UVM Project ECHO
Mental Health Advanced Series:
Anxiety in Primary Care

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Didactic presentation is recorded. Registered participants will receive the link.

The University of Vermont
LARNER COLLEGE OF MEDICINE
OFFICE OF PRIMARY CARE & AHEC PROGRAM

Project ECHO
University of Vermont

Session Agenda

- Welcome
- Objectives
- Didactic Presentation (25-35 min)
  - Q&A
- Case presentation(s)
  - Clarifying questions
  - Discussion
- Closing Announcements
  - Topic and cases for next session
  - Feedback and evaluation

ECHO Model: All Teach, All Learn

Cohort-based learning on ZOOM

- Have your camera on as much as possible, especially when joining the meeting and during discussions
- Questions and comments are welcome – use the “raise hand” feature or put them in the chat
- This is not a webinar! Participation is key

Case-based learning

- 1-2 participant cases each session using provided template
- Contact Mark Pasanen to present a case

Series Objectives

Learning objectives for this ECHO series include the ability to:

1. Describe the various diagnoses in the anxiety family, and the nuances and complexities in these diagnoses
2. Implement brief intervention and “rapid” cognitive behavioral therapy into practice
3. Design standard of care pharmacologic and therapeutic treatment regimens for patients with anxiety disorders

CMIE Disclosures

The Robert Larner College of Medicine at The University of Vermont is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing medical education for the healthcare team.

The University of Vermont has approved your application and designates each session a maximum of **1.5 *AMA PRA Category 1 credit(s)***™. This program has been reviewed and is acceptable for up to **1.5 Nursing Contact Hours**.

The Robert Larner College of Medicine University of Vermont has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for **1.5 AAPA Category 1 CME credits**.

As a Jointly Accredited Organization, The Robert Larner College of Medicine at the University of Vermont is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The University of Vermont maintains responsibility for this course. Social workers completing this course receive 1.5 continuing education credits.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to **1.5 MOC points** in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program; It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM or ABP MOC credit.

This activity was planned by and for the healthcare team, and learners will receive 1.5 Interprofessional Continuing Education (IPCE) credit for learning and change.

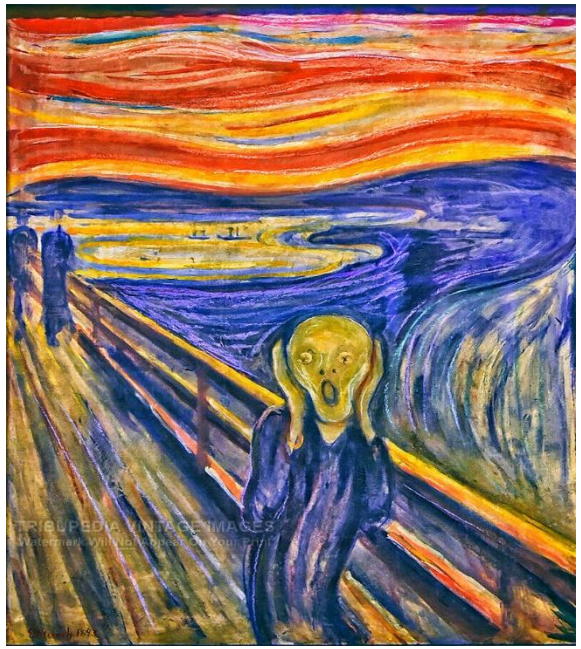
Participants should claim only the credit commensurate with the extent of their participation in the activity.

CMIE Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.

Advanced Medication and Therapeutic Interventions for Generalized Anxiety Disorder and Panic Disorder



A Evan Eyler, MD, MPH

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Session Objectives

After this session, participants will be able to:

1. Briefly describe at least 3 principles in treating patients with generalized anxiety disorder (GAD) or panic disorder in a primary care setting.

2. Briefly describe at least 3 medication options for treating GAD and 2 for treating panic disorder.

3. List and briefly describe two intensive interventions for treatment of GAD and panic disorder.

Agenda

- A word about Intensive treatments
- Brief review
- Contextual issues and a few specific considerations
- Panic disorder – diagnosis and treatment
- Generalized anxiety disorder – diagnosis and treatment
- Case discussion

Advanced Therapeutic (Intensive) Interventions

- TMS – yes, some evidence supporting the accelerated 1 Hz dorsomedial prefrontal TMS protocol in treatment of GAD.
- ECT – no, except for the anxiety component that sometimes accompanies mood disorders.
- Ketamine – no – not approved for this use and may increase anxiety.
- IOP/MADC – yes – more intensive CBT/DBT services plus medication evaluation are often helpful in treating anxiety disorders.

- What about the treatment of patients with GAD and panic disorder who are not getting better but are not candidates for these treatments?

Contextual Issues, Specific Considerations

Quick Review: What have we discussed so far? - 1

- The experience of anxiety is an essential part of being human.
- Anxiety disorders are extremely common and are *also* a significant cause of psychiatric disability.
- Anxiety exists on a continuum:
  - Motivating
  - Uncomfortable but manageable
  - Interfering significantly with daily life
  - Severe and debilitating
- Anxiety disorders are often progressive/morphing over time, manifesting differently in childhood, adolescence, young adulthood, etc.

Quick Review: What have we discussed so far? - 2

- Collaborative Care is an ideal model for use in primary care.
- Treatment includes:
  - Assessment
  - Therapies: “quick CBT,” BAT, problem solving, collaborative engagement
  - Pharmacotherapies, primarily SSRIs and SNRIs, thought there are sometimes other options.
- Results of treatment are modest:
  - Approx 60-85% of patients respond to current biological and psychotherapeutic treatments, ie, achieve a 50% reduction in symptoms.
  - Approx half of responders achieve remission (minimal symptoms).

- #1: Psychoeducation: SET REASONABLE GOALS

Goal Setting

- What is a typical day for you? What do you want to be able to do?
- What would it take to be able to do that?
  - Problem solving
  - Break it down into steps
  - Gradual re-entry
  - Balanced effort: Progress without becoming completely overwhelmed.
  - Progress will be uneven, “two steps forward, one step back.”
- #2: Psychoeducation: Progress will come with gradual re-entry into the feared situation or gradual confronting of the feared stimulus. Medication can support that effort but is not a substitute for it. Anxiety is a scary but very weak python – it will let go when pushed.
- Be gentle – this can be incredibly hard.

Cannabis works best for me

- Substances: Is cannabis a treatment for anxiety disorders?
- Anxiety disorder (lifetime) > 2-3 x more likely to use cannabis (lifetime) and to develop a cannabis use disorder after beginning use.
  - https://pubmed.ncbi.nlm.nih.gov/21641123/
  - https://pubmed.ncbi.nlm.nih.gov/23414492/
- Initial symptom relief, followed by worsening, is often seen.
  - Perceptions, Experiences, and Patterns of Cannabis Use in Individuals with Mood and Anxiety Disorders in the Context of Cannabis Legalization and Medical Cannabis Program in Canada - A Qualitative Study - PubMed (nih.gov)

Co-occurring Anxiety Disorders

- US samples, adults with GAD:
  - Current GAD, 66% have at least one co-occurring psychiatric disorder
  - Lifetime GAD, 90% have at least one co-occurring psychiatric disorder
- Worldwide, lifetime GAD, > 80% have a co-occurring disorder.
- Mood disorders most common, other anxiety disorders common too.
- "Where there is one anxiety disorder, look for another," and OCD, PTSD.
  - GAD + social phobia: 23% in last 30 days, 34% lifetime.
  - GAD + specific phobia: 25% in last 30 days, 35% lifetime.
  - GAD + panic disorder: 23% in last 30 days, 24% lifetime.
- Panic disorder:
  - Higher risk of GAD, PTSD, social anxiety dis, illness anxiety/somatic symptom dis, agoraphobia, substance use disorders, major depression, even bipolar disorder.
  - Higher risk of asthma, COPD, CAD, IBS, diabetes, migraines, thyroid disease, HTN, vestibular dysfunction, chronic pain.

Social Determinants of Mental Health

- ACEs contribute to increased anxiety as well as other psychiatric symptoms/illness: > 3 ACE 3x anxiety as zero ACE
  - Adverse Childhood Experiences and Adult Mental Health Outcomes - PMC (nih.gov)
- Childhood abuse/neglect correlated with both incident and persistent anxiety in a Quebec study of 724 older adults followed for 4 years
  - Childhood abuse/neglect and temporal patterns in late-life anxiety - PubMed (nih.gov)
- What about current domestic/intimate partner violence?
- Important for:
  - Acute planning and treatment
  - Transformation from ill person to resilient survivor

Panic Disorder

Diagnosis of Panic Disorder (DSM-5):

- Recurrent unexpected panic attacks, and:
- At least one of the attacks has been followed by 1 month or more of 1 of the following:
  - Persistent concern or worry about additional panic attacks or their consequences (losing control, going crazy, having a heart attack, etc.)
  - Significant maladaptive behavior change related to the attacks (avoidance of exercise, new situations, etc.)
- Not better explained by another psychiatric disorder
- Not better explained by the effects of a substance or medication ,or another medical condition.

Panic attacks (DSM-5):

- An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and is accompanied by 4 or more:
  - Palpitations, pounding heart, fast heart rate/ Chest pain or discomfort
  - Sweating/ Chills or heat sensations
  - Trembling, shaking/ Numbness or tingling sensations, paresthesias
  - Shortness of breath, smothering feeling/ Feeling of choking
  - Nausea, abdominal distress
  - Derealization, depersonalization
  - Fear of losing control, going crazy or dying.
- Significant cultural variation in symptom presentation:
  - Headache/ neck soreness
  - Tinnitus
  - Uncontrollable screaming or crying.

Panic attack or panic disorder?

- Prevalence:
  - Lifetime prevalence of panic disorder: approx M 2%, F 5%.
  - Lifetime occurrence of panic attacks: up to 1 in 3 people, lifetime.
- A panic attack is a symptom, not a diagnosable illness.
- Many other illnesses can present with panic attacks.
- If possible, establish a timeline regarding anxiety and mood symptoms, onset of panic attacks, any precipitating events.
- Do the panic attacks occur only in response to:
  - Social interactions/situations (Social Anxiety Disorder)
  - Specific situations or objects (Specific Phobia)
  - Obsessions (OCD) or triggering reminders (PTSD)
- Or in withdrawal (sedating substances) or intoxication (stimulating)

Ask about:

- Excessive worry?
- Anxiety In specific situations, or around specific objects or triggers?
- Persistent worry about having a serious illness?
- Trauma history or current victimization?
- Substance use?
  - Stimulating agents: Caffeine, sometimes nicotine, ADHD meds, amphetamines, cocaine.
  - Sedating agents: alcohol, cannabis, etc.
- Leaving the home, being in open or enclosed spaces, etc.
- Symptoms of depression and bipolar disorder

Non-psychiatric medical illness: Two-way street?

- If the patient is in the ED, think PE, MI! Safety first.
- Asthma, COPD, OSA – do panic attacks wake you from sleep?
- Syncope, presyncope (vasovagal, orthostatic, cardiogenic)
- Vestibular dysfunction
- Thyroid disease

- More unusual things:
  - TLE – what is level of consciousness?
  - Pheochromocytoma
  - Interestingly, probably not MVP

Treatment - 1

- Need for treatment?
- Medication, psychotherapy or both?
  - Usually both, but patient preference should prevail.
  - Usually CBT, but some people will get better with less EB treatments, even psychoeducation.
- SSRI usually first line if medication is used.
  - Any SSRI – choose by side effects, interactions, half life, price, pt preference.
  - Starting doses are lower than for treatment of depression.
  - Start low, increase in 1 week, then in 1 month.
  - Sertraline 25 mg, escitalopram 5 mg, fluoxetine 10 mg or even 5 mg.
  - Need at least 6 weeks at maximally tolerated therapeutic range dose.
  - For many patients, sexual dysfunction is the #1 complaint >> ask.
- Also: books, apps
  - NICE approves nine new digital tools for treating anxiety and depression - Pulse Today

Treatment – 2 – Next Steps

- If therapy only, add medication; if med only, add therapy.
- Other medication choices:
  - SNRI – Could start venlafaxine XR 37.5 mg and upwardly titrate. Venlafaxine has some evidence for reduction in attack frequency, anticipatory anx, avoidance.
  - Gabapentin augmentation, cautiously, if past or current SUD. Start 200 mg TID, upwardly titrate.
  - Mirtazapine augmentation, though evidence base in thin. 15 mg nightly or so.
  - TCA, MAO if you go down that road. Ever a role for benzodiazepines?
- Medications with little or no evidence:
  - Bblockers, clonidine > though some patients swear by them.
  - Antipsychotic agents, AED
  - Bupropion, buspirone
  - Vortioxetine, vilazodone unknown.
  - MAINTAIN HOPE, REASONABLE GOALS, ENCOURAGEMENT

Generalized Anxiety Disorder

Diagnostic Criteria (DSM-5)

- Excessive anxiety and worry (apprehensive expectation) occurring more days than not, > 6 months, about a number of events or activities.
- The individual finds it difficult to control the worry.
- 3+ of the following 6 symptoms (1 in kids).
  - 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)
- Clinically significant distress or impairment in social, occupational, or other important areas of functioning. And…..

Diagnostic Criteria (DSM-5)

- Not attributable to effects of a medication, substance, or non-psychiatric medical illness.
- And…The disturbance is not better explained by another psychiatric illness, such as:
  - Anxiety or worry about having panic attacks in panic disorder
  - Negative evaluation in social anxiety disorder
  - Contamination or other obsessions in OCD
  - Separation from attachment figures in separation anxiety disorder
  - Reminders of traumatic events in PTSD
  - Gaining weight in anorexia nervosa
  - Physical complaints in somatic symptom disorder/ having a serious illness in illness anxiety disorder
  - Perceived appearance flaws in body dysmorphic disorder
  - Or the content of delusional beliefs in schizophrenia or delusional disorder.

Treatment - 1

- Is treatment needed? Getting worse? Not functioning reasonably well? Co-occurring SUD? Reasonable expectations.
- Medication, psychotherapy or both?
- CBT
- Books, apps
- Pharmacotherapy:
  - SSRI, SNRI. Escitalopram, duloxetine or choose by side effects.
  - Duloxetine, desvenlafaxine sometimes less sexual dysfunction than venlafaxine or most SSRIs.
  - Start with lower doses, similar to panic disorder tx.
  - If unsuccessful, change to a second SSRI or SNRI.
  - If partial response, can try augmentation.

Treatment - 2 - Augmentation

- Caution as more agents are added. Reassess expectations.
- Buspirone – aug or can use as single agent if symptoms are mild.
  - Start 10 mg daily, upwardly titrate. Usually 60 mg/d max.
- Quetiapine
  - Start 25-50 mg, upwardly titrate. Usually 50 – 300 mg total daily dose.
- Maybe gabapentin
- Maybe mirtazapine
- Hydroxyzine
  - Sleep – antihistaminic effects, 50 mg or so.
  - Can use 25-50 mg TID-QID PRN in daytime, sedating and anticholinergic.

Practice Guidelines < 5 years old

- Overview | Generalised anxiety disorder and panic disorder in adults: management | Guidance | NICE (uvm.edu)

- World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for treatment of anxiety, obsessive-compulsive and posttraumatic stress disorders – Version 3. Part I: Anxiety disorders: The World Journal of Biological Psychiatry: Vol 24 , No 2 - Get Access (uvm.edu)

Questions?

Case Presentation

Bringing Knowledge to Action through interactive, case-based discussions

Participant presents the case and poses the question(s) for the group

↓

Clarifying questions about the case from group to case presenter

↓

Ideas, suggestions, recommendations from participants

↓

Ideas, suggestions, recommendations from ECHO faculty team

↓

Full group discussion

↓

Summary and wrap-up by facilitator

Case Presentation

DO <u>NOT</u> INCLUDE:

Names, Address, DOB, Phone/Fax #, Email address, Social Security #, Medical Record #

Consider the level of detail necessary. Go with less when possible.

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.

Case

DATES	DIDACTIC TOPIC
Feb 7	**Evaluation and Screening of Anxiety Disorders in Primary Care** Sara Pawlowski, MD
Feb 21	**Collaborative Care Model Approach to Anxiety Disorders** Kerry Stanley, LICSW and Clara Keegan, MD
March 6	**Brief Intervention Highlights and "Ultra-Rapid CBT"** Julia Terman, MA
March 20	**Advanced Medication and Therapeutic Interventions for GAD and Panic Disorder** Evan Eyler, MD
April 3	**Advanced Medication and Therapeutic Interventions for OCD and Tic Disorders** Suzanne Kennedy, MD
April 17	**Advanced Psychopharmacology for Anxiety Disorders in the Context of Substance Use Disorders** Adam Greenlee, MD
May 1	**Treatment Approaches to Agoraphobia and Social Anxiety Disorder** Liz May, MD
May 15	**Wrap-Up and Review/Participant identified Topics** Mark Pasanen, MD

Closing Announcements

- Slides are posted at www.vtahec.org
- Recording of didactic portion will be sent by email to the full cohort
  - **All recordings are for the use of registered participants only**
- Please complete the evaluation survey
- CMIE information and session QR code auto-send after evaluation
- Please contact us with any questions, concerns, or suggestions:
  - Mark.Pasanen@uvm.org
  - Patti.Smith-Urie@uvm.edu