

HOW TO OVERCOME WORRY

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Physiological, Psychological, and Theological Helps

Introduction – Questions

1. Scripture References
 - Philippians 4:6-7
 - I Peter 5:7
 - Matthew 6:34
 - Isaiah 43:2
 - Psalms 57:1
2. Worry – healthy or not
 - The Bible
 - Surgery
 - Psychiatry – The neurotransmitters
3. Seven ways to overcome worry
 - Medications can often abate worry; behavioral steps can also help including:
 - Decipher the odds. Perhaps 95 percent of worries never come true and most of life's catastrophies we never see coming. Thus, worry is useless.
 - Live one day at a time. Obsessive worriers live in the future; depressive worriers live in the past. The future is not here; the past is gone; live in the present.
 - Get the facts. Worries often fade with facts. Get more facts concerning a worry. Perhaps maximization has increased the problem. Perhaps the big picture has been missed. Perhaps facts will help.
 - Share with a friend. An old aphorism says that a burden shared is only half a burden. Build a few friendships and share often.
 - Use the time limit technique. Limit worry time to a specific 10 minute period per day. Refuse to participate in non-stop worry.
 - Accept the possible in a worry. Accept the possible if the worry just will not abate, and then take action; prepare for the worst and improve on it. However, the worst will often not happen, but this technique may offer some freedom from worry.
 - Form a plan of action. When troubles come form a plan of action; list good options; list bad options; list crazy options—be creative. Then pick out five options from a list of 25.

4. Antianxiety medication: antianxiety drugs: nuances of interest
- The first antianxiety drug were barbiturates and meprobamate in the 1930's
 - TCAs were used in anxiety disorders in the early 1960's
 - MAOIs were also found to be effective in anxiety disorders in the early 1960's
 - The benzodiazepines were found to be effective in anxiety disorders in the 1960's
 - In the 1980's buspirone (BuSpar, an azopyrone) was used in GAD
 - SSRIs (the most popular antianxiety agents today) were used in the 1980's and beyond
 - SNRIs were used in the 1990's and 2000's
 - Anticoagulants, beta-blockers, and antipsychotics have been used off-label for anxiety
 - To treat anxiety disorders with SSRI or SNRI the general rule is to start lower and go higher than in treatment of depressive disorders
 - TCAs used for anxiety can be lethal in overdose
 - Benzodiazepines increase the effects of GABA (the most calming neurotransmitter of the brain) through allosteric receptors; when GABA interacts on the postreceptor site and results in an increased passage of chloride ions
 - Some benzodiazepines increase both GABA_A and GABA_B (diazepam/Valium); most benzodiazepine increase GABA_A.
 - Buspirone (BuSpar) is approved for GAD; it is a partial agonist at 5HT_{1A}; its metabolite, 1-phenyl-piperazine, has an anxiolytic effect by action on alpha-2-adrenergic
 - Betaadrenergic blockers are used off-label for their antianxiety effects; they antagonize epinephrine and norepinephrine; they act primarily on a peripheral basis; beta-blockers include: propranolol (Inderal), timolol (Istalol), nadolol (Corgard), atenolol (Tenormin), betaxolol (Kerlone), metoprolol (Toprol XL, Lopressor), penbutolol (Levatol), acebutolol (Sectral), and esmolol (Brevibloc)
 - Gabapentin (Neurontin) and pregabalin (Lyrica) have been used off-label for anxiety; they increase GABA in a nonaddicting way
 - Tigabine (Gabrilitril) has been used off-label for anxiety; it blocks the reuptake of GABA by transport inhibition
 - GAD drugs include: benzodiazepines, buspirone (BuSpar), paroxetine (Paxil), venlafaxine (Effexor)
 - Fluoxetine (Prozac), paroxetine (Paxil), and sertraline (Zoloft) are approved for PMDD
 - SAD drugs include: sertraline (Zoloft), venlafaxine (Effexor), paroxetine (Paxil), benzodiazepines

- Panic disorder drugs include: sertraline (Zoloft), paroxetine (Paxil), venlafaxine (Effexor), benzodiazepines
- PTSD drugs include: paroxetine (Paxil), sertraline (Zoloft)
- OCD drugs include: fluoxetine (Prozac), fluvoxamine (Luvox), sertraline (Zoloft), paroxetine/Paxil, clomipramine (Anafranil); citalopram (Celexa) has been used for treatment of refractory OCD; drugs with FDA approval in pediatric OCD include: sertraline (Zoloft), fluoxetine (Prozac), and fluvoxamine (Luvox)
- SNRIs have been used for GAD, SAD, PTSD, PD, and OCD; the most common side effects include somnolence, dry mouth, and nausea
- TCAs have been used for GAD, PTSD, PD, and OCD; they do not seem very effective against SAD; TCAs with more of a serotonergic effect [amitriptyline (Elavil), imipramine (Tofranil)] have been used more in PD
- Trazadone (Desyrel) seems effective in GAD
- Other nuances of interest in antianxiety drugs are:
 - Benzodiazepines have at times paradoxically worsen the course of PTSD by inducing depression
 - The benzodiazepines, alprazolam (Xanax), and clonazepam (Klonopin), are often effective in PD
 - While buspirone (BuSpar) is effective in GAD, it seems ineffective many times in OCD, SAD, and PD
 - Beta-blockers have been used off-label in performance anxiety, but seems ineffective many times in SAD, PD, and OCD; beta-blockers have been used with somatic symptoms of anxiety; beta-blockers can block traumatic memories in PTSD
 - Anticonvulsants [gabapentin (Neurontin), valproic acid (Depakote), and tigabine (Gabrilitril)] have been used off-label in PD
 - Topiramate (Topamax) has been used off-label to decrease intrusive thoughts in PTSD
 - Sertraline (Zoloft) has been started at 25 mg/day or higher for week 1 in GAD; venlafaxine (Effexor) is often started at 75 mg/day for week 1 in GAD
 - Common side effects of SSRIs include GI (nausea, diarrhea) and headaches
 - The most common side effects of benzodiazepines is drowsiness; rare side effects of benzodiazepines include anterograde amnesia, rash, and memory problems
 - The sedative effects of benzodiazepines are increased with alcohol, analgesia, and barbiturates
 - The absorption of benzodiazepines is decreased by food; the plasma levels are decreased by barbiturates, carbamazepines, steroids, and rifampin; the plasma levels are increased by antifungals, contraceptives, cimetidine (Tagamet), disulfiram

(Anatabuse), erythromycin, fluvoxamine (Luvox), isoniazid, and nefazodone (Serzone)

- Benzodiazepines can be teratogenic; they can cause withdrawal symptoms in neonates; they can cause problems in those with COPD and sleep apnea; up to 50% of patients may have withdrawal symptoms upon discontinuation of benzodiazepines; alprazolam (Xanax) is one of the most problematic in regard to withdrawal syndrome; abuse potential may be the highest with certain benzodiazepines including: alprazolam (Xanax), diazepam (Valium), and lorazepam (Ativan)
- Benzodiazepines vary in their half-lives from long to short—examples include:

	<u>hours</u>
clorazepate (Tranxene)	60
diazepam (Valium)	40 (60 with metabolite)
chlordiazepoxide (Librium)	20 (60 with metabolite)
prazepam	60
clonazepam (Klonopin)	30-40
halazepam (Paxipam)	26-72
flurazepam (Dalmane)	48-72
triazolam (Halcion)	3
temazepam (Restoril)	15
midazolam (Versed)	2.5
alprazolam (Xanax)	14
lorazepam (Ativan)	14
oxazepam (Serax)	9

- Benzodiazepines vary in rate of onset from fast to slow:
 - clorazepate (Tranxene)—fast
 - diazepam (Valium)—fast
 - chlordiazepoxide (Librium)—intermediate
 - alprazolam (Xanax)—intermediate
 - lorazepam (Ativan)—intermediate
 - oxazepam (Serax)—slow
 - prazepam—slow
- SSRIs and SNRIs are often the first-line pharmacological intervention for anxiety in older adults

Conclusion