ANXIETY

José Gildo de Lima – Professor at the Department of Pharmaceutical Sciences - Universidade Federal de Pernambuco

Aline Cavalcanti de Lira – Pharmacist at Hospital das Clínicas – EBSERH - Universidade Federal de Pernambuco

ABSTRACT

Anxiety Disorders

With the changing age structure of the population, epidemiological shifts are observed. The incidence of infectious diseases has declined over the years and has been replaced by chronic diseases such as cardiovascular, cancer, diabetes mellitus, and psychological disorders. Anxiety disorders are more common among people suffering from chronic medical disease, and the number of medical illnesses is positively associated with the presence of anxiety (RAMOS; STANLEY, 2018, p.57).

Anxiety disorders are psychological disorders that have their basis in one of the most rudimentary and adaptive human functions: the innate stress response ('fight or flight'' response) (ABRAMOWITZ; DEACON, 2010, p. 104). So, it is possible that during our lifetime we may suffer some kind of anxiety disorder. In fact, the stress response is designed to motivate us to protect ourselves by preparing to cope with a perceived threat. But when this stress or fear is disproportionate to actual threat or danger and significantly interferes with normal daily functioning, the person is said to have an anxiety disorder (ABRAMOWITZ; DEACON, 2010, p.104, OLTHUIS; WATT; BAILE; HAYDEN; STEWART, 2015, p.12). While fear is the emotional response to an imminent threat, characterized by an acute autonomic system activation, anxiety is better described as the "anticipation of a future threat" (DONELLI; ANTONELLIA; BELLINAZZIB; GENSINIC; FIRENZUOLID, 2019, p. 2).

Anxiety is a disease which affects a large part of the world population. According to (Kessler et al (2007), approximately one in four individuals are likely to have, or have previously had, an anxiety disorder.

*Correspondence to Author:
José Gildo de Lima
Professor at the Department of Pharmaceutical Sciences - Universidade Federal de Pernambuco

Anxiety disorders are characterized by many physical, cognitive, emotional, and behavioural symptoms: trembling, tense muscles, rapid breathing; excessive and uncontrolled worries, difficulty concentrating; distress, negative affect, irritability; difficulty sleeping, hyper arousal (OLTHUIS; WATT; BAILE; HAYDEN; STEWART, 2015, p.12). However, such disorders rarely occur in isolation and co-morbidity with other mental health disorders is common (MAHDI; JHAWAR; BENNETT; SHAFRAN, 2019, p. 141). In addition, there is an association between anxiety and several cardiovascular risk factors such as obesity, hyperglycemia, dyslipidemia and hypertension (TANG; WANG; LIANC, 2017, p. 113). Thus, anxiety causes functional impairment, including academic, occupational, marital, and social dysfunction and reduced quality of life for children, adolescents, adults and older people.

Anxiety disorders are among the most common mental health disorders in youth, with prevalence rates between 9% and 32% during childhood and adolescence (HILL; WAITE; CRESWELL, 2016, p. 548). The presence of anxiety disorders in childhood, adolescence or early adulthood increases the risk of depressive disorders and the probability of a more severe course of depression (chronicity or suicide attempts) (CRASKE; STEIN; ELEY; MILAD; HOLMES; RAPEE; WITTCHEN, 2017, p. 3).

Anxiety disorders are common and costly in older adults. The detection and diagnosis of anxiety disorders in elderly people is complicated by medical co-morbidity, cognitive decline, and changes in life circumstances that do not face younger age groups. Furthermore, the expression and report of anxiety symptoms may differ with age. For these reasons, anxiety disorders in late life may be even more likely to be under-diagnosed than in younger age groups (WOLITZKY-TAYLOR; CASTRIOTTA; LENZE; STANLEY; CRASKE, 2010, p. 191).

Vulnerability and risk factors for all anxiety disorders include female sex (especially in adolescence) and a family history of anxiety or depressive disorders. Smoking and alcohol abuse are also risk factors for anxiety disorders in the sense that they are associated epidemiologically (CRASKE; STEIN; ELEY; MILAD; HOLME S; RAPEE;WITTCHEN, 2017, p. 2 and 3).

Women are more likely than men to be affected. Actually, they are twice as likely to have an anxiety disorder. Nearly 30% of women experience an anxiety disorder at some time during their lives, and there is increasing evidence that anxiety disorders are associated with adverse pregnancy outcomes (KARSNITZ; WARD, 2011, p. 266).

Children of individuals who have at least one anxiety disorder have a twofold to fourfold increased risk for anxiety disorders (CRASKE; STEIN; ELEY; MILAD; HOLMES; RAPEE; WITTCHEN, 2017, p. 3). Thus, anxiety disorders have a strong heritable basis. Twin studies confirm a likely genetic cause. These show that there is roughly 40% heritability for the variance in anxious symptoms (HILL; WAITE; CRESWELL, 2016, p. 548).

The spectrum of anxiety disorders is marked by different clinical presentations, which means that the diagnostic criteria for individual disorders can vary. The major diagnostic criteria for anxiety disorders according to the two most common classification systems, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the International Classification of Diseases, Tenth Edition (ICD-10) are (CRASKE; STEIN; ELEY; MILAD; HOLMES; RAPEE; WITTCHEN, 2017, p. 6 and 8):

• Separation anxiety disorder. Marked fear or anxiety about separation from attachment figures (eg., family members) to a degree that is developmentally inappropriate. Diagnosis requires a 4-week duration in childhood, and a longer duration, typically of at least 6 months, in adulthood;

• Selective (elective) mutism. Consistent failure to speak in particular social situations (eg., school) in which an expectation to speak exists, despite speaking in other situations. Persists for

at least 1 month (beyond the first month of school);

• Specific phobias. Marked fear, anxiety or avoidance of circumscribed objects or situations. Typically persists for at least 6 months;

• Social anxiety disorder (social phobia). It is a persistent and irrational fear of social or performance situations, such as parties and picnics. Typically persists for at least 6 months;

• Panic disorder. It causes panic attacks—repeated, unpredictable, and irrational attacks of fear and anxiety. Persists for at least 1 month;

• Agoraphobia. Marked fear, anxiety or avoidance of situations such as public transportation, open spaces, enclosed places, lines or crowds, or outside the home alone. Typically persists for at least 6 months;

• Generalized anxiety disorder. It is a pattern of serious anxiety and worry that lasts 6 months or more.

Although the specifics of each anxiety disorder vary, they share some common features. These include overestimation of the actual threat and danger associated with the feared situation, underestimation of the individual's ability to cope, and significant interference in normal life experiences such as friendships, school and family life (HILL; WAITE; CRESWELL, 2016, p. 548).

Different instruments can be used to evaluate the severity and progression of an anxiety disorder during its management. These may be self-report questionnaires, completed by the patient himself, or scales used by the physician (PULL, 2009, p. 22-25):

• Clinical Global Impression Severity Scale.

This is a scale used by psychiatric physicians to assess the overall state of gravity of a patient with a mental illness (CGI severity), as well as its evolution over time (CGI improvement).

• Hamilton Anxiety Rating Scale (HARS ou HAM-A).

This scale measures the degree of anxiety and evaluate the effectiveness of treatment on anxiety symptoms through 14 items.

• Liebowitz Social Anxiety Scale.

This is a specific scale for evaluating treatment in social phobia.

• Panic Disorder Severity Scale/PDSS.

This scale is used to evaluate patients with panic disorder.

• Hospital Anxiety And Depression Scale/HAD.

It is a questionnaire completed by the patient himself and that assesses the degree of anxiety (nonspecific of a particular anxiety disorder) and depression.

• Covi Anxiety Scale

The Covi scale consists of 3 items rated from 0 (nonexistent) to 4 (huge) to evaluate the speech, behavior and somatic complaints of the anxious subject.

• Fear Questionnaire.

This is a questionnaire used primarily in the evaluation of patients with social phobia, agoraphobia or simple phobia.

• Yale-Brown obsession-compulsion scale (Y-BOCS).

This is the most commonly used assessment scale for assessing the severity of an obsessive-compulsive disorder.

• Impact Of Event Scale (Revised) IES-R.

It is a tool used in the context of post-traumatic stress disorder.

• J. Sheehan Disability Scale SDS

This scale helps to assess the degree of disability in 3 areas: work / school, social life, family life (0-10 for each).

Pharmacotherapy for Anxiety Disorders

Treatment of anxiety disorders is indicated when a patient shows severe distress or suffers from complications resulting from the disorder (BANDELOW, MICHAELIS, WEDEKIND, 2017, p. 93). It can be done mostly on an outpatient basis or in hospitals in cases that include suicidal behavior, lack of response to standard treatments, or relevant co-morbidity (major depression, personality disorder, or substance abuse) (BANDELOW, MICHAELIS, WEDEKIND, 2017, p. 95).

In clinical practice, anxiety can be controlled by psychotherapy or pharmacotherapy, or psychotherapy associated with drug treatment. Thus, anxiety patients can be treated with most classes of antidepressant and anxiolytic agents, psychotherapeutic treatments and behavioral techniques with scientific evidence of effectiveness. It is noteworthy that in all cases, it is necessary medical care to establish an appropriate therapy adapted to the patient needs, symptoms and family and social situation. These treatments allow people with these disorders to regain control over their lives and daily activities.

In primary care units, the diagnosis of anxiety disorders should be made by a mental health professional: psychologist or psychiatrist. The sooner the person consults, the better his chances of recovery.

Among psychotherapy modalities and interventions explored in the treatment of anxiety disorders, Cognitive Behavioral Therapy (CBT) has the strongest evidence and is considered a first-line treatment option (LOVE; LOVE, 2019, *in press*). CBT is a short-term, goal-oriented treatment designed to reduce anxiety symptoms by modifying maladaptive behavior and patterns of thinking about the self, others, or the world (RAMOS; STANLEY, 2018, p.58).

If the anxiety disorders are too intense and the psychotherapy is not enough to control them a drug treatment may be necessary. So, pharmacological treatment of anxiety is viewed as an alternative or adjunct to psychological treatment (CRASKE; STEIN; ELEY; MILAD; HOLMES; RAPEE WITTCHEN, 2017, p. 11).

Modern pharmacological treatments for anxiety disorders are safer and more tolerable than they were 35 years ago. Unfortunately, treatment efficacy and duration have not improved in most cases despite a greater understanding of the pathophysiology of anxiety (FARACH; PRUITT; JUNA; JERUDA; ZOELLNER; ROY-BYRNE, 2012, p.833). Moreover, not everyone with an anxiety disorder is willing or able to take advantage of established treatments, and many clients drop out before completing treatment (ANTONY, 2010, p. 2).

Different classes of synthetic pharmacological agents have become available for clinical use but with several adverse effects. Thus, the choice of anxiolytic drugs takes into consideration the efficacy, safety and tolerability, treatment duration and discontinuation of the drug. Cost is also an important criterion when choosing a drug treatment.

According to Fedotova et al. (2017), the commonly recommended pharmacological agents for treatment of different anxiety and related disorders are serotonin reuptake inhibitors (SRIs), benzodiazepines, noradrenergic and specific serotonergic antidepressants (NaSSAs), tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), and reversible inhibitors of monoamine oxidase A (RIMAs). These pharmacological agents are recommended for treatment of specific anxiety and anxiety-related disorders in order to reduce severity of symptoms, improve overall functioning, and attain remission of symptoms (LOVE; LOVE, 2019, p. 10 *in press*). Table 1 shows the main pharmacological treatments for anxiety disorder in primary care settings for children and adolescents, and adults.

SRIs can be classified as selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs); their approval as treatments in anxiety started in the early 1990s. These medicines are thought to work by allowing serotonin and serotonin/norepinephrine to remain in the synapse longer, thereby slowing down its activity in the brain and correcting a presumed deficit in the activity of this neurotransmitter (ABRAMOWITZ; DEACON, 2010, p. 105).

Despite side effects, SSRIs are currently first-line treatment options for most anxiety disorders as they are more effective and safe than any other current drug (SARTORI; SINGEWALD, 2019, *in press*). Side effects characteristically last a few weeks, which is why most practitioners start patients on a lower dose and increase after

a week, or as tolerated (KARSNITZ; WARD, 2011, pp. 277). These drugs do not induce physical dependence or abuse. The available SSRIs are (es)citalopram, sertraline, fluoxetine, Fluvoxamine, paroxetine, and sertaline. The SNRIs are most useful for treating the somatic symptoms associated with anxiety disorders, and they include drugs such as duloxetine and venlafaxine. Side effects of SNRIs are similar to those reported for SSRIs.

TCAs and benzodiazepines are considered second-line drugs. TCAs are typically only used if SSRIs are not effective or have not been tolerated, and do not carry a dependency warning and may be used by persons at risk for or actively abusing other substances (KARSNITZ; WARD, 2011, pp. 278).

MAOIs, also an effective treatment for anxiety disorders, have significant drug-drug or drug-food interactions and adverse side effects. Consequently, monoamine oxidase inhibitors are rarely used in primary care for treatment of anxiety disorders (KARSNITZ; WARD, 2011, p. 268).

Table 1 Pharmacological treatment of anxiety disorder in children and adolescents, and adults. Adapted from (LOVE; LOVE, 2019, *in press*).

Drugs	Side effects	Use
SSRIs: Citalopram [a]Escitalopram Fluoxetine [a]Fluvoxamine Paroxetine Sertraline	Nausea, insomnia, somnolence, jitteriness, diarrhea, sexual dysfunction	Children and adolescents: OCD and SAD Adults: GAD, OCD, PTSD, SAD and panic disorder
SNRIs: Duloxetine [a]Venlafaxine	Nausea, insomnia, somnolence, jitteriness, sexual dysfunction, hypertension	Children and adolescents: GAD Adults: GAD, OCD, PTSD, SAD and Panic disorder
Benzodiazepines: Alprazolam Lorazepam [a]Diazepam [a]Clonazepam	Somnolence, dizziness	Children and adolescents: anxiety Adults: GAD, panic disorder, Anxiety disorder and symptoms of anxiety (short-term)
TCAs: Clomipramine [a]Imipramine	Orthostasis, anticholinergic, weight gain, cardiac arrhythmias	Children and adolescents: OCD Adults: OCD, panic disorder and PTSD
Other medication: Hydroxyzine	Dry mouth, dry eyes, sedation Dizziness, seating, nausea, insomnia, somnolence	Children and adolescents: anxiety, acute
Buspirone	Somnolence, dizziness Somnolence, dizziness	Adults: anxiety, acute Adults: GAD
Gabapentin Pregabalin Propranolol	Bradycardia, hypotension, dizziness, weight gain	Adults: anxiety (adjunct) and SAD Adults: GAD and SAD
Quetiapine	Somnolence, dizziness, weight gain, and other long-term metabolic side effects	Adults: anxiety, acute (SAD, performance anxiety, panic) PTSD, prophylactic Adults: GAD, OCD and PTSD

[a] only in adults. Abbreviations: SSRIs, Selective Serotonin Reuptake Inhibitors; SNRIs, Serotonin-Norepinephrine Reuptake Inhibitors; TCAs, Tricyclic Antidepressants; GAD, Generalized Anxiety Disorder; OCD, Obsessive Compulsive Disorder; PTSD, Posttraumatic Stress Disorder; SAD, Social Anxiety Disorder.

Beginning with chlordiazepoxide in 1960, benzodiazepines have been used extensively for the treatment of anxiety and related disorders. Eight benzodiazepine derivatives have been approved by the Food and Drug Administration for this purpose (SHADER; GREENBLATT, 1993, p. 1398). These anxiolytics include diazepam and lorazepam (low-potency benzodiazepines), and alprazolam and clonazepam (higher potency benzodiazepines).

Benzodiazepines are efficacious, but their use is recommended for a short period of time. Prolonged use of benzodiazepines may aggravate the problems of the anxious person,

exposing them to a risk of tolerance and dependence (SOUSA; VEDANA; MIASSO, 2016, p. 9). The longer the treatment and the higher the doses, the stronger the dependency and the harder the withdrawal. Discontinuation of the drug must be gradual and supervised (RADAN, 2017, p. 46). These drugs should be used cautiously (or not used at all) in individuals with alcohol or other substance use disorders (CRASKE; STEIN; ELEY; MILAD; HOLMES; RAPEE ;WITTCHEN, 2017, pp. 11).

In addition to their anxiolytic properties, benzodiazepines are clinically useful in the treatment of insomnia, epilepsy and other neuropsychiatric disorders (TECOTT, 2010, p. 529).

Benzodiazepines are less toxic and less likely to cause fatal accidents than barbiturates and meprobamate, the first drugs historically used for anxiety disorders. Thus, benzodiazepines took the place of barbiturates, becoming the most used drugs with sedative, anxiolytic, hypnotic, myorelaxant and anticonvulsant properties. This was also due to the lower potential for addiction and the higher therapeutic index (LIRA; LIMA; BARRETO; MELO, 2014, p.224).

As mentioned above, benzodiazepines should be used for short-term anxiety treatment

and should not exceed two to four months, except in very special cases. However, in practice, it is the continuity of a use that goes beyond a specific purpose and an indefinite time, in which

the medicine occupies a fundamental and indispensable place in the lives of many individuals (LIRA; LIMA; BARRETO; MELO, 2014, p.224).

All these pharmacological agents should be used after consideration of their risks and benefits to the patient in order to maximize patient compliance and treatment response (LOVE; LOVE, 2019, *in press*).

Compliance with medication treatment by people with anxiety disorder

Among the strategies for the treatment of anxiety disorder is surely the guarantee of adherence to pharmacological treatment, a preponderant factor in restoring the user's health.

Adherence is a multifactorial process that is structured through a partnership between who cares and who is cared, taking into account the frequency, constancy and perseverance regarding the care needed for a person living with health problems (SILVEIRA; RIBEIRO; BRANT, 2005, p. 94).

According to Tavares et al. (2016), adherence to drug treatment is necessary to achieve better treatment outcomes. Therefore, it is necessary the commitment of the patient himself as well as the involvement of family members and the continuous and constant monitoring of health professionals. The main factors of non-adherence to treatment are related to individual patient characteristics (socioeconomic profile, gender, age, income, education, drug use, acceptance and level of knowledge of the disease), the disease itself (apparent symptoms and chronicity), the medications used (efficacy and safety) and the interaction between the patient and the health services (doctor-patient relationship, posture and language of the professional, trust in the health team, duration of the consultation and aspects of accessibility to the service) (CAMARGO; CAPITÃO; FILIPE, 2014, p. 224).

Certain health conditions or treatments may have characteristics that lead to specific barriers to adherence. According to Cruz et al. (2016), in primary care services, difficulties related to drug therapy in anxiety disorder, which contribute to

the patient's non-adherence to treatment, involve:

1- Lack of knowledge or insufficient knowledge about pharmacological diagnosis and treatment.

Understanding about the disorder and treatment is necessary to justify the need for the drug and, therefore, to motivate adherence. Patients may feel unhappy to see that the medicine does not provide immediate effect. They may consider the effects of pharmacological treatment limited and therefore feel unconvinced about its effectiveness. As anxiety disorders are often associated with prolonged disabilities and can lead to remissions and relapses, it is very important that the doctor, when prescribing a drug, carefully explain to the patient that the drug has no healing power, but only relieves the symptoms (NIH, 2015, p. 3).

Adequate knowledge of the patient about the medicines which he takes is a fundamental factor for adherence to them. Recently, in their study on adherence to medication treatment by people with anxiety disorder, Sousa, Vedana and Miasso (2016) found that there was a higher frequency of adherence among participants with more than 50% knowledge in relation to the name, dose and frequency of medication administration.

It is noteworthy that it is indispensable for the patient to know the dose of the medicines that he takes, given the serious consequences that an excessive dose of medicines can cause, especially in patients with anxiety disorder who take antidepressants and anxiolytics (SOUSA; VEDANA; MIASSO, 2016, p.8).

2- Their concerns, fears and dissatisfaction with the adverse effects of medicines.

Concern and fear of adverse reactions due to the use of anxiolytic medications can compromise treatment adherence. The possibility of side effects is a concern during treatment with psychotropic drugs, because it can inhibit the patient starting treatment or even abandon it. It is important that health professionals, especially doc-

tors and pharmacists, can provide users with information about their medications, the likely benefits of treatment; the expected side effects; the withdrawal syndrome; drug interactions, etc (SANTA CATARINA, 2015, p.7). Besides that, patients may be dissatisfied with the realization that the drug does not provide immediate effects, the effects of pharmacological treatment are limited and little convinced of its efficacy.

3- Drug supply failures.

Essential anxiolytic medications must be provided and constantly available at all levels of health care. On-site treatment should be offered at the time of diagnosis and monitored at subsequent appointments to assess response and possible need for change (SANTA CATARINA, 2015, p.5).

4- Inability to use medicine and the need for a service that is not reduced only to the medicalization.

Hence the importance of a multidisciplinary and interdisciplinary team to develop an intervention plan to encourage adherence to drug treatment by users and to establish strategies that focus on listening, education, autonomy and skills for the safe use of prescription drugs.

In short, understanding these aspects that hinder adherence is the first step in their management and overcoming. It is noteworthy that in the daily practice of health services, the difficulties of adherence must be identified and understood on a case by case basis. This is because the experience of difficulties, as well as ease of adherence, differs from one person to another. It is in the listening process that specific individual contexts may be appropriated by the team, favoring the appropriate and resolute approach (BRASIL; 2008, p.19).

Regardless of the prescription of pharmacological treatment, the following general recommendations should be made to all patients and families, as recommended by the Clinical Protocol of the Psychosocial Care Network for the reception and treatment of generalized anxiety disorders (SANTA CATARINA; 2015, p. 6):

a) The patient should be encouraged to practice daily relaxation methods to reduce physical symptoms of tension;

b) The patient should be encouraged to engage in pleasurable activities and physical exercise, and to resume activities that were useful in the past;

c) Identifying and challenging exaggerated concerns or pessimistic thoughts can reduce anxiety symptoms;

d) Identifying events that trigger excessive worry can help formulate strategies to reduce anxiety;

e) Discuss what the patient is doing to handle unpleasant situations by identifying and reinforcing attitudes that are working;

f) Identify some specific measures the patient may take in the coming weeks.

Examples of the profile of benzodiazepine users in the context of Primary Health Care

Primary Health Care requires a broad intervention in several aspects to have a positive effect on the population's quality of life. Thus, Primary Health Care must have important strategies, with actions aimed at promoting and protecting both individual and collective health (LIRA; LIMA; BARRETO; MELO, 2014, p.223).

The irrational use of medicines is a frequent condition in society and reaches a central role in contemporary therapy. The World Health Organization (WHO) estimates that more than half of all medicines are inappropriately prescribed, dispensed, or sold (OFORI-ASENSO; AGYEMAN, 2016, p. 1). The primary care pharmacist is recognized by the WHO as the best trained professional to conduct actions to improve access and promote the rational use of medicines through pharmaceutical assistance.

According to Carvalho and Dimenstein (2004), benzodiazepine consumption has become a complex public health problem that is widespread. Benzodiazepines are among the most indiscriminately consumed psychotropic substances in the world. Its consumption can lead to changes in behavior as well as lead to psychic and/or physical dependence, often resulting in serious personal and social complications. Such medications are called soothing, tranquilizing and sedative because they exert a selective action on anxiety.

In general, the prescription of these drugs is also inadequate, especially at the primary level of care in family health units. The main reasons are the lack of time, the underestimation of the number of users, the severity of use and side effects, and even the non-observance of the guidelines (NORDON; AKAMINE; NOVO; HUBNER, 2009, p.153).

Bearing in mind that Pharmaceutical Assistance is committed to ensuring safe and effective access to medicines through activity committed to the principles of primary care and to a better understanding of individual and social problems as a consequence of indiscriminate use of benzodiazepines, it is essential to obtain epidemiological data for the expansion and qualification of care for people with mental disorders.

Lira et al. (2014) conducted a quantitative, descriptive, observational study to identify the epidemiological profile of benzodiazepine users residing in areas attached to the Family Health Unit (FHU) Chico Mendes and Ximboré, in the Sanitary District (DS) V, in the city of Recife-PE. Thus, the study indicated an overview of the practice of using benzodiazepines, referring to the reflection of the principles of primary care and their contributions to the expansion and qualification of care for people in the territory, since health promotion is now listed as one of the reorientation strategies of the new care model.

Sixty Nine medical records of users were evaluated according to the mental health database, belonging to the reference teams of a FHU in 2011. The main results were:

- A female group (71 %, n = 49), aged between 22 years and 105 years and average of 52, is the predominant in the use of benzodiazepines;

- A lot of women was not in the job market and played its activities in family environment;

- Body practices and physical activities are not reported in the history of FHU users;

- Prolonged use of benzodiazepines was more prevalent among diazepam users compared to clonazepam;

- The main benzodiazepines utilized by the users were: diazepam, 45 % (n=31), clonazepam 39 % (n=27), e bromazepam 12 % (n=8);

- Among users, 95.5 % (n = 63) used the drug for at least one year, with an average use close to 56 months;

- Regarding the number of benzodiazepine prescriptions, 66.2 % were made by a general practitioner or specialist in areas other than neurology and psychiatry. The specialists (neurologist and psychiatrist) accounted for 29.4 % of the indications. 4.4 % of users practiced self-medication;

- In relation to the therapeutic use of prescribed benzodiazepines: 42.6 % as hypnotic/sedative; 41.2% as anxiolytic; 8.8% for depression; 5.9% as anticonvulsant/antiepileptic; and 1.5% for pain.

- Regarding the acquisition of benzodiazepines: 58 % (n = 40) of the users obtained the drugs from public pharmacies of the primary care network, 40.6 % (n = 28) bought from pharmacies and/or drugstores, and 1.4 % (n = 1) got in an undetermined way.

More recently, Belarmino (2019) conducted a quantitative, descriptive, retrospective, and documentary study to describe the sociodemographic profile of benzodiazepine users living in areas assigned to the FHU Mangueira II, in DS IV, in the city of Recife PE.

The sample consisted of 110 users, in which it was observed that 81 % (n = 89) correspond to women aged 41 to 59 years, 89 % (n = 98) of users use benzodiazepines for more than 12 months and the predominant active pharmaceutical ingredient was clonazepam.

Moreover, it was also observed that there is usually a renewal of "blue recipes" in the service without due follow-up, so greater attention is needed to this common and accepted case in the healthcare sector.

These two studies show some commonalities: the USF benzodiazepine user population is mostly women; diazepam and clonazepam are the most prescribed drugs; and there is chronic use of benzodiazepines for over 12 months.

These results suggest that the benefits of effective pharmaceutical care, based on permanent attention by an interdisciplinary team, can address problems related to the irrational use of drug therapy and prevent co-morbidities in Primary Health Care.

Furthermore, these studies contribute to the knowledge of the characteristics of people included in the primary health service who use benzodiazepines, pointing out the importance of future studies in this regard, given the harmful consequences of prolonged use of benzodiazepines and the need for access to medicines with safety, efficacy and resolubility of attention, through the principles of Primary Health Care and the conception that health production is also production of subjects (LIRA; LIMA; BARRETO; MELO, 2014, p.227).

Conclusions

According to its definition, anxiety disorders are related to fear. Ironically, they make us afraid, especially when associated with other mental health disorders. They debilitate, incapacitate and decrease the quality of life of patients. In addition, anxiety disorders cause a considerable economic impact not only to those affected, but also to family members and the health care system.

Anxiety disorders are very prevalent diseases and affect millions of people regardless of gender, age, race and socioeconomic status. It is a globalized problem, to use a current term. It is present in western and eastern societies, indigenous communities and other peoples.

With the advancement of psychology, psychiatry and knowledge of the pathophysiology of the disease, we now have safer and more effective psychotherapeutic and pharmacological treatments.

In primary care, the treatment of these disorders should be done by a multidisciplinary team with an interdisciplinary approach. However, these treatments should be complemented by family participation: listening, empathy, compassion, support, and understanding are important factors for the patient to regain their physical and mental health and lead a normal life.

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