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Live Expert Interview: Anxiety Disorders in Primary Care Settings

Announcer Introduction:
Welcome to CME on ReachMD. This activity, titled “Anxiety Disorders in Primary Care Settings”, is provided by Prova Education.
The following is a live interview recorded at Prova Education’s Guideline to Practice: Managing Challenging Cases in Primary Care.
Your host is Dr. Matt T. Rosenberg. Dr. Rosenberg will speak with Dr. Larry Culpepper, Professor of Family Medicine at Boston University School of Medicine.
Prior to beginning the activity, please be sure to review the faculty disclosure statements as well as the Learning Objectives.

Dr. Rosenberg:
Anxiety disorder is a common psychiatric condition that is often underdiagnosed and undertreated. This psychiatric condition may be accompanied by physical symptoms and patients often present in primary care office with physical rather than psychologic complaints. The interview, right now, will focus on recognizing anxiety symptoms and formulating an individualized treatment plan that uses the most appropriate therapeutic strategies to address patients’ physical and mental healthcare needs. Larry, again, thank you for coming today.

Dr. Culpepper:
Yes.

Dr. Rosenberg:
I have got a bunch of questions for you and about 15 minutes. So, we’re just going to time this appropriately.

Dr. Culpepper:
Okay.

Dr. Rosenberg:
And then we’ll kind of ad lib a little bit when we get through. So we’ll do what we can.

Dr. Culpepper:
Yes. Okay. That sounds good.

Dr. Rosenberg:
So, the first question is, what are the most common anxiety disorders seen in primary care and how do they present?

Mr. Culpepper:
Oh! (laughter)

Dr. Rosenberg:
Loaded question. You can probably do that for an hour.

Dr. Culpepper:
Well, it depends on your setting, the age, and a lot of things, but generalized anxiety disorder is a very common disorder. The catch is, is it rarely exists by itself. GAD is often comorbid. It’s comorbid in 60% of major depression. It’s comorbid with other anxiety disorders, and

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it's part of a lifespan sequence of anxiety disorders. So, particularly for us in family medicine, I would take a lifespan approach to thinking about the anxiety disorders rather than the psychiatrist's approach which is cross-sectional, let-me-look, disorder by disorder. So, here's the way anxiety plays out in our patients. You start early in life with a significant genetic predisposition, and then if you're in an unstable early environment, lots of surprises, "Oh my God, where's my next food coming, am I going to get hit again," you develop internal anxious processes. Now, the first anxiety disorder to emerge in most people is actually social anxiety disorder. And social anxiety disorder is more than, "Oh, my God, I'm nervous; I'm going to be a wallflower." It is actual physiologic response that concerns people and makes them withdraw. They don't engage with their environment with peers nearly as much. Common onsets are 4 to 5 years of age; 12 to 13 years of age are the peaks. And if you think about what's going on in your life that makes sense. Then what emerges is generalized anxiety. Start out, I'm anxious with other people. Now, I'm anxious with the world in some ways. Then what happens is in your 20s what will emerge is panic disorder or panic attacks. A pearl. What's the condition that panic attacks are most frequent in. Well, 10 to 12% of normal people have a panic attack on occasion. It's most frequent in major depression. But panic attacks are common. There are physiologic meltdown, "Oh my God, I don't know what I'm going to do" and I melt down. I'm on the freeway and I'm going to get trapped, I'm running out of gas, and I melt down. Panic disorder sets in when we begin avoiding the situations. So, "I can't go there because if I go there I'm going to have a panic attack." It's a developed fear of the panic condition itself and the anxiety around it, and so that emerges typically in the 20s, 30s, and if you're really severe, you'll get agoraphobia coming in after that. Now separate from that, and I'm not really going to get into it, are specific phobias, "Oh my God, I can't stand spiders," things like that. PTSD we used to think of as an anxiety disorder. It's been reclassified as a trauma condition. And while it has overlaps with anxiety, it's not in the anxiety bag anymore. And that makes sense because it's a response to an external condition. That's the typical course of anxiety. That doesn't mean that you can't be 50 and have new-onset anxiety or new-onset panic, but what it does mean is if you've got somebody that's been a happy-go-lucky, normal, not-anxious person, and they come in with anxiety symptoms after probably about 35, think organic. Start looking for what's going on body-wise that's precipitating this, or cardiovascular, is it PAT? What else is going on, because late-onset is a cue? So, that's probably the most important. If you think about that development, you can think about people in your practice, their families, sort of how their trajectory is, and that's the way I recognize anxiety.

Dr. Rosenberg:
I'll tell you what's interesting from a clinical standpoint, the way you just described that is very helpful, more of a disorder than the situational issue. And what's interesting is, how many times a week, a day, patients come into the office saying, "I need anxiety meds."…

Dr.Culpepper:
You betcha.

Dr.Rosenberg:
… and then you find out it's a situational as opposed to a constant event.

Dr. Culpepper:
Exactly. And that's a critical differentiator. Now, GAD, classically waxes and wanes. So, it's up and down, up and down, depends on what's going on in environment, depends on sleep, depends on a lot of other conditions. But it typically waxes and wanes. Social anxiety disorder typically relates in part to the stressors your under. For us, in primary care, there are a couple of pitfalls that we need to avoid. One is, "Oh, it's just Mrs. Jones. She's always like that." Well, yes, but if I said that about someone with diabetes, "Oh, yes, she's always going into ketoacidosis, that's just Mrs. Jones." That's a big problem. Because what we know is that we do have treatments and we do have approaches that can be very helpful to these patients. The other thing to think about is, where we really come into play, is anticipatory. If you think about what else happens in that trajectory; kids grow up, they start social interactions, they go away to the military or college or work, they progress through work situations, and at those transitions, there's the unknown. And that's a big precipitant of anxiety. So, helping them anticipate, helping them plan, is very useful. Some counseling can go a long way. The other is job-wise. I had a social anxiety, severely affected socially anxious, 20-some-odd years old. Had ended up dropping out of college because it was just too much, but had completed online work. And he's a fantastic programmer in Boston. He's a whiz at it. But he drives in at work an hour early; he gets into his cubicle without seeing anybody. He usually stays late. He does not go out to lunch. And he does that, not because he's a workaholic, but because he's avoiding. And as a result, he's very productive. Then, when he was about 30, tap-tap, "You're great, we're promoting you to team leader," and he fell apart. No surprise there. Fortunately, he came in early, we recognized it. He allowed me to call his supervisor. We talked about it. He went back to being a programmer. He was happy, they were happy, and it prevented a life-affecting meltdown.

Dr. Rosenberg:
You're describing something that's interesting. Have you heard of Peter Principle before?

Dr. Culpepper:

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Yes.

Dr. Rosenberg:
Peter Principle is when you get elevated to a point where you're no longer effective. Because you're effective at the job, they think you should be promoted. I've always thought about that in regards to work efficacy, but I should start thinking about that in terms of competence.

Dr. Culpepper:
Yes.

Dr. Rosenberg:
And abilities and acceptability of that.

Dr. Culpepper:
Yes.

Dr. Rosenberg:
That's fascinating. Let me ask you this question. I have a specific answer on that, but do you screen, number one, and if so, how?

Dr. Culpepper:
Number one, no I do not screen. It doesn't mean I don't case file. This is a critical issue for us in primary care. A lot of the specialists just don't understand this. When we talk about screening, it's everybody that walks through the door, I do something to to try to recognize a condition early, before it manifests symptomatically. There's no evidence that screening for anxiety disorders changes outcome later.

Dr. Rosenberg:
Sure.

Dr. Culpepper:
Part of that is because they're there. They're in front of us. If we're receptive, in terms of understanding the patient sitting across the table from us, we pick up at the point that they're getting in trouble, and we can intervene. I don't screen, but I do case file. So, if I've got somebody that's got a suspicious history that is having problems, is developing new morbidities, I very well may screen that individual. And there, what I typically use is the GAD, 2GAD7.

Dr. Rosenberg:
Right. It's interesting. I think, in primary care, we see these patients. I'm in practice now 21-22 years. You can actually see the change. So, do we need a survey of sorts to do that? I didn't think we did, and I've been a patient center medical home now for about 8 years.

Dr. Culpepper:
Ah! Now we're in a different situation.

Dr. Rosenberg:
Now we're in a different situation. So, we were required to check on that. Results were so interesting we've expanded that. So, we now do a PHQ, a GAD, we do widespread depression and dependence scores, and what's interesting is everybody gets those once a year, unless they're on meds, and then they get them every q.3.

Dr. Culpepper:
Yes.

Dr. Rosenberg:
Okay? Because we're watching change. And what I have found with the patients is if we ask them the question on the survey, and they do it on an iPad, alone, and I get a printout, and I look at that and I say, "Were there any questions that struck a chord with you?" And it's amazing the answers I've heard, and that we would initiate therapy, whereas I wouldn't have picked it up before. So, it's just a different way of looking at it.

Dr. Culpepper:
No question. Couple of things there. You now have staff that can work with you. They may not have the life perspective. They may not have the capacity, in terms of picking up cues from patients that you do, so as you delegate things, it makes sense to think about that. We just don't have evidence yet. The PHQ2 plus the GAD2 have been put together as basically a 4-question screener, and a lot of places use that, and I think that is a very effective approach. Now, one of the caveats, people think GAD7, "Oh, it's just picking up GAD, but how do I identify the other things?" Well, actually, no. We did a study a decade ago; there've been a number of studies. The GAD7 is

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a great screener, positives do relate to anxiety, but there's no correlation between the GAD7 positive and GAD as opposed to any other disorder. So, GAD is a general anxiety disorder family screener, not specific for GAD.

Dr. Rosenberg:
Right. Well, I think when we get the score it brings it to our attention that there may be an issue

Dr. Culpepper:
Yes. Yes.

Dr. Rosenberg:
And, we're running out of time, I want to close it on this. What it does is it initiates the fact that something's going on and should we investigate it further. And one of the questions, I'm not, I like pharmacotherapy, but that doesn't mean I'm going to that.

Dr. Culpepper:
Sure.

Dr. Rosenberg:
The cornerstone for therapy for us is behavioral, cognitive therapy. I've been fortunate enough to have a good psychologic services around me. I partnered up with a psychologist probably 10 years ago. Not in my office, but he's next to my office. And I said, "Anyone who lights up, I'm going to offer help." It's amazing the connection that has happened.

Dr. Culpepper:
That's ideal.

Dr. Rosenberg:
And it helps us prevent medications. Let me just ask you this brief question, brief answer should I say. Anxiety, the whole idea of the short-acting benzo's, remember Valium, Mommy's little helper, we all cringe when somebody comes in and says, "I need my Xanax," because of the, not only the overdose potential but the addictive potential with that. What do we do?

Dr. Culpepper:
Okay. First off, I totally agree. You can't teach a patient how to live their life with a pill, but you can certainly help them increase their coping capacity with cognitive behavioral therapy, with problem-solving therapy, which is another very useful approach, and basically in our office, oftentimes our staff can just engage in just basic counseling, in terms of how to parse a big problem into discrete little problems, figure out what one to start on, and what modest step to get started. Very simple approach, but it can be very helpful for somebody who is so anxious they just can't cope. So, that is useful and then thinking what we're trying to do long-term is help patients life their lives, not help patients be dependent on us and our office. That's where CBT comes in, because it's not just what to do, but it's stepping back and gaining the perspective that, "Oh, I'm in that situation again. I know what to do! I'm going to use that same approach." And that's what really is helpful with therapy. Now, that having been said, I do use, on occasion, antidepressants, the SSRIs for depression, anxiety, particularly if there are other things going on or if the patient just has a lot of stresses that they're not going to be able to get out of. They work, but they're not terribly effective and it's not going to put a lot of patients into remission. But oftentimes, it provides them the capacity to engage much more fully in CBT. And then, it's the decision of when do we get them off of it?

Dr. Rosenberg:
Right. So the analogy is, you've got a patient with a broken leg, you're not going to make them walk on it. You're going to give them a crutch. So as long as we identify that as a crutch, and that's where I get a little bit nervous about the excessive use of the short-acting medications because, unfortunately, people tend to really like them and not want to go off, and they don't realize the harm that's being done.

Dr. Culpepper:
Yes, yes. Now, that having been said, over my career, I have had a very small number of patients, 40 years, probably less than 10, that I have maintained on long-term, long-acting benzo's, because it was the only thing that kept them functioning.

Dr. Rosenberg:
Long-acting or short-acting?

Dr. Culpepper:
Long-acting.

Dr. Rosenberg:
Long-acting, okay. But not the short-acting. Not using that.

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Dr. Culpepper:
So, 12 hour, 24, so the diazepam, clonazepam, and this comes back to an indictment of us. When we look at what drugs get used. You go to Psychiatry World, 80% of what they use are 12 hours or longer, and only about 20% are the alprazolams and the short-acting. When you flip to primary care, 80% of what we use are the short-actings. The one that says the patient, 3 or 4 hours later, “It’s time for my next pill.”

Dr. Rosenberg:
I know.

Dr. Culpepper:
And that’s what we want to get away from.

Dr. Rosenberg:
And, right, and we have to be firm. It’s one of those, you don’t always get what you want, but you are going to get what you need.

Dr. Culpepper:
Exactly.

Dr. Rosenberg:
So, I appreciate your time and this has been fun.

Dr. Culpepper:
It has been.

Dr. Rosenberg:
Thank you.

Dr. Culpepper:
Thank you and thanks for listening.

Announcer Close:
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