Body System: Psychogenic		
Session Topic: Anxiety Disorders Treatment		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Family physicians have a knowledge gap related to the changes in the DSM V classification of anxiety disorders, and how these changes are related to the ICD-10 codes. • Family physicians have knowledge and performance gap related screening and diagnosing patients with anxiety disorders, particularly when anxiety is comorbid to chronic health conditions. • Family physicians have a knowledge and competence gap related to utilizing effective pharmacologic, psychosocial, and complementary and alternative therapies for patients with anxiety disorders.	1. Differentiate between the DSM IV and DSM V classification of anxiety disorders. 2. 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. 3. Select treatment that consider several factors, including patient preference, treatment success history, and other factors that may interfere with successful treatment (e.g., presence of comorbid psychological or medical problems, intolerable adverse effects, adherence potential, third-party reimbursement issues. 4. Review evidence base behind current pharmacologic treatments for anxiety disorders.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

• Family physicians have knowledge and competence gap related to utilization of a patient-centered approach to anxiety disorder management, emphasizing interdisciplinary collaborations that include the integration of behavioral health specialists.		

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide an overview to differentiate between the DSM IV and DSM V classification of anxiety disorders.
- Provide 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.
- Provide recommendations for selecting treatment that consider several factors, including patient preference, treatment success history, and other factors that may interfere with successful treatment (e.g., presence of comorbid psychological or medical problems, intolerable adverse effects, adherence potential, third-party reimbursement issues.

- Provide a review of the evidence base behind current pharmacologic treatments for anxiety disorders.

Needs Assessment

Anxiety disorders are the most common mental illness in the U.S., affecting 40 million adults age 18 and older, or 18% of the U.S. population; with only 36.9% receiving treatment.[1,2] Physicians made a diagnosis of mental disorders during 47 million ambulatory office visits, and ordered stress management health education services during 25 million ambulatory office visits 2010.[3] Over 33% of family physicians offer psychiatric services in their practice.[4] Prevalence of each anxiety disorder varies by gender and age.

Practice Gaps

American Academy of Family Physicians (AAFP) CME Needs Assessment Survey data suggests that family physicians have statistically significant and meaningful knowledge gaps to utilize psychotropic medications, crisis counseling, stress management strategies generally to manage psychiatric disorders; and have significant gaps to manage patients with anxiety specifically.[5] More specifically, CME outcomes data from 2014 AAFP Assembly (now called FMX) *Anxiety Disorders* sessions, suggest that physicians have knowledge and practice gaps regarding appropriate screening (e.g. anxiety GAD scale); changes between DSM IV vs. V; managing potential abuse of benzodiazepine; coordination of care with behavioral specialists; evidence-based pharmacologic & non-pharmacologic treatment options; and cognitive behavioral therapy.[6] In addition to abuse and dependence, other major risks associated with benzodiazepine use include the following:[7]

- Cognitive impairment. Benzodiazepines cause acute adverse effects: drowsiness, increased reaction time, ataxia, motor incoordination, and anterograde amnesia. Additionally, a meta-analysis of studies looking at withdrawal from an average of 17 mg per day of diazepam (Valium) found that long-term use led to substantial cognitive decline that did not resolve three months after discontinuation.
- Motor vehicle crashes. The risk of driving while on benzodiazepines is about the same as the risk of driving with a blood alcohol level between 0.050% and 0.079% (an alcohol level greater than 0.08% is illegal in all states).
- Hip fracture. Benzodiazepines increase the risk of hip fracture in older persons by at least 50%. In a study of 43,343 persons, zolpidem increased the risk of hip fracture by 2.55 times in those older than 65 years.

The DSM V chapter on anxiety disorder no longer includes obsessive-compulsive disorder, which is now included with the obsessive-compulsive and related disorders; and posttraumatic stress disorder and acute stress disorder (now included with the trauma- and stressor-related disorders) are also no longer included.[8] The DSM V now includes the following anxiety disorders:[9,10]

- Separation Anxiety Disorder
- Selective Mutism

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

Standard treatment options for anxiety disorders include therapy, medication, and complementary and alternative treatments.[2] Family physicians should be familiar with DSM IV criteria, the relevant changes in the DSM V criteria, first line therapies for anxiety disorder, and be able to coordinate care with a psychiatrist when conditions warrant referral.

Family physicians should be familiar with screening instruments for anxiety disorders, and be able to select the appropriate diagnostic tool to diagnose patients presenting with anxiety or anxiety-related symptoms, or when symptoms are suspected by the physician.[11] It is important to note that diagnostic tools such as GAD scales are not intended as screening instruments for GAD or social phobia, as screening is not recommended. Additionally, depression is often a comorbid condition of anxiety disorders; however, the AAFP *recommends against* routinely screening adults for depression when staff-assisted depression care supports are not place. There may be considerations that support screening for depression in an individual patient. Staff-assisted depression care supports" refers to clinical staff that assist the primary care clinician by providing some direct depression care and/or coordination, case management, or mental health treatment.[12] The AAFP *recommends* screening of adolescents (12-18 years of age) for major depressive disorder (MDD) *when systems are in place* to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. The AAFP *concludes that the current evidence is insufficient to assess the balance of benefits and harms* of screening of children (7-11 years of age).[12] Patients with chronic health conditions (e.g. pain, asthma, CAD, COPD) will frequently screen positive for anxiety disorders; therefore, family physicians should follow evidence-based recommendations for screening patients with chronic health condition for anxiety disorders.[13-16]

If the diagnostic tool indicates a positive screen, physicians should be prepared to perform a more in-depth diagnostic interview to confirm the diagnosis and negotiate the treatment and follow-up strategy with the patient.[11] Physicians can improve the care of patients with an anxiety disorder by engaging patients in collaborative care plans within the context of the patient-centered medical home model of care.[17,18] Family physicians should be familiar with current evidence-based therapies for anxiety disorders, and be able to develop treatment plans developed collaboratively with the patient, which may be managed in the ambulatory setting, or coordinated with a behavioral health specialist. Treatment involves psychosocial, pharmacologic, and complementary and alternative (CAM) interventions, which should begin with supportive listening and education about anxiety.[19]

Physicians may improve their care of patients with anxiety disorders by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[19-22]

- Physical activity is a cost-effective treatment for GAD and PD.
- Selective serotonin reuptake inhibitors are considered first-line therapy for GAD and PD.
- To avoid relapse, medication should be continued for 12 months after symptoms improve before tapering.
- When used in combination with antidepressants, benzodiazepines may speed recovery from anxiety-related symptoms but do not improve longer-term outcomes. Because benzodiazepines are associated with tolerance, they should be used only short term during crises.
- Psychotherapy can be as effective as medication for GAD and PD. Cognitive behavior therapy has the best level of evidence.
- Successful treatment requires tailoring options to individuals and may often include a combination of modalities.
- Patients experiencing anxiety should be evaluated for depression.
- Cognitive behavior therapy has been shown to be at least as effective as medication for GAD with less attrition and more durable effects.
- Some SSRIs (escitalopram [Lexapro], paroxetine [Paxil], sertraline [Zoloft]); SNRIs (venlafaxine [Effexor], duloxetine [Cymbalta]); and benzodiazepines are more effective than placebo in the treatment of GAD.
- SSRI or SNRI therapy is more beneficial for patients with GAD and comorbid depression than benzodiazepine or buspirone (Buspar) therapy.
- Kava is effective in the treatment of GAD, but safety concerns limit its use.
- Exercise is an effective treatment option for depression in adults, but there is only minimal evidence to support its use in anxiety treatment.
- A large number of small, flawed studies found exercise superior to placebo, and aerobic and high-energy resistance exercise more superior to placebo and equal to treatment with selective serotonin reuptake inhibitors for mild to moderate depression.
- A single, but positive, trial showed exercise to be better than placebo, but not as good as clomipramine (Anafranil) in short-term reduction of panic disorder symptoms. No follow-up data were gathered; therefore, duration of effects is not clear. Little additional information is available.
- Yoga is a therapeutic option for depression, and it also has positive effects on anxiety disorders.
- Yoga is superior to placebo for depression with no adverse events reported, although there are no clear necessary or sufficient styles, postures, or practice durations.
- A systematic review and subsequent randomized controlled trials show consistent positive effects of yoga on anxiety disorders compared with placebo in flawed, small studies.
- Tai chi, qigong, and meditation have not shown effectiveness as alternative treatments for depression or anxiety.
- Use of inositol in a dosage of 12 to 18 g per day is a treatment option for panic disorder.

- Effectiveness similar to SSRI and better than placebo for reducing intensity and frequency of panic attacks; side-effect profile comparable to SSRI; supported by two RCTs, although both were small
- Inositol, 12 to 18 g per day, may be used to treat obsessive-compulsive disorder but not in combination with SSRIs.
- In trials of patients with treatment-resistant OCD, inositol by itself was better than placebo in reducing OCD symptoms26 but not in reducing anxiety scale scores; when added to SSRIs, inositol had no additional effect.
- Physicians should not encourage the use of St. John's wort, valerian, Sympathyl, or passionflower for anxiety based on small or inconsistent effects in small studies. Side-effect profiles are benign.
- Small, unreplicated trials with design flaws suggest some limited effectiveness
- All other nutritional supplements have no research evidence suggesting a positive effect on anxiety disorders. Physicians should recommend other treatments.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Diagnosis and management of generalized anxiety disorder and panic disorder in adults[22]
- Diagnosis of anxiety disorders in primary care[11]
- Generalized anxiety disorder and panic disorder (with or without agoraphobia) in adults. Management in primary, secondary and community care[23]
- Generalized anxiety disorder: practical assessment and management[19]
- Exercise, yoga, and meditation for depressive and anxiety disorders[20]
- Herbal and dietary supplements for treatment of anxiety disorders[21]
- Engaging Patients in Collaborative Care Plans[17]
- Integrating a behavioral health specialist into your practice[24]
- FamilyDoctor.org. Generalized Anxiety Disorder | Overview (patient education)[25]

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