The Journal for Nurse Practitioners 17 (2021) 18–25

Contents lists available at ScienceDirect

The Journal for Nurse Practitioners

journal homepage: www.npjournal.org

Identifying and Managing Anxiety Disorders in Primary Care

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Keywords:
anxiety disorders
mental health
pharmacotherapy
primary care

A B S T R A C T

Anxiety disorders are among the most common psychiatric diagnoses and present in patients as excessive fear and worry. Many seeking care for symptoms of anxiety disorders have a chief concern other than anxiety. Because most individuals first seek treatment for anxiety disorders in primary care, it is important to screen, assess, diagnose, and potentially initiate treatment for them in these settings. If left untreated, anxiety disorders can cause significant personal, social, and occupational impairment. Elevated anxiety levels can lead to a fight-or-flight fear response. Evidence-based treatment options are available in both primary care and specialty clinic settings.

More than 30 million Americans experience anxiety, commonly described as fear or worry, over the course of their lifetime.[1] A certain level of anxiety can be helpful and warranted, leading to improved performance or appropriate responses in threatening situations. High levels of anxiety, though, can impact an individual's ability to think clearly, respond accordingly, and maintain attention/concentration to finish tasks.[2] Individuals diagnosed with anxiety disorders experience unremitting levels of anxiety with fear and worry.[2] Approximately 25% to 50%[3] of patients experiencing symptoms of anxiety disorders present to their primary care provider with various somatic complaints[4] and medically unexplained symptoms.[5] This makes diagnosing associated disorders challenging.[3] Anxiety disorders are very treatable, and as a result, screening in primary care settings is essential.[5]

The most common psychiatric diagnosis in the United States is anxiety-related disorders.[6] This group of disorders has an earlier age of onset[6] and is more common among women than men.[7] The point prevalence of anxiety disorders is 13.3%,[3] and lifetime prevalence is 28.8%.[6] Different anxiety disorders include generalized anxiety disorder (GAD), panic disorder (PD), phobias, social anxiety disorder (SAD), and separation anxiety disorder. Without early recognition and treatment, patients can suffer psychosocial and occupational impairment, including higher rates of divorce and unemployment,[4,8] poorer quality of life, and greater reliance on public assistance.[9] Individuals with acute or chronic disorders are also at high risk of suicide.[4,10] The presence of an anxiety disorder itself is a risk factor for developing other anxiety, mood, and substance use disorders.[11]

Screening and Tools

As of May 2020, United States Preventative Services Task Force (USPSTF) guidelines on screening for anxiety disorders is in progress, with no current recommendation. A quarter of patient visits in primary care settings are related to mental health issues.[12] Thus, screening has diagnostic utility for clinicians as well because many symptoms of anxiety are nonspecific and somatic. Symptoms can involve musculoskeletal, cardiac, respiratory, gastrointestinal, and neurologic systems (Table 1).[13,14] Completed medical workups of symptoms without identifiable causes warrant screening and assessment to rule out anxiety disorders.[15]

Fortunately, simple screening questions as well as brief, validated, and easily interpretable and accessible anxiety tools are available[16,17] for primary care providers. These tools are also helpful in differentiating different anxiety disorders (Table 2)[18] and can be especially helpful for providers working under significant time constraints treating patients without obvious medical conditions.

A clinician can ask simple questions that might raise suspicion for a specific anxiety disorder and warrant further assessment and diagnosis (Table 3).[3,15,19-21] Questionnaires for screening are free and available online. Examples of commonly used questionnaires include the Generalized Anxiety Disorder 7 (GAD 7),[17] the Panic Disorder Severity Scale (PDSS), and the Social Phobia Inventory (SPIN). A positive screening for an anxiety disorder is not sufficient for a diagnosis, but is an indication for a diagnostic workup using the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V).

Assessment and Diagnosis

Diagnostic Challenges

Accurately diagnosing an anxiety-related disorder is difficult. Rates of misdiagnosis for GAD, PD, and SAD are 71%, 85.8%, and 97.8%, respectively,[22] by primary care providers. Many disorders are

https://doi.org/10.1016/j.nurpra.2020.10.019
1555-4155/

Table 1
Physical Symptoms of Anxiety[13,14]

Muscle tension
Muscle tenderness
Restlessness
Fatigue
Tachycardia
Dizziness
Sweating
Headaches
Gastrointestinal distress

categorized under anxiety disorders (Table 2).[18] Among individuals seeking care for GAD, only 13.3% state anxiety as their chief concern, whereas 47.8% state somatic complaints.[23] Understanding the salient features of common anxiety disorder presentations in primary care can help clinicians more accurately diagnose them.

The defining features for various anxiety disorders depend on the type of object or situation that induces the anxiety or fear.[18] Ultimately, that stimulus leads to a specific behavioral response.[18] Understanding the distinction between "anxiety" and "fear" is important in understanding the different anxiety disorders. By definition, anxiety is the anticipation of a future, unidentifiable, and obscure threat, whereas fear is the emotional response to an acute, real, objectively harmful stimulus[24,25] (Table 4).[18] These emotional states can elicit defensive behaviors, including freezing, fight, alertness, avoidance, or risk assessment.[24]

Anxiety and fear can be adaptive, productive, and normal emotional states[26] when the situation is warranted. Disordered pathology arises, however, when the anxiety and fear are excessive and persistent. In excess, anxiety affects goal-directed attentional systems by impairing an individual's ability to respond appropriately, to maintain focus without distraction, and to perform as required.[27]

The focus of this report is on anxiety disorder presentations commonly seen in the primary care setting, including GAD, SAD, and PD. Accurate diagnosis of an anxiety disorder requires ruling out other causes of anxiety, including substances and other medical conditions. The impairment and disturbances should also not be better explained by the physiological effects of a substance or by another medical condition.[18]

Generalized Anxiety Disorder

The DSM-V criteria requires that individuals with GAD experience future oriented or anticipatory anxiety and worry for the majority of days in the past 6 months. The anxiety and worry must be difficult to control, resulting in significant distress and impairments (functional, social, or occupational, or all 3). Finally, the individual associates the anxiety with at least 3 of the following criteria:

1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued

Table 2
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Anxiety Disorders[18]

Diagnosis
Generalized anxiety disorder
Social anxiety disorder
Panic disorder
Specific phobias
Substance/medication-induced anxiety disorder
Anxiety disorder due to another medical condition

Table 3
Screening for Anxiety Disorders[3,15,19,20,21]

Disorder	Screening Questions	Key Features	Screening Tools	Items, No.	Administered by
Generalized anxiety disorder	Do you consider yourself a worrier? What do you worry about?	Somatic and psychic symptoms present; constant worry about everyday topics that is difficult to control;	General Anxiety Disorder 7 (GAD-7) Hamilton Rating Scale for Anxiety (HAM-A)	7 14	Self Clinician
Panic disorder	Have you ever had a panic attack? Do you ever unexpectedly feel nervous and notice your heart beating quickly or that it's hard to breathe?	Sudden, unexpected, and recurrent anxiety attacks with or without trigger; physical manifestations can include dyspnea, tremor, sweating, palpitations; avoidance behaviors to avoid further panic attacks	Panic Disorder Severity Scale (PDSS)	7	Clinician
Social anxiety disorder	Do you avoid social situations? Are you uncomfortable in social situations? Are you uncomfortable with public speaking? Do you feel nervous around others and worry they will judge you?	Fear of social situations where individual might be judged negatively or embarrass themselves; avoidance of social situations; differentiate from performance anxiety	Social Phobia Inventory (SPIN) Liebowitz Social Anxiety Scale Clinician/ Self-Report (LSAS-CR/SR)	17 24	Self Self or clinician

Table 4
Differentiating Anxiety and Fear[18]

Variable	Anxiety	Fear
Definition	Focused on preparing for future danger/threat	Focused on immediate danger/threat
Clinical features	Muscle tension Vigilance	Fight-or-flight response with autonomic arousal
Behavioral response	Cautious Avoidant	Escape
Potential pathology	Generalized anxiety disorder	Panic disorder

3. Difficulty concentrating; mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance

When experiencing GAD, an individual's anxiety and worry are focused on routine elements of daily life and are out of proportion with his or her current reality when anxiety is present.[28] Worries can be related to health, family, finances, and work. Individuals may ruminate over to-do lists and play out worst case scenarios.[28] Finally, the constant state of anxiousness can result in physical manifestations (Table 1).[13,14]

Social Anxiety Disorder

According to the DSM-V, individuals with SAD experience fear or anxiety about being in situations that involve engaging in social interactions, facing observation by others (ie, eating in public), and performing in front of others (ie, public speaking). The individual fears scrutiny, negative evaluation, and rejection. Thus, the social situations almost always cause distress or impairment. The individual responds by avoiding the situation or feeling intense anxiety/fear while enduring it. It is necessary to determine whether the fear is related exclusively to speaking or performing in public, because this would be classified as performance anxiety.

Panic Disorder

PD has a lifetime prevalence between 1.5% and 3%.[6,29] A diagnostic feature outlined for PD includes panic attacks or recurrent and unexpected episodes of fear, worry, or distress.[30] The attacks present in individuals as a sudden surge of intense fear or intense discomfort that reaches a climax within 10 minutes.[30] This sudden surge can occur when the individual is calm or when anxious. At least one of the attacks occurs after 1 or more months of experiencing either of the following: constant concern or worry about having additional panic attacks or feeling their consequences (Table 3),[3,15,19-21] or a behavioral response related to the attack.[18] This can include avoiding triggering sources. Finally, diagnosis requires an individual to endorse at least 4 of 13 physical symptoms associated with the attacks (Table 5).[18] PD may or may not be associated with agoraphobia.

Individuals diagnosed with PD often feel distress about the recurrence of future panic attacks, the context in which they happen, and their consequences.[30,31] They may avoid situations as a result. Research indicates a strong association between PD and suicidal ideations and attempts.[32] It is important to note that panic attacks can occur as symptoms of other anxiety disorders as well.

Differential Diagnosis

Understanding the common comorbidities (Table 6)[2,18,33-36] and differential diagnoses associated with anxiety-related disorders can help a clinician make a more accurate diagnosis with a higher degree of confidence. For example, there are medical conditions with symptoms that overlap with anxiety disorders. Differential diagnoses[37] can include hyperthyroidism, pheochromocytoma, hyperparathyroidism, arrhythmia, or obstructive pulmonary diseases. Additionally, other psychiatric disorders[37] should be considered as well, including major depressive disorder and bipolar disorder. Substance use should also be ruled out before diagnosis. Specific differential diagnoses for GAD, PD, and SAD can be found in Table 7.[18,33]

Treatment

Anxiety disorders are complex, and treatment modalities can vary from person to person based on a number of factors (Table 8).[38] Anxiety disorders do not always require treatment if symptoms are mild or transient and cause little to no impairment in social and occupational functioning.[21] Effective treatment can include psychiatric medication management in primary care settings or specialized therapy in secondary psychiatric care settings, or both.[33] Treatment adherence is also important. Thus, primary care providers should educate patients about their anxiety, different treatment options, and the adverse effects of the medications.[21] This section will focus on the pharmacologic and nonpharmacologic treatment of GAD, PD, and SAD as they are most commonly encountered in primary care settings.[39]

Nonpharmacologic Treatment

Cognitive behavioral therapy (CBT) is effective in reducing the symptoms of anxiety disorders and for helping maintain some remission in the long-term.[40] Although CBT has the strongest research support for treating anxiety disorders, other psychotherapies have demonstrated limited support and require further evaluation. Firstly, psychodynamic therapy has some research support as an efficacious treatment for various anxiety disorders, including GAD,[41] PD,[42] and SAD.[43] In psychodynamic therapy, childhood and current relationships, including the therapeutic alliance, are discussed and analyzed to reduce symptoms.

Table 5
Symptom Checklist for Panic Disorder[18]

Palpitations, pounding heart, or accelerated heart rate
Sweating
Trembling or shaking
Sensation of shortness of breath or smothering
Feelings of choking
Chest pain or discomfort
Nausea or abdominal distress
Feeling dizzy, unsteady, light-headed, or faint
Chills or heat sensations
Paresthesia
Derealization (feeling of unreality) or depersonalization (being detached from oneself)
Fear of losing control or "going crazy"
Fear of dying

Table 6
Common Comorbidities Associated with Anxiety Disorders[2,18,33,34,35,36]

General Anxiety Disorder	Panic Disorder	Social Anxiety Disorder
Other anxiety disorder	Major depressive disorder	Other anxiety disorder
Unipolar depressive disorder	Bipolar disorder	Substance use disorder
	Other anxiety disorder	Major depressive disorder
	Substance use disorder	Bipolar disorder
	Cardiovascular conditions	Body dysmorphic disorder
	Arrhythmias	
	Chronic obstructive pulmonary disease or asthma	

Secondly, mindfulness- and acceptance-based psychotherapies have also demonstrated some efficacy for anxiety disorders such as GAD[44,45] and panic and agoraphobia disorder.[46,47] Mindfulness- and acceptance-based psychotherapies aim to reduce symptoms by helping clients develop a nonjudgmental awareness of various internal states (thoughts, emotions, and physical sensations) based on acceptance rather than resistance.

Ultimately, for patients resistant to psychotropic medications, there are other options. There is growing evidence to suggest natural, nonchemical treatments that include mindfulness, meditation, and yoga can also be effective in treating anxiety.[48]

First-Line Pharmacologic Treatment

Anxiety disorders can be caused by dysfunctions in serotonin, noradrenaline, dopamine, γ-aminobutyric acid, glutamate, cholecystokinin, opioid receptors, or the hypothalamic-pituitary-adrenal axis.[49,50] Thus, there are a variety of treatment targets. The first-line treatment for anxiety disorders includes selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs)[50-52] (Table 9),[50,53] which are classified as antidepressants. These are the preferred first-line agents given their relative overall tolerability, safety, and low potential for misuse compared with tricyclic antidepressants (TCAs), monoamine oxidase inhibitors, and benzodiazepines.[2,54]

Screening for bipolar disorder is extremely important before initiating an antidepressant. Hypomania and mania can be adverse effects of antidepressant treatment,[55] including SSRIs, mirtazapine, venlafaxine, and TCAs.[56] Whether the medication class triggers bipolar disorder or induces it is unclear.[57] Prescribing clinicians should screen for past experiences of mania or hypomania with antidepressant treatment and evaluate for bipolar disorder when necessary.[56] Referring or consulting with a psychiatric provider might be warranted (Table 10).[2,4]

It can take up to 6 weeks for patients to feel the anxiolytic effects[37,52,58] of an SSRI or SNRI, although some may achieve benefits in 2 weeks. However, providers should adequately trial a medication for at least 6 weeks unless there are noxious adverse effects. Some adverse effects are transient, appearing within the first 2 weeks of treatment[21] (Table 11).[53,59,60] Among psychotropic medications, SSRIs have the least reported adverse effects.[61] Gradual titration with a lower starting dose[21] of SSRIs is helpful in avoiding or reducing adverse effects associated with higher doses.[62]

Additionally, starting SSRIs at a lower dose is particularly helpful at reducing potential activation (restlessness, jitteriness, nervousness) that might worsen panic.[63] Long-term considerations for patients include sexual dysfunction and weight gain with SSRI treatment[59,64] and sexual dysfunction, discontinuation syndrome, and increased blood pressure with SNRIs.[65]

The efficacy of SSRIs and SNRIs appears comparable through various trials, but they can differ in categories of evidence and recommendation grade[54] for specific anxiety disorders. Ultimately, selecting the right medication can include weighing the evidence and grade, patient preferences, and the adverse effect profile for treatment-naïve patients.[66]

Second-Line Pharmacologic Treatment

Tricyclic Antidepressants

When an SSRI or SNRI is not effective after adequate trial (Table 9),[50,53] is contraindicated, or has been poorly tolerated in the past, trial with a TCA might be helpful. Clomipramine and imipramine are 2 with more evidence to support use for PD. Some studies have found TCA effectiveness for GAD with utility for anxious mood, muscle tension, poor concentration, and insomnia.[66]

Patients may feel anxiolytic effects at 2 weeks, and efficacy might be comparable to benzodiazepines when appropriately dosed.[67] However, there is a heavy adverse effect profile with prominent anticholinergic effects, α-adrenergic blockade, seizures, and cardiac complications. Thus, caution is advised in certain populations. First, TCAs present greater risk for lethal QTc prolongation compared with SSRIs.[68,69] Second, this is an important consideration when a patient has cardiac comorbidities or higher risk for suicide.[70] TCA overdose can be lethal, and toxicity can result in electrocardiogram changes, including the deadly rhythm torsades des pointes[71] (Table 11).[53,59,60]

Benzodiazepines

Benzodiazepines are the most widely prescribed anxiolytic agent because they are favored by patients for their rapid therapeutic effects.[72] However, they have significant short-term and long-term adverse effects[73] and should be used sparingly because of the strong risk for dependence and addiction. They should be avoided in patients with a history of addiction and substance use disorders. Additionally, research suggests that benzodiazepines are ineffective with comorbid anxiety and depression that is significant.[74]

Patients treated with short-acting benzodiazepines like alprazolam (Xanax; Pfizer Inc) may experience “breakthrough” or

Table 7
Differential Diagnoses Associated with Anxiety Disorders[18,33]

General Anxiety Disorder	Panic Disorder	Social Anxiety Disorder
Social anxiety disorder	Hyperthyroidism	Normative shyness
Obsessive compulsive disorder	Hyperparathyroidism	Agoraphobia
Posttraumatic stress disorder	Caffeine or stimulant abuse	Panic disorder
Adjustment disorder	Pheochromocytoma	General anxiety disorder
Other depressive disorder	Partial complex seizures	Separation anxiety disorder
Bipolar disorder	Other seizure disorder	Delusional disorder
Psychotic disorder	Other cardiopulmonary conditions	Autism spectrum disorder
	Eating disorder	Personality disorder
	Posttraumatic stress disorder	

Table 8
Factors Impacting Choice of Treatment Plan[38]

Patient's preference
Severity of illness
Comorbidities
Concomitant medical illnesses
Substance use
Suicide risk
History of previous treatments
Affordability
Treatment availability

"interdose" anxiety, causing patients to take more than the prescribed dose.[48] Withdrawal from short-, medium-, and long-acting formulations can precipitate seizures with abrupt discontinuation.[75]

Benzodiazepines can be sedating and unsafe, affecting driving and using machinery, and can also interact with alcohol.[73] They also have short-term implications for attention, concentration, and memory[76] while also increasing long-term risk for dementia compared with those without prior use.[77,78]

Benzodiazepines should not be used, however, given the risks associated with it. Chronic use presents major challenges[79] and deprescribing them has become a major obstacle for providers. They should be avoided despite some past research recommending use for short-term treatments including while titrating an SSRI or SNRI to therapeutic doses.[66]

Pregabalin

If initiating an SSRI or SNRI is not feasible, pregabalin is also an option for treating anxiety disorders including GAD and SAD.[21,80] Patients may find earlier symptom relief with pregabalin, especially with notable improvement in sleep,[21] compared with other antidepressants. Additionally, SSRIs and SNRIs are not known for alleviating somatic symptoms of anxiety, unlike pregabalin, which can reduce somatic and psychic symptoms.[81] However, there is potential for abuse,[82] so screening for substance use disorders, current or previous, is imperative.

Buspirone

Buspirone is both an effective and well-tolerated second-line anxiolytic option for the treatment of GAD, especially in benzodiazepine-naïve patients.[83] It is not effective as an acute anxiolytic because therapeutic effects can take 2 to 4 weeks.[84] It can be useful when the adverse effects of an SSRI cannot be tolerated and is approved for the short- and long-term treatment of GAD.[85]

Table 10
Reasons to Refer to a Mental Health Specialist[2,4]

Patient does not respond to treatment trial(s) after adequate dosing for 4-6 weeks
Patient is unresponsive to 2 trials of first-line medications
Anxiety disorder has comorbid substance use disorder, major depression, or personality disorder
Patient is immediately suicidal
Degree of impairment and functioning is severe
Discomfort managing psychotropic medications in primary care

Other Treatment Options

SSRIs, SNRIs (for GAD), and TCAs are more standard in the treatment of anxiety disorders, although other options are available when these are not a fit for the patient. Examples may include using a medication that is approved for another anxiety disorder or even one that is not approved but has been effective in randomized controlled trials or open trials.[38] These can include moclobemide, opipramol, hydroxyzine, mirtazapine, and inositol.[38] First- and second-generation antipsychotics can be useful in treatment of anxiety, but might require consultation with, supervision under, or referral to a psychiatric specialist.[3]

Medication Considerations

Discontinuing Treatment

When an SSRI, SNRI, or TCA is abruptly discontinued, patients can experience "discontinuation syndrome." Associated symptoms are flu-like and can include diaphoresis, myalgia, dizziness, insomnia, irritability, and tearfulness.[2] Therefore, downward titration is important, especially when a patient is treated at higher doses.[2]

Switching Medications

Adequate trial of a first-line medication is typically 6 weeks while allowing 2 weeks at the full therapeutic dose.[2] When a patient is not responding to a particular treatment, then switching to another medication may ultimately be indicated. If a medication is well tolerated but response is limited, a clinician should consider increasing the prescribed dose while considering therapeutic levels, adverse effects, and patient-specific comorbidities. If there is still a limited response at a higher dose, then switching within or between classes is indicated.[66] Half-lives of medications should be considered and incorporated when switching medications.

Table 9
Medication Selection for Anxiety Disorders[21,50,53]

Class	Medication	GAD	PD	SAD	Starting Dose	Dosing
SSRI	Citalopram	• 2	• 2	• 2	10 mg	20-40 mg
	Escitalopram	•1	• 2		5 mg	10-20 mg
	Fluoxetine	•2	•1	•2	10 mg	20-80 mg
	Fluvoxamine		•2	•2	50 mg IR or 100 mg ER	50-300 mg
	Paroxetine	•1	•1	•1	10 mg IR or 12.5 mg ER	20-50 mg
	Sertraline	•1	•1	•1	25 mg	50-150 mg
SNRI	Duloxetine	•1			30 mg	60-120 mg
	Venlafaxine[a]	•1	•1	•1	37.5 mg	75-225 mg
TCA	Clomipramine		•2		25 mg	75-250 mg
	Imipramine		•2		25 mg	150-300 mg
Calcium modulator	Pregabalin	•2			75 mg BID	150-600 mg
Anxiolytic	Buspirone	•1			10-15 mg	≤ 60 mg

1 = United States Food and Drug Administration-labeled indication; 2 = off-label use; ER = extended release; GAD = general anxiety disorder; IR = immediate release; PD = panic disorder; SAD = social anxiety disorder; SNRI = serotonin-norepinephrine reuptake inhibitors; SSRI = serotonin reuptake inhibitor; TCA = tricyclic antidepressant.
[a] Venlafaxine: ER capsules only for GAD, PD; ER capsule or tablet for SAD.

Table 11
Medications and Common Adverse Effects[53,59,60]

Medication	Adverse Effects
SSRI	Nausea, sleep disturbances, sexual dysfunction, appetite changes, headache, dry mouth, gastrointestinal upset, increased anxiety
SNRI	All adverse effects of SSRIs plus hypertension and tachycardia
TCA	Dry mouth, dizziness, blurred vision, constipation, sedation, orthostatic hypotension, tachycardia
Buspirone	Dizziness, nervousness, nausea, headache, jitteriness
Pregabalin	Peripheral edema, dizziness, somnolence, ataxia, weight gain

SNRI = serotonin-norepinephrine reuptake inhibitors; SSRI = serotonin reuptake inhibitor; TCA = tricyclic antidepressant.

Clinical Guidance for Referral and Hospitalization

Individuals with symptoms of anxiety disorders will often present to primary care initially. Hospitalization may be indicated for patients with suicidal ideations and unresponsiveness to treatments.[39] It is appropriate to initiate treatment in the outpatient setting with first-line agents for trials with titration and dosing. This can include switching medications within the same class, switching to another class, or augmenting when there is a partial response. In some cases, referral might be best (Table 10).[2,4]

Special Populations

Older Patients

Research in older populations is limited. Controlled studies have found certain medications, such as duloxetine, venlafaxine, pregabalin, and quetiapine, are effective for those older than 65 years.[38] However, this population is at higher risk for adverse effects with a greater sensitivity to adverse effects.[21] Education on adverse effects should include anticholinergic effects, orthostatic hypotension with risks for falls, and cardiovascular events.[21]

Children and Adolescents

Anxiety disorders increase risk for suicide attempts in children and adolescent populations.[86,87] Additionally, treatment with antidepressants can increase risk for suicidal ideations especially in the early weeks after initiating the drug. Thus, treating this population requires caution, providing education, and potential collaboration with specialty level of care.

Pregnancy and Breast-feeding

Research suggests that treatment with a combination of therapy and medications is favorable compared with leaving anxiety or depression untreated.[88] However, this population requires a higher level of care to avoid increased risk and harm to a fetus. Antidepressants have been associated with increasing risks for spontaneous abortions, stillbirths, preterm labor, respiratory distress, endocrine dysfunction, or a combination of these.[89]

Treatment might include using the lowest effective dose, monotherapy, and encouraging simultaneous use of counseling services.[88] This population might require careful collaboration with a psychiatric provider or the obstetrician, or both. Additional care is recommended for breast-feeding mothers with weighing risks and benefits.[21]

Summary

Anxiety disorders are common, with symptoms that manifest physically and psychologically. When the disorders are moderate to severe, they can be debilitating for an individual, leading to significant impairment in functioning. Treatments, pharmacologic and nonpharmacologic, are evidence-based and widely available. Most individuals present first to their primary care providers with symptoms of an underlying anxiety disorder. Thus, it is crucial that primary care providers understand how to recognize symptoms of anxiety, especially when the chief concern is unrelated. Recognizing, screening, and subsequently initiating some plan or treatment can be tremendously impactful in improving an individual's quality of life and overall level of functioning.

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In compliance with national ethical guidelines, the authors report no relationships with business or industry that would pose a conflict of interest.