Anxiety Disorders in Primary Care

Danielle H. Metzler, MD[a], David Mahoney, MD, MBE[b], John R. Freedy, MD, PhD[a,*]

KEYWORDS

• Anxiety disorders • Primary care • Generalized anxiety disorder
• Social anxiety disorder • Panic disorder • Pharmacologic treatment
• Collaborative care

KEY POINTS

- Anxiety disorders are highly prevalent, with an estimated lifetime prevalence of 29% in the United States.
- Screening all patients for anxiety is not currently recommended. However, when suspected, a useful screening tool is the Generalized Anxiety Disorder scale–2, which asks 2 questions and is approximately 86% sensitive for detecting generalized anxiety disorder.
- Selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors are first-line treatment options for anxiety. Tricyclic antidepressants are effective but, given their risky side-effect profile, are now considered third-line agents. Benzodiazepines are also effective, but because of their risk for dependence, providers should prescribe with caution and ideally for time-limited periods (days to weeks).
- Psychotherapy is found to be as effective as pharmacotherapy in the treatment of most anxiety disorders and for best results should be used in conjunction with medication.
- An emerging model for managing mental health problems in primary care settings is the collaborative care model. This model shows great promise and likely will become a sustainable approach to many mental health issues addressed in primary care settings.

INTRODUCTION

Anxiety disorders are the most common mental health disorders evaluated and treated in a primary care setting.[1] Lifetime prevalence is as high as 29% in the United States.[2] Patients suffering from anxiety disorders experience lower quality of life,[3] decreased productivity, and increased rates of medical services use. Kroenke and colleagues[1] found that those with anxiety disorders had a higher rate of self-reported disability

[a] Trident Family Medicine Residency, Department of Family Medicine, Medical University of South Carolina, 9228 Medical Plaza Drive, Charleston, SC 29406, USA; [b] Mount Pleasant Family Practice, Roper St. Francis Physicians, 1400 Hospital Dr., Mount Pleasant, South Carolina, 29464, USA
* Corresponding author.
E-mail address: freedyjr@musc.edu

Prim Care Clin Office Pract 43 (2016) 245–261
http://dx.doi.org/10.1016/j.pop.2016.02.002 primarycare.theclinics.com
0095-4543/16/$ – see front matter

days (11.2–30.6) compared with those with no anxiety disorder (5.7). Further, anxiety disorders cause a significant economic burden and have become an escalating public health dilemma.

As the health care system evolves and proceeds toward a more comprehensive and integrative approach to patient care, primary care physicians must be able to recognize and initiate treatment of anxiety disorders. Interestingly, anxiety disorders are regularly misdiagnosed by primary care providers, often because the patient presents with somatic complaints.[4,5] In fact, estimates are that less than a quarter of patients present with feelings of anxiety as the chief complaint and that almost half of patients actually present with a somatic complaint.[4] Rates of misdiagnosis in one study were as high as 71% for generalized anxiety disorder (GAD).[4] In addition, many patients experience subthreshold symptoms and, as expected, contribute to the vast population of missed diagnoses and overlooked opportunities for treatment.[4]

Patients with psychiatric disorders tend to incur more visits with health care providers. Thus, prevalence data should be interpreted with caution, as it is often collected from clinic populations in which the sample of patients with psychiatric disorders is higher than that of the general population.[6]

SCREENING

Despite the widespread prevalence of anxiety disorders in primary care, there are no concrete data suggesting a benefit to screening.[6] There are no current United States Preventive Services Task Force recommendations on screening for anxiety disorders. However, there are several tools that can be used in a primary care office to screen for anxiety when the diagnosis is suspected. The Generalized Anxiety Disorder–7 (GAD-7) is the most well-known and has been validated for GAD, as well as for panic disorder and posttraumatic stress disorder (PTSD).[6] Recently, an abbreviated version, the GAD-2, has been shown to be 86% sensitive and 83% specific for detecting GAD when a score of 3 or more is tallied.[1] Composed of the first 2 questions of the GAD-7, the GAD-2 asks, "over the last 2 weeks, how often have you been bothered by the following problems: (a) feeling nervous, anxious or on edge, and (b) not being able to stop or control worrying?"[1] (**Table 1**).

The Beck Anxiety Inventory is a screening tool that helps distinguish between anxiety disorders and depressive disorders.[6] It is a 21-item questionnaire that is often used in outpatient psychiatric clinics.[6] A truncated version has been developed and tailored for primary care use—the Beck Anxiety Inventory–Primary Care—but has not yet been widely adapted.[6]

A multistage screening tool called *The Symptom Driven Diagnostic System–Primary Care* is a 16-item patient survey that screens for multiple mental health disorders in a primary care setting.[7] The pilot study found a 90% sensitivity and only 54% specificity in detecting generalized anxiety disorder.[7] Sensitivity was even lower for panic disorder at roughly 78%.[7] The advantage to this screening tool is that it is patient administered, saving the primary care provider time. In addition, this tool attempts to screen for several psychiatric disorders, helping to point the clinician in the right direction. However, it is not readily available, and the true efficacy in real-world practice is currently unknown.[6]

Several PTSD screening tests have been used in both military and civilian primary care settings. The most brief of these screening tests is the 4-item Primary Care PTSD Screen. Four yes/no questions are keyed to possible PTSD symptoms occurring within the past month: nightmares/intrusive thoughts, thought/situational avoidance, hypervigilance/easily startle, and numb/detached feeling.[8] Freedy and colleagues[9]