Anxiety Disorders Treatment Protocol

All Team Members: Patient Self-Management Education & Support

Anxiety disorders are the most common mental health problems in the United States. There are several types of anxiety disorders including obsessive-compulsive disorder, post-traumatic stress disorder, social phobia, generalized anxiety disorder, and panic disorder. This protocol will focus on the last 2 disorders.

Generalized Anxiety Disorder (GAD): People with GAD experience long-term constant anxiety and worry about many parts of their life. They feel helpless to control this worrying. The anxiety and worry prevent them from functioning normally with family and friends, at work, at school, or in other ways. It is common that people with GAD experience difficulty sleeping, headaches, fatigue, muscle tension, restlessness, or irritability related to their anxiety. People with GAD are at increased risk for substance abuse (including alcohol), depression, and suicide.

Panic Disorder (PD): People with PD experience panic attacks and intense worry about when the next attack will happen. Panic attacks are sudden attacks of fear that last for minutes. Usually people with panic attacks fear that they will lose control or that disaster is coming when there is no real danger present. Often people will have physical symptoms during a panic attack such as sweating, difficulty breathing, racing heart, dizziness, chest pain, or a feeling that they are having a heart attack.

Post-Traumatic Stress Disorder (PTSD) is a debilitating condition where a patient is stuck in "survival mode" following exposure to a significant threat to themselves or others. Evidence-based treatment consists of a combination of medications and psychotherapy targeting cognitive distortions and

relaxation. Substance use disorders are quite frequent in this population, indicating a need for consistently enquiring about substance misuse, as well as avoiding abusable substances in treatment when possible.

Obsessive Compulsive Disorder (OCD) is a debilitating disorder where anxiety-inducing beliefs (obsessions) are experienced to the exclusion of other thoughts, and are remedied with behaviors that are excessive, yet are engaged in to reduce anxiety. Both the obsessions and the compulsions are excessive enough that they interfere with functioning. Evidence-based treatment of OCD consists of medications and psychotherapy targeting the futility of compulsions and learning to tolerate obsessions (cognitive behavioral therapy and exposure and response prevention).

Social Phobia, or Social Anxiety Disorder, is marked by significant anxiety when in social situations, or when performing in front of others. It is marked by physiological reactions, such as tachycardia, diaphoresis, tremor, as well as fears of being judged by others. Evidence-based treatment of Social Phobia includes both medications (SSRIs and beta-blockers) as well as psychotherapy or practice (such as joining a Toastmasters Club).

All anxiety disorders are treated with psychotherapy and/or medications. The most common type of psychotherapy is called Cognitive Behavioral Therapy (CBT). CBT involves helping patients to identify their automatic ways of thinking, behaving, and reacting to situations that cause anxiety. An important part of CBT is teaching patients different ways of thinking, behaving, and reacting so that they experience less fear and anxiety. The most common medications used to treat anxiety are medicines also used to treat depression (anti-depressants). Sometimes additional medications are needed. When starting some anti-depressants, patients may have thoughts or make plans to kill themselves (suicidal ideation). It is very important to monitor patients closely during the first few weeks – months of treatment to identify and help patients who are having suicidal ideation.

Sleep hygiene	Patients should use their bed for sleep and sex only. Move the television out of the bedroom. Develop a regular and relaxing routine for bedtime. Set a regular time to get up and get dressed each day. Drink caffeinated beverages (if at all) in the morning only.
Exercise	Exercise is an excellent anxiolytic (something that decreases anxiety). It doesn't need to be strenuous. Daily brisk walking for 30 minutes is enough. Do some exercise outside the house every day, if possible. The evidence is strongest for aerobic exercise (walking, swimming, running, biking) but strength building (weight-lifting and using exercise machines) also helps.
Social activation	People with anxiety may isolate themselves and constantly think about their worries. It is important that they stay connected

	with family and friends, even if they do not feel like it. They should schedule meetings and activities that they used to enjoy. This is adopting the "fake it until you make it approach."
Quit drugs. Limit alcohol	Many illicit drugs, like cocaine and methamphetamines, may elevate mood in the short-term, but can also make anxiety worse in the short-term and long-term. Alcohol may decrease anxiety in the short-term, but can worsen anxiety in the long-term. Alcohol makes falling asleep easier, but staying asleep harder. Alcohol use also increases risk of suicide. Support your patients to quit.
Limit tobacco and caffeine	Both tobacco and caffeine are stimulants which can worsen anxiety. Decreasing the amount of (or not using) caffeine and tobacco can make anxiety much better.
Practice mindfulness techniques or do CBT homework	Mindfulness **techniques may include sitting or walking meditation, yoga, and the body scan.** CBT homework may include writing down automatic thought and behavior patterns and thinking about underlying belief systems
Take medications as directed	Patients may be prescribed: - Anxiolytic medication (some of the same medicines commonly used to treat depression) - Possibly another medicine to increase the effect of the anxiolytic. Talk to patients to see if they are taking their prescribed medicines and if there are barriers to adherence. Many patients also take dietary supplements, alternative medications (such as SAMe) or herbal medications. Ask about these so that you can see if there are toxic side effects or interactions with prescribed medicines.

Educate the patient about warning signs of worsening anxiety or risk of suicide and when to call the team:

- Persistent thoughts of hurting or killing themselves, especially with a specific plan
- Access to weapons or other dangerous means of hurting themselves
- Substance abuse or increased use
- Increasing social isolation: not spending time with other people
- Increasing anhedonia: not enjoying the things/activities they used to enjoy
- Increasing feelings of hopelessness or feeling helpless to control their worrying
- Increasing difficulty with sleep
- Increasing irritability or arguing with friends and family
- Increasing number or severity of panic attacks
- Increasing worry or fear of the next panic attack which leads to avoidance of usual activities

- Increasing problems at work or school
- Difficulty doing the basic activities of daily life (food preparation, paying bills, keeping themselves clean)
- Medication side effects that are bothersome

NP:

I. Assessment and Diagnosis of GAD:

a. Screening for GAD: PHQ-4 http://www.aafplearninglink.org/Resources/Upload/File/AAFPLL-Act%201-DL%20Resource%20PHQ-4-11-13-11(1).pdf

i. Score >3 on first 2 questions is positive screen for anxiety

b. The GAD-7 diagnostic tool: http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

i. Scoring:

1. Mild: 5 or greater
2. Moderate: 10 or greater –further evaluation should be done
3. Severe: 15 or greater –further evaluation should be done

c. Summary of DSM-IV criteria for diagnosis of GAD:

i. Excessive anxiety and worry about multiple different events or activities (such as work or school performance), that occurs on the majority of days for at least six months.
ii. Difficulty controlling the worry
iii. Anxiety and worry are associated with at least 3 of the following. Some symptoms must occur the majority of days for at least six months.

1. Restlessness, feeling “keyed up” or “on edge”
2. Being easily fatigued
3. Difficulty concentration or “mind going blank”
4. Irritability
5. Muscle tension
6. Sleep problems: difficulty falling asleep, difficulty staying asleep, or restless unsatisfying sleep

iv. The anxiety and worry are not focused on just one thing (the symptoms do not fit the criteria for another psychiatric disorder like panic disorder, social phobia, obsessive-compulsive disorder, separation anxiety disorder, anorexia nervosa, somatization disorder, hypochondriasis or post-traumatic stress disorder)
v. The anxiety, worry, or associated physical symptoms cause significant distress or impairment in social, work-related, or other areas of functioning

vi. The symptoms are not due to the direct effects of a substance or a medical condition. The symptoms do not occur only when the patient is experiencing a mood or psychotic disorder. The symptoms do not occur in the setting of a pervasive developmental disorder

d. Pertinent Psychiatric Evaluation:
   i. History of present illness and current symptoms
   ii. Past psychiatric history (including previous treatments)
   iii. Past medical history
   iv. History of substance abuse / screen for substance abuse
   v. Personal history (major life events)
   vi. Mental status exam
   vii. Physical exam (especially to rule out other causes of anxiety symptoms)
   viii. Diagnostic tests to rule out other causes of anxiety symptoms: TSH, **ECG?**
e. Screen for:
   i. Depression, Bipolar, or other anxiety disorders
   ii. Suicidality: Suicide Risk Assessment at every visit
      1. Ask about suicidal thoughts, plans, means, and behaviors
      2. Ask about past suicidal behavior or family history of suicide
      3. Talk about current stressors
      4. Assess possible protective factors such as reasons for living

II. Treatment of GAD: Please see II. under **CHW & NP** for more specifics about non-pharmacologic therapies. All therapeutic choices should be individualized to the particular patient's needs and preferences. The treatment of GAD requires very active patient participation.

a. Step 1: Education (at a level the patient can understand) about:
   1. The disorder and treatment options
   2. Basic "brain health": sleep hygiene, avoidance of substances (including alcohol, tobacco and caffeine), regular exercise, healthy nutrition, and identifying meaning and purpose in life
   3. Educate the family or caregiver about the disorder as well

b. Step 2: Psychological therapies: May include cognitive behavioral therapy (CBT), mindfulness-based stress reduction (MBSR), and training in relaxation techniques
   a. Self-help resources
   b. Individual therapy
   c. Group therapy

c. Step 3: For patients with severe functional impairment or lack of response to treatments above. Consider patient safety: can the patient be treated as an outpatient or is inpatient treatment necessary?
    a. Intensive individual therapy
    b. Medication management
    c. Combination of both

d. Medications: In choosing a medication, consider age, previous treatment response, risk of intentional or accidental overdose, patient preference, tolerability/side effects, interactions with patient's other medications, and cost. Please see Depression protocol for chart of starting and usual doses

Table 1. Medications to treat GAD, Panic Disorder, Post-Traumatic Stress Disorder, and Social Phobia

Medication type	Examples	Side effects (SE) / Disadvantages	Advantages	Generic Available
SSRI (all may have sexual SE)	Sertraline (Zoloft)	Gastrointestinal SE more common (diarrhea). May have withdrawal syndrome (WS)	Few medication interactions	Yes
	Citalopram (Celexa)	Possible risk QTc prolongation at doses over 40mg/day, mild WS possible	Few medication interactions	Yes
	Escitalopram (Lexapro)	Mild WS possible	Few medication interactions. Low risk of insomnia	Yes
	Paroxetine (Paxil)	Many medication interactions. Significant WS. May cause constipation, dry mouth, drowsiness, urinary retention, wt gain.	Low risk of insomnia	Yes
	Fluoxetine (Prozac)	Very long half-life, slow effects of titration. Interactions with many medications. Can be "activating" or cause agitation. Dose in AM to avoid insomnia.	Very mild to no withdrawal syndrome	Yes
SNRI	Venlafaxine (Effexor)	Can worsen HTN. May be "activating" or cause agitation. Significant WS	Few medication interactions. May help comorbid pain conditions (i.e.	IR: yes ER: Yes

			neuropathy)	
	Duloxetine (Cymbalta)	Can cause liver enzyme abnormalities, night sweats, sedation.	Low risk of insomnia. May help comorbid pain conditions (i.e. neuropathy)	No
TCA	Imipramine	Contra-indicated in heart block. High risk of cardiac arrhythmia in overdose. Anti-cholinergic SE (dry mouth, constipation, orthostatic hypotension)	May help headaches.	Yes
	Amitriptyline (Elavil)	Anti-cholinergic SE (dry mouth, constipation, urinary retention, orthostatic hypotension). Risk of cardiotoxicity, decreased seizure threshold. Contra-indicated in heart block.		Yes
	Nortriptyline (Pamelor)	Fewer anti-cholinergic SE. Sedating. Risk of cardiotoxicity, decreased seizure threshold. Contra-indicated in heart block.	Taken at bedtime, may help sleep	Yes
	Clomipramine (Anafranil)	Anti-cholinergic SE. Risk of cardiotoxicity, decreased seizure threshold. Contra-indicated in heart block.	Taken at bedtime, may help sleep	Yes
Benzodiazepine	Clonazepam (Klonipin) (used more in GAD)	Risk of addiction, overdose, withdrawal, falls, memory / cognitive problems	Long-acting	Yes
	Lorazepam (Ativan)	Same as above. Shorter acting: may increase abuse potential	Safe in hepatic dysfunction	Yes
	Alprazolam (Xanax)	Same as above. Shorter acting: may increase abuse potential	Use as prn in PD	Yes
Miscellaneous Anxiolytic	Buspirone (Buspar)	May cause sedation or dizziness. Goal dose is at least 15mg TID.	Pregnancy category B, non-addictive	Yes
Sedating Antihistamine	Hydroxyzine (Vistaril)	May cause sedation, dizziness, cognitive impairment. Respiratory depression in overdose	Low abuse potential	Yes
Anti-epileptic	Gabapentin	May cause sedation, dizziness,	May help	Yes

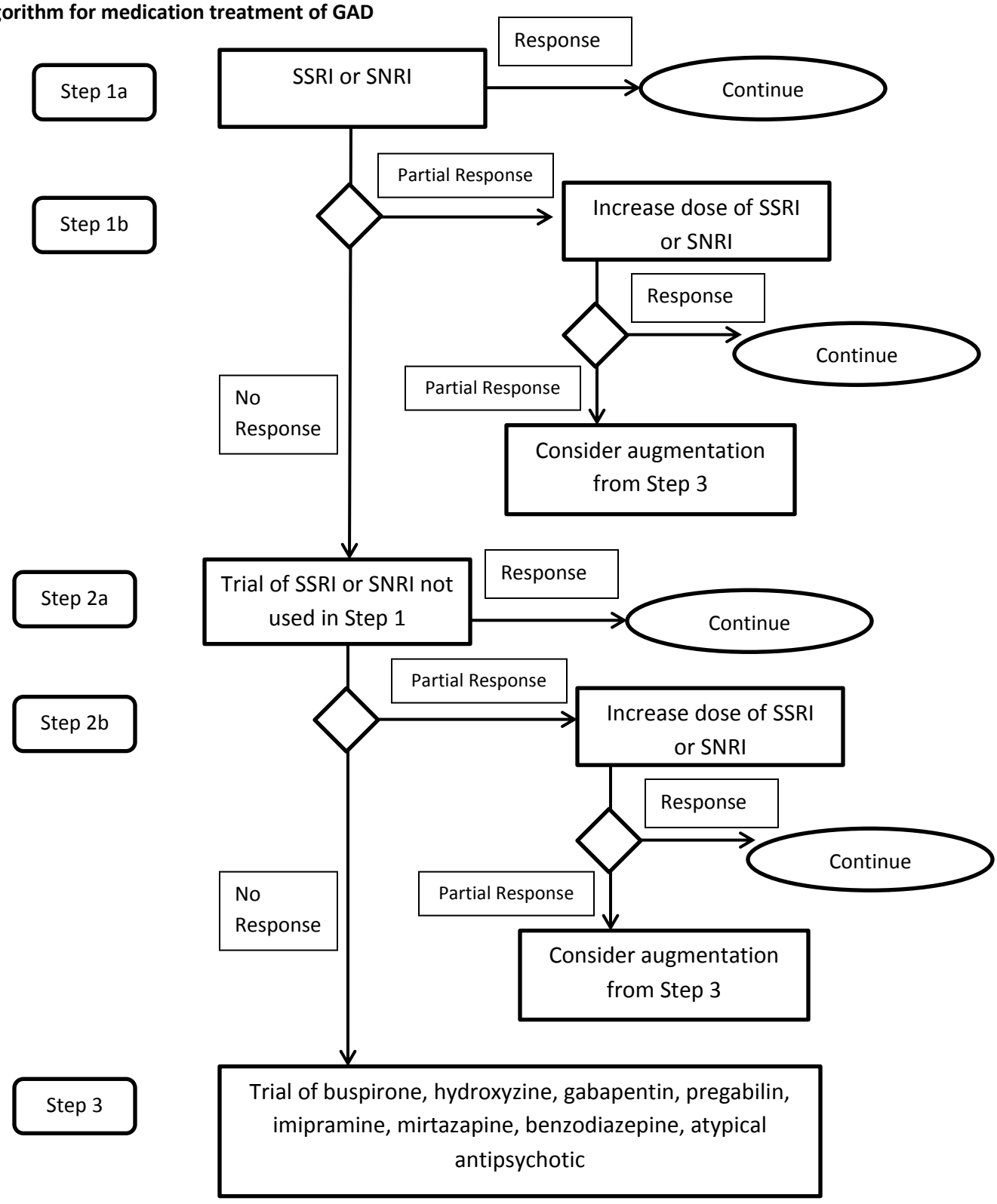
	(Neurontin)	ataxia, cognitive impairment (esp in elderly). May worsen depression, increase risk of suicidal ideation. WS includes lowered seizure threshold	comorbid pain conditions (i.e. neuropathy)	
	Pregabalin (Lyrica)	May cause sedation, dizziness, ataxia, cognitive impairment (esp in elderly). May worsen depression, increase risk of suicidal ideation. Caution in heart failure, possible fluid retention. WS includes lowered seizure threshold. Rare cases of abuse.	May help comorbid pain conditions (i.e. neuropathy)	No
Beta-Blocker	Propanolol	May worsen depression. Monitor for bradycardia. Avoid in cocaine/meth users.	PRN use in Social Phobia	Yes
Alpha-1 antagonist	Prazosin	May cause orthostatic hypotension	Decreases nightmare severity &/or frequency	Yes
Other	Mirtazapine	May cause significant weight gain, sedation	Evidence supports use in PTSD	Yes

a. First Line: SSRI or SNRI (see Table 1)
    1. It is important to warn patients of slow onset of action (may not notice effect for weeks to 2 months), possible **short-term** side effects (headaches, nausea, fatigue, increased anxiety), and possible withdrawal syndrome (if not tapered).
        a. Patients should not stop the medication abruptly and should contact the team if they are experiencing disturbing side effects.
    2. Warn patients of possible increased risk of suicidal ideation with SSRI / SNRI early treatment (first few weeks).
        a. Patients should contact team immediately if they feel hopeless or suicidal.
        b. Team should assess patient suicidality at every visit
    3. Team should follow-up with patient within the first few weeks of treatment (to monitor efficacy, side effects, need for dose adjustment)

4. If there is a partial response by 4 weeks on a therapeutic dose, slowly increase dose of SSRI/SNRI or consider augmentation (see c. below)
5. If there is no response by 6-8 weeks on a therapeutic dose, taper off the SSRI/SNRI and proceed to second line.
6. Sometimes short-term benzodiazepines, buspirone, or hydroxyzine are used to manage acute anxiety until SSRI / SNRI takes effect (such as lorazepam 1-2mg/day in divided doses for a month). Caution with these as they can be habituating, misused, diverted.

b. Second Line: A different SSRI / SNRI. Choice is usually based on medication side effect profile and other issues mentioned above
c. Third Line:
    1. If partial response to SSRI/SNRI, augment with:
        a. Buspirone
        b. Hydroxyzine
        c. Benzodiazepines
            i. concern about overdose, falls, addiction and misuse potential
            ii. Not for use in patients with depression or in the elderly (higher risk of falls, delirium, cognitive SE) or in patients on opioids or who are drinking heavily
    2. If poor response to trial of 2 SSRI/ SNRI medications, consider use of:
        a. TCA (imipramine has the best data for GAD)
        b. Buspirone
        c. Benzodiazepines
            i. Concern about overdose, addiction and misuse potential
            ii. Not for use in patients with depression or in the elderly or in patients on opioids or who are drinking heavily
        d. Gabapentin or Pregabalin
            i. Some evidence of therapeutic effects with elderly patients with anxious depression
d. Fourth Line (present to Project ECHO clinics at this stage)
    1. Mirtazapine
    2. Antipsychotics

Algorithm for medication treatment of GAD



III. Diagnosis of Panic Disorder:

a. The diagnosis of PD is a "diagnosis of exclusion" meaning that you have ruled out all medical causes of a panic attack, such as:

1. COPD exacerbation, asthma attack, or other lung process
2. Heart failure exacerbation, cardiac angina, arrhythmia, or Mitral Valve Prolapse
3. Anaphylaxis or other allergic response
4. Hyperthyroidism
5. Hypoglycemia
6. Substance use (caffeine, cocaine, amphetamines, cannabis, PCP, hallucinogens) or withdrawal (alcohol, benzodiazepines)
7. Steroids
8. Beta-agonist inhalers (albuterol)

b. DSM IV criteria (simplified)

i. Both of the below:

1. Recurrent panic attacks: A period of intense fear or discomfort that includes at least 4 of the following symptoms. (Symptoms must develop rapidly and peak within 10 minutes). Palpitations/pounding heart, sweating, trembling/shaking, shortness of breath, feeling of choking, chest discomfort, nausea or abdominal pain, dizziness/lightheaded, paresthesias, chills/hot flushes, de-realization or depersonalization, fear of losing control/"going crazy"/dying,

2. At least 4 weeks of any of the following:
   a. Persistent worry about having another attack
   b. Worry about the meaning of attacks ("losing my mind", losing control, having a heart attack, etc)
   c. Change in behavior due to the attacks (ie avoiding things or places associated with the attacks)

ii. The attacks are not due to the direct effects of a substance or medical disorder (as reviewed above)

iii. The attacks are not better explained by a different mental disorder such as Social Phobia, Specific Phobia, Obsessive-Compulsive Disorder, Post Traumatic Stress Disorder, or Separation Anxiety Disorder

c. Pertinent Psychiatric Evaluation:

i. History of present illness and current symptoms

ii. Past psychiatric history (including previous treatments)

iii. Past medical history
iv. History of substance abuse / screen for substance abuse
v. Personal history (major life events)
vi. Mental status exam
vii. Physical exam: (to rule out other causes of anxiety symptoms)
viii. Diagnostic tests to rule out other causes of anxiety symptoms: TSH, **ECG?**

d. Screen for:
   i. Mood disorders
   ii. Personality disorders
   iii. Suicidality: Suicide Risk Assessment at every visit
      1. Ask about suicidal thoughts, plans, means, and behaviors
      2. Ask about past suicidal behavior or family history of suicide
      3. Ask about current stressors
      4. Assess possible protective factors such as reasons for living

IV. Treatment of PD: Please **see IV. under CHW & NP** for more specifics about non-pharmacologic therapies. All therapeutic choices should be individualized to the particular patient's needs and preferences. The treatment of PD requires very active patient participation.

a. Establish treatment goals:
   i. Decreasing frequency and intensity of attacks
   ii. Decreasing anxiety about when next attack will occur
   iii. Improving functionality

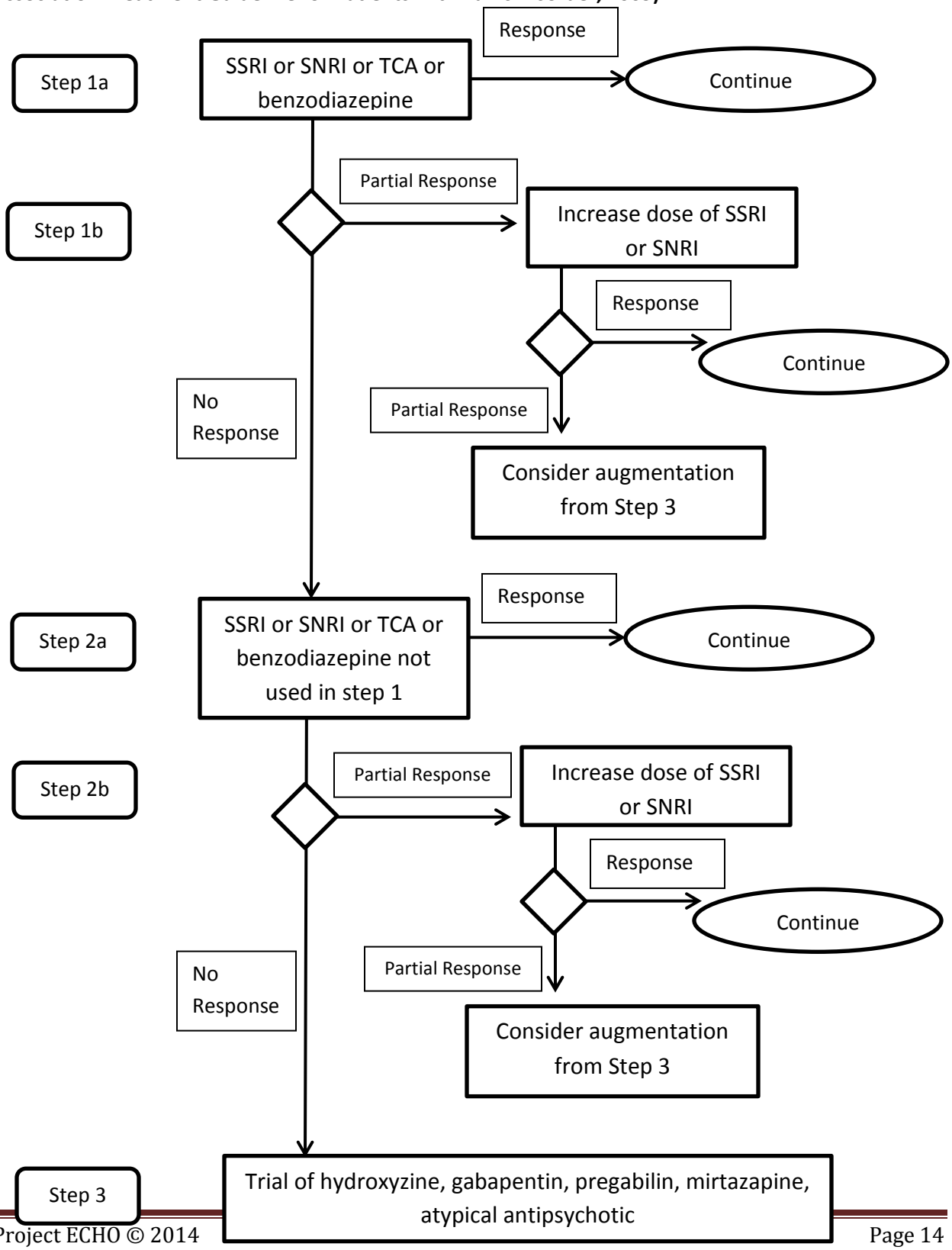
b. Step 1: Education (at a level the patient can understand) about:
   i. The nature of panic attacks (common, not life-threatening, will spontaneously resolve, last only minutes)
      1. Also educate the family or caregiver about the disorder (if appropriate)
   ii. Basic "brain health": sleep hygiene, avoidance of substances (including alcohol, tobacco and caffeine), regular exercise, healthy nutrition, and identifying meaning and purpose in life

c. Step 2: Psychological therapies: May include cognitive behavioral therapy (CBT), mindfulness-based stress reduction (MBSR), and training in relaxation techniques
   i. Self-help resources
   ii. Individual therapy
   iii. Group therapy

d. Step 3: For patients with severe functional impairment or lack of response to treatments above. Consider patient safety: can the patient be treated as an outpatient or is inpatient treatment necessary?
    i. Intensive individual therapy
    ii. Medication management
    iii. Combination of both

e. Medications: In choosing a medication, consider age, previous treatment response, risk of intentional or accidental overdose, patient preference, tolerability/side effects, interactions with patient's other medications, comorbid medical and psychiatric conditions, and cost. Please see Table 1. above for commonly used medications and the Depression protocol for chart of starting and usual doses.
    i. First Line: SSRI/ SNRI (due to better side effect profile)
    ii. Second Line: TCA
    iii. Third Line: Benzodiazepines. Note these medications may be preferred as solo therapy or in combination with anti-depressants for patients (without a mood disorder) who have very severe symptoms in whom rapid control of symptoms is crucial.
        1. Concern about overdose, addiction and misuse potential
        2. Not for use in patients with depression or in the elderly
        3. **Scheduled use of benzodiazepines is preferred to Prn use for PD**
    iv. Fourth Line: Present at Project ECHO at this stage
        1. Mirtazapine
        2. Gabapentin

Algorithm for medication treatment of Panic Disorder (Adapted from the American Psychiatric Association Treatment Guideline for Patients with Panic Disorder, 2009)



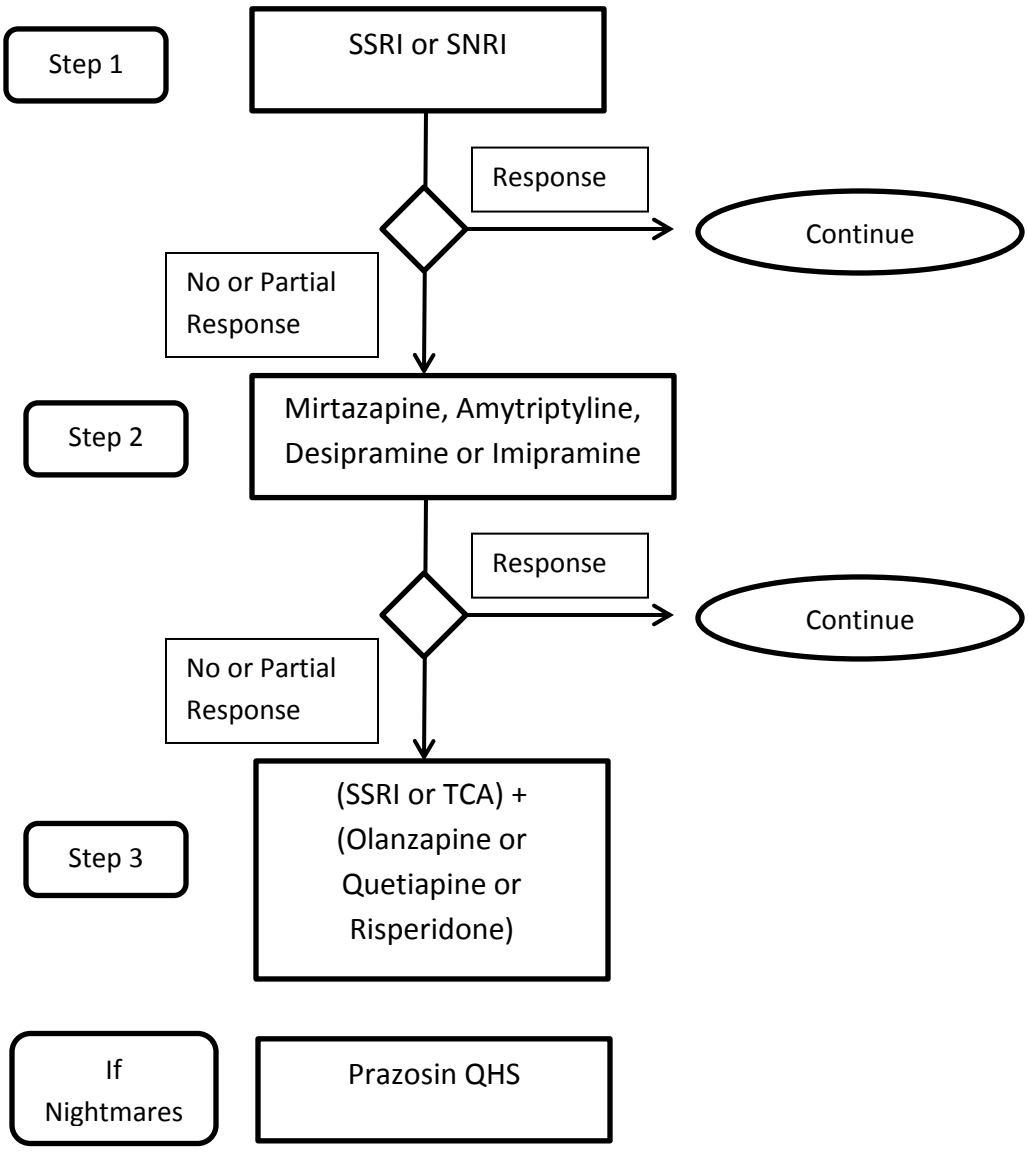
V. Diagnosis of Post-Traumatic Stress Disorder:
   a. DSM IV-TR Criteria:
      i. Must have both:
         1. Exposure to trauma (actual or threatened death or serious injury to self or others)
         2. Response involves intense fear, helplessness or horror
         3. AND meets the following criteria for greater than 1 month
      ii. Resulting in re-experiencing in at least one of the following ways:
         1. Recurrent intrusive distressing memories of the trauma
         2. Recurrent distressing dreams of the trauma
         3. Flashbacks
         4. Intense distress with cues (psychological &/or physiological)
      iii. Resulting in avoidance in at least 3 of the following ways:
         1. Avoids thoughts, feelings or conversation about the trauma
         2. Avoids activities, place, or people reminiscent of the trauma
         3. Inability to recall aspects of the trauma
         4. Feeling detached or estranged from others
         5. Restricted affect
         6. Sense of foreshortened future
      iv. Resulting in persistently increased arousal in at least 2 of the following ways:
         1. Difficulty falling or staying asleep
         2. Irritability or outbursts of anger
         3. Difficulty concentrating
         4. Hypervigilance
         5. Exaggerated startle response
   b. DSM V Criteria:
      i. Exposure to trauma (actual or threatened death, serious injury, or sexual violence with either first-hand or second-hand exposure)
      ii. Symptoms (below) for at least 1 month
      iii. Resulting in at least one symptom of intrusion
         1. Recurrent intrusive memories of the trauma
         2. Recurrent distressing dreams
         3. Dissociation/flashback
         4. Intense distress when cued
      iv. Resulting in persistent avoidance associated with trauma
      v. Resulting in at least 2 forms of negative mood/cognition
         1. Inability to remember the trauma
         2. exaggerated negative beliefs/expectations of self, others

3. Distorted cognitions about the cause/consequence of trauma leading to self-blame
4. Persistent negative emotions (fear, horror, anger, guilt, shame)
5. Markedly diminished participation or interest in significant activities
6. Feelings of detachment or estrangement from others
7. Persistent inability to feel positive emotions (happiness, satisfaction, loving others)

vi. Resulting in at least 2 symptoms of marked arousal/reactivity

1. Irritable behavior and unprovoked angry outbursts
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance

ALGORITHM FOR MEDICATION TREATMENT OF PTSD (Adapted from American Psychiatric Association treatment guidelines)



VI. Diagnosis of Obsessive Compulsive Disorder (OCD):

a. DSM-IV-TR Criteria:

i. Presence of either Obsessions or Compulsions

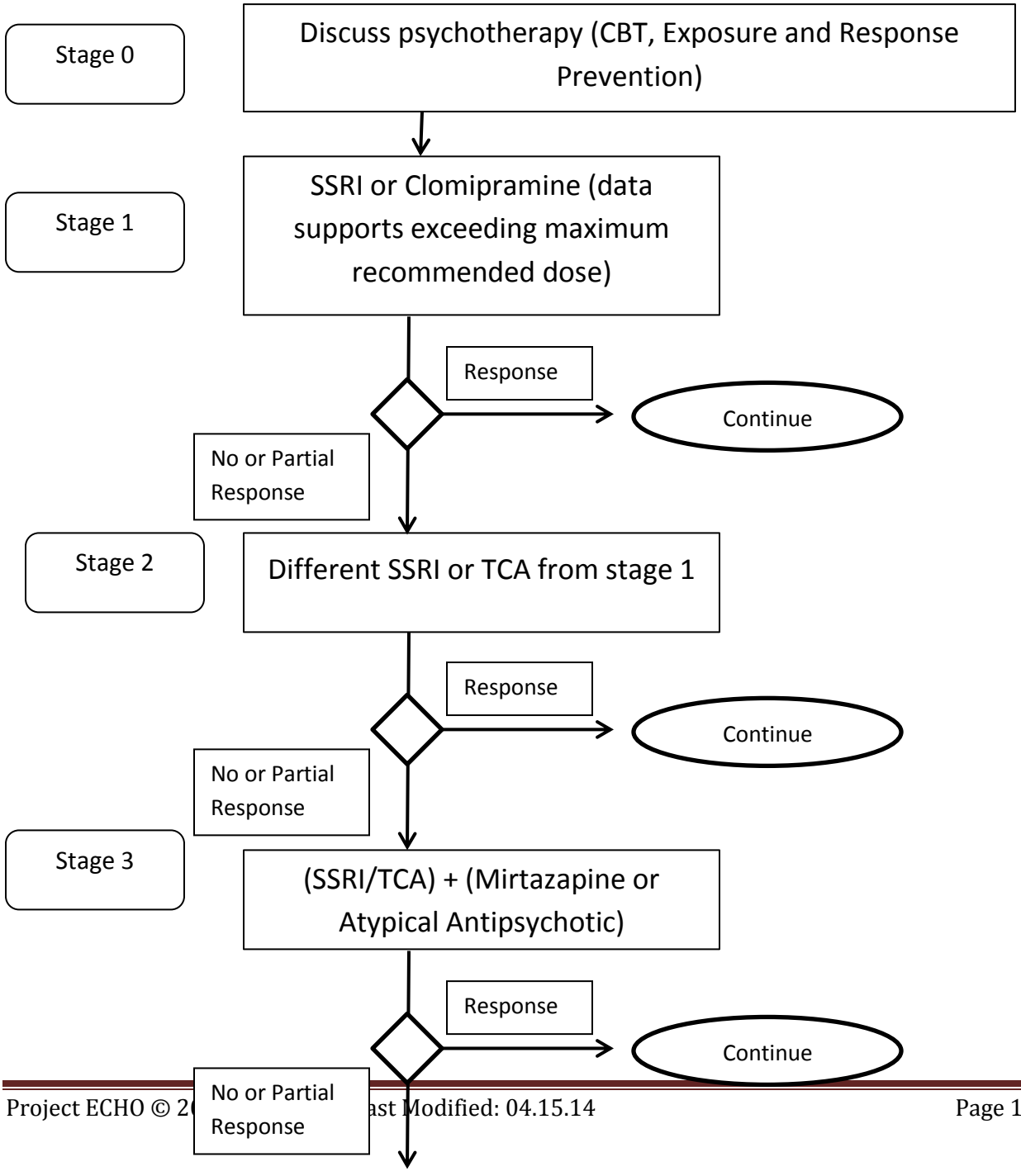
1. Obsessions: Recurrent, persistent thoughts, impulses or images that are experienced as intrusive or inappropriate and cause distress or anxiety, are not part of real-life problems; person attempts to ignore or suppress them, or neutralize them with some other thought or action; person recognizes that they are a product of their own mind
2. Compulsions: Repetitive behaviors or mental acts the person feels driven to perform in response to an obsession, or in response to rules that must be applied rigidly; the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, they are not connected in a realistic way with what they are designed to neutralize

ii. Obsessions or Compulsions are excessive or unreasonable

iii. Obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day) or significantly interfere with normal routine, functioning, or relationships

b. DSM V Criteria: Same as DSM IV-TR

ALGORITHM FOR TREATMENT OF OCD (Adapted from the American Psychiatric Association Treatment Guideline)



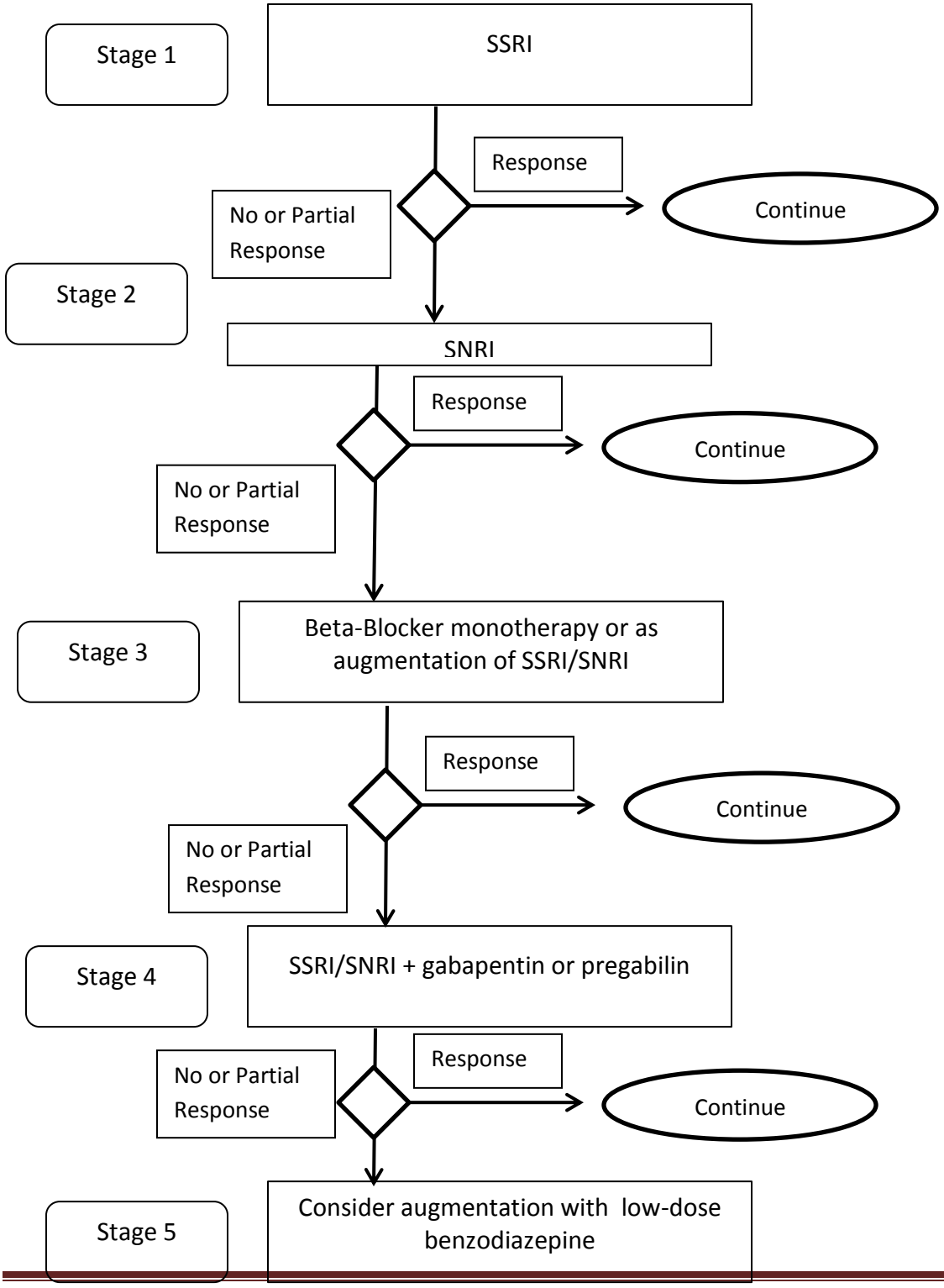
Stage 4	SSRI + Clomipramine or SSRI/TCA + Buspirone or SSRI/TCA + Pindolol

VII. Diagnosis of Social Phobia:

a. DSM V:

i. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others
ii. Individual fears acting in a way that will show anxiety symptoms that will be negatively evaluated
iii. The social situations almost always provoke fear or anxiety
iv. The fear and anxiety is out of proportion of the actual threat posed by the social situation and to the sociocultural context
v. The fear, anxiety or avoidance is persistently, typically lasting more than 6 months
vi. The fear, anxiety or avoidance causes clinically significant distress or impairment in functioning

ALGORITHM FOR TREATMENT OF SOCIAL PHOBIA:



CHW & NP: NONPHARMACOLOGIC TREATMENT OF ANXIETY DISORDERS

I. Treatment of GAD: focus on non-pharmacologic therapy

a. General principles:

i. Assess type and severity of functional impairment (impact on work, school, family life, social life, and leisure activities).

1. Target therapies to improve these impairments
2. Assess if patient can be safely treated outpatient

ii. Establish treatment goals

iii. Support patient through anxiety-provoking aspects of treatment (considering medication side effects, confronting anxiety provoking situations)

iv. Assess and address barriers to treatment adherence

1. Anxiety may become more intense (briefly) with initiation of treatment
2. Discuss likely timeframe of improvement so patient does not become discouraged/frustrated

b. Therapy: May include the following:

i. Education about GAD and treatment options

ii. Basic "brain health": Sleep hygiene, avoidance of substances (including alcohol, tobacco and caffeine) regular exercise, healthy nutrition, and identifying meaning and purpose in life

iii. Exercise- there is excellent evidence for the impact of regular exercise (not necessarily rigorous) for short and longer term control of anxiety

iv. Cognitive Behavioral Therapy: May include psychoeducation, self-monitoring, countering anxious beliefs, modification of anxiety-maintaining behaviors, and relapse prevention

v. Mindfulness-Based Stress Reduction

vi. Relaxation Techniques

c. Follow-up on medication use, barriers to use, effects, and side effects

II. Diagnosis of PD: **See III. In NP** section above

III. Treatment of PD: focus on non-pharmacologic therapy

a. General principles:

i. Assess type and severity of functional impairment (impact on work, school, family life, social life, and leisure activities).

1. Target therapies to improve these impairments
2. Assess if patient can be safely treated outpatient

ii. To assess baseline symptoms and response to therapy, ask patient to keep a diary of symptoms:

1. When attacks happen and how long they last
2. What they are feeling and thinking during the attacks

iii. Establish treatment goals:

1. Decreasing frequency and intensity of attacks
2. Decreasing anxiety about when next attack will occur
3. Improving functionality

iv. Support patient through anxiety-provoking aspects of treatment (considering medication side effects, confronting anxiety provoking situations)

v. Assess and address barriers to treatment adherence

1. Anxiety may become more intense (briefly) with initiation of treatment
2. Discuss likely timeframe of improvement so patient does not become discouraged/frustrated

b. Therapies

i. Education about nature of panic attacks (common, not life-threatening, will spontaneously resolve, last only minutes)

ii. Basic “brain health”: Sleep hygiene, avoidance of substances (including alcohol, tobacco and caffeine) regular exercise, healthy nutrition, and identifying meaning and purpose in life

iii. Exercise- there is excellent evidence for the impact of regular exercise (not necessarily rigorous) for short and longer term control of

iv. Cognitive Behavioral Therapy: May include psychoeducation, self-monitoring, countering anxious beliefs, exposure to fear cues, modification of anxiety-maintaining behaviors, and relapse prevention

v. Mindfulness Based Stress Reduction

vi. Relaxation Techniques

IV. Follow-up on medication use, barriers to use, effects, and side effects

CHW:

I. Medication reconciliation: review which meds the patient is taking, how/when they are taking, barriers to use, etc

II. Substance Abuse Assessment: (caffeine, cocaine, amphetamines, cannabis, PCP, hallucinogens alcohol, benzodiazepines). Perform motivational interviewing and supportive counseling around these topics. Make appropriate referrals to supportive groups and detox/cessation programs

III. Suicide Risk Assessment at every visit
   a. Ask about suicidal thoughts, plans, means, and behaviors
   b. Ask about past suicidal behavior or family history of suicide
   c. Talk about current stressors
   d. Assess possible protective factors such as reasons for living

IV. Review patient self-management goals ("change plan"). Perform motivational interviewing around these goals. May include: Sleep hygiene, exercise, social activity, decreasing substance use, MBSR techniques or CBT homework, regular medication use, etc.

V. Explore if any social pathways need to be added, revisited or updated.
   a. Consider referrals to county/state agencies for Medicaid, other funding assistance (likewise for federal agencies—e.g., for SSI, SSDI, Medicare, etc.)
   b. Consider referrals to subsidized housing.
   c. Consider referrals to supported employment.

When to present to Project ECHO

   b. Moving beyond third line treatment
   c. Poor response to treatment or not tolerating treatment
   d. Significant medical comorbidity
   e. Poor adherence to treatment
   f. Questions about counseling techniques
   g. Other confounding symptoms, ie paranoia, moodiness, self injurious behaviors, suicidality

References:

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http://publications.nice.org.uk/generalised-anxiety-disorder-and-panic-disorder-with-or-without-agoraphobia-in-adults-cg113

2. American Psychiatric Association. Treating Panic Disorder: A Quick Reference Guide. 2009. http://focus.psychiatryonline.org/content.aspx?bookid=28&sectionid=1663909
3. Bystritsky, A. Pharmacotherapy for Generalized Anxiety Disorder. In: UpToDate, Stein, MB (Ed), UpToDate, Waltham, MA, 2013
4. Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder, American Psychiatric Association, 2004
5. **Practice Guideline for Treating People with Obsessive-Compulsive Disorder, American Psychiatric Association, 2007, update 2013**
6. **Canton J, et al. Optimal treatment of social phobia: systematic review and metaanalysis, Neuropsychiatric Disease and Treatment, 2012;8:203-215**