A pragmatically philosophical approach for managing anxiety disorders on an outpatient basis for the non-specialist

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Disclosures

- All of my income comes from the University of Utah.

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January 25, 2019

Patterns in Outpatient Benzodiazepine Prescribing in the United States

Sumit D. Agarwal, MD[1,2]; Bruce E. Landon, MD, MBA, MSc[3,4]

Jama Network.

- **Findings** In this serial cross-sectional study of 386 457 ambulatory care visits from 2003 through 2015, the use of benzodiazepines in ambulatory care increased substantially from 3.8% to 7.4% of visits, including coprescribing with other sedating medications. Use among psychiatrists was stable (29.6% vs 30.2%) but increased among all other types of physicians, including primary care physicians (3.6% vs 7.5%), who as a group accounted for about half of all benzodiazepine visits.

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1. Anxiety is a NORMAL feature of life..

- All normally functioning humans are anxious about what others think of them, whether or not they are good people, their fit into their work, family, community structure and the meaning and fate of their lives.
- People who are not anxious about these kinds of things probably have a kind of Psychopathy and have a profound inability to connect with others and can be very dangerous.
- Normal anxieties flare in times of disappointment, change, disconnection, or uncertainty.

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2. We live in times of uncertainty, change, and disconnection

- Until very recently, most humans on earth had a system of belief that integrated their current life situation and status into the tapestry of the universe with spiritual connections to nature, the dead, their communities. Even objectively miserable lives contributed to this wholeness.
- Most people had the sense of belonging to a "team" that was uniquely special and being a valued member of that team in some way.
- Secularization and Globalization, though certainly with upsides, are changes that have led to uncertainty and disconnection and therefore anxiety.

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3. Anxiety is NOT the same as an ANXIETY DISORDER

- Everyone has anxiety, but not everyone has an anxiety disorder.
- Anxiety disorders are a collection of:
    - Brain changes related to genetic and developmental factors.
    - Cognitions (Thoughts and Attitudes)
    - Behaviors (related to avoidance)
- That have become entrenched and currently mal-adaptive ways of dealing with one's current circumstances.
- That cause consistent disability or distress over a prolonged period of time in regardless of external circumstances.
- It is possible that at some point in the past these ways of being were adaptive and helped a patient survive.

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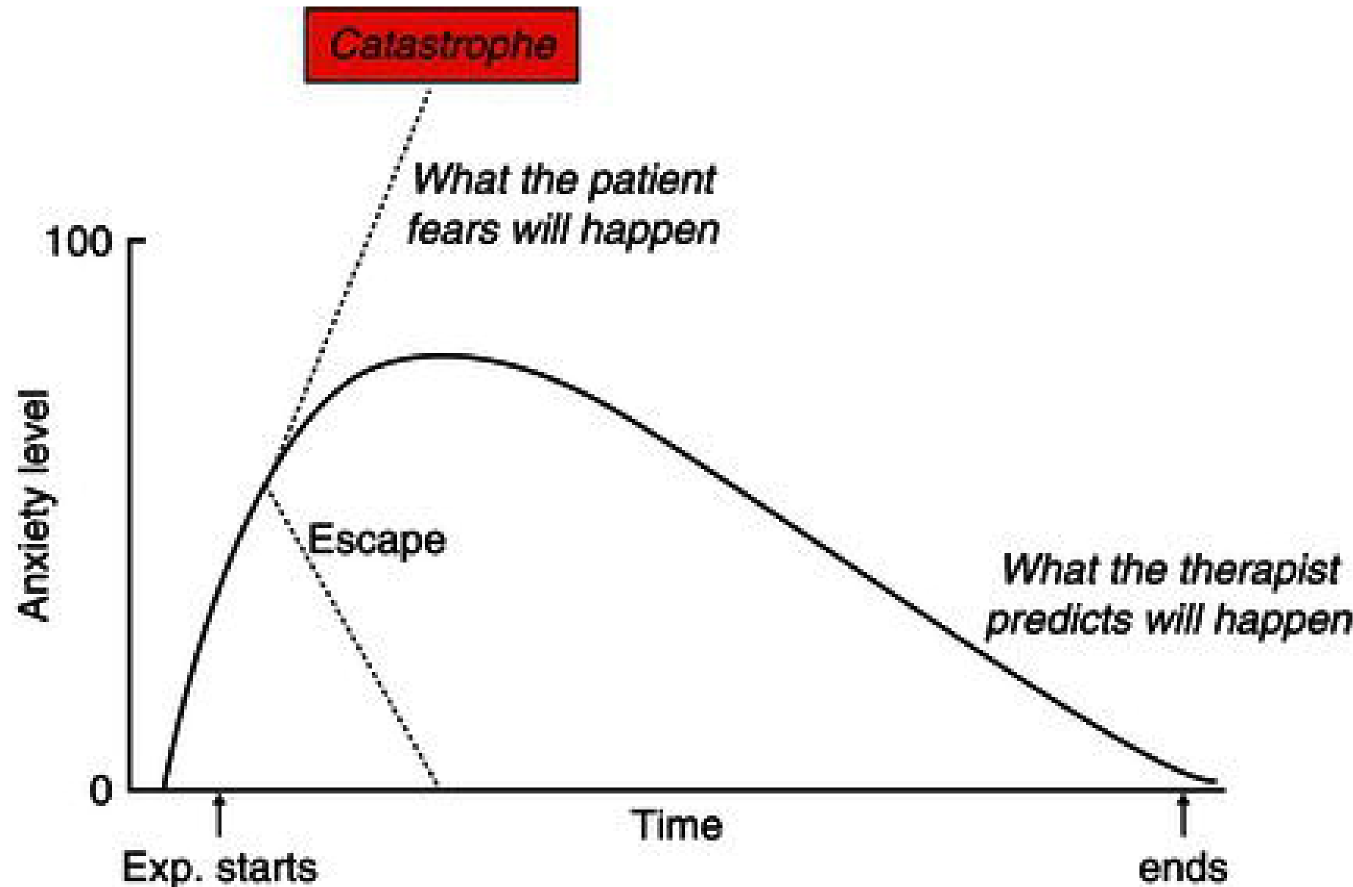
An example of an ANXIETY disorder vs anxiety

- Everyone can have a panic attack. Think of the last time your toilet overflowed, your car broke down on the highway, you didn't know 10 answers in a row on a major test, etc.
- Some people have panic DISORDER which is a kind of Anxiety Disorder in which:
  - The person is genetically or environmentally more susceptible to panic attacks, likely because of brain structures that control release of hormones into the sympathetic nervous system.
  - The person has certain cognitions about what is happening when she is having a panic attack or what will happen if she keeps having panic attacks: "I am going to die" "People will all notice and laugh at me."
  - The person has certain behaviors that perpetuate the disorder and increase the disability. She no longer leaves her home. She stops doing important things. She AVOIDS situations in which she may have panic attacks.
  - These cognitions and behaviors re-inforce the neuroanatomical circuits, creating a rut that gets deeper and deeper.

4. The anxiety curve is a great way to educate patients about anxiety disorders and a great theoretical guide for treatment choices.



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Tips about how to BE with patients who come with anxiety.

- Different language for the same concept: Help patients to HEAL, Don't FIX! (IF they were honest, even surgeons would have to admit that they do not fix people, they approximate tissue so that the body can HEAL).
- Start with open uncommitted listening. Promise to help a patient think through strategies only after you understand the problem.
- Manage the CounterTransference ANXIETY you will inevitably feel as patient is desperate for help. You may feel like you are saving a drowning person and about to drown yourself.
- Don't just do something, sit there (for a minute)
- Listen, empathize, and give feelings a name. Appropriate names feel things better because they take away their dark energy.
- Express your willingness to work WITH them on this problem (rather than take it from them).

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Healing vs. Fixing

- Healing
- Patient sees you as expert that can help her with her problem.
- She is open to getting help that is not immediate or effortless on her part
- You see yourself as someone who can offer a professional relationship that can help patient with her problem over time
- You are willing to listen and sit with your own anxiety without needing to jump in right away with solutions
- You are okay with not knowing everything and with getting consultation and support as necessary.
- You understand that outcomes have a lot to do with patient's choices. And part of your job is to skillfully recommend good choices.
- Healing is a process
- You find your work meaningful.

- Fixing
- Patient see you as a person who can fix their problem in a relatively straightforward and pain-free way
- Patient has strong preconceived notions about what that fix will look like.
- You feel "responsible" to fix the patient
- You don't have confidence in your training, judgment, ability to sit with the patient or you don't have time to do so.
- Patients reaction to you oscillate between praise/ idealization and devaluation depending on if you give them what they want and if they "feel better."
- Your sense of yourself and your value as a clinician depends on how the patient does
- You burn out.

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If a patient with anxiety insists that you fix him…

- If a patient resists your efforts to be in relationship with him and insists that you FIX him consider the following possibilities
  A. The patient is in a state of extreme anxious distress and is at high risk of suicide. He may need you to take responsibility for his safety which includes you seriously considering hospitalization
  B. The patient is not interested in working with you as a human being who has training, but is only interested in using you to get what he thinks he needs which usually means a specific mediation. When this person doesn't get what he wants from you, he will try to exploit your vulnerability to being experienced as a nice helpful person.
- As a healthcare provider, you have the right to NOT be available for for manipulative relationships.

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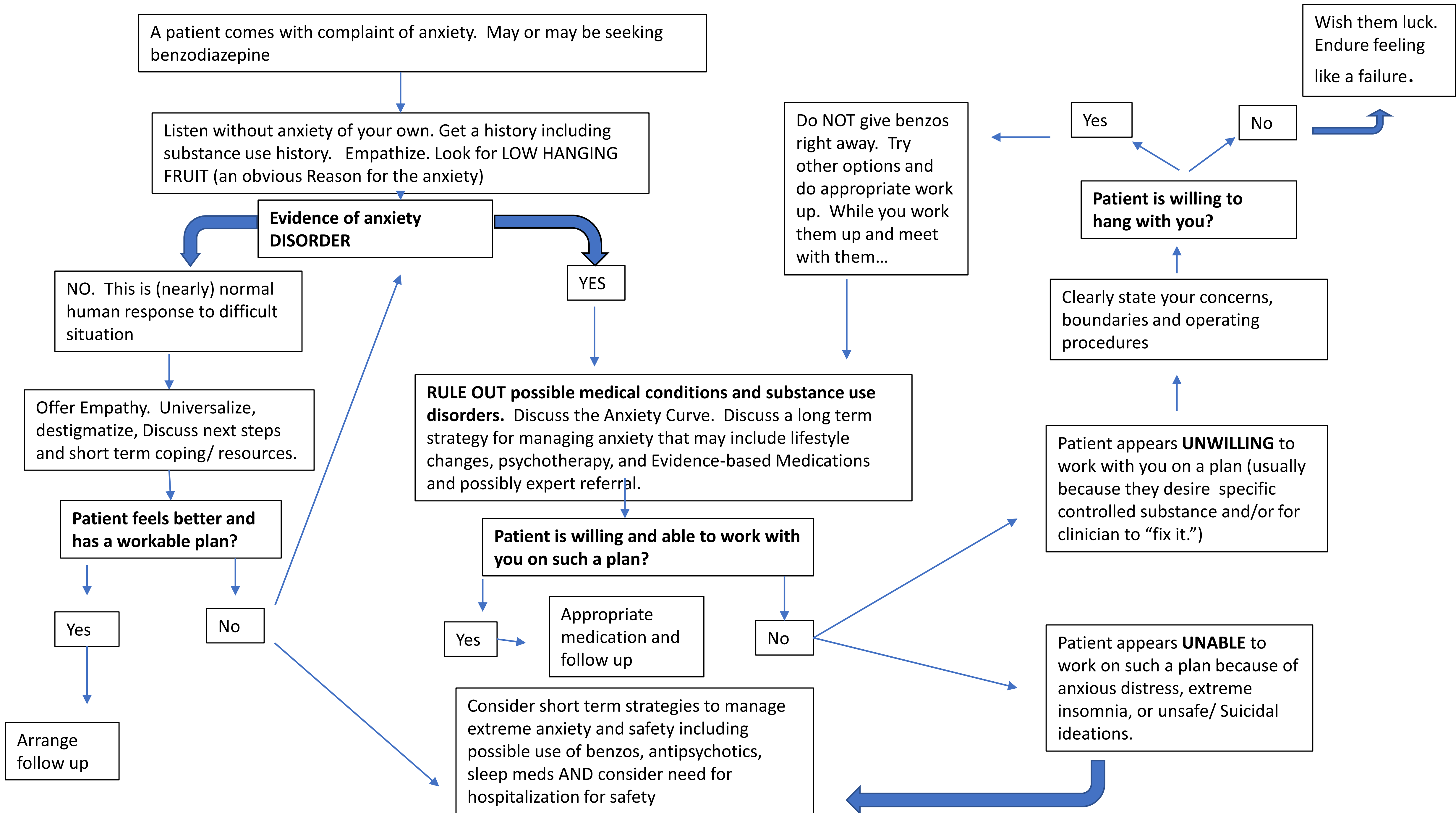
A patient comes with complaint of anxiety. May or may be seeking benzodiazepine
Listen without anxiety of your own. Get a history including substance use history. Empathize. Look for LOW HANGING FRUIT (an obvious Reason for the anxiety)
Evidence of anxiety DISORDER
NO. This is (nearly) normal human response to difficult situation
Offer Empathy. Universalize, destigmatize, Discuss next steps and short term coping/ resources.
Patient feels better and has a workable plan?
Yes
No
Arrange follow up
YES
RULE OUT possible medical conditions and substance use disorders. Discuss the Anxiety Curve. Discuss a long term strategy for managing anxiety that may include lifestyle changes, psychotherapy, and Evidence-based Medications and possibly expert referral.
Patient is willing and able to work with you on such a plan?
Yes
Appropriate medication and follow up
No
Consider short term strategies to manage extreme anxiety and safety including possible use of benzos, antipsychotics, sleep meds AND consider need for hospitalization for safety
Patient appears UNWILLING to work with you on a plan (usually because they desire specific controlled substance and/or for clinician to “fix it.”)
Patient appears UNABLE to work on such a plan because of anxious distress, extreme insomnia, or unsafe/ Suicidal ideations.
Clearly state your concerns, boundaries and operating procedures
Patient is willing to hang with you?
Yes
No
Do NOT give benzos right away. Try other options and do appropriate work up. While you work them up and meet with them…
Wish them luck. Endure feeling like a failure.

Is there some low hanging fruit?

- Does the person have a medical issue or a substance abuse issue that needs attention?

- Does the person have a relationship problem, a job problem, a financial problem, or another problem and needs you to say "that sounds really stressful, of course you would be anxious with this going on in your life. What are your next steps in dealing with this?"…Don't underestimate the power of Empathy in helping people feel better.

Is the patient **safe** and **functional**?

Does he/she need hospitalization, further evaluation, increased monitoring at home, and/or meds to bring down anxiety to the point he/she can function?

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What is standard evidence-based treatment for anxiety disorders?

- **Consider PSYCHOTHERAPY FIRST** (or most people wont consider it at all).
- There are many possible therapies for anxiety disorder. Most of the evidence-based therapies for anxiety disorders target **AVOIDANCE**. They help people face their fears and sit in their discomfort.

    - Examples: Exposure and Response Prevention for OCD and specific phobias. Prolonged Exposure Therapy for PTSD.

- <u>Talk therapies should be at least be offered first line for mild and moderate cases anxiety disorders</u> (before meds).

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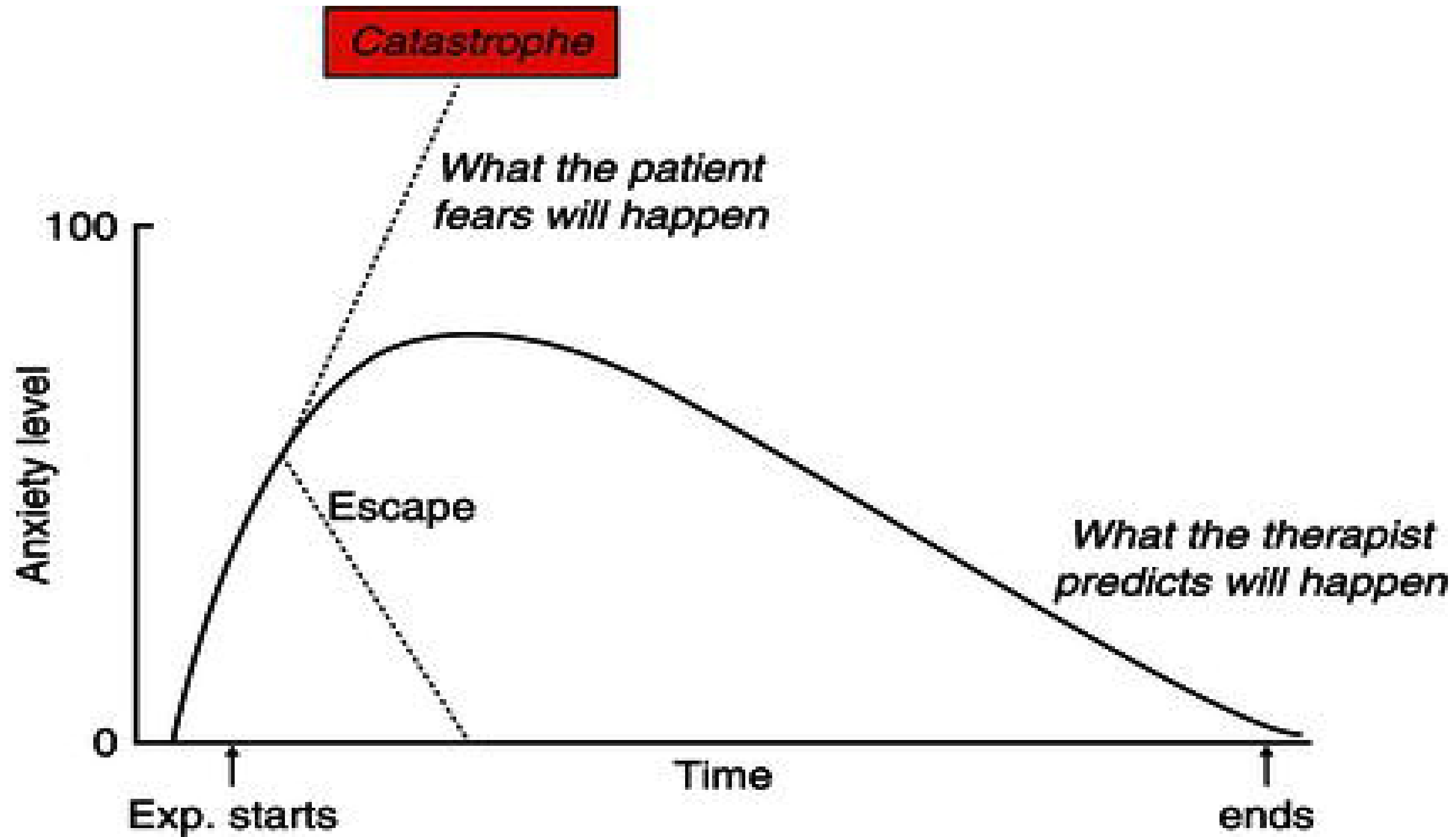
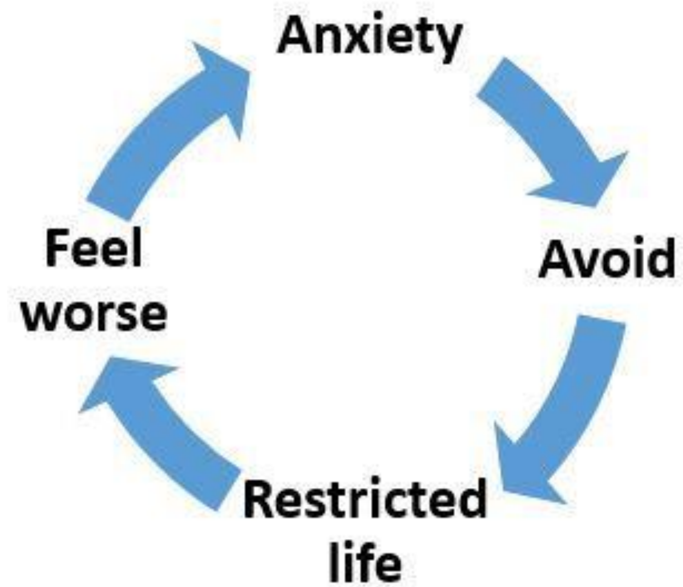

Catastrophe
What the patient fears will happen
100
Anxiety level
Escape
What the therapist predicts will happen
0
Time
Exp. starts
ends

What feeds anxiety?

AVOIDANCE.



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Medications

- **For moderate/ severe anxiety**, offer a generic, low-side effect SSRI like sertraline or escitalopram. SNRIs (venlafaxine) and Mirtazapine are also reasonable.
- For anxiety disorders, these doses may eventually need to be pushed towards the FDA maximum, which will increase side effects.
- Anxious patients don't like side effects which makes this a balancing act and usually means that you have to start at a low dose.
- It is reasonable to use SCHEDULED benzodiazepines as a bridge to full SSRI effectiveness (for about a month). In practice, it is hard to ever get patients off, so avoid if possible.
- It is also reasonable to use SCHEDULED benzos in addition to other evidence based treatments for very ill patients with severe anxiety disorders as long as benzos are helping them be better and function.
- Unless being taken only occasionally, better to schedule Benzodiazepines so that they are not used primarily as an avoidance strategy.

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Starting an SSRI for an anxiety disorder…

Sertraline (Zoloft®) can be started at 25mg and titrated as high as 200mg daily.

- Compared to others, patients seem to have more initial nausea and diarrhea on Sertraline. Sexual side effects increase at higher doses but will go away if patient stops med

Fluoxetine (Prozac®) can be started as low as 10mg and increased as high as 80mg

- Compared to others, Fluoxetine has a much longer half life which means it is good for persons who struggle with medication compliance. It tends to make people more activated at first (which can feel like anxiety)

Escitalopram (Lexapro®) can be started as low as 5mg and titrated to 30mg.

- It tends to be rather well tolerated

I don't recommend Fluvoxamine (Luvox®), Paroxetine (Paxil®), or Citalopram (Celexa®) as first line because of side effects and interactions, though they all clearly are helpful for refractory cases or in special circumstances.

Mirtazapine or SNRI

Mirtazapine (Remeron) can be started as low as 7.5mg nightly and titrated to 45mg nightly.

- It will cause sedation and some mild weight gain, but can be an excellent choice for insomnia in the setting of an anxiety disorder

Venlafaxine (Effexor®) can be started as low as 37.5mg daily and titrated rapidly to 225mg

- This medication can cause a rather brutal discontinuation syndrome if a patient were to stop cold-turkey.

Duloxetine (Cymbalta ®) can be started as low as 20mg and titrate as high as 120mg daily.

- Like Venlafaxine, the discontinuation syndrome can be significant. Excellent choice for anxiety in the setting of chronic pain.

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What are Benzodiazepines for….

Reasonably well functioning people who are undergoing extreme stress for a short period of time (death in family, divorce) and need occasional relief from overwhelming stress in order to fulfill life responsibilities.

Reasonably well-functioning people who need help with anxiety for very discreet and infrequent situations (flying on a plane)

Persons with significant impairment from serious mental illnesses including severe anxiety disorders, bipolar disorder, schizophrenia, catatonia who need adjunctive treatment in addition to other first line evidence based treatments. (Caution: usually not helpful and harmful in PTSD and other prolonged trauma disorders, personality disorders that have been called "bipolar," OCD and others).

Monotherapy ONLY if one cannot tolerate other medication treatments, has severe anxiety, and is functional with the treatment.

For someone in a state of severe anxious distress, with severe insomnia, especially with suicidal ideation. If this kind of person needs Benzos he also needs very much increased monitoring and possible hospitalization.

Closely monitored alcohol withdrawal, seizures (outside of the scope of this presentation)

What are my limits and boundaries around prescribing Benzos?

- I will not give if I do not honestly believe that it will improve patients level of functioning (or if patient is not trying to function).
- I will not prescribe if patient is using other controlled, addictive, illicit, or anxiolytic substances. For me this means:
  - Opioids of any kind
  - Stimulants
  - Alcohol more than occasionally for a significant period of time outside of immediate stressor
  - Marijuana use that is more than very occasional
- I will not give if patient has significant substance use history (even if resolved).
- I will know the individual very well and/or I will pull a DOPL reports AND submit patient to urine drug screenings before and possibly during benzo treatment
- I am extremely cautious with elderly folks for whom risks of premature dementia, falls, and delirium are high.

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INSTEAD OF BENZOS: IN PATIENTS WHO NEED ADDITIONAL MEDICATIONS CONSIDER….

- Beta Blockers (Propranolol), Alpha 1 antagonists (esp. Prazosin), Alpha 2 agonists (Clonidine)
- Buspirone (Buspar®)
- Anticonvulsants, especially those with evidence in anxiety: Pregabalin (Lyrica®) or Gabapentin (Neurontin®)
- Anti-histamines, especially hydroxyzine (Vistaril®) which has quite good evidence in treating anxiety disorders
- As a last resort or in extreme cases antipsychotics (especially Quetiapine (Seroquel®) and Olanzapine (Zyprexa®)) which have efficacy, but also significant side effect burdens.

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