

## **ADDENDUM II- NON SEDATIVE-HYPNOTIC TREATMENT OF ANXIETY, TRAUMA AND OBSESSIVE-COMPULSIVE DISORDERS**

**SCOPE:** This toolkit is intended to offer non-sedative-hypnotic treatment options for providers, clients, and the interested general public for the treatment of anxiety, trauma and obsessive-compulsive disorders. It is a supplement to the BHS Safer Prescribing of Sedative-Hypnotic Guideline.

**GENERAL CONSIDERATIONS:** Anxiety, trauma and obsessive-compulsive disorders encompass a group of conditions including but not limited to generalized anxiety disorder, panic disorder, social anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder. These disorders may present alone or co-occur with other psychiatric conditions such as depression, bipolar disorder, schizophrenia, and substance use disorders. Proper diagnosis and treatment of other psychiatric conditions may alleviate anxiety, such as antipsychotics for schizophrenia or mood stabilizers for mania. Anxiety may manifest as a symptom of an underlying medical problem or as a side-effect of medications. Treatment of these disorders should begin by evaluating for and treating any underlying medical problems and by targeting any contributory medications. These disorders may be treated with non-pharmacological interventions, such as psychotherapy and behavioral treatments, as well as with medications. Selective serotonin reuptake inhibitors (SSRIs) are recommended as first line pharmacologic treatment for anxiety, trauma and obsessive-compulsive disorders.

Psychotherapy can help uncover underlying causes of fears, teach clients how to relax and decrease anxiety responses, look at situations in new ways and develop better coping and problem-solving skills. Many people find relief from acute symptoms in 8-10 weeks of focused therapy, with ongoing treatment helpful in maintaining and supporting change. In general, the types of psychotherapy most studied and found to be effective focus on cognitive and behavioral change. Cognitive-Behavioral Therapy (CBT) focuses on helping individuals understand how automatic thoughts and false beliefs lead to exaggerated emotional responses, such as anxiety, which then lead to behavioral consequences. Behavioral techniques include greater exposure to anxiety-provoking stimuli. Over time, one becomes desensitized to the triggering event. Other psychotherapeutic techniques include Acceptance and Commitment Therapy (ACT), Prolonged Exposure therapy (PE) and Cognitive Processing Therapy (CPT). Relaxation techniques, breathing exercises, stress reduction, and lifestyle changes including diet and physical exercise may all contribute to the effectiveness of both psychotherapy and psychopharmacological treatment of anxiety disorders. In addition, there are many self-help manuals available with detailed instruction and worksheets (examples are included in this toolkit) as well as mobile apps specific for anxiety disorders. Mobile apps can be effective tools that make therapy more accessible, efficient, and portable for those suffering with anxiety. The Anxiety and Depression Association of America has reviewed several apps for anxiety. Clients and providers can find more information about those apps at [www.adaa.org](http://www.adaa.org).

**SPECIAL CONSIDERATIONS FOR OLDER ADULTS:** The use of sedative-hypnotics in older adults should be avoided due to increased risk of adverse events including falls and hip fractures that can lead to hospitalization and death, increased risk of delirium, cognitive impairment, and motor vehicle accidents. A recent meta-analysis compared the evidence of various interventions for tapering off benzodiazepines in older adults. This study found that supervised taper augmented with psychotherapy, such as CBT, resulted in higher odds of not using benzodiazepines post-intervention. Other interventions studied included taper plus a provider prescribing intervention (education, medication regimen reviews, prescribing feedback) and taper plus pharmacotherapy.

**SPECIAL CONSIDERATIONS FOR CONCOMITANT OPIOID TREATMENT:** Studies show that 16.5-50% of patients with chronic pain also suffer from an anxiety, trauma or obsessive-compulsive disorder. The combination of opioids and sedative-hypnotics can create synergistic sedation with a risk of dangerous respiratory depression. Recent guidelines from the American Society of Interventional Pain suggest that the use of sedative-hypnotic medications are relatively to absolutely contraindicated in individuals on chronic opioid treatment because of the safety risks. Because of the heightened risks of sedative-hypnotic medications and the high rate of anxiety disorders, alternative treatments for anxiety and related disorders are needed.

**GENERALIZED ANXIETY DISORDER**

Generalized anxiety disorder (GAD) is characterized by excessive anxiety and worrying that is hard to control, causes significant distress and impairment, and occurs on more days than not for at least six months. Other symptoms associated with the disorder include feeling on edge, becoming easily fatigued, problems concentrating, irritability, muscle tension, and sleep disturbance. CBT addresses the above problems by encouraging evidence-based thinking to change the catastrophizing of negative events, and enhancing problem-solving, decision-making and time management skills. Behaviorally, CBT aims to reduce procrastination and avoidance by repeated exposure to anxiety-provoking situations. Progressive muscle relaxation can reduce muscle tension and vigilance to threat.

Refer to appendix 1 for worksheets to be used during CBT sessions for the treatment of GAD. Refer to appendix 2 for mobile phone applications that can be used in conjunction with in-person therapy.

Refer to table below for pharmacological treatment of GAD. Refer to appendix 3 for information on herbal supplements.

Medication Class/Name	Dosage Range	Comments
SSRIs (sertraline, paroxetine, citalopram, fluoxetine, escitalopram)	Similar to dosing for depression	Should be used first line as they have the most evidence to support use. All are thought to be equally effective. Start at lower doses to avoid initial agitation. Medication selection guided by side effect profile.
SNRIs (venlafaxine XR, duloxetine)	Similar to dosing for depression	Comparable efficacy to SSRIs. Start at lower doses to avoid initial agitation. Medication selection guided by side effect profile
Mirtazapine	7.5mg-45mg/day	Less studied than SSRIs and SNRIs. Lower doses are more sedating. May increase appetite, triglycerides. May cause weight gain.
Buspirone	10mg-60mg/day	Works best when used in conjunction with SSRIs/SNRIs. Onset of effect is delayed by 2 weeks, so best if doses daily rather than PRN.
Hydroxyzine	25mg-400mg/day	May be helpful for symptomatic use in the short term. <b>Anticholinergic, especially at high doses- refer to Safer Prescribing of Antipsychotic Medications Guideline for more information about the risks of anticholinergic medications.</b>

Pregabalin	150mg-600mg/day	May be helpful for discontinuing long term benzodiazepines for those with GAD. Dose should be reduced for CrCl<60ml/min. Upon discontinuation, dose should be tapered over a week.
Gabapentin	300mg-1200mg TID	Dose should be reduced for CrCl<60ml/min.
Imipramine	75mg-300mg	Not first line because of poor tolerability. Monitor for anticholinergic side effects. <b>Cardiotoxic in overdose.</b>

## PANIC DISORDER

Panic disorder is characterized by recurrent panic attacks (abrupt episodes of intense fear lasting minutes to hours) accompanied by anxiety about having future attacks and/or the consequences of those attacks or a change in behavior related to the attacks (i.e., avoidance of the precipitating circumstances). CBT teaches clients a set of cognitive and somatic coping skills to manage their anxiety as they increase their exposure to feared situations and sensations. They learn to replace catastrophic thoughts with more neutral thoughts and coping strategies, and learn breathing and relaxation skills to control dysregulated physiological responses. They are then encouraged to practice these skills in the presence or feared bodily sensations or situations. Through repeated exposure, clients learn that panic-related symptoms are not harmful, that they can be tolerated and managed, and that tasks can be accomplished which were previously avoided.

Refer to appendix 1 for worksheets to be used during CBT sessions for the treatment of Panic Disorder. Refer to appendix 2 for mobile phone applications that can be used in conjunction with in-person therapy.

Refer to table below for pharmacological treatment of Panic Disorder. Refer to appendix 3 for information on herbal supplements.

Medication Class/Name	Dosage Range	Comments
SSRIs (sertraline, paroxetine, citalopram, fluoxetine, escitalopram)	Similar to dosing for depression	Most evidence to support use. All are thought to be equally effective. Start at lower doses to avoid initial agitation. Medication selection guided by side effect profile.
SNRIs (venlafaxine XR, duloxetine)	Similar to dosing for depression	Comparable efficacy to SSRIs. Start at lower doses to avoid initial agitation. Medication selection guided by side effect profile.
Clompiramine Imipramine	100mg-250mg/day 75mg-250mg/day	Comparable efficacy to SSRIs, but less well-tolerated. Monitor for anticholinergic side effects. <b>Cardiotoxic in overdose. Clompiramine is contraindicated in epilepsy.</b>
Phenelzine Tranlycypromine	45mg-90mg/day 30mg-60mg/day	Last line, for treatment resistant disorders. Allow for 2-week wash out period when switching to or from an alternate antidepressant (5 weeks for fluoxetine). <b>Patients must avoid tyramine containing foods.</b>
Mirtazapine	7.5mg-45mg/day	Less studied than SSRIs and SNRIs. Lower doses are more sedating. May increase appetite, triglycerides. May cause weight gain.

Pindolol	2.5mg TID	Can augment antidepressant. <b>Avoid in patients with asthma.</b>
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### SOCIAL ANXIETY DISORDER

Social anxiety disorder (SAD), also known as social phobia, is a common disorder characterized by excessive fears of scrutiny, embarrassment, and humiliation in social or performance situations, leading to significant distress or impairment in functioning. A subset of patients with SAD have symptoms only during performance situations. CBT treatment is designed to help the client understand the maladaptive nature of their concerns about social situations, identify specific thoughts and beliefs associated with social situations, and by exposing themselves to social encounters which challenge these maladaptive thoughts and beliefs. Group therapy has been shown to be effective within twelve weeks and provides the opportunity to work with social situations in treatment which individual therapy does not.

Refer to appendix 1 for worksheets to be used during CBT sessions for the treatment of SAD. Refer to appendix 2 for mobile phone applications that can be used in conjunction with in-person therapy.

Refer to table(s) below for pharmacological treatment of SAD.

Medication Class/Name	Dosage Range	Comments
SSRIs (sertraline, paroxetine, citalopram, fluoxetine, escitalopram)	Similar to dosing for depression	Most evidence for paroxetine and sertraline.
Venlafaxine XR	75-300mg/day	Comparable efficacy to SSRIs. Monitor for increases in blood pressure.
Mirtazapine	7.5mg-45mg/day	Less evidence than SSRIs and SNRIs. Lower doses are more sedating. May increase appetite, triglycerides. May cause weight gain.
Pregabalin	Target dose of 600mg/day, titrated from 100mg TID	Dose should be reduced for CrCl<60ml/min. Upon discontinuation, dose should be tapered over a week.
Phenelzine	45mg-90mg/day	Last line, for treatment resistant disorders. Allow for 2-week wash out period when switching to or from an alternate antidepressant (5 weeks for fluoxetine). <b>Patients must avoid tyramine containing foods.</b>
Gabapentin	300mg-1200mg TID	Dose should be reduced for CrCl<60ml/min.
Propranolol (performance anxiety)	20mg-240mg/day in divided doses	Mixed evidence about effectiveness in performance anxiety and panic disorder. <b>Avoid in patients with asthma or other airway disease.</b> Monitor blood pressure and heart rate.

### POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder (PTSD) is a chronic and disabling disorder that develops following exposure to a traumatic event involving actual or threatened injury. It is characterized by intrusive thoughts, re-experiencing of trauma through flashbacks and nightmares, avoidance of trauma reminders,

hypervigilance, negative alterations in mood, and sleep disturbance. CBT with exposure therapy is recommended as a first-line treatment. Exposure to memories or triggering situation(s) in a safe environment allows for emotional processing, so that individuals can reduce strong emotional responses and avoidance behaviors, leading to a greater feeling of safety. In addition, coping skills training for assertiveness, stress management, relaxation, sleep hygiene and exercise complement all forms of treatment and do not focus on traumatic events. Clients who suffer from both trauma related symptoms and substance use disorder(s) may benefit from a Seeking Safety Group which is offered widely throughout the SFHN BHS system.

Refer to appendix 1 for worksheets to be used during CBT sessions for the treatment of PTSD. Refer to appendix 2 for mobile phone applications that can be used in conjunction with in-person therapy.

Refer to table below for pharmacological treatment of PTSD.

Medication Class/Name	Dosage Range	Comments
SSRIs (sertraline, paroxetine, citalopram, fluoxetine, escitalopram)	Similar to dosing for depression	Most evidence for fluoxetine, paroxetine and sertraline. Common practice to push the dose to the highest end of the therapeutic range before concluding that a therapeutic trial has failed. Medication selection guided by side effect profile.
Venlafaxine XR	37.5mg-300mg/day	Improves symptoms of re-experiencing and avoidance/numbing, not helpful for hyperarousal. Monitor for increases in blood pressure.
Mirtazapine	7.5mg-45mg/day	Less studied than SSRIs and SNRIs. Lower doses are more sedating. May increase appetite, triglycerides. May cause weight gain.
Nefazodone	200mg-600mg/day in 2 divided doses	Take on an empty stomach. Risk of <b>hepatotoxicity- do not use with known liver disease</b> . Monitor LFTs every 3-6 months and discontinue therapy if AST/ALT reach 3x or greater the upper limit of normal.
Imipramine Amitriptyline	75mg-300mg 50mg-200mg	Not first line because of poor tolerability. Monitor for anticholinergic side effects. <b>Cardiotoxic in overdose</b> .
Phenelzine	45mg-90mg/day	Last line, for treatment resistant disorders. Allow for 2-week wash out period when switching to or from an alternate antidepressant (5 weeks for fluoxetine). <b>Patients must avoid tyramine containing foods.</b>
Prazosin	3-15mg	Helpful for trauma-related nightmares. Start with 1mg and titrate carefully, monitoring blood pressure. Watch out for first dose effect
Clonidine Guanfacine	0.1mg-0.6mg/day 1mg-4mg/day	Decrease sympathetic outflow from the CNS. May be helpful for agitation and hyperarousal not adequately treated by SSRIs. Monitor blood pressure and pulse.

### OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder (OCD) is characterized by distressing, intrusive, obsessive thoughts and/or repetitive compulsive physical or mental acts that the individual feels driven to perform in order to reduce anxiety. CBT with exposure and response prevention helps clients gain mastery over their fears

without having to act on them ritualistically. Before exposure, an individual creates an exposure hierarchy, ranking triggers from most to least distressing. Exposure begins with the least distressing items and moves up the hierarchy. During exposure, clients refrain from acting on compulsive responses and practice new behavioral responses daily. This type of therapy will, by definition, create discomfort, and education should be provided.

Refer to appendix 1 for worksheets to be used during CBT sessions for the treatment of OCD. Refer to appendix 2 for mobile phone applications that can be used in conjunction with in-person therapy.

Refer to table below for pharmacological treatment of OCD. Refer to appendix 3 for information on herbal supplements.

Medication Class/Name	Dosage Range	Comments
SSRIs (sertraline, paroxetine, citalopram, fluoxetine, escitalopram)	Similar to dosing for depression	Most evidence to support use. Higher doses produce a higher response rate and symptom relief.
Clomipramine	100-250mg/day	May be more effective than SSRIs but less tolerated. Titrate from 25mg/day to minimum effective dose. Contraindicated in epilepsy. <b>Cardiotoxic in overdose.</b>
Venlafaxine XR	75-300mg/day	Comparable efficacy to SSRIs. Monitor for increases in blood pressure.

## **APPENDIX 1: CBT WORKSHEETS**

[Introduction to Anxiety](#)

[My Fears](#)

[What are Panic Attacks?](#)

[Panic Assessment](#)

[The Cognitive Behavioral Model](#)

[Challenging Negative Thoughts](#)

[Cognitive Distortions](#)

[Core Beliefs](#)

[Countering Anxiety](#)

[The Mental Health Benefits of Exercise](#)

[Exposure Hierarchy](#)

[Relaxation Techniques](#)

[Progressive Muscle Relaxation Script](#)

[Thought Log](#)

## APPENDIX 2: MOBILE PHONE APPLICATIONS

**These apps are not intended to be used as self-help without the guidance of a professional mental health care provider.**

### 1. ACT Coach

ACT Coach was designed for individuals who are in Acceptance and Commitment Therapy (ACT) with a mental health professional and want to use an ACT App in conjunction with their therapy. The App is designed to improve rates of patient participation in treatment and, as a result, treatment outcomes. Additionally, the App is designed to help providers adhere to published treatment protocol.

ACT aims to help individuals live with unpleasant thoughts, feelings and impulses without avoiding them or being controlled by them. In ACT, patients are encouraged to commit to actions based on what they value, with a focus on the present, even in the face of these unpleasant experiences. ACT Coach is designed to be used in conjunction with therapy to help with strategies for integrating personal values into their daily lives. It also includes reminders of ACT philosophy and principles and tools for tracking how they are doing in their therapy.

ACT Coach is designed to be used interactively by both clinician and patient as an aide to face-to-face therapy using ACT principles. A requirement for successful use of this App by health care providers is formal clinical training in ACT. This App does not provide training in ACT and will not serve as a substitute for this training.

#### Need to Know:

- The App provides patients with exercises, tools, information and tracking logs to help them practice what they learn in therapy in their daily life.
- ACT can be useful for anyone who struggles with depression, anxiety, posttraumatic stress disorder or other trauma-related difficulties.

#### Features include:

- Six mindfulness exercises to practice the ACT core concepts of acceptance and willingness
- Tools to help identify personal values and to take concrete actions to live by them
- Logs for keeping track of useful coping strategies and willingness to practice ACT skills

ACT Coach is available for Apple mobile devices (iPhone, iPad, and iPod touch). Download the free app at: <https://mobile.va.gov/app/act-coach>

## 2. Mobile App: PE Coach

PE Coach is designed for individuals to use in Prolonged Exposure (PE) therapy for Posttraumatic Stress Disorder (PTSD) with a behavioral health professional. The App provides tools to help users work with their therapist during PE therapy to process their traumatic experience and reduce anxiety and fear.

PE Coach is designed to be used interactively by both clinician and patient as an aide to face-to-face PE Therapy. A requirement for successful use of this App by health care providers is formal clinical training in PE Therapy. This App does not provide training in PE and will not serve as a substitute for this training.

### Need To Know:

- PE Coach provides tools for patients using PE Therapy to reduce their symptoms of PTSD.
- PE Coach is integrated with smartphone calendar functionality to encourage patient recall and session attendance.
- The App can be useful to any trauma survivor participating in PE treatment.

### Features Include:

- Audio and visual information about PE and common reactions to trauma.
- Capability for audio recording of PE therapy sessions directly onto the patient's mobile device.
- PTSD symptom tracking over time to evaluate treatment progress and outcomes.
- Tools to support patient tasks between sessions.
- An interactive breathing retraining coach.

Download the free app at either of these sites:

- <https://itunes.apple.com/us/app/pe-coach/id507357193?mt=8>
- <https://play.google.com/store/apps/details?id=org.t2health.pe>

## 3. Mobile App: CPT Coach

CPT Coach was designed for individuals with posttraumatic stress disorder (PTSD) who are participating in Cognitive Processing Therapy (CPT) with a professional mental health care provider and want to use a CPT App in conjunction with their therapy. The App is designed to improve rates of patient participation in treatment and, as a result, treatment outcomes. Additionally, the App is designed to help providers follow published treatment protocol.

### Need to Know:

- The App contains support materials for a complete course of CPT to help patients manage their treatment, including between session assignments, readings, PTSD symptom monitoring and mobile versions of CPT worksheets.
- CPT has been shown to be one of the most effective treatments for PTSD from both civilian and military-related traumas.

### Features Include:

- An assessment tool for tracking symptoms and progress
- CPT homework assignments and worksheets for each session

- Reminders for therapy sessions
- Educational materials about CPT and its treatment components

Trauma survivors often have ways of thinking about the world that can cause emotional distress and disrupt their daily activities, as they avoid various people, places and situations to avoid thinking about their traumatic experience. To reduce symptoms of PTSD and improve functioning, survivors can work to process their thoughts and feelings about their trauma, so that they are more comfortable with difficult memories. CPT focuses on enhancing processing of the trauma and reducing avoidance behaviors. The CPT Coach App augments therapy by making it easier for patients to complete the necessary practice assignments, as well as by providing convenient educational material, support and reminders.

CPT Coach is not a self-help tool for patients. It is designed to be used interactively by both clinician and patient as an aide to face-to-face treatment using CPT principles. A requirement for successful use of this App by health care providers is formal clinical training in CPT. This App does not provide training in CPT and will not serve as a substitute for this training.

CPT Coach is available for Apple mobile devices (iPhone, iPad, and iPod touch). Download the free app at: <https://itunes.apple.com/us/app/cpt-coach/id804271492?mt=8>

### APPENDIX 3: HERBAL SUPPLEMENTS

In contrast to prescription medications, companies that manufacture herbal supplements do not have to seek FDA approval before putting their products on the market. They can claim that their products address a nutrient deficiency, support health or are linked to body functions, as long as they include a disclaimer that the FDA has not evaluated the claim. Once an herbal supplement is on the market, the FDA is responsible for monitoring its safety. If a product is found to be unsafe, the FDA can take action against the company and may require the product to be removed from the market.

The regulations surrounding herbal supplements do not guarantee that they are effective or safe for anyone to use. Supplements should be reviewed for possible adverse effects and drug interactions before being cleared for client use. Most insurance plans do not cover herbal supplements, so clients may have to pay out-of-pocket if they wish to try them. The table below describes some supplements used for GAD, PD and OCD.

<b>Generalized Anxiety Disorder</b>			
<b>Supplement</b>	<b>Dose range</b>	<b>Efficacy</b>	<b>Comments</b>
Chamomile	1100mg/day	One small randomized trial showed modest efficacy (p =0.047) in mild to moderate GAD.	Well tolerated, though allergies and anaphylaxis reported
Kava	125-250 mg/day	Number of studies found in favor of kava over placebo in anxiety, but results are not consistent.	<b>Hepatotoxicity</b> , sedation, tremors, ataxia, visual disturbance, mild euphoria, urinary retention, scaly skin rash with heavy use
L-theanine	200-400mg/day	May provide relief of anxiety symptoms in psychotic disorders, but no evidence to support use in GAD.	Well tolerated
<b>Panic Disorder</b>			
<b>Supplement</b>	<b>Dose range</b>	<b>Efficacy</b>	<b>Comments</b>
Inositol	12-20gm/day	Limited evidence from 2 small studies.	Flatulence, mania
<b>Obsessive-Compulsive Disorder</b>			
<b>Supplement</b>	<b>Dose range</b>	<b>Efficacy</b>	<b>Comments</b>
Inositol	18gm/day	Limited evidence as monotherapy; No evidence for additional benefit as augmentation to SSRI treatment.	Flatulence, mania
N-acetyl cysteine	1200-2400mg/day	Limited evidence from small randomized controlled trial suggest tolerability and efficacy for adjunct treatment.	Well tolerated
Valerian Root	765mg/day	Superior to placebo as monotherapy in one small study.	Somnolence, vivid dreams

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