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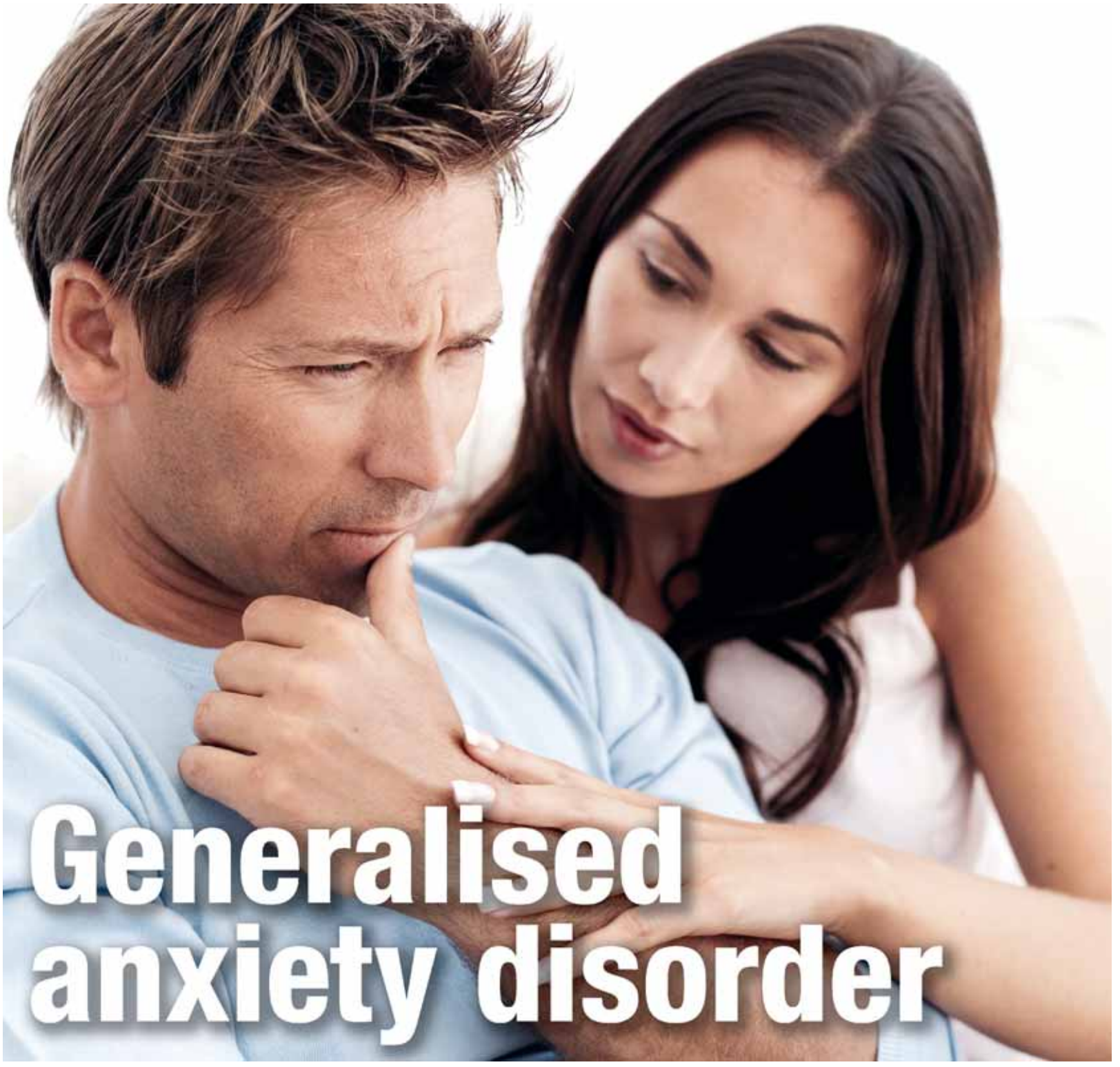

Generalised anxiety disorder

inside

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Background

UNTIL relatively recently, generalised anxiety disorder (GAD) has been seen as the diagnosis made if the anxiety syndrome failed to fit nicely into any of the other more easily recognisable patterns such as panic disorder, obsessive–compulsive disorder (OCD), post-traumatic stress disorder (PTSD) or phobias. However, as our understanding of anxiety improves, it appears that GAD is more common, more disabling, and more treatable than originally thought.

Recognising anxiety disorders

It is clear that anxiety disorders are hard to recognise. For a start, patients often do not mention the word anxiety. They might not themselves recognise that they are anxious, or they might not be familiar with the language to describe emotional states. Often patients don't think of anxiety (or in fact any emotions) as something the doctor can help with.

Furthermore, as the symptoms of anxiety are often physical, and patients are often focused on finding an assumed pathological cause, it is not until quite late in the consultation that the doctor notices the symptoms are anxiety related. As a consequence the opportunity to explore the anxiety has often been lost.

The key to recognising anxiety disorders is to trust your instincts. If you suspect the patient is anxious

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(often they make you feel anxious) then ask some non-judgemental, simple questions. It is also often useful to book a separate appointment to explore anxiety symptoms in more detail, as it usually takes up to 30 minutes.

There is a lot of overlap between the anxiety disorders. Differentiating the syndromes is useful because there are different responses to different drugs, and the psychological treatment options vary. The main syndromes to separate out are panic disorder, OCD and post-traumatic stress disorder (PTSD).

PTSD is relatively straightforward to uncover by asking about past traumatic experiences. However, if the patient does not know you well and trust you, they may not divulge the trauma straightaway. Panic disorder, OCD and GAD can be explored by asking some standard questions (see box right).

Questions to ask about panic disorder, OCD and GAD

For anxiety disorders generally

- Is your anxiety or worry predictable? Does it only ever happen in certain situations or places, like shopping malls?
- Does your anxiety or worry ever go away?
- Do you have anxiety attacks that come from out of nowhere?
- Is your anxiety or worry linked with physical symptoms such as a racing heart, shortness of breath and sweating?
- Do you always feel wound up, on edge or nervous?
- Do you have any thoughts that come into your head and make you worry?
- Are there rituals or things you have to do to stop feeling worried or to prevent a catastrophe?

For GAD

- Do you often feel anxious, nervous, worried or on edge?
- How often? Most days, some days or almost never?
- How difficult is it to control your worry? Very, a bit or not very difficult?
- Is your worry realistic or reasonable or is it out of control?
- What do you worry about? One thing, or many things? Do you worry a lot about too many things?
- Does your worry or anxiety help you, or does it interfere and slow you down?
- Do you have trouble relaxing?
- Do you feel fidgety because of your worry?
- Do you find you are becoming easily annoyed or irritable?
- Does it feel like something terrible might happen?

The worry is associated with a variety of physical and emotional symptoms.

Clinical features of GAD

GAD is characterised by excessive, uncontrollable worry about a number of events or activities. The worry is pervasive, difficult to control and out of proportion to the situation. The content of the worries covers several domains, such as concerns for one's family, finances, work and personal health.

The worry is associated with a variety of physical and emotional symptoms. Symptoms usually involve motor tension (such as restlessness and muscle tension) and hyperarousal, manifested by irritability, poor concentration or a feeling of being 'on edge'. Over time this contributes to fatigue, sleep disturbance, headaches and gastrointestinal disturbances.

GAD usually has a gradual onset from the late teens to late 20s. It is a fluctuating though chronic condition, with few patients ever experiencing a full remission of symptoms.

Epidemiology

GAD is one of the most commonly occurring mental disorders. The 2007 National Survey of Mental Health and Wellbeing in Australia reported the 12-month prevalence of GAD to be 2.7%, making it the fourth most common anxiety disorder (after PTSD, social phobia, and agoraphobia).[1] However, given it is usually chronic, it is more common as a lifetime diagnosis.

GAD is reported to be present in as many as 22% of primary care patients who complain of anxiety problems, making it the most common anxiety disorder in primary care.[2] People with GAD visit their doctor twice as frequently as those with comparable chronic physical conditions.

Surprisingly, GAD is under-represented at specialist treatment centres, perhaps indicating that patients are not sufficiently distressed to seek specialist intervention, or that they consider their anxiety is not

amenable to treatment.

As expected for a disorder that has a gradual onset and is chronic, people with GAD tend to present later than those with other anxiety disorders.

People with GAD have been found to have significant impairments in a range of functional domains. The degree of role impairment and quality-of-life impairment in GAD is similar in magnitude to that in other anxiety disorders, major depressive disorders and somatoform disorders, and greater than in substance-use disorders. GAD is associated with considerable economic costs, owing to lost work productivity and high medical resource use.

GAD is a chronic problem and patients frequently report the disorder to have spanned most of their lifetimes. It is more prevalent in females (3.5% compared with 2% in males) and is associated with age over 24, being separated, widowed, divorced, unemployed, a homemaker, and not having university qualifications.[1,3]

Diagnosis and classification

CLASSIFICATION in psychiatry is a challenging and controversial subject, and GAD illustrates this perfectly. Is the anxiety a pathological disorder, a personality trait or a part of depression? Is it a continuum along which we all have a place, or is it a discrete problem experienced by some but not others? Is it adaptive or maladaptive, normal or abnormal?

In this article we are mainly referring to GAD as described in the most recent edition of the DSM-IV (see box, right).

The DSM criteria rely more on the psychic symptoms of anxiety than the somatic symptoms. However in primary care there is a large subset of patients whose GAD has a much stronger somatic focus. This group will inevitably present more frequently to primary care physicians. Many anxious patients in primary care present with somatic rather than psychic symptomatology. More than 50% of patients with GAD in primary care present with somatic symptoms only.[4]

It has been suggested that the severity of anxious symptomatology, rather than its duration or the presence of worry, should be one of the most important criteria for the diagnosis of GAD in primary care.

A seven-item anxiety rating scale called the GAD-7 (table 1, page 33) has been developed and validated for use in primary care settings.[5] A score of 10 or greater on this scale strongly suggests the presence of GAD. Regarding the severity of GAD, scores of 5, 10 and 15 reflect mild, moderate and severe GAD, respectively.

The first two items of the GAD-7 tool are particularly important, and a score under 3 at this point suggests further exploration for GAD may be unnecessary. As a consequence, these two questions are often used to screen for GAD.

DSM-IV definition of GAD

A. Excessive anxiety and worry occurring more days than not for at least six months, about a number of events or activities.

B. The individual finds it difficult to control the worry

C. The anxiety and worry are associated with at least three of the following symptoms (with at least some of the symptoms present, more days than not, for the past six months)

1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating or mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance — difficulty falling or staying asleep or restless, unsatisfying sleep.

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder.

E. The anxiety, worry of physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance or a general medical condition and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.

Differential diagnosis

In psychiatry, the diagnostic algorithm used by clinicians is called the diagnostic hierarchy. The diagnostic hierarchy is particularly important in sorting out pathological anxiety states. The hierarchy considers organic conditions ahead of psychotic disorders, which are, in turn, considered ahead of mood disorders, after which come anxiety disorders, and then finally behaviour disorders.

Conditions that appear to occupy a position lower down the hierarchy can often be accounted for and subsumed by conditions higher up the hierarchy. So, for example, an organic condition, such as a dementia, may display features of several other mental disorders lower on the hierarchy. Although hallucinations and disorders of thought and behaviour in a patient with dementia might be suggestive of schizophrenia, these symptoms can be adequately accounted for by the existence of dementia. In this example, the existence of the organic disorder negates a diagnosis of schizophrenia by virtue of dementia occurring higher up in the diagnostic hierarchy.

Therefore the key disorders to rule out to make a diagnosis of anxiety are all the disorders higher on the hierarchy, namely organic disorders, schizophrenia and depression.

Organic disorders

Firstly, consider the organic disorders. Anxiety can be confused with several medical syndromes, especially when the medical disorder has not been recognised. Nevertheless, research suggests that anxiety resulting from medical causes may be qualitatively different from primary anxiety disorders, especially with respect to the psychic anxiety component.[6] Hyperthyroidism, in particular, needs to be actively excluded.

Any number of other medical conditions may contribute to generalised anxiety, particularly those that might cause symptoms of autonomic overactivity. Other organic factors that might initiate and maintain anxiety-like disturbances include chronic use of prescribed drugs (eg, salbutamol), legal substances (eg, caffeine) and illicit drugs (eg, amphetamines), and withdrawal syndromes.

Schizophrenia

It is true that schizophrenia does cause significant anxiety that can easily be mistaken for GAD (especially early in the course), but in practice the differentiation is usually easy because of the paranoia and other symptoms of impaired

reality testing that go hand in hand with schizophrenia.

Depression

Depression can be far more difficult to distinguish. In mild forms of depression, patients are often preoccupied with worry and anxiety, and the lowered mood and anhedonia (lack of enjoyment) of depression are easily missed. If either of these symptoms is present, it is important to carefully enquire about other features that distinguish depression, such as guilty ruminations and suicidal ideas.

If the criteria for depression are met, we tend to not make a diagnosis of GAD unless the GAD symptoms have clearly been present for far longer than the depression (in which case the conditions are diagnosed as comorbid) or the symptoms of GAD remain after successful treatment of the depression.

Anxiety disorders

Having considered diagnoses higher on the hierarchy, the next task is to consider which anxiety disorder best matches the symptoms the patient reports. This can be difficult, as there is a large overlap in symptomatology, and comorbidity is common.

Many also argue that this process is relatively futile, as there is large overlap in treatments regardless of which anxiety disorder is diagnosed. However, the specifics of the psychological strategies chosen and the differences in expected outcome do make this process relevant and important.

Phobic disorders are relatively easy to distinguish, as they are characterised by anxiety reliably elicited by specific environmental stimuli. The type of phobia diagnosed depends on the nature of the stimuli involved. In contrast, panic disorder and generalised anxiety represent anxiety that occurs without a specific external stimulus. While panic disorder and GAD both usually have some level of persistent anxiety, panic disorder is differentiated from GAD by the presence of discrete panic attacks.

Consequently, distinguishing GAD from panic disorder is easily done if the patient has frequent, spontaneous panic attacks and agoraphobic symptoms. This distinction is more challenging in the GAD patient who also has occasional panic attacks.

A further challenge is in distinguishing GAD and social phobia. Patients who report social anxiety but without clear-cut phobic avoidant behaviour should possibly be diagnosed with GAD and not social phobia. GAD and social phobia can coexist as long as anxiety is not only related to fear of negative evaluation by others but also results from the presence of pervasive worries about day-to-day concerns.

OCD is characterised by recurrent unwanted but irresistible thoughts and the ritualised repetitive acts resulting from these obsessions, in the absence of pre-existing psychosis or depression. While the worry shown in GAD may often appear as ruminative and obsessive, GAD worries are typically self-initiated, as opposed to unwanted and intrusive obsessions.

Also, GAD worries are ego-syntonic (meaning acceptable to, or consistent with, one's sense of self), which distinguishes them from obsessions that are ego-dystonic.

Finally, GAD worries are related to an undefined set of ongoing concerns in a patient's life, as opposed to a specific set of concerns in OCD such as contamination, violence or blasphemy.

PTSD is differentiated from GAD in that the anxiety and other symptoms arise as a direct result of a trauma.

One final group of psychiatric disorders that might contribute to diagnostic confusion are the somatisation disorders, and particularly neurasthenia. Symptoms may overlap considerably with GAD.

There are two main types of neurasthenia. In one type, the main feature is a complaint of increased fatigue after mental effort, often associated with some decrease in occupational performance or coping efficiency in daily tasks.

In the other type, the emphasis is on feelings of bodily or physical weakness and exhaustion after only minimal physical effort, accompanied by a feeling of muscular aches and pains and inability to relax.

In both types a variety of other unpleasant physical feelings is common, such as dizziness, tension headaches, and feelings of general instability. Worry about decreasing mental and bodily well-being, irritability, anhedonia, sleep disturbance and varying minor degrees of both depression and anxiety are all common.

Despite the presence of some or all of the above-noted symptoms, if the psychic symptoms of anxiety predominate, the primary diagnosis should be GAD.

Table 1: The GAD-7 anxiety rating scale†

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
***Total score = ____**	Add columns	____ +	____ +	____

If you checked off any of the seven problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Circle one	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

*Score: 5-9 = mild anxiety; 10-14 = moderate anxiety; 15-21 = severe anxiety

†Adapted and reproduced with permission[5]

Comorbid conditions

Studies have indicated that 'pure' cases of GAD are rare. GAD frequently co-occurs with other affective, anxiety, substance-use or personality disorders and this probably contributes to the high health care use and high impairment seen in GAD.

The most frequently diagnosed comorbid disorder is major depression, occurring in up to 84% of people with GAD.[7] Panic disorder and agoraphobia are the next most frequent comorbidities. OCD is less commonly coexistent with GAD.

Medical conditions also frequently occur in people with GAD. Perhaps surprisingly, it has been noted that there is a larger association between chronic pain conditions and anxiety disorders than between chronic pain disorders and depression. These findings seem to suggest that the emphasis on depression in the pain literature is likely misplaced, and that GAD should be more vigilantly sought and addressed in relation to pain syndromes.

Chronic medical conditions, such as hypertension, lipid disorders, COPD and asthma, are also commonly associated with GAD. The presence of an anxiety disorder in patients with physical disorders may confer a greater level of disability, so recognising and treating these non-psychiatric comorbidities is important.

Treatment

ANXIETY disorders are particularly rewarding to treat. Most patients are enthusiastic, engaged and motivated. The therapies are relatively straightforward and can mostly be done in short consultations if necessary. There are multiple resources in bookshops and on the web, and many referral options for a range of strategies. In fact there are so many strategies and options it can be quite overwhelming to decide where to start and in what order to try things. It is useful to broadly divide the options into:

- General measures.
- Psychological measures.
- Pharmacological measures.

These are the steps we follow when we see someone with what, on first consultation, sounds like an anxiety disorder:

- Explain to the patient that it sounds like some of the problems they are describing are related to anxiety and that we'd like to go into more detail about it (this usually involves booking another appointment).
- Spend an appointment specifically exploring all of the anxiety symptoms, do the examination, form a differential diagnosis, and order appropriate investigations. This is an essential step, as if you do not adequately examine and investigate, the patient's engagement will be tempered by their concern that something is being missed.
- Once a specific diagnosis is made, explain that there are multiple treatment options, and while we recommend some things as first or second or third line, each person is different and sometimes it's a case of trial and error. Also, ask the patient to do some reading, and get an idea of whether they prefer psychological or pharmacological approaches (each person has their own philosophy about what is the best approach to mental wellbeing).
- With the patient, draw up a plan of what you'll try and in what order. There is an art here in balancing the notion that there are lots of things to try and not everything will work, with maintaining a positive therapeutic outlook and not overwhelming the already anxious patient with excessive choice.

General measures

All treatment in psychiatry begins with education. For GAD it should include information about anxiety and worry, and how the somatic state is affected by emotions. Online resources can be of significant benefit, with the Panic Anxiety Disorder Association (PADA) site (see Online resources, page 36) often proving particularly beneficial in providing information.

Next are the five pillars of good mental health (often called psychological first aid). These are:

- Sleep — advice about sleep hygiene and the basics of getting a good night's sleep is essential. All patients with anxiety grapple with poor sleep.
- Exercise — spend some time talking about exercise and helping the patient get started if they are neglecting it. Simple strategies like walking for 20 minutes a day can lead to bigger things which flow on to relaxation, weight control and better sleep.
- Nutrition — it is obvious, but worth reminding patients, that they must eat a balanced diet to feel healthy and good. This absolutely includes advice about reducing caffeine and alcohol. This is so important in anxiety disorders that it warrants a regular review each appointment to check progress.
- Stress — discuss stress levels, especially at work, and talk about strategies

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to reduce stress, such as problem solving and relaxation strategies (see later).
- Relationships — again it's obvious, but humans are social animals and you cannot treat an individual without paying attention to their relationships and helping them think constructively about maintaining healthy relationships.

Note that none of these pillars of good mental health requires any specific training — every doctor can address them, and all patients need to consider them.

Psychological treatments

Psychological therapies are clearly beneficial in the management of GAD and are certainly more effective than placebo.[8] Numerous reviews have concluded that a cognitive behavioural approach to treatment is effective, and that improvements can be maintained for up to a year after discontinuing these therapies. As a consequence, most clinicians consider psychological therapies to be first line.

The challenge is to decide which type of therapy and who should provide it. Many GPs have now done training in cognitive behavioural therapy or related therapies. These therapies are easy to do in the office and a basic course of therapy is usually 6-12 sessions. Alternatively, psychologists and psychiatrists are relatively easy to access now that both are covered by Medicare payments. Some basic strategies can be implemented by any clinician, even those without specific training.

Relaxation

Basic relaxation techniques are particularly useful in dealing with GAD. Slow-breathing exercises are very effective at lowering baseline anxiety, and patients should be instructed in how to do this. Looking at the second hand of a watch or clock, begin by breathing in over three seconds. One can silently count out "in, two, three" if a watch is not accessible. This is then followed by a brief pause before a three-second expiration. The patient can be instructed to say a brief mantra while exhaling, such as "relax". Again, if no watch is available, the patient can silently count "out, two, three" to ensure the cycle lasts a full six seconds. Ideally this should be continued for three or more minutes.

Progressive muscle relaxation is also of great benefit and can easily be demonstrated in the office. This exercise involves gradually and systematically relaxing all the muscles in the body over several minutes. This encourages a relaxed state and promotes a reduction in general anxiety. Basic scripts for this are readily available (see Online resources, page 36).

Numerous reviews have concluded that a cognitive behavioural approach to treatment is effective.

Finally, if you don't have time to do these in the office, ask the patient to explore commercial options such as relaxation DVDs or yoga.

Structured problem solving

This provides a good framework for goal-setting and these problem-solving strategies can be applied to a wide range of circumstances to assist in making future decisions. There are several basic steps the patient can be taken through.

Firstly one needs to identify a problem. The second step is to brainstorm and list all possible solutions to the problem. Next, each listed solution needs to be carefully assessed (usually with a list of pros and cons). The most practical solution is chosen and a stepwise plan as to how to implement it is thought out. The final step involves reviewing progress after the plan is carried out to determine whether the proposed solution had been effective.

Graded exposure

This can be useful in the management of worry, particularly when the patient has taken to using avoidance of certain situations, experiences or behaviours because of their anxiety. In graded exposure, a feared situation is identified, then a hierarchy of small steps identified with the goal of reducing or eliminating the fear. The patient is encouraged to progressively master each stage, confronting fears regularly and frequently, using relaxation and encouragement. The therapist will emphasise habituation to anxiety in each situation until the feared situation has been confronted.

Specific psychological therapies

There is less agreement on the extent to which different therapies produce differential effects. A wide range of psychological therapies has been used in GAD, including behavioral therapy, CBT, cognitive analytical therapy, supportive psychotherapy, psychodynamic therapy and psychoanalysis.

In reality, most clinicians choose a therapist they trust, and refer to that clinician rather than search out a clinician who uses a specific technique. This is not unreasonable. However if you have a choice, for GAD, CBT and related therapies have the most evidence.

CBT is used as a generic term to describe a range of therapies, all of which share a common approach and similar methods. They begin with education and relaxation training. The behavioural part involves a range of strategies to help the patient change their behaviour and so reduce their anxiety. These include systematic desensitisation, exposure therapy and various forms of conditioning. The cognitive component refers to a range of strategies aimed at recognising dysfunctional thinking (including unrealistic and erroneous beliefs, attitudes and expectations), understanding how it contributes to anxiety, and finding ways to change it.

CBT has been used with good effect in managing GAD and is recommended as a first-line treatment for GAD. Published literature suggests CBT for GAD may be superior to non-directive treatments such as supportive therapy and psychodynamic therapies.[9]

Novel psychological therapies have emerged in recent years in response to less encouraging longer-term outcomes when CBT is used for GAD. These newer therapies, including acceptance and commitment therapy (ACT) and mindfulness-based cognitive therapy have gained widespread support.

Broadly speaking, cognitive emotion regulation theory (on which much of the psychological therapies are based) proposes that emotions can be regulated through one of two methods. The first method involves manipulating the evaluation of external or internal emotion cues, a process termed antecedent-focused emotion regulation. The second method involves manipulation of the emotional response, which is termed response-focused emotion regulation.

While both CBT and ACT encourage adaptive emotion-regulation strategies, they target different stages of the emotional process. CBT promotes adaptive antecedent-focused emotion-regulation strategies; in other words, facilitating a change in how the patient evaluates emotion cues. In contrast, the acceptance strategies of ACT use response-focused emotion-regulation strategies, such as suppression, to encourage the patient to alter the maladaptive emotional responses to emotion cues.

Although there are fundamental differences in the philosophical foundation of CBT and ACT, ACT techniques are fully compatible with CBT and are increasingly being incorporated into CBT practice.

Mindfulness-based cognitive therapies are similar but add the element of 'mindfulness', which is derived from Buddhist philosophies, and aims to assist the patient to accept uncertainty with equanimity. Patients are encouraged to become more tolerant of uncertainty in the face of ambiguity, both by directly challenging beliefs that certainty is either necessary or achievable, and indirectly through the use of behavioural experiments. It has been shown that intolerance of uncertainty plays a key role in the acquisition and maintenance of excessive worry, which leads to GAD.

Pharmacological treatments

Antidepressants, benzodiazepines and buspirone have been shown to be effective in treating GAD. They can be used alone or in combination with psychological therapies.

Antidepressants

Antidepressants are the first-line medication option for most anxiety disorders, including GAD. Their efficacy is a class effect. However, only a few are specifically approved for GAD in Australia (including paroxetine, venlafaxine and escitalopram). The evidence in older people is not as strong, and the evidence in young people is lacking.

The problem with antidepressants in GAD is that most have early side effects of restlessness, mild agitation and sometimes insomnia — all symptoms that can be mistaken for a worsening of GAD. Therefore, the prescribing doctor should:
- Warn the patient they may feel a little worse at first.
- Start low (usually half the recommended starting dose for the first week).
- Consider targeted and short-term use of a benzodiazepine, explaining carefully that it is only for the first 2-3 weeks.

Once the drug is tolerated, increase the dose according to clinical response, remembering that for anxiety disorders most patients require doses at the higher end of the recommended range. There are no clear guidelines about when to stop medication in GAD, so it is probably wise to follow the basic rules used in depression:
- Stop medication 12 months after remission is achieved with the first course of treatment.
- If relapse occurs, re-treat and aim for two years of remission before stopping.
- If a third relapse occurs, consider the benefits of five years of treatment or more. It is probably worth considering a specialist opinion before going down this path (see later).
- Weaning off antidepressants is more relevant if higher doses have been used. In this instance a gradual taper, reducing by a tablet every week or two is reasonable, and then halving the last tablet. Some antidepressants, particularly venlafaxine, have a slightly greater tendency to precipitate a withdrawal syndrome and the practice of a slower taper is recommended.

Benzodiazepines

For many years benzodiazepines were the preferred pharmacotherapy for GAD and there is ample evidence that benzodiazepines are safe and provide effective symptomatic relief for most patients. Different people respond to different benzodiazepines, so sometimes a little trial and error is required.

The utility of benzodiazepines is limited by:
- Side effects such as impaired cognitive performance, drowsiness and lethargy, especially in the elderly, with resultant accidents and falls.
- Tolerance to anxiolytic effects.
- Dependence after prolonged use; benzodiazepines should be avoided in people with a history of addiction to other drugs.
- Discontinuation of benzodiazepines after long-term use can result in:
  - — rebound anxiety
  - — an intensification of GAD symptoms in 25-75% of individuals
  - — a withdrawal syndrome in 40-100%
  - — a relapse of original symptoms in 63-81%.
- Problems in pregnancy and breastfeeding.
- Neonatal and infant mortality when used in late pregnancy or while breastfeeding.

Given these problems, it is generally considered that benzodiazepines are second line after antidepressants for pharmacological treatment of GAD. However, benzodiazepines remain popular, and tend to be used by patients more than antidepressants.

Buspirone

Buspirone is indicated for the short-term treatment of anxiety and appears to have equivalent efficacy to that of benzodiazepines. It produces virtually no sedative effects, no withdrawal syndrome or rebound anxiety after discontinuation. A return of GAD symptoms may occur on stopping this medication.

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The onset of the anxiolytic effect may take several weeks, and this lag effect may account for the low prescription rates of this medication. An additional problem is buspirone's short half-life, meaning it needs to be taken three times a day. It is not reimbursed on the PBS but is available on the RPBS or by private script.

Combining psychological and pharmacological therapies

Studies of concurrent use of behaviour modification or cognitive therapy and benzodiazepines have indicated that these treatments can be combined without a reduction in effectiveness. It seems that long-term benzodiazepine use may not significantly interfere with CBT in individuals who have sought treatment for GAD.

Furthermore, diazepam alone is less effective than in combination with CBT or behaviour modification. However, changes in GAD symptoms achieved with CBT alone were similar to those achieved with CBT and diazepam; therefore, though the use of benzodiazepine does not appear to interfere with CBT, benzodiazepines do not add to treatment effect.

Treatment conclusions

CBT appears at least as effective in the short term as pharmacotherapy, causes no adverse effects or withdrawal syndromes, and aims to increase coping skills and increase the sense of mastery and control in patients. In other anxiety disorders the same strategies have been shown to bring about long-term changes in measures thought to represent vulnerability to neurosis.

First-line treatment for GAD remains psychological, with reasonable evidence for applied relaxation combined with some form of CBT. Medication in the form of antidepressants is second line in GAD but can be safely combined with CBT with no risk of reducing the benefit of psychological therapies. Although benzodiazepines continue to be used, their long-term use should be discouraged because of the potential for side effects and dependence.

When to refer to specialist services

The main difficulty in referring to specialist psychiatric services, be they private or public, is discussing the referral with the patient. Stigma regarding mental illness continues to exist despite medical and community education programs. As a consequence the issue of referral needs to be dealt with in a sensitive, tactful manner. Discussing emotional factors in illness, explaining and demystifying psychiatric services and addressing patient's fears and beliefs about psychiatrists and psychologists are key elements in the referral process.

Situations in which referral should be considered include:

- Very severe or disabling symptoms.
- High suicide risk.
- Failure to respond to treatment.
- Uncertainty about the diagnosis.
- Possible organic brain disease or dementia.
- The need for greater resources, such as gaining access to specialised psychological therapies.
- Special circumstances (eg, adolescents, comorbidity with drugs or alcohol).
- Patients not accepting the advice or treatment recommended.

Authors' case study

MRS C, 35, presents with worries about her health, her marriage, and her children. She quit her job about four months ago after a dispute with a colleague and since then can't seem to stop worrying. Her family has pressured her to do something about it.

On questioning she reveals that her work problems had been longstanding and she had contemplated quitting for some time. She appeared to worry over many work problems that were beyond her control or influence. You note she has a long history of minor somatic complaints for which no specific cause was found. She has been investigated for abdominal pain, without a cause being found, on three separate occasions.

On systematic questioning Mrs C reveals she has had three acute attacks of breathing difficulty and chest pain that resulted in emergency department presentations, with discharge later that day. The first one resulted in further investigations, but the latter attacks were assumed to be anxiety attacks by the ED doctors. She has some compulsions around hand-washing but they are not overly time consuming, and she has suffered no major traumas.

She reports her family is frustrated with her constant concerns, particularly her two teenagers, who say she is too strict and worries about them too much. In the last six months she has taken to having a glass of wine before dinner to calm her nerves. She also drinks four cups of brewed coffee each day.

Of note, she denies depressive symptoms; in particular she says she can cheer up and laughs when relaxing with friends, and continues to take part in her long-term hobby of ballroom dancing. While she reports periods in her life when her mood has been lowered, she has never had treatment for depression nor does she have a family history of depression.

Mental state examination reveals a well-groomed woman who is over inclusive in her answers and preoccupied with detail. Mrs C's mood is anxious, she appears stressed, and overwhelmed by her problems. She does not appear depressed, has no psychotic features such as hallucinations, and her cognitive functioning is grossly normal. Physical examination is unremarkable. Her EUC, FBC and thyroid function tests are normal.

It is always difficult to exclude depression in patients who are anxious.

The most likely diagnosis is GAD. However, careful attention and further review of Mrs C's coffee and alcohol intake are required to exclude the stimulant effects of caffeine, and to ensure she is not developing alcohol dependence. It is always difficult to exclude depression in patients who are anxious. However, she denies specific depressive symptoms such as lowered mood and anhedonia (loss of enjoyment of usual activities) and her past history does not support the diagnosis.

A normal physical examination and basic investigations make an organic diagnosis very unlikely, but of course an open mind must be maintained, and this can be reconsidered later if the patient fails to respond to treatment or the course of the disorder is unusual.

The initial treatment plan for Mrs C was carried out by her GP and focused on exploring her ideas about her worries and confirming the diagnosis. She was seen once weekly for a half-hour appointment. She was given some literature and read about anxiety on the Panic Anxiety Disorder Association website (see Online resources).

She easily cut back her caffeine intake, which did seem to help her a little. She discussed her alcohol intake and agreed to be careful not to increase it further. She was introduced to the principles of structured problem solving and she spent one session learning basic relaxation techniques, which she then practised at home.

Over the first eight weeks of treatment Mrs C reported she felt significantly better, and was thinking about returning to work, but was concerned that she would fall back to her usual ways and be overwhelmed by her anxiety and worry once again. After much discussion, she agreed it would be wise to have a course of CBT with a psychologist before returning to work to really ensure she was ready for work and that her anxiety disorder was under control.

Mrs C continued with her GP fortnightly and continued to address issues around her problem solving and also talked more about her worries regarding her children. She saw the psychologist on nine occasions, who did further work on problem solving and relaxation, and added graded exposure around attending workplaces and her hand washing compulsions. The psychologist also added cognitive techniques addressing the thinking that led to her excessive worrying.

Four months after her initial presentation Mrs C rated her anxiety as 3 out of 10 (on presentation it was 8 out of 10) and she reported better relationships with her family. She had begun looking for a new job and had attended her first interview. Her GP appointments were cut back to monthly and she had finished with the psychologist.

She negotiated some basic relapse planning, essentially agreeing to return more promptly if for any reason her symptoms worsened.

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Further reading

Available on request from julian.mcallan@reedbusiness.com.au

Online resources

- Panic Anxiety Disorder Association (PADA): www.panicanxietydisorder.org.au
- beyondblue: Helping yourself: Practise breathing and muscle relaxation techniques: www.beyondblue.org.au/index.aspx?link_id=90.621
- Reach Out Australia — especially good for young people: au.reachout.com/find/issues/mental-health-difficulties

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GP's contribution

DR LIZ MARLES
Redfern, NSW

Case study

RUTH is in her late 60s and first came to our practice a year ago. Her main concern was pain in her foot, which has been an issue for more than a year, but she presented with a list five pages long of medications that she could not tolerate. She had recently been referred to podiatry for orthotics but complained that she was unable to afford them and thought they were unlikely to help.

For the past 17 years Ruth has lived on her own. She was previously a single mother, having divorced when her only child was five, and worked as a receptionist after that. At age 17 her daughter Sarah formed a serious relationship with a boy whom Ruth did not approve of, and moved in with him. They married and now have three children, but, despite living in the next suburb, Ruth only sees Sarah and her grandchildren once or twice a year.

When Sarah moved out, Ruth stopped working and developed chronic fatigue. She has also had fibromyalgia and irritable bowel symptoms. Ruth now lives a very solitary life.

When questioned Ruth admits to often feeling restless, sleeping poorly and worrying about her health, finances and future most days. She denies panic attacks and thinks her overriding problems are physical ones, where she is in a 'Catch-22' because she can't take any medication.

She is a non-smoker and

doesn't drink alcohol, and her FBC, EUC, LFTs, TSH, CRP and previous rheumatology screen are all normal. Although her symptoms have been relatively constant since her daughter moved out, Ruth finds it hard to believe that psychological factors could be playing a part.

Questions for the author

How likely is it that Ruth has GAD?

Ruth has a very long history of multiples worries, which is strongly suggestive of GAD. It is also important to exclude depression: whether she can still laugh, whether she has hobbies she still enjoys, and suicidal ideas are important to explore.

Is it appropriate to continue prescribing diazepam in these circumstances?

My guess is that Ruth has been on diazepam for many years, and so stopping will be a major struggle and not the number one priority at this stage. Instead it would be better to focus on psychological strategies, and address the diazepam six months down the track when she has greater control over her symptoms.

Ruth is requesting further investigations for her foot, which I feel are not warranted. Are further investigations likely to increase or decrease her anxiety?

Further tests will reassure her temporarily about her foot, but her overall anxiety is likely to switch to other matters. Hence a prudent approach to investigations is required.

You need to balance sensible clinical investigation with her overall management plan. Try making a deal in advance when she presents with new symptoms — you will do the key investigations, but she must agree to take a more holistic approach and address her anxiety.

How would diazepam be used in these circumstances to introduce an SSRI/SNRI?

You could increase the dose of the diazepam temporarily while starting an SSRI/SNRI; however, I would more strongly recommend psychological measures in Ruth's case. Get her to commit to some psychological approaches such as relationship advice (the issues with her daughter seem very important), relaxation or seeing a psychologist. If this is too confronting, try simple measures such as yoga first, then move on from there.

Given her age and the chronicity of her symptoms, is CBT still likely to be effective?

Yes. Long-term symptoms often respond very well and older people are often more open to new approaches. The key is in how you present these ideas to Ruth. Explore her ideas about health and psychology and present it in a way that is in keeping with her views.

Don't challenge her, instead try something like: "You've got so many stresses in your life — your health, your relationship with your daughter, your finances, even your loneliness — maybe its time we tried other approaches. At the very minimum it will help you with your sleep and restlessness, and who knows, sometimes learning to de-stress helps with muscular problems too."

How to Treat Quiz

Generalised anxiety disorder — 4 June 2010

INSTRUCTIONS

Complete this quiz online and fill in the GP evaluation form to earn 2 CPD or PDP points. We no longer accept quizzes by post or fax.

The mark required to obtain points is 80%. Please note that some questions have more than one correct answer.

ONLINE ONLY

www.australiandoctor.com.au/cpd/ for immediate feedback

1. Which THREE statements are correct?
a) Generalised anxiety disorder (GAD) is characterised by excessive, uncontrollable worry about a number of events or activities
b) The worry is pervasive and difficult to control and out of proportion to the situation
c) Physical and emotional symptoms include motor tension and hyper-arousal
d) GAD usually has a sudden onset, with periods when patients are completely symptom free, alternating with periods of significant anxiety

2. Which THREE statements are correct?
a) GAD is the most common anxiety disorder in primary care
b) People with GAD visit their doctor twice as frequently as those with comparable chronic physical conditions
c) GAD is more prevalent in males than in females
d) The degree of role impairment and quality-of-life impairment in GAD is similar to that of other anxiety disorders, major depressive disorders, and greater than in substance use disorders

3. Which TWO statements are correct?
a) It is uncommon for patients with GAD in primary care to present with somatic symptoms only
b) The duration of anxious symptomatology, rather than its severity, is one of the most important criteria for diagnosing GAD in primary care
c) The GAD-7 rating scale is an important and useful tool for assessing the severity of GAD
d) The diagnostic hierarchy used in psychiatry consists of organic conditions, psychotic disorders, affective disorders, anxiety disorders and behaviour disorders

4. Which THREE statements are correct?
a) Conditions that appear to occupy a position lower down the diagnostic hierarchy can account for and subsume conditions higher up the hierarchy
b) The key disorders to rule out to make the diagnosis of an anxiety disorder are organic disorders associated with anxiety, schizophrenia and depression
c) The symptoms of organic causes of anxiety may be qualitatively different from primary anxiety disorders, especially the psychic anxiety component
d) Medical conditions that may contribute to generalised anxiety include hyperthyroidism, and chronic use of salbutamol, caffeine or amphetamines

5. Which TWO statements are correct?
a) The differentiation of GAD from schizophrenia with anxiety is usually easy because of the presence of delusions
b) In people with mild depression and anxiety, lowered mood and anhedonia are universally present
c) A history of guilty ruminations and suicidal ideas should be sought in those with lowered mood and anhedonia
d) Panic disorder and generalised anxiety are disorders that occur in response to a specific external stimulus

6. Which THREE statements are correct?
a) Panic disorder can be differentiated from GAD by the presence of recurrent discrete panic attacks
b) Patients who report social anxiety with clear-cut phobic avoidant behaviour should be diagnosed with GAD rather than social phobia
c) In patients with GAD, worries are typically self-initiated, in contrast to the unwanted and intrusive obsessions in obsessive–compulsive disorder
d) In neurasthenia, the patient may complain of increased fatigue after mental effort, as well as symptoms of anxiety

7. Which THREE statements are correct?
a) Major depression is the most common disorder that coexists with GAD
b) Depression is more common than anxiety in people with chronic pain
c) For GAD, patient education should include information about anxiety and worry, and how the somatic state is affected by emotions
d) The five pillars of good mental health are sleep, exercise, nutrition, stress management and healthy relationships

8. Which THREE statements are correct?
a) The response of anxiety to cognitive behavioral therapy (CBT) usually does not endure after discontinuation of CBT
b) Structured problem solving includes developing a list of all possible solutions to an identified problem
c) Graded exposure can be useful in managing worry when the patient avoids certain situations, experiences or behaviours based on their anxiety
d) The behavioural part of CBT may include systematic desensitisation, exposure therapy or various forms of conditioning

9. Which TWO statements are correct?
a) The cognitive part of CBT uses strategies that recognise dysfunctional thinking, understanding how it contributes to anxiety, and finding ways to change it
b) CBT promotes a change in the maladaptive emotional responses to emotion cues
c) Acceptance and commitment therapy (ACT) promotes a change in how the patient evaluates emotion cues
d) Intolerance of uncertainty plays a key role in the acquisition and maintenance of excessive worry, which leads to GAD

10. Which TWO statements are correct?
a) Benzodiazepines are the first-line medication option for GAD
b) Most antidepressants have the early side effects of restlessness, mild agitation and insomnia
c) Most patients with GAD require antidepressant doses at the lower end of the recommended range
d) Benzodiazepine use is limited by impaired cognitive performance and tolerance to its anxiolytic effects

CPD QUIZ UPDATE

The RACGP requires that a brief GP evaluation form be completed with every quiz to obtain category 2 CPD or PDP points for the 2008-10 triennium. You can complete this online along with the quiz at **www.australiandoctor.com.au.** Because this is a requirement, we are no longer able to accept the quiz by post or fax. However, we have included the quiz questions here for those who like to prepare the answers before completing the quiz online.

Australian Doctor Education

HOW TO TREAT Editor: **Dr Giovanna Zingarelli**
Co-ordinator: **Julian McAllan**
Quiz: **Dr Giovanna Zingarelli**

NEXT WEEK In 2005, 26,546 Australians were diagnosed with breast, ovarian or colorectal cancer. About 5-10% of people with cancer have an inherited mutation in one of the so-called tumour suppressor genes. The next How to Treat reviews the presentation, screening and management of such familial cancers. The authors are **Dr Alison Trainer**, staff specialist in clinical genetics, Peter MacCallum Cancer Institute and Southern Health, Melbourne, Victoria; and **Professor Robyn Ward**, clinical associate dean, Prince of Wales Clinical School, University of NSW; director, area cancer services, and specialist medical oncologist, South East Sydney and Illawarra Area Health Service and Prince of Wales Hospital, Randwick, NSW.