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Review Article

Roles of Family Physicians in Management of Anxiety Disorder Management in Primary Care

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Abstract

The aim of this review is to identify the available management methods to boost General practitioners' medical diagnosis as well as treatment of individuals with anxiety disorders, who either have or do not have a comorbid depressive problem. Comprehensive search was performed using electronic databases as; PubMed, and Embase, to find studies concerning with anxiety disorder management in primary care. published in English language, up to, 2019 November. Psychological illness, anxiety disorders specifically, prevail in primary care. Nonetheless, even though they are as usual as depression, they often receive much less focus as well as they stay unacknowledged and also untreated. The high percentages of co-morbidity with psychiatric conditions and also physical diseases cause differing as well as misinforming presentations. The patients do not usually connect their problems with health to psychological problems. They even resist these medical diagnoses and reveal aversion to accept treatment. In day-to-day method, these aspects paired with minimal time for meetings with clients conspire against GPs' precise diagnosis of anxiety problems.

Keywords: *Family Physicians; Anxiety Disorder; Primary Care*

Introduction

Anxiety disorders comprise the most popular category of psychiatric conditions [1]. Anxiety conditions have a negative effect on lifestyle and also are associated with considerable healthcare- and efficiency prices [2]. Adults with an anxiety disorder primarily receive treatment in primary care. In lots of regions nonetheless, the quality of care for adults with anxiety disorders leaves space for renovation [1]. Although medical standards suggest cognitive behavioral therapy (CBT) or antidepressant medicine as the management of choice in health care, these evidence-based treatments are rarely effectively applied in primary care [3].

The World Health Organisation study on mental troubles as a whole health care showed a 10.1% occurrence rate for anxiety conditions [1]. Anxiety disorders are typical disorders with a 12-month prevalence transforming in between 2.4 and 18.2% among the regular population [2]. For the subgroups of anxiety disorders, the occurrence is 0.6 - 5.2% for social phobia (SP), 0.5 - 3.8% for generalized anxiety disorder (GAD), as well as 0.3 - 4.0% for obsessive compulsive disorder (OCD) [3,4].

Consequently, GPs frequently see these problems in their patients. The most usual kinds are panic disorder, with or without agoraphobia, and also generalised anxiety disorder [2]. General practitioners typically treat anxiety problems with antidepressants or benzodiazepines. These drugs are effective yet have a number of drawbacks, including the risk of dependency, side-effects and inadequate patient compliance. Additionally, anxiety signs commonly recur when the drugs are ceased [5]. These disadvantages are unnecessary in treatment programs based upon cognitive and behavioral principles. However, such programmes are usually not ideal for primary care because they are time-consuming and also need comprehensive training of the specialist. Most research into the efficacy of cognitive behavioural therapy (CBT) has happened in secondary treatment settings [5].

Given the high degree of comorbidity and prevalence of depressive and anxiety disorders, however, it appears sensible to research the treatments to improve the quality of care for such condition.

Aim of the Study

The aim of this review is to identify the available management methods to boost General practitioners' medical diagnosis as well as treatment of individuals with anxiety disorders, who either have or do not have a comorbid depressive problem.

Methodology

Comprehensive search was performed using electronic databases as; PubMed, and Embase, to find studies concerning with anxiety disorder management in primary care. published in English language, up to, 2019 November. several keywords were used in our search strategy such as: "anxiety", "depression" "Management," "Therapy" "Treatment", "primary care", "Family medicine". Moreover, references found in retracted studies were searched for more evidence available.

Discussion

Diagnostic challenges

Family doctors typically miss out on the accurate medical diagnosis of anxiety disorders In a research study of 840 primary care clients, rates of misdiagnosis were 85.8% for panic disorder (PD), 71% for generalized anxiety disorder (GAD) and also 97.8% for social anxiety disorder (SAD) [6]. The primary step in making an exact medical diagnosis is to comprehend the condition. Table 1 consists of a quick description of the crucial features of the major anxiety disorders. Sadly, client summaries of their signs can misguide also one of the sharpest medical professionals. Clients may report physical or emotional distress, including somatic grievances, discomfort, sleep disruption, and depression, yet are unaware that they are in fact experiencing anxiety [7]. Wittchen and associates noted that just 13.3% of people with GAD offered with anxiousness symptoms as a primary issue, whereas somatic worries were defined 47.8% of the time [8]. Screening for key signs and symptoms associated with the disorder can aid identify the diagnosis. People with anxiety conditions also have high numbers of existing together added mental diseases, even more making complex the diagnostic procedure.

Panic disorder (PD)
Specifier: With or without agoraphobia
Panic disorder with agoraphobia (AG, PDA)
Social phobia (SP)
Specifier: Generalized
Specific phobias (SPP)
Specifier: Animal, environmental, blood-injection injury, situational type
Post-traumatic stress disorder (PTSD)
Specifier: Acute versus chronic, with delayed onset
Acute stress disorder
Obsessive-compulsive disorder (OCD)
Specifier: With poor insight
Anxiety disorders due to:
Specifier: With generalized anxiety, with panic attacks, with obsessive-compulsive symptoms

Table 1: *Anxiety disorders [7].*

Diagnosis

Initial diagnosis

The majority of (70% - 90%) individuals with anxiety or depression existing to their primary care company with a somatic complaint [9]. Some may report one certain, physiological symptom (e.g. diarrhea or insomnia), whereas others may complain of a selection of

seemingly unrelated symptoms [10]. Migraines, intestinal disorders, muscle discomfort, breast pain or rigidity, and also palpitations are common physical symptoms experienced by patients with anxiety. Signs and symptoms not able to be medically explained after a preliminary workup must increase the clinician's uncertainty of an anxiety or depressive disorder [9]. Roughly 40% to 50% of individuals with clinically unexplained signs and symptoms have an anxiety disorder, no matter the specific sign(s) [11]. Although the nature of the physical problems does not, the variety of somatic signs and symptoms does seem to correlate with a higher chance of an underlying psychiatric disorder [11].

While the diagnosis of a psychological health problem is being taken into consideration, the provider needs to thoroughly take into consideration feasible clinical reasons for the person's grievances. In this context, it is critical that the provider continue to be empathic and encouraging toward the patient. All patients (and most particularly anxious people) desire to be heard and also have their issues taken seriously. In so doing, the provider gets a trusting and positive doctor-patient partnership that will at some point become the basis for accepting the diagnosis (whether a psychological or physical wellness problem, or both) and recommended managing strategy. Premature reassurance can be disadvantageous with anxious individuals that might really feel misinterpreted as well as disrespected if not approached in a thoughtful as well as methodical way. An extensive workup may be needed in some individuals prior to the diagnosis of anxiety will be accepted. Clinical reasons for anxiety that are most commonly mentioned tend to be endocrine or neurologic in etiology [9]. Standard lab effort might be warranted, such as a metabolic panel, thyroid feature examinations, or cortisol degrees, to dismiss electrolyte abnormalities, hyperthyroidism, or Cushing disorder, specifically. Cautious inquiry right into the individual's clinical as well as social background ought to consist of questions concerning use medications, immoral compounds, vitamins, or natural herbs. High levels of caffeine as well as alcohol intake, in addition to nicotine usage, ought to be evaluated [10].

Symptoms of specific anxiety disorders

Diagnosis of details anxiety disorders entails identification of a specific emphasis for the anxiety. For example, if an individual has panic attacks and also catastrophises about these as showing an imminent heart attack/suffocation, a medical diagnosis of panic attack may be required. Nonetheless, if anxiety or the panic attacks happen only on direct exposure to social scenarios, then social phobia may be the diagnosis (Figure 1). Full diagnostic criteria are offered in the Diagnostic and Statistical Manual of Mental Disorders (fourth edition, text revision) (DSMIV-TR) [12]. Certainly, in the basic practice setup, numerous people do not fit neatly right into this framework and have symptoms of numerous problems without meeting the standards for a particular condition.

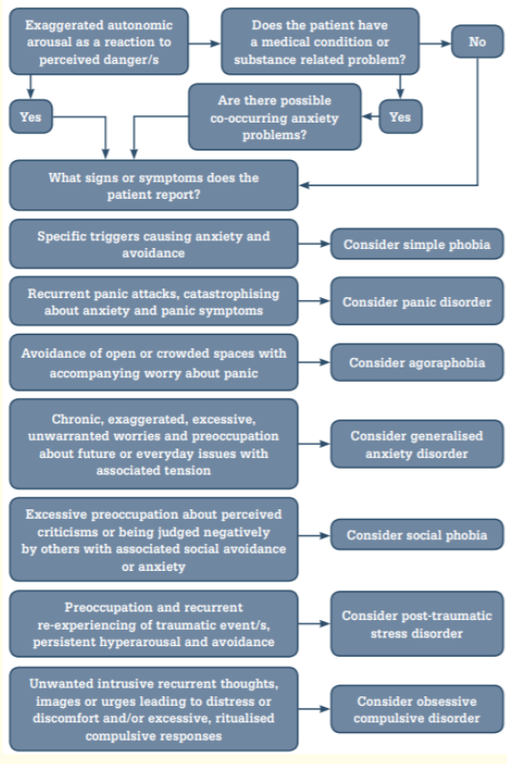

Figure 1: *Differential diagnosis of anxiety disorders [12].*

Screening tools

Effective screening tools are offered to find anxiety conditions (Table 2). Finding time to use these accessories can be challenging in an active primary care practice. Testing tools created to deal with the complete spectrum of co-occurring affective and anxiety problems are especially valuable. The Hospital Anxiety and Depression Scale compares clinical depression and anxiousness if both are present [12]. Other broad-based tools, such as the PRIME-MD-PHQ, can identify anxiety and mood conditions.

Diagnosis	Screening Tools	Screening Question
GAD	GAD-7 GAD-2	Do you consider yourself a worrier?
SAD	SPIN Mini-SPIN	When you are in a situation where people can observe you, do you feel nervous and worry that they will judge you?
PD	PHQ panic disorder scale	Do you have waves of nervousness that come out of the blue and you notice things in your body like your heart goes fast or it is hard to breathe?
PTSD	PC-PTSD PCL-C M-3	Have you experienced a trauma that still haunts you?
OCD	MINI Y-BOC PRIME-MD	Do you have thoughts that occur over and over that really bother you? Are there things you have to do over and over, such as washing your hands, checking, or counting?

Table 2: *Screening tools [13-16].*

The Generalized Anxiety Disorder- 7 (GAD-7) is one of the most popular and also has actually been validated for GAD, in addition to for panic attack as well as posttraumatic stress disorder (PTSD) [13]. Just recently, a shortened variation, the GAD-2, has been revealed to be 86% sensitive and 83% specific for detecting GAD when a rating of 3 or more is tallied [14].

Numerous PTSD testing tests have actually been used in both army and also civilian medical care setups. One of the quickest of these testing tests is the 4-item Primary Care PTSD Screen. Four yes/no concerns are keyed to feasible PTSD signs happening within the past month: nightmares/intrusive ideas, thought/situational evasion, hypervigilance/easily startle, and also numb/detached sensation [15]. Freedy as well as associates used a civilian primary care sample to figure out a sensitivity of 85.1% and a specificity of 82.0% based on a cutoff rating of 3, using the Clinician-Administered PTSD Scale as the gold basic comparison [16]. Comparable level of sensitivity and specificity numbers have been discovered for military examples [15]. Although screening for anxiety disorders is not regularly advised for every individual, it may still be beneficial, especially if there are systems in place to look after the people who screen positive. Primary care suppliers who have a great working relationship with psychological health and wellness professionals in the community can help these patients navigate their way with the clinical system to an extra detailed treatment program for their mental wellness.

Medication

First-line therapies: A number of medications are readily available for dealing with anxiety (Table 3). Selective serotonin reuptake inhibitors (SSRIs) are generally considered first-line therapy for GAD as well as PD [17,18]. Tricyclic antidepressants (TCAs) are better examined for PD, however are believed to be effective for both GAD and PD [17,18]. In the therapy of PD, TCAs are as efficient as SSRIs, but unfavorable effects may limit making use of TCAs in some individuals. Venlafaxine, prolonged launch, works as well as well tolerated for GAD and also PD, while duloxetine (Cymbalta) has been effectively reviewed just for GAD. Azapirones, such as buspirone (Buspar), are far better than placebo for GAD but do not seem reliable for PD [20]. Mixed evidence suggests bupropion (Wellbutrin) might have anxiogenic effects for some patients, hence calling for close monitoring if made use of for treatment of comorbid depression, seasonal affective disorder, or smoking cigarettes cessation [19]. Bupropion is not authorized for the treatment of GAD or PD.

Disease type	Active substance class	Drug	Daily dose
Social phobia	SSRI	Escitalopram	10 - 20 mg
		Paroxetine	20 - 50 mg
		Sertraline	50 - 150 mg
	SNRI	Venlafaxine	75 - 225 mg
	MAO inhibitors	Moclobemide	300 - 600 mg
Panic disorder	SSRI	Citalopram	20 - 40 mg
		Escitalopram	10 - 20 mg
		Paroxetine	20 - 50 mg
		Sertraline	50 - 150 mg
	SNRI	Venlafaxine	75 - 225 mg
	TCA	Clomipramine	75 - 250 mg
Generalized anxiety disorder	SSRI	Escitalopram	10 - 20 mg
		Paroxetine	20 - 50 mg
	SNRI	Venlafaxine	75 - 225 mg
		Duloxetine	60 - 120 mg
	Anticonvulsants	Pregabalin	150 - 600 mg
	Anxiolytic drugs (tricyclic)	Opipramol	50 - 300 mg
	Azapirones	Buspirone	15 - 60 mg

Table 3: *The pharmacotherapy of anxiety disorders. according to the German guidelines [20].*

Drugs ought to be titrated slowly to decrease the initial activation. Due to the common hold-up in start of activity, drugs need to not be considered inefficient up until they are titrated to the high end of the dose array as well as proceeded for at the very least four weeks. As soon as symptoms have improved, medicines ought to be utilized for year before tapering to limit relapse [26]. Some clients will certainly call for longer treatment.

Benzodiazepines are effective in minimizing anxiety, but there is a dose-response partnership connected with tolerance, sedation, confusion, and enhanced mortality [21]. When used in mix with antidepressants, benzodiazepines might speed recovery from anxiety-related signs but do not boost longer-term end results. The higher threat of dependancy and also unfavorable results makes complex making use of benzodiazepines [22]. NICE standards recommend only short-term use during situations [26]. Benzodiazepines with an intermediary to long onset of action (such as clonazepam [Klonopin]) might have much less possible for abuse and also less threat of rebound [23].

Second-line therapies: Second-line therapies for GAD include pregabalin (Lyrica) and quetiapine (Seroquel), although neither has actually been reviewed for PD. Pregabalin is extra reliable than placebo yet not as reliable as lorazepam (Ativan) for GAD. Weight gain is a typical adverse effect of pregabalin. There is limited evidence for the use of antipsychotics to treat anxiety disorders. Although quetiapine appears to be efficient for GAD, the damaging result account is considerable, including weight increase, diabetes mellitus, and hyperlipidemia [24]. Hydroxyzine is taken into consideration a second-line treatment for GAD, yet there are marginal data for its usage in PD [25]. Its fast beginning can be striking for patients needing instant relief, and also it may be a better alternative if benzodiazepines are contraindicated (e.g. in people with a background of substance abuse). Based upon medical experience, gabapentin (Neurontin) is occasionally suggested by psychiatrists to treat anxiety on an as-needed basis when benzodiazepines are contraindicated. Of note, the placebo reaction for medications utilized to deal with GAD and PD is high.

Cognitive-bahavior therapy alone

It is generally acknowledged that the treatment of anxiety problems is suboptimal due to an absence of CBT specialists or the availability of cost-effective visits. There is a terrific requirement to distill the essence of great treatment and to bring it into the health care setup, with a focus on education as well as staff training. Oxford University Press has published many superb manuals that consist of both specialist as well as patient guides [27]. The expansion of the Internet-based, self-administered treatments calls for further study into the effectiveness of this method of dissemination [28]. Complex anxiety disorders may not have the ability to be self-treated sufficiently, whereas a details fear might be self-treated alone or with the assistance of a friend of relative.

Koszycki., *et al.* gone over whether self-administered CBT could stand alone or could be maximized with therapist-directed CBT, self-administered CBT, or drug increased with self-administered CBT [29]. Their work suggested that even self-administered therapy might be an efficient addition to the CBT armamentarium.

Although lots of therapies are effective for anxiety, not all of them can help everybody and not every one of them are effective for all anxiety conditions. An easy phobia is simpler to deal with than a difficult instance of PTSD. One of the most empirically supported therapies are SSRIs and CBT. Relapse rates for CBT, compared to medicine, are an understudied area, although our professional experience recommends that CBT has a longer treatment impact if the person remains to utilize the skills as well as tools found out in therapy.

Conclusion

Psychological illness, anxiety disorders specifically, prevail in primary care. Nonetheless, even though they are as usual as depression, they often receive much less focus as well as they stay unacknowledged and also untreated. The high percentages of co-morbidity with psychiatric conditions and also physical diseases cause differing as well as misinforming presentations. The patients do not usually connect their problems with health to psychological problems. They even resist these medical diagnoses and reveal aversion to accept treatment. In day-to-day method, these aspects paired with minimal time for meetings with clients conspire against GPs' precise diagnosis of anxiety problems.

GP can successfully identify as well as handle individuals with a range of anxiety problems. Lots of clients would certainly take advantage of psychotherapy and/or psychopharmacology. Complicated or extreme anxiety disorders are best taken care of with examination and collaboration with specialist in psychiatry as well as psychologist.

Bibliography

1. Ormel J., *et al*. "Common mental disorders and disability across cultures. Results from the WHO Collaborative Study on Psychological Problems in General Health Care". *The Journal of the American Medical Association* 272 (1994): 1741-1748.
2. The WHO World Mental Health Survey Consortium. "Prevalence, severity, and unmet need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys". *The Journal of the American Medical Association* 291.21 (2004): 2581-2590.
3. Fehm L., *et al*. "Size and burden of social phobia in Europe". *European Neuropsychopharmacology* 15.4 (2005): 425-434.
4. Wittchen H-U and Hoyer J. "Generalized Anxiety Disorder: Nature and Course". *The Journal of Clinical Psychiatry* 62.11 (2001): 15-18.
5. Rickels K and Rynn M. "Pharmacotherapy of generalized anxiety disorder". *The Journal of Clinical Psychiatry* 63.14 (2002): 9-16.
6. Vermani M., *et al*. "Rates of detection of mood and anxiety disorders in primary care: a descriptive, cross-sectional study". *The Primary Care Companion for CNS Disorders* 13.2 (2011).
7. American Psychiatric Association. "DSM-5 Task Force. Diagnostic and statistical manual of mental disorders: DSM-5". Arlington (VA): American Psychiatric Association (2013).

8. Wittchen H-U., *et al*. "Generalized anxiety and depression in primary care: prevalence, recognition, and management". *The Journal of Clinical Psychiatry* 63.8 (2002): 24-34.

9. Simon GE., *et al*. "An international study of the relation between somatic symptoms and depression". *The New England Journal of Medicine* 341 (1999): 1329-1335.

10. Gliatto MF. "Generalized anxiety disorder". *American Family Physician* 62.7 (2000): 1591-1600.

11. Kroenke K., *et al*. "Physical symptoms in primary care: predictors of psychiatric disorders and functional impairment". *Archives of Family Medicine* 3 (1994): 774-779.

12. American Psychiatric Association. "Diagnostic and statistical manual of mental disorders". 4th edition. Washington, DC. American Psychiatric Association (2000).

13. Narayana S and Wong CJ. "Office-based screening of common psychiatric conditions". *Medical Clinics of North America* 98 (2014): 959-980.

14. Kroenke K., *et al*. "Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection". *Annals of Internal Medicine* 146 (2007): 317-325.

15. Prins A., *et al*. "The primary care PTSD screen (PCPTSD): development and operating characteristics". *Primary Care Psychiatry* 9 (2003): 9-14.

16. Freedy JR., *et al*. "Post-traumatic stress disorder screening test performance in civilian primary care". *Family Practice* 27 (2010): 615-624.

17. Otto MW., *et al*. "An effect-size analysis of the relative efficacy and tolerability of serotonin selective reuptake inhibitors for panic disorder". *The American Journal of Psychiatry* 158.12 (2001): 1989-1992.

18. Kapczinski F., *et al*. "Antidepressants for generalized anxiety disorder". *Cochrane Database Systematic Review* 2 (2003): CD003592.

19. Wiseman CN and Gören JL. "Does bupropion exacerbate anxiety?". *Current Psychiatry Reports* 11.6 (2012): E3-E4.

20. Bandelow B., *et al*. "Deutsche S3-Leitlinie Behandlung von Angststörungen".

21. Weich S., *et al*. "Effect of anxiolytic and hypnotic drug prescriptions on mortality hazards: retrospective cohort study". *British Medical Journal* 348 (2014): g1996.

22. Furukawa TA., *et al*. "Antidepressant plus benzodiazepine for major depression". *Cochrane Database Systematic Review* 2 (2001): CD001026.

23. Hoge EA., *et al*. "Generalized anxiety disorder: diagnosis and treatment". *British Medical Journal* 345 (2012): e7500.

24. Depping AM., *et al*. "Second-generation antipsychotics for anxiety disorders". *Cochrane Database Systematic Review* 12 (2010): CD008120.

25. Guaiana G., *et al*. "Hydroxyzine for generalised anxiety disorder". *Cochrane Database Systematic Review* 12 (2010): CD006815.

26. National Institute for Health and Care Excellence. "Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care" (2011).

27. Barlow DH., *et al*. "Unified Protocol for Transdiagnostic Treatment of Emotional Disorders". New York: Oxford University Press (2011).

28. Botella C., *et al*. "An Internet-based self-help treatment for fear of public speaking: A controlled trial". *CCyberpsychology, Behavior, and Social Networking* 13.4 (2010): 407-421.

29. Koszycki D., *et al*. "A randomized trial of sertraline self-administered cognitive behavior therapy, and their combination for panic disorder". *Psychological Medicine* 41.2 (2011): 373-383.

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