Are There Reasons to Fear Anxiety Screening?

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Mental disorders are a leading cause of disease burden worldwide, with anxiety disorders being the second most influential contributor, after depressive disorders, to global disability-adjusted life-years. Anxiety disorders are characterized by anxious mood and, often, phobic avoidance, which result in extreme distress, functional impairment, or both. The Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (DSM-5) recognizes the following types of anxiety disorders likely to be seen in adults: generalized anxiety disorder, social anxiety disorder, panic disorder, agoraphobia, specific phobias, substance/medication-induced anxiety disorder, and anxiety disorder due to another medical condition. The latter 2 instances of anxiety are caused by identifiable and, mostly, treatable sources and should be considered “rule-outs” before concluding that one of the other anxiety disorders is present.

Anxiety disorders typically have onset early in life, hence the importance of screening for anxiety in children and adolescents when there is the opportunity to promptly intervene and prevent what can often be lifelong impairment. There are also 2 anxiety disorders that are encountered predominantly, though perhaps not exclusively, in pediatric settings: selective mutism and separation anxiety disorder. The US Preventive Services Task Force (USPSTF) recently recommended screening for anxiety in children aged 7 to 18 years, but it is too early to know the extent to which these guidelines are being implemented and far too early to know if they have had a positive impact.

In a new Recommendation Statement in this issue of JAMA, the USPSTF now recommends, based on an accompanying Evidence Report, that all adults aged 18 to 64 years be screened for anxiety. This is a B recommendation, stemming from adequate evidence that screening tools can accurately identify anxiety in this population and moderate evidence that efficacious treatments exist. The recommendation emphasizes the need to include persons who are pregnant or postpartum, an important consideration given that anxiety disorders are more common in women than men. The USPSTF did not find sufficient evidence to make a recommendation for or against screening in older adults. Below are some of the implications of these new recommendations.

The anxiety disorders are a heterogeneous group, sharing symptoms of anxiety and avoidance but differing in the foci of the fears associated with each disorder. There are many anxiety disorders with distinct diagnostic criteria can make it more challenging for clinicians to ask the right questions to arrive at the correct diagnosis (or, often, diagnoses) and to apply or refer for the appropriate treatment. For example, despite the moniker “generalized anxiety disorder,” there is nothing particularly generalized about the disorder. Rather, generalized anxiety disorder is a very specific anxiety disorder, characterized at its core by excessive worry about multiple parameters of daily living (eg, finances, job, health). Conversely, one of the commonly used screening measures, the 7-Item Generalized Anxiety Disorder (GAD-7) scale (or the briefer GAD-2), is not specific for generalized anxiety disorder but rather is also sensitive to several of the other anxiety disorders. This feature of the anxiety screening instruments has the potential beneficial effect of enabling the identification of many of the anxiety disorders, not solely generalized anxiety disorder. It may also be problematic, because positive screening results may unearth symptoms stemming from a broad array of anxiety-related conditions, some of which the clinician may be relatively unfamiliar with and unprepared to address.

In addition to generalized anxiety disorder, commonly encountered in adult medical settings—and likely to be picked up with anxiety screening—are panic disorder, characterized by recurrent unexpected attacks of acute anxiety and associated physical symptoms; agoraphobia, characterized by avoidance of a variety of anxiety-provoking situations (eg, driving a car; crossing bridges; going to supermarkets) and often a consequence of panic disorder; and social anxiety disorder, characterized by fear and avoidance of social situations in which the individual perceives himself to be under scrutiny (eg, public speaking; meeting new people).

With these distinctions in mind, it is important to remember that the USPSTF recommendations are geared toward screening for “anxiety”—which is a symptom, sometimes a trait, but not a disorder—and whereas a positive screen result will often reflect an anxiety disorder, it might alternatively reflect myriad other stress-related anxiety-inducing circumstances (eg, marital or occupational stress) or anxiety-related conditions (eg, major depression with anxious distress; alcohol withdrawal). The GAD-7 and GAD-2 ask about “the past 2 weeks;” so they are just as liable to detect anxiety associated with transient stressors—which may be expected to dissipate with time and nonspecific psychological support—as they are to detect severe or chronic anxiety problems, which may require more intensive and specialized care. In pointing to the need for further evaluation and treatment, anxiety screening will also highlight the current and worsening disparities in access to mental health treatment in the face of increased need demonstrated by these groups.
What happens when a patient screens positive? Further evaluation is required at the point of screening to determine the level of acuity and need for referral or treatment. Whereas most anxiety-positive screen results will reflect anxiety stemming from a mental disorder for which further psychological evaluation is in order, some anxiety symptoms will be the result of a physical health condition (eg, thyroid disease) or lifestyle problem (eg, excessive caffeine or other stimulant intake) that sits squarely in the wheelchair of the primary care clinician. Clinicians screening for anxiety in the primary care setting should be prepared to rule out these possible causes of anxiety before referring to a mental health practitioner, particularly if that mental health practitioner does not have medical training.

Although not called out in the USPSTF Recommendation Statement, a positive screen result for anxiety should be immediately followed with clinical evaluation for suicidality. Though widely understood that depression may be accompanied by suicidal ideation, suicidal intent, or both and that assessment of depression must include an evaluation of suicide risk, the high risk of suicide in the anxious patient—even in the absence of comorbid depression—is not widely appreciated, and a positive anxiety screening result may be less likely to trigger suicide screening than a positive depression screen result. Anxiety screening will typically take place concurrently with USPSTF-recommended depression screening, which should prompt specific questions about suicidal ideation.

Also not directly discussed in the USPSTF Recommendation Statement is the high likelihood that a positive screen result for PTSD (PTSD). Whereas PTSD was classified as an anxiety disorder through the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), the framers of the DSM-5 decided to move PTSD into a separate category of “trauma and stressor-related disorders.” Nevertheless, it is indeed the case that anxiety screening instruments such as the GAD-7 (or GAD-2) will detect PTSD. The USPSTF seems to have missed an opportunity to highlight this inevitable consequence of screening for anxiety, ie, that some of what is picked up will be PTSD. Clinicians should be alerted to this omission and be prepared to follow up with requisite questions about traumatic experiences that will be needed to home in on a diagnosis of PTSD that may require additional follow-up, referral, or both.

Evidence-based treatments (psychological and pharmacological) for anxiety disorders are available and have shown to be efficacious but may be less familiar to primary care physicians than is the case for the treatment of depression. There are models for treating anxiety in primary care, such as using mental health specialists as consultants to primary practitioners for most cases, and allowing for referral for more complex cases, but these models have not been widely disseminated beyond research settings. This recommendation to routinely screen for anxiety disorder must be accompanied by the recognition that there are too few mental health specialists available to manage the care of all patients with anxiety disorders, and even fewer who provide services for low-income and non-English-speaking populations.

The uptake of these new anxiety screening recommendations should provide an impetus and an opportunity for primary care clinicians to become more comfortable with diagnosing and treating anxiety disorders, which may require additional training. Anxiety disorders can be distressing and disabling, and appropriate recognition and treatment can be life-altering and, in some cases, lifesaving, for patients.

REFERENCES


