoms of withdrawal: excitability, nightmares, anxiety, insomnia, panic attacks, hallucinations, depression, paranoid thoughts, poor memory/concentration, psychosis
  - Physical symptoms of withdrawal: headache, seizures, pain or stiffness in head/neck, altered sensation of limbs, weakness and fatigue, muscle twitch/tremor, GI symptoms, appetite and weight changes
  - There is no standard benzodiazepine tapering schedule

Black Box Warnings for Benzodiazepines

- Use with other CNS depressants, especially opioids, significantly increase risk of profound sedation, respiratory depression, low blood pressure and even death

- Possible side effect of aggressive behavior with possible paradoxical agitation with anxiety, psychosis, confusion, mood lability with risks increased when given with other CNS depressants including alcohol

Additional Considerations with Benzodiazepine Use

Pregnancy: Should be avoided in pregnancy due to risk of premature birth and low birth weight

Older Adults: Benzodiazepines are included in the Beers Criteria as potentially inappropriate medications for use in older adults.

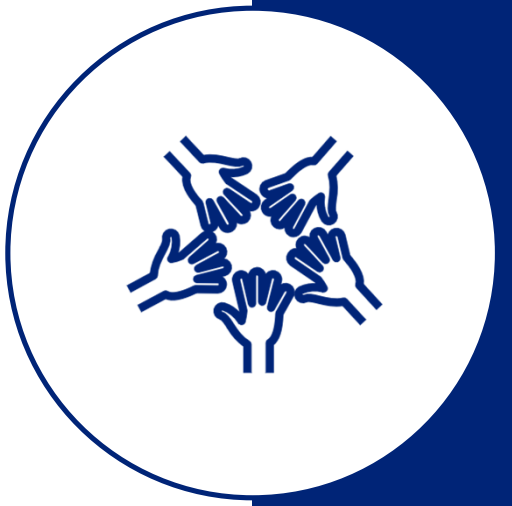
- Increased sensitivity and decreased metabolism of long-acting agents
- Psychomotor impairment
- Car accidents
- Cognitive impairment including anterograde amnesia (diminished short-term recall)
- Increased risk of falls

By the 2023 American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2023 Jul;71(7):2052-2081. doi: 10.1111/jgs.18372. Epub 2023 May 4. PMID: 37139824

Interprofessional Collaboration and Conclusion

Interprofessional Collaboration

- Collaborative care improves outcomes
- Holistic approach with medication and therapy
- Better monitoring and adjustments
- Roles of healthcare providers
- Shared responsibility for patient safety and education
- Psychiatrists, pharmacists, and therapists working together



Conclusion and Key Takeaways

Early recognition and treatment are crucial

First-line treatments include SSRIs, SNRIs, and CBT

Benzodiazepines should be used short-term due to risks

Preventing prescription misuse is a shared responsibility

Collaborating between healthcare providers is essential for optimal care

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Thank You!

Resources

NIH National Institute of Mental Health

Employee Assistance Program

988 SUICIDE & CRISIS LIFELINE

Appendix: Generalized Anxiety Disorder (GAD)

- **Excessive anxiety and worry** (apprehensive expectation), occurring more days than not for at least 6 months, about **a number of events or activities** (such as work or school performance).
- The individual finds it difficult to control the worry.
- The anxiety and worry are associated with three (or more) of the following six **symptoms** (with at least some symptoms having been present for more days than not for the past 6 months): Note: Only one item is required in children.
  - Restlessness or feeling keyed up or on edge.
  - Being easily fatigued.
  - Difficulty concentrating or mind going blank.
  - Irritability.
  - Muscle tension.
  - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder, contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Appendix: Panic Disorder

- Recurrent **unexpected panic attacks**. A panic attack is an abrupt surge of **intense fear** or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following **symptoms** occur: Note: The abrupt surge can occur from a calm state or an anxious state.
  - Palpitations, pounding heart, or accelerated heart rate.
  - Sweating.
  - Trembling or shaking.
  - Sensations of shortness of breath or smothering.
  - Feelings of choking.
  - Chest pain or discomfort.
  - Nausea or abdominal distress.
  - Feeling dizzy, unsteady, light-headed, or faint.
  - Chills or heat sensations.
  - Paresthesias (numbness or tingling sensations).
  - Derealization (feelings of unreality) or depersonalization (being detached from oneself).
  - Fear of losing control or “going crazy.”
  - Fear of dying. Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.
- At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
  - Persistent concern or **worry about additional panic attacks** or their consequences (e.g., losing control, having a heart attack, “going crazy”).
  - A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to **avoid having panic attacks**, such as avoidance of exercise or unfamiliar situations).
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).
- The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).

Appendix: Social Anxiety Disorder

- Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, **meeting unfamiliar people**), being observed (e.g., eating or drinking), and performing in front of others (e.g., **giving a speech**). Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.
- The individual fears that he or she will act in a way or show anxiety symptoms that will be **negatively evaluated** (i.e., will be humiliating or **embarrassing**; will lead to rejection or offend others).
- The social situations almost always provoke fear or anxiety. Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.
- The **social situations are avoided** or endured with intense fear or anxiety.
- The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
- If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.
- Specify if: Performance only: If the fear is restricted to speaking or performing in public.

Appendix: Specific Phobia

- Marked fear or **anxiety about a specific object or situation** (e.g., flying, heights, animals, receiving an injection, seeing blood). Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.
- The phobic object or situation almost always provokes **immediate fear** or anxiety.
- The phobic object or situation is actively avoided or endured with intense fear or anxiety.
- The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).
- Specify if: Code based on the phobic stimulus:
  - Animal (e.g., spiders, insects, dogs).
  - Natural environment (e.g., **heights**, storms, water).
  - Blood-injection-injury (e.g., **needles**, invasive medical procedures).
  - Situational (e.g., **airplanes**, elevators, enclosed places).
  - Other (e.g., situations that may lead to choking or vomiting; in children, e.g., loud sounds or costumed characters).

Appendix: Obsessive-Compulsive Disorder (OCD)

- Presence of obsessions, compulsions, or both:
  - Obsessions are defined by (1) and (2):
    - **Recurrent and persistent thoughts**, urges, or images that are experienced, at some time during the disturbance, as **intrusive and unwanted**, and that in most individuals cause marked anxiety or distress.
    - The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
  - Compulsions are defined by (1) and (2):
    - **Repetitive behaviors** (e.g., **hand washing**, ordering, **checking**) or mental acts (e.g., praying, **counting**, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
    - The behaviors or mental acts are aimed at preventing or **reducing anxiety** or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
    - Note: Young children may not be able to articulate the aims of these behaviors or mental acts.
- The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).
- Specify if:
  - With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
  - With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.
  - With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.
- Specify if:
  - Tic-related: The individual has a current or past history of a tic disorder.

Reminders

Continued Education Credit is available to:

- RNs/LPNs/Social Workers – CEU
- MD/DO/PAs/Pharmacists – CME

Steps:

- Navigate to Optum Health Education: https://www.optumhealtheducation.com/ucs-grand-rounds

MS Teams UCS Grand Rounds Channel

Know someone who would benefit from UCS Grand Rounds?

- Send them the link to the UCS Grand Rounds Channel, so they can add the series to their calendar and receive reminders, access live event materials, and access UCS Grand Rounds events
- MS Teams UCS Grand Rounds Channel
- MS Teams UCS Grand Rounds Event Series
  - ❑ Click on the ellipsis and select add to calendar