Treatment of anxiety disorders and its role in suicide prevention

Leo SHER, Field editor

Millions of people around the world suffer from anxiety disorders [1]. About 20% of people in the U.S. experience an anxiety disorder [2]. Most of these individuals receive treatment in general medical rather than specialty psychiatric settings [3]. A recent study examined the frequency of anxiety disorders in primary care in the UK [4]. The British Health Improvement Network was used to identify all patients aged 10–79 years with a new diagnosis of anxiety in 2002–04 and age-, sex- and calendar-year-matched controls. The study showed that the prevalence of anxiety was 7.2% and the incidence was 9.7 per 1000 person-years. This study also indicated that anxiety patients used health care services more frequently than controls.

Many patients with anxiety disorders experience physical symptoms related to anxiety and subsequently visit their primary care providers. Anxiety disorders are disabling and generate increased expenses because the physical manifestations of anxiety often prompt costly diagnostic procedures [5].

Despite the high prevalence rates of anxiety disorders, they often are underrecognized and undertreated. In primary care, only a small minority of anxious patients receive treatment targeting their anxiety [6].

Most anxiety disorders begin in childhood, adolescence, and early adulthood. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) [7] classifies the anxiety disorders into the following categories: anxiety due to a general medical condition; substance-induced anxiety disorder; generalized anxiety; panic disorder; acute stress disorder; posttraumatic stress disorder; adjustment disorder with anxious features; social phobia; obsessive-compulsive disorder; specific phobias.

Different anxiety symptoms, such as panic, worry, rumination, and obsessions, can present in a variety of psychiatric conditions including mood disorders, psychotic disorders, personality disorders, somatoform disorders, and cognitive impairment disorders (e.g., delirium). Anxiety also can be observed as part of a drug withdrawal or drug intoxication effect. Other important causes in the differential diagnosis include sleep disorders such as restless legs syndrome, sleep apnea, and periodic limb movement; medication-induced anxiety, migraine, seizure disorders, or other CNS-based disorders.

The treatment plan for anxiety disorders in primary care should include [8]: initial education of the patient and discussion about treatment; provision of some simple cognitive-behavioral therapy skills; selection of initial medication treatment; selection of alternative or adjunctive treatments when the initial approach has not produced optimal results; monitoring treatment outcome; indications for mental health referral.

It is important to note that avoiding an authoritarian and prescriptive approach with the anxious patient is essential, since such a style inadvertently encourages repeated reassurance seeking and discourages self-activation.

Anxiety disorders have consistently been associated with an increase in suicidal behavior in cross-sectional community and clinical studies [9–11]. For example, a recent epidemiological study indicated that among individuals reporting a lifetime history of suicide attempt, over 70% had an anxiety disorder and the presence of an anxiety disorder was significantly associated with having made a suicide attempt [11]. It is clear that patients with anxiety disorders warrant explicit evaluation for suicide risk.

It is very important for primary care physician to be able: to recognize anxiety disorders; to inquire about suicidal ideation or plan; to distinguish patients that can be treated in a primary care setting from patients that need to be referred to a psychiatrist.

Primary care is where patients often present physical and emotional issues that signal distress. Studies indicate that many individuals who commit suicide have seen a primary care provider within the month prior to their death [12]. Educating primary care physicians about psychiatric conditions including anxiety disorders and suicidal behavior will safe many lives.

The World Federation of Societies of Biological Psychiatry (WFSBP) has created a new Task Force, "Treatment of Mental Disorders in General Medical Practice." Robertas Bunevicius (Lithuania) is the Chair of this Task Force. Siegfried Kasper (Austria) is the Co-Chair. Florence Thibaut (France) is the Secretary of the Task Force. Members of the Task Force (in alphabetical order): Wioletta Barańska-Rybak (Poland), Wiesław J. Cubała (Poland), David Fiellin (USA), Jaanus Harro (Estonia), Henry R Kranzler (USA), Alison Moore (USA), Victor JM Pop (Netherlands), Elmars Rancans (Latvia), Jill Rasmussen (UK), Richard Saitz (USA), Djea Saravane (France), Thomas E. Schlaepfer (Germany), Leo Sher (USA), SW Tang (Hong Kong), Leonas Valius (Lithuania), David Wong (Hong Kong), Larisa M. Zhitnikova (Russia), and Josef Zohar (Israel). It is to be hoped that the new Task Force will promote the psychiatric education among clinicians working in the fields of family medicine, internal medicine, cardiology, pediatrics, developmental disabilities, surgery, oncology, gynecology, etc., and contribute to treatment of mental disorders around the world.

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