Anxiety Disorders in Primary Care

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INTRODUCTION

Anxiety disorders, the most common psychiatric diagnosis in the United States, have an estimated prevalence of 13.3%. Even though potentially and significantly debilitating, these conditions often command less attention than higher-profile affective and psychotic illnesses. Supporting the serious nature of these conditions is the study by Kroenke and coworkers of 965 randomly selected patients in primary care clinics. The study found 19.5% had at least one anxiety disorder. As the number of anxiety diagnoses rose, accompanying impairment correspondingly increased. These conditions are also associated with elevated divorce rates, greater unemployment, a diminished sense of well-being, and increased reliance on public assistance. Significantly, suicide risk elevates with acute and chronic anxiety disorders.

Patients with anxiety disorders often seek treatment from primary care providers (PCP). They may present with medically unexplained symptoms, making identification of the correct diagnosis a challenge. The patient may be oblivious to recognizing...
their symptom as anxiety and the correct diagnosis becomes easier to miss. Given that 25% to 50% of primary care clinic patients present with medically unexplained symptoms, it is important for the PCP to screen for psychiatric illnesses, including anxiety disorders.6

Adequate treatment is necessary. Effective management for each of the anxiety disorders is available, but currently underused, leaving patients in a less-than-optimally treated state. For example, in Kroenke’s sample of 965 patients, 41% with anxiety disorders went untreated.2

This article reviews epidemiology, screening tools, impact on patients, costs, and treatment of each of the major anxiety disorders.

METHODS

A PubMed literature search was conducted in September and October of 2013 using the following terms: “Anxiety Disorders and Primary Care,” “Generalized Anxiety Disorder and Primary Care,” “Social Anxiety Disorder and Primary Care,” “Post Traumatic Stress Disorder and Primary Care,” and “Obsessive-Compulsive Disorder and Primary Care.” Abstracts from articles on adults, written in English and published within the past 5 years, were reviewed for relevance. Additional articles and texts were identified from references found in the bibliographies of appropriate manuscripts.

DIAGNOSTIC CHALLENGES

PCPs often miss the accurate diagnosis of anxiety disorders. In a study of 840 primary care patients, rates of misdiagnosis were 85.8% for panic disorder (PD), 71% for generalized anxiety disorder (GAD), and 97.8% for social anxiety disorder (SAD).7 The first step in making an accurate diagnosis is to understand the disorder. Table 1 contains a brief description of the key features of the major anxiety disorders. Unfortunately, patient descriptions of their symptoms can mislead even the most astute physician. Patients may report physical or psychological distress, including somatic complaints, pain, sleep disturbance, and depression,8 but are unaware that they are actually experiencing anxiety. Wittchen and colleagues9 noted that only 13.3% of patients with GAD presented with anxiety symptoms as a chief complaint, whereas somatic concerns were described 47.8% of the time. Table 2 contains a case illustrating a common presentation for a person with GAD. Screening for key symptoms associated with the disorder can help identify the diagnosis. Patients with anxiety disorders also have high rates of coexisting additional mental illnesses, further complicating the diagnostic process.

CO-OCCURRING MENTAL DISORDERS

Co-occurring mental conditions are commonly found in patients with anxiety disorders. These can be disorders of mood, substance use, psychosis, or another anxiety disorder. It is estimated that up to 90% of persons with GAD experience one or more comorbid psychiatric diagnoses.11 Stein and coworkers12 found that in patients with posttraumatic stress disorder (PTSD), major depression is seen in 61% of patients, GAD in 39%, social phobia in 17%, PD in 6%, and substance use disorders in 22% of patients. Additionally, the presence of comorbid psychiatric conditions worsens prognosis. Patients with multiple psychiatric diagnoses experience lower remission rates, increased rate of suicide, and higher use of health care.8,11
Table 1

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Key Features Including Signs/Symptoms</th>
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<tbody>
<tr>
<td>Generalized anxiety disorder</td>
<td>Excessive, uncontrolled anxiety/worry about several things that interfere with ability to function. In addition, worry accompanied by other symptoms, such as fatigue, muscle tension, irritability, restlessness, and sleep disturbance.</td>
</tr>
<tr>
<td>Social anxiety disorder</td>
<td>Marked anxiety or fear in social settings where there is risk of scrutiny or judgment. Results in avoidance of situation or enduring situation with marked distress.</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>Recurrent panic attacks described as unexpected waves of anxiety associated with multiple physical and cognitive symptoms. Common symptoms include elevated heart rate, shortness of breath, trembling, abdominal distress, dizziness, and fear of death or losing control.</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>After trauma exposure person experiences symptoms that can include intrusive thoughts of trauma, negative mood, dissociation, avoiding thinking about the trauma or external reminders of it, and hyperarousal.</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>Presence of unwanted recurrent intrusive thoughts or images and/or repetitive behaviors or mental acts, such as counting or checking performed to reduce anxiety. These thoughts/acts impair function or are significantly time-consuming.</td>
</tr>
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</table>


Table 2

Case | Key Diagnostic Features |
--- | ------------------------|
A 36-year-old woman comes in with a chief complaint of insomnia. She feels constantly on edge and finds it hard to fall asleep because of concern about her parents. She also experiences muscle stiffness and shoulder and back pain. On questioning, she describes unremitting worry that something terrible will happen to her elderly parents. The patient lives in a state distant from her parents. There is a family history of cardiovascular disease and she worries they will die of heart attacks. The patient calls her parents multiple times a day to check in with them and feels extremely anxious if she cannot reach them. She also worries about how her kids are doing in school even though they are getting good grades, and about her finances even though she is in good standing financially. She has been experiencing the worry for 5 y. She has missed multiple days of work because of her incapacitating worry. | She experiences multiple symptoms associated with the worry including feeling on edge, sleep disturbance, muscle stiffness, shoulder pain. The worry is uncontrolled. The worry is about multiple things. 5-y history indicating chronic problem. It is impairing function as evidenced by missing multiple days of work. |
HUMAN AND FINANCIAL COST

Patients with anxiety disorders present significant costs in terms of health care use, loss of workforce productivity, disability, and quality of life. The estimated direct and indirect cost of PD per 1 million persons in 2005 was between $241.7 and $287.6 billion US dollars.13 The estimated health costs for persons with GAD are 64% higher than those without GAD, and patients with obsessive-compulsive disorder (OCD) are estimated to lose 3 years of wages because of their illness over their lifetime.14,15 Moitra and colleagues16 found patients with SAD had significantly impaired workplace function compared with individuals with other anxiety disorders and unemployment was twice as likely. Those who suffer from anxiety also experience disability outside of work resulting in poor quality of life and diminished life satisfaction.

IMPACT OF SUBTHRESHOLD SYMPTOMS

Multiple studies describe that persons suffering from anxiety symptoms that are subdiagnostic threshold have significantly more impairment than those who report no symptoms.17–20 Problems these patients encounter include poor perceived health, psychological distress, and increased use of medical services.17–20 Predictably, data indicate that there are far more patients with subthreshold anxiety symptoms than there are patients with diagnosed, threshold disorders; yet it is questionable if this group is identified or treated.17,19,20 Data do not yet exist for criteria for treatment in subthreshold cases.

INCREASED RISK OF SUICIDE

Practitioners associate increased risk of suicide with depression; however, many do not realize anxiety disorders also increase risk. Suicidal ideation, rates of self-injury, and suicide attempts are elevated in persons with anxiety disorders.21–23 Bomyea and colleagues24 found approximately 26% of patients with anxiety disorders endorsed passive suicidal ideation and 16% endorsed suicidal thoughts in the previous month. Both current and lifetime anxiety disorders confer increased suicide risk. Kahn and colleagues4 found suicide risk among patients with anxiety disorders was increased by a factor of 10 or more compared with the general population, regardless of the type of anxiety disorder. The association between suicide and anxiety disorders underscores the importance of detection and treatment.

SCREENING TOOLS

Effective screening tools are available to detect anxiety disorders (Table 3). Finding time to use these adjuncts can be challenging in a busy primary care practice. Screening tools designed to address the full spectrum of co-occurring affective and anxiety disorders are especially useful. The Hospital Anxiety and Depression Scale distinguishes between depression and anxiety if both are present.25 Other broad-based instruments, such as the PRIME-MD-PHQ, can identify anxiety and mood disorders.26 For the case shown in Table 2, either of the screening tools for GAD listed in Table 3 are appropriate.

CHANGES FROM DIAGNOSTIC AND STATISTICAL MANUAL OF PSYCHIATRIC DISORDERS-IV TO DIAGNOSTIC AND STATISTICAL MANUAL OF PSYCHIATRIC DISORDERS-V

The newest version of the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM), the DSM-V, is now available.10 Some highlights are relevant. Agoraphobia is
now in a category of its own rather than a qualifier for PD. The diagnosis of PTSD is no longer found in the anxiety disorder section but is now described in the section on, “Trauma and Stress-Related Disorders.” In addition, the trauma can have occurred to a close family member or friend, or the trauma could be first-hand repeated or extreme exposures to details, such as those experienced by police officers. The later criteria mean that such persons as first responders could develop PTSD. OCD is now found under the classification, “Obsessive-Compulsive and Related Disorders.” Although PTSD and OCD are no longer officially classified in the category of “anxiety disorders” in the DSM-V, they share the same issues of underdiagnosis and approaches to treatment so they are therefore included in this review.

EPIDEMIOLOGY, COURSE OF ILLNESS, AND PROGNOSIS

GAD

The prevalence rates for GAD in primary care settings range from 3.7% to 14.8%. GAD accounts for 50% of anxiety disorders seen in this setting. Only depression is a more commonly identified psychiatric diagnosis. GAD tends to be a chronic illness with fluctuating symptom severity. A 12-year longitudinal study found 60% of patients recovered; however, approximately half of these patients relapsed during that time. Disability caused by GAD is comparable with that of major depressive disorder.

SAD

The 1-month prevalence of SAD in primary care is 7%. This condition is a chronic illness marked by long duration and has a rate of recovery of only 38%. One study described the probability of recovery from SAD in 12-year follow-up as 37%; this number was lower than for GAD and PD. SAD is associated with marked impairment in work productivity and decreased income.

PD

The median prevalence of PD in primary care is 4% to 6%, whereas the median prevalence in the general population is 2.7%. The course of PD is similar to other anxiety disorders in that it is chronic and relapsing. In the Harvard/Brown Anxiety Research Study, nearly one-third of patients with PD were likely to experience a
recurrence within a year after recovery and another study by Simon and coworkers found that nearly half had recurrence in 2 years.\textsuperscript{38,45,46}


**PTSD**

The prevalence for PTSD in primary care settings is estimated to be 11.8%.\textsuperscript{12} This is higher than the 1-year prevalence rate of 3.5% to 6% for the general US population.\textsuperscript{47} In Stein’s study of 368 patients in a primary care clinic, 65% reported a history of exposure to a severe, potentially traumatic event. Similar to other anxiety disorders, patients with PTSD are more likely to reach out to their primary care physicians than to a mental health specialist. PTSD is a chronic condition with only one-third recovering at 1 year and one-third still experiencing symptoms 10 years after trauma exposure.\textsuperscript{48}


**OCD**

OCD has an estimated lifetime prevalence of 1.6%.\textsuperscript{1} The onset of the condition can be in adolescence; however, patients may be sufficiently embarrassed or ashamed preventing them from revealing their symptoms. Consequently, the average time to diagnosis is 11 years.\textsuperscript{49} An estimated 70% of patients with OCD experience a chronic course, whereas only 23% experience a waxing and waning course.\textsuperscript{49} Data vary for remission rates with treatment. In the largest trial of 213 patients, 22.1% had partial remission, 16.9% had full remission, and 59% of patients who remitted subsequently relapsed.\textsuperscript{50}


**TREATMENT**

Treatment of anxiety disorders can be difficult and intimidating for the PCP. There are specific recommendations for interventions that can be accomplished without the support of psychiatrist or psychotherapist. Many options address multiple anxiety disorders. Table 4 provides an overview of treatment options for each anxiety disorder.


**PHARMACOTHERAPY**

Pharmacotherapy for anxiety disorders is separated into two categories of medications each having a different purpose. The first consists of agents that aim to prevent future anxiety, whereas the second treat acute anxiety, but do not decrease future occurrences.

First-line pharmacologic treatment of anxiety disorders aims to prevent future symptoms. This is best accomplished with single-agent treatment with a selective serotonin reuptake inhibitor (SSRI) or serotonin noradrenergic reuptake inhibitor (SNRI).\textsuperscript{51–54} These medications have been shown to be effective in reducing anxiety symptoms in multiple placebo-controlled trials, but no single agent has proved consistently more effective than others.\textsuperscript{51–55} The choice of SSRIs and SNRIs over tricyclic antidepressants (TCAs) as first-line therapy is due largely to their lack of anticholinergic side effects and toxicity in overdose.\textsuperscript{51} Increased tolerability does not translate to increased efficacy, however, and some experienced PCPs may be more comfortable with use of TCAs because they have been in use for more than 40 years. The antidepressant mirtazapine is an effective agent either as single agent or combined with SSRIs for augmentation.\textsuperscript{55} Unfortunately, these medicines can require 4 to 8 weeks to show efficacy. Treatment of anxiety disorders typically requires higher doses and longer duration than indicated for unipolar depression.\textsuperscript{56} Brief medication trials can give the false perception of failure and treatment resistance. The ability to wait for response is therefore required on the part of provider and patient.
Table 4

<table>
<thead>
<tr>
<th></th>
<th>GAD</th>
<th>PD</th>
<th>OCD</th>
<th>SAD</th>
<th>PTSD</th>
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</thead>
<tbody>
<tr>
<td><strong>Medication-based treatment recommendations</strong></td>
<td>Daily SSRI/SNRI Anxiolytics may be needed as a bridge for severe symptoms until antidepressants provide relief</td>
<td>Daily SSRI/SNRI Use long-acting anxiolytics because short-acting agents are unlikely to actually abort panic attacks</td>
<td>Daily SSRI/SNRI Anxiolytics may be needed as a bridge for severe symptoms until antidepressants provide relief</td>
<td>Daily SSRI/SNRI Propranolol is useful for public speaking</td>
<td>Daily SSRI/SNRI Use prazosin for nightmares Anxiolytics may be needed as a bridge for severe symptoms until antidepressants provide relief Benzodiazepines are generally not recommended</td>
</tr>
<tr>
<td><strong>Psychotherapy recommendations</strong></td>
<td>Cognitive behavioral therapy</td>
<td>Cognitive behavioral therapy</td>
<td>Exposure and response prevention</td>
<td>Cognitive behavioral therapy</td>
<td>Prolonged exposure Cognitive processing therapy</td>
</tr>
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</table>
Anxiolytic medications compose the second set of pharmacologic agents for treatment of acute anxiety. These medicines abort current symptoms of anxiety and do little to prevent symptom recurrence. Anxiolytics can be divided into benzodiazepines and nonbenzodiazepines.

Benzodiazepines are frequently thought of as the classic anxiolytic. This class of medication provides a wide range of choices in terms of onset of action, half-life, and the presence of an active metabolite. There are no specific recommendations in terms of use of one benzodiazepine over another in the treatment of anxiety disorders. In general terms, benzodiazepines with shorter half-lives and more rapid onset of action are more likely to lead to rebound anxiety when effects of the medication wane, leading to a need to take more of the medication. If possible, longer-acting benzodiazepines (ie, clonazepam) should be used in conjunction with antidepressants, when the provider needs to decrease anxiety acutely, to allow for treatment engagement, and/or treat symptoms that are threatening patient safety. If possible, treatment should be limited in duration and stopped once antidepressants lower overall anxiety levels and patients are able to engage in other forms of treatment. Although benzodiazepines are effective, physiologic dependence develops in all users so misuse poses potential problems. Tapering benzodiazepines must be gradual and can be dangerous if completed too abruptly. The withdrawal syndrome that accompanies benzodiazepine cessation closely parallels that of alcohol withdrawal. The mildest form is rebound anxiety that can be seen with reducing or missing doses and is most common with short-acting benzodiazepines (ie, alprazolam). In rare cases, severe withdrawal symptoms can be seen, which can lead to seizure, coma, and death. Although exact rates of risk are unknown, severe withdrawal is rare and more likely in patients taking higher doses, for prolonged periods, and for whom the medication is discontinued abruptly. Co-occurring substance use disorder is common and in such situations treatment with benzodiazepines is contraindicated.

When anxiety needs to be controlled acutely, but benzodiazepines are not indicated, there are other alternatives. The anticholinergic agent hydroxyzine, β-blocker propranolol, and gabapentin are effective alternatives as anxiolytics without abuse potential.

PSYCHOTHERAPY

Several psychotherapy modalities are effective in the treatment of anxiety disorders. The modality that has the most robust data is cognitive behavioral therapy (CBT). CBT is designed to identify the maladaptive automatic thoughts and behaviors, and then restructure them through therapeutic exercises. CBT has been shown sufficiently effective for several anxiety disorders, with very limited side effects, so it is often considered first-line treatment. Disorder-specific and general protocols are created to address all major anxiety disorders. Major drawbacks to therapy include difficulty in engaging the patient (a significant barrier with anxiety disorders) and limited or variable availability of well-trained therapists. With the advent of manualized therapy and computer-based therapy, treatment can now be delivered without therapists. This provides an exciting resource for rural areas or for isolated primary care physicians with limited support. Social workers, nurses, and medical assistants can be trained to provide therapy and primary care physicians can guide the patient through the protocol in a few office visits.

COMBINATION TREATMENT

Although psychotherapy and pharmacotherapy have been shown to be individually effective, studies consistently demonstrate that combination treatment gives superior results compared with either treatment alone.
ADJUNCTIVE TREATMENTS
Although recognized as components of behavioral therapies, breathing exercises, muscle relaxation, and mindfulness-based meditation techniques are effective alone or in conjunction with other therapies. Exercise as adjunctive therapy produces mixed results. Randomized controlled trials of exercise as treatment of anxiety disorders compared with waitlist control do show a benefit for exercise therapy. Trials that compare exercise therapy with pharmacotherapy or CBT, however, show no benefit for exercise over these traditional treatments. Although it may seem, then, that exercise may be better than no intervention, yet not superior to pharmacotherapy or psychotherapy, one cannot yet draw that conclusion. There is significant variability between the discussed studies in terms of type of exercise intervention, population, and control groups, making it difficult to draw any firm conclusions when looking at the collection of studies as a whole.

COMPLEMENTARY AND ALTERNATIVE MEDICINE
A robust review of the use of complementary and alternative medicine (CAM) is outside the scope of this article, although CAM is commonly used in patients with anxiety disorders. The Coordinated Anxiety Learning and Management study reports 43% of patients relied on CAM when they believed that their symptoms were inadequately treated. CAM includes such remedies as St. John’s wort and kava, substances with potential negative side effects so their use should be identified by the practitioner. St. John’s wort frequently interacts with medications through the P-450 system. Additionally, providers often do not recognize that combining St. John’s wort with other serotonergic agents can precipitate serotonin syndrome. Kava is potentially hepatotoxic. PCPs should identify patients using alternative agents so they can monitor for side effects and drug-drug interactions.

USE OF RATING SCALES IN TREATMENT
Rating scales are very useful in terms of diagnosis and following treatment response, but providers should not mistake changes in rating scales as a replacement for the subjective experience of the patient. Treatment choices (ie, dose changes, medication initiation, or discontinuation) should be driven by patient choice and subjective experience of improvement or lack thereof.

SPECIFIC TREATMENTS AND RECOMMENDATIONS GAD
The generalized nature of symptoms in GAD requires the use of pharmacotherapy oriented toward prevention. SSRIs and SNRIs are considered the mainstay of therapy. Anxiolytics, although effective for a short time, have limited overall utility given that they need frequent repeat dosing as a result of accompanying rebound anxiety. Longer-acting benzodiazepines, such as clonazepam, offer some benefit, but still fail to inhibit future anxiety once the medication has worn off. Severe cases of GAD may require that serotonergic medications be pushed to maximum dosage and response to medication may not appear until 12 weeks or more have elapsed. Augmentation with agents, such as mirtazapine, buspirone, and even atypical antipsychotics, has been effective but this strategy is best done with psychiatric consultation.

Psychotherapy for GAD is very effective. CBT for GAD focuses on psychoeducation and identifying and restructuring common automatic thoughts, such as
catastrophizing. Several different manualized protocols have been developed and can be used in a primary care setting.\textsuperscript{59} For patients who are particularly emotionally sophisticated and motivated, some of these protocols can be completed with very limited practitioner support or even without supervision.\textsuperscript{64,65} Although many protocols exist, we recommend “Mastery of your anxiety and worry” as part of the “Treatments That Work” series, published by Oxford University Press, because this manual is practical, effective, and well validated. Although treatment manuals for providers are not free of charge, a single therapist’s guide can be reused for hundreds of patients. A sample case of combination treatment is presented in Table 5.

<table>
<thead>
<tr>
<th>Table 5</th>
<th>Generalized anxiety disorder case and treatments</th>
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<tr>
<td><strong>Case: Treatment Generalized Anxiety Disorder</strong></td>
<td></td>
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<tr>
<td>A 36-year-old woman comes in with a chief complaint of insomnia. She feels constantly on edge and finds it hard to fall asleep because of concern about her parents. She also experiences muscle stiffness and shoulder and back pain. On questioning, she describes unremitting worry that something terrible will happen to her elderly parents. The patient lives in a state distant from her parents. There is a family history of cardiovascular disease and she worries they will die of heart attacks. The patient calls her parents multiple times a day to check in with them and feels extremely anxious if she cannot reach them. She also worries about how her kids are doing in school even though they are getting good grades, and about her finances even though she is in good standing financially. She has been experiencing the worry for 5 y. She has missed multiple days of work because of her incapacitating worry.</td>
<td>• Start SSRI or SNRI medication</td>
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<td></td>
<td>○ Sertraline, 25 mg PO Q day × 7 d, then increase to 50 mg PO Q day</td>
</tr>
<tr>
<td></td>
<td>○ Therapy focused on psychoeducation and understanding safety behaviors (calling parents). Therapy also challenges automatic, catastrophic thoughts (ie, “my parents will die”)</td>
</tr>
<tr>
<td>Return visit in 6 wk:</td>
<td>Continued treatment:</td>
</tr>
<tr>
<td>Patient has mild symptom improvement, but still feels anxious</td>
<td>• Increase sertraline to 100 mg PO Q day because symptoms have improved somewhat, but further improvement may be seen with a higher dose</td>
</tr>
<tr>
<td></td>
<td>• May need future dose increase to 200 mg</td>
</tr>
<tr>
<td></td>
<td>• Continued CBT protocol</td>
</tr>
<tr>
<td>Return in 12 wk:</td>
<td>Continued treatment</td>
</tr>
<tr>
<td>Patient completed CBT; feels appreciably improved. Worry decreased, she makes fewer calls to her parents, and chronic pain has significantly subsided. Sleep is improved and she no longer misses work. Patient would like to continue her current medication regimen as it is.</td>
<td>• Maintain sertraline at 100 mg per day for now because the patient is pleased with her improvements and would like to continue her current treatment</td>
</tr>
<tr>
<td></td>
<td>• Return in 6 mo to assess progress</td>
</tr>
</tbody>
</table>
**PD**

Treatment of PD centers on the prevention of panic attacks and reducing anxiety about impending attacks. Treatment with SSRIs and SNRIs is effective in preventing attacks and reducing overall anxiety. These agents do nothing to treat an acute attack, however, and reducing symptoms typically takes 4 to 8 weeks or longer. Severe cases of PD may require high dosing of SSRIs and prolonged treatment, but improvement can be tracked by frequency of attacks.

 Providers may find that patients benefit from an agent to abort an impending attack at its onset. Benzodiazepines are the agent of choice; however, these medications must be prescribed with caution. If a patient has attacks that last less than 20 minutes, limited efficacy is seen from a short-acting benzodiazepine because the agent’s onset occurs after the attack has resolved. There is also evidence that use of benzodiazepines worsens the response or outcome of psychotherapy, an important treatment modality in PD. Some providers find that using longer-acting benzodiazepines, such as clonazepam, may reduce overall anxiety that can contribute to or trigger attacks, but use of these agents should be reserved for cases when patients are unable to function without them or cannot otherwise tolerate the use of serotonergic medications.

Psychotherapy for PD is at least as effective a treatment as pharmacotherapy and at times superior to medication. CBT for PD is the most studied and validated. Although more experienced therapists have been shown to provide better outcomes for their patients, novice therapists can also be effective. Online and manualized CBT protocols for PD are well-validated and can be used with limited supervision or, with certain versions, by the patient alone. “Mastery of your anxiety and panic” is another manualized favorite from the “Treatments That Work” series, published by Oxford University Press.

**SAD**

Medication for true SAD requires serotonergic agents. SSRIs and SNRIs are first-line choices. Positive results may not be evident for up to 8 weeks. There is limited use for anxiolytic agents except for specific anxiety-provoking events (ie, public speaking) that acutely worsen symptoms. In these cases, propranolol can be used at low doses and side effects are minimal. There have been no studies, however, that demonstrate efficacy for β-blockers for the treatment of overall symptoms of SAD. Benzodiazepines can be tried, but used with caution, as previously described.

CBT for social phobia centers on exposure to anxiety-provoking situations to demonstrate that resulting anxiety is tolerable and not dangerous. Over time, repeated exposure leads to an overall symptom reduction and patients are able to tolerate what they could not before. This modality can be combined with cognitive restructuring techniques that examine and challenge assumptions that patients make about themselves (ie, “I will embarrass myself”). A combination of exposure and cognitive restructuring may be the most effective psychotherapy available. Although effective, patients are frequently unable to engage in it on their own or with only limited provider guidance. Therapists require more extensive treatment experience than merely familiarizing themselves with a treatment manual; therefore, we recommend patient referral to a trained therapist.

**OCD**

Pharmacologic treatment of OCD also centers on the use of serotonergic agents. SSRIs and SNRIs are first choice and treatment of adults often requires prescribing...
maximum dosage. Time to efficacy can be as long as 12 weeks at this dose. Treatment-resistant cases of OCD may respond to higher-potency serotonergic medications, such as clomipramine, a TCA with significant serotonergic activity, or to the addition of augmentation agents, such as atypical antipsychotics. These strategies should be managed by a psychiatrist. Little benefit is seen from short-acting anxiolytic medication other than in extreme cases when they are needed to reduce anxiety sufficiently severe so as the patient is inhibited from travel to a provider’s office.

Exposure and response prevention therapy is the gold standard of treatment of patients with OCD. This therapy consists of exposing the patient to an anxiety-provoking stimulus (ie, germs from a dirty sink) and then preventing typical response behavior (ie, hand washing). Through experience of anxiety, the patient learns that it is tolerable and response behaviors are unnecessary. Taking a patient through this type of therapy requires a highly trained therapist and a committed patient. PCPs should refer patients with OCD, willing to engage in psychotherapy, to experienced therapists whenever possible.

**PTSD**

Pharmacotherapy for PTSD spans several different agents because there are often multiple symptom domains that require treatment. Overall mood and anxiety symptoms associated with PTSD are well-treated by SSRIs and SNRIs. These agents can also help reduce the acute hypervigilance and explosive anger outbursts that manifest with this disorder. Efficacy after starting medication is usually evident in 4 to 8 weeks. Patients may require acute anxiolytics for management of immediate symptoms while serotonergic agents take effect. Benzodiazepines can be used, but have no long-term effect on PTSD and might possibly be harmful by prolonging recovery time. Many patients with PTSD experience trauma-related nightmares. Treatment with prazosin is considered the first-line agent of choice, but providers should counsel patients about the risk of dizziness and orthostatic hypotension with use. Treatment-resistant or complex cases of PTSD (those with severe symptoms, extreme mood variability, and psychosis) can be treated with the addition of antipsychotic agents and/or mood stabilizers, and should also be referred to a psychiatrist.

The standard of care for PTSD uses psychotherapy and medication management. Multiple therapies have been developed. Two forms of therapy shown to have the best efficacy are prolonged exposure and cognitive processing therapy. Prolonged exposure focuses on exposing the patient (in a real or imaginative way) to the trauma they experienced and progressively habituating the patient to the resultant anxiety. Cognitive processing therapy seeks to restructure assumptions and thoughts raised by exposure to trauma. Both therapeutic modalities require trained, experienced therapists for successful treatment.

**DISCUSSION AND CONCLUSION**

Anxiety disorders are prevalent and debilitating. They are often underdiagnosed and undertreated in the primary care setting. Because of their propensity to cause generalized and poorly differentiated symptoms, detection can prove difficult. Multiple, effective screening tools exist to aid the PCP in this challenge. Once identified, however, treatments are predictably effective. Protocols for managing GAD, PD, SAD, OCD, and PTSD have much in common. Even if delineation of the specific disorder is unclear, the PCP will rarely go wrong by providing a prescription for a serotonergic antidepressant and referral for psychotherapy. Psychotherapy is important for
adequate treatment and many online and manualized treatments have greatly increased patients' access to care.

Although this article serves as an overview, individual cases can vary in presentation and course. Of all challenging cases, those determined to be treatment-resistant cases can be the most problematic.

In conclusion, PCPs can effectively diagnose and manage patients with a variety of anxiety disorders. Many patients would benefit from psychotherapy and/or pharmacotherapy. More complex or severe anxiety disorders are best managed with consultation and collaboration with colleagues in psychiatry and psychology.

REFERENCES


