Attending to Anxiety Disorders in Primary Care

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Anxiety disorders are highly prevalent among patients in primary care. These conditions can be disabling and costly to the patient and to the health care system. Despite the prevalence of anxiety disorders, however, patients often remain undiagnosed and untreated, and patients with unrecognized anxiety disorders tend to be high users of general medical care. Diagnosis may be complicated by the typical presentation in primary care; patients with anxiety disorders may present with multiple somatic complaints and comorbid disorders, causing great effort and expense in identifying the cause of unexplained symptoms. Once anxiety disorders are identified, patients may be treated using well-tested and efficacious psychosocial and pharmacologic treatments. It is therefore important for primary care physicians to recognize and treat patients with anxiety disorders.

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Anxiety disorders are commonly seen in primary care, affecting about 10% of patients.[1] These disorders can be just as physically and socially disabling as many chronic physical illnesses such as diabetes or hypertension.[2] Yet, there is substantial evidence that the diagnosis is often missed and patients remain untreated.[3–6] Of the anxiety disorders described in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, (DSM-IV) those most often seen in primary care are generalized anxiety disorder (GAD), social anxiety disorder, panic disorder, and posttraumatic stress disorder (PTSD). People with these disorders tend to be high users of general medical services, but they may present with somatic complaints and seldom seek psychiatric care.[7] Identifying and diagnosing patients with these disorders is therefore particularly important for the primary care physician.

In the community, anxiety disorders are among the most prevalent of all psychiatric disorders. Studies of prevalence, however, result in widely varying findings depending on the methods, analyses, and diagnostic criteria used. Estimates of lifetime prevalence of anxiety disorders in the community range from 13.9% to 24.9%.[8–11] Similarly, in primary care, a wide range of lifetime prevalence is reported for anxiety disorders, from 11.5% to 30%.[12–14]

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PRESENTATION AND RECOGNITION

Despite their prevalence in the community and in primary care populations, anxiety disorders frequently remain undiagnosed and untreated.[4,13,15–18] Recognition and diagnosis of primary care patients with anxiety disorders can be complicated because patients often present with comorbid disorders or with a variety of somatic complaints.[3,7,19–22] Typically, both the patient and the physician focus on the physical symptoms, therein often failing to consider the possibility of a psychiatric disorder.[20] In a study of patients presenting with somatic complaints to a general medical clinic, 29% had a depressive or anxiety disorder.[7] Independent predictors of a mental disorder included recent stress, multiple physical symptoms (more than 6), higher patient ratings of symptom severity, lower patient ratings of overall health, physician rating of the encounter as difficult, and patient age under 50 years. Additional studies have shown a correlation between the number of medically unexplained symptoms and the likelihood of a current DSM-IV depressive or anxiety disorder.[23,24]

Individuals with long-term, chronic conditions like GAD or social anxiety disorder may have endured their symptoms for many years, not recognizing that their symptoms are out of the ordinary. Furthermore, in the case of early-onset, often lifelong, disorders like social anxiety disorder, individuals may see the symptoms as part of their "personality" and not consider that they might be remediable with treatment. They may seek treatment if they develop depression, which they are able to recognize as a new and unfamiliar condition.[25] Surprisingly, patients with PTSD may also be unlikely to seek treatment.[26] Patients with panic disorder, however, usually seek care because panic attacks can be alarming and are often interpreted by

the individual to reflect a physical problem such as a heart attack or stroke. In one study, more than 50% of patients sought treatment in the year of panic disorder onset.[27] Patients with panic disorder in primary care will often present with somatic complaints alone, most frequently cardiac, gastrointestinal, pulmonary, or neurologic complaints.[28] Although diagnosis of panic disorder in primary care may have improved over the past decade, many patients are still undertreated.[29]

PREVALENCE AND COMORBIDITY

General Anxiety Disorder

Characterized by excessive, uncontrollable worry about everyday life, GAD affects many patients with this disorder throughout their lives.[30] In community samples, lifetime prevalence of GAD has been reported as 5.1%[10] and 4.5%,[11] while in primary care patients, lifetime prevalence is reported as 8%.[14] Recent studies of primary care patients estimate the point prevalence of GAD to be in the range of 3.7% to 8.5%.[4,12–14,31]

GAD tends to be a chronic condition; symptoms wax and wane over time, with short-term exacerbations of acute anxiety in response to stress.[30,32] Symptoms show substantial overlap with those of other medical and psychological disorders, particularly major depressive disorder and other anxiety disorders, complicating diagnosis. Comorbid disorders are extremely common among patients with GAD in primary care; at least one third of primary care patients with GAD experience major depressive disorder.[4] Other psychiatric disorders often comorbid with GAD are substance abuse disorders and other anxiety disorders.[33]

Social Anxiety Disorder

Fear and anxiety associated with social or performance situations, resulting in functional impairment or distress, are characteristic of social anxiety disorder.[30] Anxiety may be generalized to many social situations or specific (i.e., related to 1 or only a few social situations). Typically, social anxiety disorder emerges during the teenage years and persists; in some individuals, however, it may begin very early in childhood. Lifetime prevalence estimates in community samples vary greatly, partly because of variations in diagnostic criteria between the DSM-III and -IV; estimates range between 1.9% and 13.7%.[9–11,34] In primary care settings, estimates of the lifetime prevalence of social anxiety disorder range from 8.2% to 14.4%,[13,14,17] while primary care studies report the point prevalence of social anxiety disorder to be between 2.6% and 7%.[13,14,31,35]

Most patients with social anxiety disorder have 1 or more comorbid psychiatric disorders. Data from the National Comorbidity Survey indicate that approximately 41% of patients with social anxiety disorder have an affective disorder, 57% experience another anxiety disorder, and 40% have a substance abuse disorder[36]; other researchers report similar findings.[5,35]

Panic Disorder

Panic disorder is marked by recurrent, unexpected panic attacks with persistent concern about future panic attacks or worries about their implications or consequences. During a panic attack, a patient may experience palpitations, accelerated heart rate, chest pain, nausea, trembling, sweating, shortness of breath, choking, or dizziness.[30] Community surveys report lifetime prevalence in the range of 1.6% to 4.5%.[8–11,37] In primary care, reports of lifetime prevalence range from 6% to 8.6%.[13,14,38] Point prevalence in primary care has also been reported as 1.5% to 3.1%.[12–14,31] The average age at onset of panic disorder is in the mid-20s, although some patients develop symptoms earlier in life.[39] Panic disorder is frequently comorbid with depression,[29] as well as social anxiety disorder, GAD, and agoraphobia.[6] Factors associated with poorer treatment outcomes for panic disorder in primary care include unemployment and frequent emergency room visits prior to starting treatment.[40]

Posttraumatic Stress Disorder

Persistent symptoms of anxiety that follow an extremely traumatic event involving actual or threatened violent injury to oneself or involving the injury or death of another person characterize PTSD. Two epidemiologic surveys, using DSM-III-R and DSM-IV definitions of PTSD, found lifetime prevalence rates of 7.8%[41] and 9.2%.[42] Studies in primary care populations found that 2%,[31] 9%,[16] and 11.8%[15] of patients currently meet criteria for PTSD.

Seen about twice as often in women as in men,[43] PTSD tends to be chronic. In one study, PTSD was most persistent in women who were victims of trauma. For these women, the probability of persistence after 10 years is 50%.[44] Typically reported comorbidities include depression, substance abuse disorders, and other anxiety disorders such as GAD, panic disorder, and social anxiety disorder.[15]

QUALITY OF LIFE

Multiple studies employing a variety of indices found that patients with anxiety disorders report a significant impact on the quality of life and on psychosocial functioning.[45] The earliest studies compared the effects of anxiety disorders with the effects of disorders whose effects are better understood, demonstrating, for example, that the impaired occupational and social functioning caused by GAD or panic disorder is comparable to that caused by depression.[46–48] More recent studies examined the types of impairment associated with each anxiety disorder. In one study, for example, Schonfeld and colleagues[49] used the Short-Form Health Survey and found that PTSD had significant

negative effects across all of the functioning scales; the main impact was seen in the subscales for role limitations (emotional), role limitations (physical health), and vitality. The greatest impact of panic disorder or agoraphobia, however, was found in the subscales for role limitations (physical health) and bodily pain, while the most serious effects of GAD were observed in the subscales for emotional role limitations and physical health role limitations. In social anxiety disorder, the largest effect was seen primarily in the subscale for emotional role limitations. The relationship between medical and anxiety comorbidity in primary care patients and their combined impact on quality of life remains to be further studied.

TREATMENT OF ANXIETY DISORDERS

Pharmacotherapy and cognitive-behavioral (psychosocial) therapy are the most commonly used options available to primary care providers to treat patients with anxiety disorders.[50] In 1997 and 1998, primary care physicians employed pharmacotherapy in more than half of office visits related to anxiety disorders (almost always to treat patients with panic disorder or GAD) and psychotherapy in less than 5% of such visits.[51] Forty percent of patients with anxiety disorders who visited primary care physicians during this period were not treated for their anxiety disorders by any means.[51] The use of psychotherapy has declined from 23% of office visits for anxiety disorders in 1985, most likely because of an increased reliance on anxiolytic agents, notably selective serotonin reuptake inhibitors (SSRIs). The proportion of atypical antidepressants (bupropion, mirtazapine, nefazodone, trazodone, and venlafaxine) prescribed by primary care physicians increased from 1.5% of office visits for anxiety disorders in 1985 to 17% in 1993 and 1994, to 25% in 1997 and 1998, whereas the proportion of tricyclic antidepressants, tetracyclic antidepressants, and monoamine oxidase inhibitors decreased from 14% to 7%.[51]

Pharmacotherapeutic Agents

SSRIs are typically considered first-line pharmacotherapy in treating patients with anxiety disorders because of their broad ability to relieve anxiety and/or depressive symptoms that are manifested in GAD, social anxiety disorder, panic disorder, and PTSD. Other useful agents include dual reuptake inhibitors (serotonin-norepinephrine reuptake inhibitors). Although antidepressants are highly effective, they must be administered for 2 to 4 weeks before beneficial effects on most anxiety disorders are observed. In cases where more immediate relief is desired, benzodiazepines may be coadministered, then subsequently tapered as the SSRI takes effect.[50,52]

Given the chronicity of most anxiety disorders, these treatments should be prescribed for at least 1 year.[53,54] Difficult to diagnose and treat, PTSD is managed more effectively if symptoms manifest within 6 months of the traumatic stimulus.[55,56] If left untreated, the disorder may persist for up to 10 years in 40% to 50% of patients.[53] Thus, primary care physicians should ideally refer all patients with PTSD to mental health professionals so that cognitive-behavioral therapy and pharmacotherapy can be used in combination. The primary care physician may provide the pharmacotherapy (or, in some cases, refer to a psychiatrist for this aspect of care) while another mental health professional provides the psychotherapy. Pharmacotherapy and psychotherapy are effective in reducing 3 symptoms of PTSD: flashbacks of the event, avoidance of stimuli that bring the event to recall, and sympathetic hyperactivity or hypervigilance. Pharmacotherapy alone is often not sufficient to attain an optimal outcome using the presently available pharmacotherapeutic agents.[55] Combinations of pharmacologic therapies are more likely to be prescribed for patients with PTSD than for patients with other anxiety disorders, reflecting patients' (and physicians') frequent dissatisfaction with currently available agents as monotherapy. SSRIs are typically used alone or, more frequently, in combination with mood stabilizers, more specific antianxiety agents, antipsychotics, adrenergic and antiadrenergic agents, or sedative hypnotics.[55,56]

Cognitive-Behavioral Therapy

Psychological interventions are highly effective in treating patients with anxiety disorders. Cognitive-behavioral techniques associate internal or external stimuli with feelings of anxiety and train patients to recognize these stimuli and take steps to reduce anxiety by making certain decisions about their symptoms. Patient training may include increased education about a comorbid medical condition that is contributing to feelings of anxiety, or the alleviation of fears of underlying physical symptoms.[51] In most circumstances, primary care physicians do not have the time to provide formal cognitive-behavioral therapy to their anxious patients, who are therefore referred to mental health professionals experienced in these techniques.[53,54]

As mentioned earlier in this article, patients with PTSD are most effectively treated with a team management approach that includes cognitive-behavioral techniques. A mental heath professional may also recognize comorbid anxiety disorders or substance abuse that needs to be managed in order to treat the patient with PTSD.[53] For many other anxiety disorders, the primary care physician can recommend high-quality educational and/or self-help books or refer patients to anxiety support groups in the area. These interventions can be very effective alone or when combined with pharmacotherapy provided by the primary care practitioner.

Collaborative Care

Collaborative care is being investigated as a means of treating patients with anxiety disorders with comorbid

conditions for which treatment is being sought through their primary care providers.[57–59] Treatment is provided by a primary care physician, psychiatrist, and behavioral health specialist. Models of care vary somewhat, but common elements of these collaborative care programs include the coupling of pharmacotherapy and cognitive-behavioral therapy, with intensive management of adherence by a care manager.[57]

Early indications are that collaborative care, even when constrained to include only pharmacotherapy as the therapeutic ingredient, is highly effective for treating panic disorder in primary care. Collaborative care has been studied in 115 patients with panic disorder who were randomly assigned to collaborative care or to usual primary care.[60] Most patients in this study were recruited and screened in waiting rooms of primary care physicians; others joined by referral. On the day of randomization, patients randomly assigned to collaborative care were mailed educational materials, then received care from a primary care physician in addition to a psychiatrist. Patients had contact with a psychiatrist for an hour within 1 week of referral (at which time an SSRI was prescribed and key messages were reinforced from the education materials), a consultation by telephone during week 2, a 30-minute session during week 4, and another consultation by telephone for weeks 6 through 8. Psychiatrists telephoned patients for 5-minute conversations once every 3 months, up to 1 year. Up to 3 extra sessions with the psychiatrist could be scheduled for some patients with persistent symptoms. Care by the primary physician continued during the 12-month study period. Patients randomly assigned to usual care received treatment from the primary physician and could be referred to university or community mental health practitioners.[29]

In addition to demonstrating that collaborative care was effective compared with treatment as usual in reducing anxiety and improving function, cost-effectiveness was also evaluated.[61] Patients with panic disorder who were randomly assigned to collaborative care experienced 74 more anxiety-free days during the 1-year study period than patients randomly assigned to usual care. This improvement was attributed to collaborative care.

CONCLUSION

Anxiety disorders are prevalent among patients in primary care and are associated with the frequent use of medical care services. It is important, therefore, for primary care physicians to recognize anxiety disorders and to identify and diagnose these disorders in their patients. Most patients with anxiety disorders in the primary care setting can be effectively treated using readily available pharmacologic, psychosocial, and collaborative techniques. Treatment of anxious patients can be professionally rewarding for the primary care physician: many patients with anxiety disorders show remarkable improvement with treatment. For those patients who prove to be more difficult to treat, referral to a mental health professional should be initiated, with the primary care physician maintaining an active awareness of how treatment is progressing and how concurrent treatment of ongoing medical illness may impact overall patient functioning.

Drug names: bupropion (Wellbutrin and others), mirtazapine (Remeron), nefazodone (Serzone), trazodone (Desyrel and others), venlafaxine (Effexor).

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