Anxiety Disorders Management: Effectively Treating the Anxious Patient

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Off label use of medications for anxiety such as: Desvenlafaxine, Citalopram, Gabapentin, Pregabalin, Hydroxyzine for GAD, Vortioxetine, Vilazodone, Mirtazapine, Propranolol, Quetiapine, MAO inhibitors, Bupropin

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Dr. Winner has been a family physician at Sansum Clinic—the largest multispeciality clinic in Central California—since 1991. He is also a former chairman of the Department of Family Medicine at Santa Barbara Cottage Hospital, California. Dr. Winner recognized not only that stress-related illness was extremely frequent, but also that prescribing medication was only part of the solution. Therefore, in 1992, he founded Sansum Clinic’s Stress Reduction Program. He continues to run the program and teach in it. He has written journal articles and speaks on the topics of stress, health, and physician wellness. In addition, he is the author of the book Relaxation on the Run: Simple Methods to Reduce Stress in Seconds Plus Practical Lifestyle Tips for a Happier and Healthier Life.
Learning Objectives

1. Use evidence-based recommendations and guidelines to screen and diagnose patients who present with anxiety, anxiety-related symptoms, or when symptoms are suspected to be related to a chronic health condition.

2. Consider co-morbid conditions, potential side effects, drug interactions, and costs when choosing therapy.

3. Identify non-pharmacologic interventions that are efficacious for treatment of anxiety disorders.

4. Develop a collaborative care plan that considers patient preference, treatment success history, scheduled patient follow-ups, and enhanced interprofessional communication.

Audience Engagement System

Step 1

Step 2

Step 3
Holistic Approach to the Anxious Patient

1. Accurate diagnosis of both psychological and other medical disorders
2. Brief educational and counseling interventions (maximum benefit per time spent)
3. Medication when desired and appropriate
4. Team approach and referrals to counseling and/or psychiatry when appropriate

Why offer brief psychoeducation/counseling:

• Patients often do not follow through with counseling referrals
• It may take a while get into a counselor
• Important to have adequate education/training helpful before deciding whether to start a long course of medication
• Issues of cost, insurance coverage, finding a counselor qualified to effectively treat anxiety
• With an extra 10 to 20 minutes, you may make a big difference – “much more satisfying than a cortisone injection”
Page Turners with Exciting Titles

• The Girl with the Dragon Tattoo
• The Hunger Games
• Diagnostic and Statistical Manual

No Longer Categorized Under Anxiety Disorders in DSM V

• OCD (Obsessive Compulsive Disorder) instead is categorized as “Obsessive-Compulsive and Related Disorders” which also includes Hoarding Disorder, Trichotillomania (Hair-Pulling Disorder), and Excoriation (Skin-Picking) Disorder
• PTSD (Post Traumatic Stress Disorder), Acute Stress Disorder, and Adjustment Disorder is now categorized under “Trauma- and Stressor-Related Disorders”
Anxiety Disorders – What’s Left in DSM V

• Separation Anxiety Disorder
• Selective Mutism
• Specific Phobia
• Social Anxiety Disorder (Social Phobia)
• Panic Disorder
• Panic Attack Specifier
• Agoraphobia
• Generalized Anxiety Disorder
• Substance/Medication-Induced Anxiety Disorder
• Anxiety Disorder Due to Another Medical Condition
• Other Specified Anxiety Disorder
• Unspecified Anxiety Disorder

Tests for Anxiety Disorders:

• Screening (not recommended for general population): GAD-7 Screening Tool  http://www.phqscreeners.com
• For evaluation and to monitor treatment effectiveness: The PROMIS Emotional Distress-Anxiety Short Form and the Severity Measure for Generalized Anxiety Disorder-Adult both at:  https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures
• Also Severity Measures for Panic Disorder, Social Anxiety Disorder and Agoraphobia also at:  https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures
When to Suspect Anxiety Disorder or Excessive Stress

1. The patient complains of being stressed out, anxious or symptoms worse since life has been more stressful
2. Symptoms associated with anxiety and stress such as palpitations, perioral and extremity tingling, etc.
3. Medical problem which is often exacerbated by stress/anxiety (headaches, IBS, fibromyalgia, etc.)
4. Review of Systems: excessive anxiety or stress

Overall Strategy

1. Never give the impression that a problem is not real. (Do not use terms like “worried well.”)
2. Empathize and communicate empathy
3. Make the right diagnosis (for example: Panic Disorder vs PSVT vs combination of the two; hyperthyroidism; COPD; asthma; bipolar disorder)
4. Is there a anxiety disorder exacerbating medical condition or a medical condition exacerbating an anxiety disorder or both?
5. Then discuss pharmacological and non-pharmacological options
18 yo female complains of:

• anxiety for about a year; worse over the last couple of weeks
• episodes of uncontrollable shaking
• feels her heart race and she feels like she cannot get a deep breath; she gets scared that she will stop breathing
• afraid to eat because she is afraid of choking
• stressful issue at school 3 weeks ago and she developed more severe anxiety
• pulse usually 76; at highest 104
• although she is scared of getting an anxiety attack -- forces herself to go to places

Some of the thoughts that bothered her:

• "I hate how I am feeling."
• "I wish my heart would slow down."
• “I wish I felt I normal again.”
• “I wish I would stop shaking.”
• “Why am I shaking?”
• “What if I have cancer?”
• “I'm going to die."
Panic Attack: at least 4/13 symptoms

1. Palpitations, pounding heart of accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feelings of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, light-headed, or faint
9. Chills or heat sensations
10. Paresthesias
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
12. Fear of losing control or “going crazy”
13. Fear of dying

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Panic Disorder

• At least 2 of the panic attacks are “unexpected” or out of the blue (including nocturnal panic attacks)

• At least 1 of the attacks followed by either “persistent concern or worry about additional panic attacks” or “significant maladaptive behavior related to the attacks”

• Not from a substance, other medical disorder or better explained by another psychiatric disorder

• If these 3 criteria not met, instead of panic disorder, use panic attack specifier which can be added to other disorders

Options of treatment:

1. “You have a biochemical problem. I recommend correcting that problem with at least a year’s treatment of an SSRI medication and another medication for when the panic attacks are severe.”

2. Provide 15 minutes of education and behavioral treatment and decide together if medication and/or additional counseling would also be helpful.

Option 2: After a year of suffering patient felt immediately better after our first visit. She decided against any pharmacological treatment. This case and other like it most professionally gratifying. Father emails that the “whole family is extremely GRATEFUL.”
**Differential Diagnosis**

- Make a real diagnosis of anxiety disorder, other medical problem, or both (medical problem can exacerbate anxiety and anxiety can exacerbate medical problem)
- Consider arrhythmia such as PSVT
- Hyperthyroidism
- Substance abuse or withdrawal
- Hyperparathyroidism
- Pheochromocytoma (extremely rare)
- Sleep apnea
- If chest pain were a component would consider cardiac conditions, pulmonary embolism, etc.
- Rare to have first panic attack over age 40, so other problems higher in differential in those cases
- Other psychiatric disorders: mood disorders, OCD, PTSD, etc.

**Lifestyle**

- Good diet and regular exercise
- Balance
- Not over doing caffeine or alcohol
- Getting enough sleep and good sleep hygiene
- Screening for recreational drug use
- Screening for side effect from therapeutic medications
General Brief Counseling Principles

• Empathize and express empathy
• Emphasize patient’s strength and point out strength alone is not enough
• Discuss diagnosis
• Just like anything else need to develop a skill set

Explain the Sensations: Hyperventilation

• Reduction in PCO2 can result in dizziness, light-headedness, and/or tingling and numbness in extremities, lips and face.
• Chest breathing (as opposed to diaphragmatic breathing) can cause discomfort from intercostal muscles.
• May have odd sensations interpreted as not feeling real, or being out of body.
• The messages from the medulla to reduce breathing can be interpreted as air hunger or not getting a good breath.
• Abdominal sensations may come as the blood is deviated from the intestines to the muscles and/or from the preponderance of nerve cells in the gut
Mindful Diaphragmatic Breathing

• Easier to learn/practice when calm
• May be easier to learn lying down
• May need to ask people to exaggerate the expansion of abdomen with inhalation
• May initially feel unusual till gets used it
• For some: counting to slow down breathing
Basic Chinese Finger Trap Cycle

- Finger Trap Tight
- Resistance
- Finger Trap Tighter

Anxiety
Basic Anxiety Cycle

- Anxiety
- Resistance
- Anxiety Worse
Increased Anxiety
Resist Physical Sensations
Resist Emotions
Resist Circumstances
Resist Thoughts
Red route with cortical interpretation in 0.5 seconds longer

Eustress

Use Stress
Brief Counseling Addressing Resistance

• Physical sensations: heart racing, abdomen tight, neck tight – enough evaluation for reasonable reassurance and then accept feeling for now
• Emotions: instead of “too anxious and panicked” – “high energy level or energy burst” and feel the energy flow through your veins (analogies of super hero, Wonder Woman, Popeye, Tarzan, etc.)
• Circumstances: not liking current job – can change future but present is only as it is so accept it for now
• Thoughts: “My heart is beating too hard” “What if I have a heart attack” “I can’t stand being this anxious” “I wish I could have peace of mind” I can’t stand these bothersome thoughts” – learn to notice thoughts without believing or resisting them

Tasks

1. **Teach about panic attacks**: surge of energy followed by resistance creating much more and prolonged anxiety; perhaps discussed effects of hyperventilation with chest breathing
2. **Teach skills**: mindful diaphragmatic breathing, reframing initial surge as useful energy burst; don’t believe (or resist) all your thoughts
3. **Practice**: gives them an experiential feel for applying that information
4. **Discuss plan**: possible counseling referrals and pros and cons of medications
Resistance Training

Non-Resistance Training
Can have patient record both information and exercises

Some of the thoughts that bothered her:

- "I hate how I am feeling."
- "I wish my heart would slow down."
- "I wish I felt I normal again."
- "I wish I would stop shaking."
- "Why am I shaking?"
- "What if I have cancer?"
- "I'm going to die."
Non-Resistance Training

- Start with guided breath meditation and body scan
- Before giving “bothersome thought,” repeat instruction not to believe or resist the thought.
- After repeating thought, let it go and focus on the sensation of one diaphragmatic breath and relax a muscle group.
- Intermittent brief instructions. Instructions for physical sensations: fully allow it to be there, not forever, but just for this moment
- Instructions for emotion of anxiety: instead of anxiety call it “high energy level” or “energy burst” and see if you can enjoy the energy flowing through your veins
- Instructions for circumstances: reminder that we work towards change but this present moment can only be as it is

Extra Hints with Non-Resistance Training

- Can have patient record both the education and exercise with the voice memo app of phone.
- List patient’s “bothersome thoughts” before starting
- Before starting the meditation, check that the patient can demonstrate diaphragmatic breathing – if trouble doing it sitting, may need to do it lying down. May need to exaggerate expanding abdomen.
- For one of the thoughts repeat it 2 or more times to demonstrate that the patient can let a thought go again and again.
- You might try the thoughts “This won’t work” and/or “I need to clear my mind.”
Non-Resistance Training Review

• At the end check in: usually patients are more relaxed, even after thinking several of their most bothersome thoughts. So they learn it’s not the thoughts themselves that cause anxiety but how one deals with the thoughts.

After Non-Resistance Training, Review:

• A panic attack is not dangerous
• If you don’t believe or resist the thoughts, you don’t get a full panic attack
• Mindful diaphragmatic breathing – focus on the sensation of your abdomen with one full inhalation and exhalation
• Relax muscle group
• Instead of calling panic or anxiety, label it an “energy burst” and feel the useful energy in your veins (analogies of Tarzan/King Kong/Super hero/Popeye)
Generalized Anxiety Disorder (GAD): at least 3 out of 6 (at least some more days than not).
1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.

Compared with panic attacks, can be more “subtle” and harder to diagnose. Often anxious since young age

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GAD

• Myths: worry is an expression of love and concern, and that worrying prepares people for the future
• Often, concerned with “What if” thoughts. However, nothing is 100% safe -- Everything is risk vs benefit. (including risk of medication)
• Do an accurate risk/benefit analysis and act accordingly.
• Then practice noticing thoughts without getting lost in them.

GAD, SAD, Agoraphobia, Specific Phobia

• Typically 6 months or more
• Symptoms cause clinically significant distress or impairment
• Not from another medical condition
Social Anxiety Disorder (SAD?)

- Main issue is concern about being evaluated by others. (“What will others think of me” or “Others will hate me”)
- Risk for alcohol use disorder*
- Plant a seed: Who do you connect with: showy people that act perfect or real people with flaws?
- Who would have a happier more effective life: Goal to impress, or goal to have a real connection?
- Non-resistance training to feel energy without resistance and letting go of thoughts without resistance or believing the thoughts.


Agoraphobia, Marked Fear 2 out of 5:

1. Using public transportation.
2. Being in open spaces.
4. Standing in line or being in a crowd.
5. Being outside of home alone.

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More Often in Children

• Separation Anxiety Disorder: worries of losing attachment figure (most often parent, could be spouse)
• Selective Mutism: failure to speak in specific social situations

Specific Phobia

• If frequent issue: exposure therapy (given assignments from qualified counselor and a good week is one with anxiety)
• Uncommon issue such as once a year flight: perhaps benzodiazepine
**Substance/Medication-Induced Anxiety Disorder**

- During substance/medication use (Excess caffeine use, amphetamines, etc.)
- After use (hallucinogen, etc.)
- During withdrawal (opioid, etc.)

**Anxiety Disorder Due to Another Medical Condition**

- Hyperthyroidism
- Hyperparathyroidism
- Pheochromocytoma
- COPD
- Seizure disorder
- PSVT

**Other Specified Anxiety Disorder**

- Doesn’t quite fit the other specified diagnoses.

**Unspecified Anxiety Disorder**

- You’re too lazy or busy to figure it out.
Typical thoughts associated with other anxiety disorders

• Social Anxiety Disorder: “People will hate me.” (Concerned about what others will think)
• Separation Anxiety: “My parent/spouse might be harmed.”
• GAD: “I’ll loose my job and never get another one.” (catastrophizing, fortune telling and “what if” concerns)
• Agoraphobia: “What if I have a panic attack when I’m away from home.” (Worried about loss of control)
• OCD: “I wish these thoughts would go away.” (Resisting the thoughts -- task is to learn that thoughts are just thoughts)

Case 2:

• 18 yo female who started college 4 months ago
• Whole life anxious person, but much more so since began college
• Affecting her on daily basis and has an almost constant anxiety
• Was diagnosed with GAD and started on escitalopram 3 weeks ago, but has intolerable fatigue with even 5 mg
AES Question #1

Next pharmacological step:

1. Take the escitalopram at night
2. Change to paroxetine (Paxil) 20 mg daily
3. Change to fluoxetine (Prozac) 10 mg daily
4. Change to buproprion (Wellbutrin XL) 300 mg daily
5. Change to vortioxetine (Trintellix) 10 mg daily
(Note: Poll question: I will go over answers later in presentation so don’t list one correct answer please)

Medications

• Start low and go slow (usually ½ starting dose for SSRI’s/SNRI’s
• SSRI’s/SNRI’s not considered a treatment failure till on top dose for at least 4 weeks or if intolerable side effects before then.
• Some side effects like nausea with escitalopram almost always resolve in a week
• Typically treat for 12 months to reduce risk of relapse
### SSRI’s

- Citalopram (Celexa): potential drug interactions and QT prolongation
- Escitalopram (Lexapro): may be more effective than citalopram and less drug interactions
- Sertraline (Zoloft): dose can be 25 to 200 mg; more potential sexual side effects but most effective for premature ejaculation
- Paroxetine (Paxil and Paxil CR): somewhat sedating, associated with more weight gain, also more sexual side effects and since short acting probably most potential for discontinuation syndrome
- Fluoxetine (Prozac): more activating and less sedating (long half life so least discontinuation syndrome)
- Fluvoxamine (Luvox): first one FDA approved for OCD; sedating

### SNRI’s

- Venlafaxine (Effexor XR): wide range of dosage from 37.5 to 225 mg daily; high incidence of withdrawal so need to taper slowly; can be used for migraine prophylaxis
- Duloxetine (Cymbalta): may be a good choice if also treating fibromyalgia, neuropathic or other chronic pain
- Desvenlafaxine (Pristiq)
Additional SSRI/SNRI Side Effects

• Manic episode
• Elevated LFT’s
• Hyponatremia
• Increased sweating
• Increased GI bleeds (consider for patients on NSAIDS or other GI risk)

Additional SSRI/SNRI Side Effects

• QT prolongation
• Headaches
• Increased suicidal thoughts (particularly with those under 24 yo)
• Emotional blunting
• Post SSRI Sexual Dysfunction (PSSD)*

Benzodiazepines

- Might speed recovery, but do not improve long term outcomes
- Try to avoid them because of risks of sedation, dependence, overdose, increased risk of hip fracture and MVA’s, and elevated mortality
- In general, use them for a crisis only – if the patient cannot wait for an SSRI to kick in
- Can be helpful as a “safety blanket” – a patient may be less worried about having a panic attack if he/she has lorazepam, even if they never use it.
- May be an uncommon patient that needs regular benzodiazepines but may be safer to leave that choice to a psychiatrist
- Clonazepam (Klonopin) might have less addiction potential than shorter acting medication like alprazolam (Xanax)
- High risk of overdose when combined with opiates

Other Medications
(off label unless otherwise indicated)

- **Buspirone (Buspar):** only for GAD (FDA indication)
- **Gabapentin (Neurontin) or pregabalin (Lyrica)** for GAD: also helpful for neuropathic pain
- **Hydroxyzine (Atarax):** for GAD (indicated short term anxiety)
- **Vortioxetine (Trintellix) and vilazodone (Viibryd):** probably less effective than SSRI’s; less fatigue and sexual side effects; may cause diarrhea
- **Mirtazipine (Remeron):** very sedating and may cause weight gain, might be helpful if a lot of insomnia
Other Medications
(off label unless otherwise indicated)

- **Propranolol**: for performance anxiety (subtype of SAD)
- **Tricyclic antidepressants**: not frequently used for anxiety since typically would need higher doses (with more potential for side effects) than for other indications such as chronic HA’s, migraine prophylaxis and chronic pain
- I would mostly leave **antipsychotics and MAO inhibitors** to a psychiatrist’s discretion because of the frequency of significant side effects

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**Pharmacotherapy for GAD**

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<th>Smaller Sample Size</th>
<th>Poor tolerability</th>
<th>Poor Evidence</th>
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<td>Duloxetine</td>
<td>Mirtazapine</td>
<td>Quetiapine (large effect)</td>
<td>Vilazodone</td>
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<td>Bupropion (few patients)</td>
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AES Question #2

Case 2: Next pharmacological step when fatigue from 5 mg escitalopram:

1. Take the escitalopram at night
2. Change to paroxetine (Paxil) 20 mg daily
3. Change to fluoxetine (Prozac) 10 mg daily
4. Change to buproprion (Wellbutrin XL) 300 mg daily
5. Change to vortioxetine (Trintellix) 10 mg daily

Herbal Products

- Kava Kava: avoid it because of risk of liver failure
- Valerian: no significant difference in 4 week small trial
- Passion flower: only small trials with mixed results
- Marijuana (long term may do worse with anxiety and mood disorders*)
- CBD oil?

Nutritional Supplements: Only Small Trials

• Zinc for OCD and panic disorder
• Antioxidant vitamins for GAD
• Inositol for panic disorder, agoraphobia and OCD

Referrals:

• Counseling: especially CBT (Cognitive Behavioral Therapy), exposure therapy and mindfulness based therapies
• Classes: most research done on MBSR (Mindfulness-Based Stress Reduction); MBSR, over 8 weeks, has about 27 hours of class in addition to 30 to 60 minutes of daily homework (mostly mindfulness exercises); Google “MBSR near me” and check teacher’s credentials; other stress reduction classes
• Psychiatry: if having difficulty with medication
Other Effective Behavioral Interventions

• Physical exercise
• Yoga
• Tai Chi
• Meditation
• Internet CBT

Books for Patients:

• *Relaxation on the Run* by Jay Winner
• *The Anxiety and Phobia Workbook* by Edmund Bourne
• *Hope and Help for Your Nerves* by Clair Weekes
• *Don’t Panic* by Reid Wilson
• *What Every Therapist Needs to Know About Anxiety Disorders* by Martin Seif and Sally Winston
Free Guided Meditations

- http://stressremedy.com/audio/
- http://marc.ucla.edu/mindful-meditations
- https://health.ucsd.edu/specialties/mindfulness/programs/mbsr/Pages/audio.aspx
- UCLA Mindful app
- Mindfulness Coach app

Other Resources:

- https://adaa.org/
- https://www.anxietyandstress.com/about-anxiety

Anxiety Disorders and Suicide

- Face-to-face interviews were conducted with 34,653 adults between 2004 and 2005 in the United States.
- Patients with anxiety disorders had more suicide of attempts
- Higher when concurrent mood or personality disorder

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2940247/
Summary: Practice Recommendations

1. Accurate diagnosis and reassurance
2. Patient education: mechanism of anxiety disorder, anxiety disorders are largely about resistance (Chinese finger trap), mindful diaphragmatic breathing, “energy bursts”, can notice thoughts without believing or resisting them
3. Non-resistance training and/or referral to counselor proficient in CBT, mindfulness and exposure (and perhaps recommend reading and audio exercises)
4. If indicated, can discuss pros, cons, risks and benefits of medication (usually SSRI/SNRI; limit use of benzodiazepines)
Questions