Generalised anxiety disorder (GAD)

The following questions can be used as discussion points for peer groups or self-reflection of practice.

It is recommended that the following article is read before considering the questions:

- **Generalised anxiety disorder (GAD) in adults, bpac^{nz}, Dec, 2024**

Anxiety is a normal human emotion that affects most people at some time. It becomes a disorder when it is of greater intensity and duration than expected and if it leads to impairment/avoidance behaviours or disability. Anxiety disorders are the most prevalent mental health condition in the community, yet many people do not seek treatment.

There are a range of anxiety disorders, including generalised, social, panic, phobias, separation anxiety and selective mutism, and patient presentation varies. One of the predominant forms is generalised anxiety disorder (GAD), which is characterised by excessive and uncontrollable worry about multiple aspects of everyday life, e.g. employment, education, relationships. It is common for people with GAD to have mixed anxiety and depression and other co-morbid anxiety disorders. An anxiety disorder can be a long-term condition and symptoms will fluctuate in intensity over time; however, symptoms can be managed and complete recovery is possible for some people.

GAD is usually diagnosed clinically in primary care based on the presence of characteristic symptoms, but there are some patients for whom discussion with, or referral to, a psychiatrist or other mental health specialist should be considered, e.g. if there is diagnostic uncertainty, safety concerns or significant co-morbidities such as substance misuse.

A step-based approach to management is generally recommended, beginning with education about anxiety and advice on lifestyle factors, followed by specific psychological or pharmacological treatment(s) as needed. Some patients, e.g. those with mild anxiety, may only require education and self-management strategies, while others, e.g. those with more severe symptoms or co-morbid depression, may require a combination of treatment options.

Cognitive behavioural therapy (in person or online) is first-line psychotherapy. Selective serotonin reuptake inhibitors and venlafaxine are first-line medicines, initiated at a low dose. Second- and third-line options include other antidepressants, buspirone, pregabalin and benzodiazepines (short-term use only).

When deciding on psychological or pharmacological treatment, consider factors such as patient preference, co-morbidities, availability and cost, possible adverse effects and current or prior response to treatments. Self-directed strategies should be recommended alongside the chosen treatment, e.g. exercise, yoga, mindfulness, sleep hygiene techniques, journalling.

Patients should be followed up regularly (in person or via phone), e.g. every two to four weeks, and then with decreasing frequency as they stabilise, e.g. every three to six months. Monitor adherence, symptoms/response and adverse effects, including self-harm/suicidal ideation. Pharmacological treatment should be continued for 6 – 12 months after symptoms have resolved to reduce the risk of relapse.

Modify the patient's treatment regimen if there is inadequate response after an appropriate trial (at least four to six weeks) of psychological and/or pharmacological treatment. Discuss with or refer the patient to a psychiatrist (or other mental health specialist) if there is insufficient response after modifying treatment.

Questions for discussion

1. What is your usual approach to diagnosing a patient with GAD? Do you use a screening questionnaire such as the GAD-2? In your experience, do you find that GAD often co-exists with other anxiety, mood or spectrum disorders such as OCD, depression or ADHD?

2. What is your preferred approach to managing anxiety? Do you usually begin with non-pharmacological methods, or do you prescribe medicines? How do you manage anxiety if it co-exists with another condition, e.g. depression?

3. In terms of non-pharmacological methods, what lifestyle or self-directed activities do you find to be the most effective and acceptable for patients with GAD? CBT is the gold standard psychotherapy for GAD; is access for

in-person treatment an issue in your region? Do you recommend online CBT? If so, have you had feedback from patients on how useful this is?

4. In what circumstances would you prescribe pharmacological treatment for GAD? Which medicine(s) do you find to be the most effective? Do you ever prescribe benzodiazepines for GAD? If so, what parameters do you put in place to ensure appropriate use?

5. After establishing a treatment regimen for a patient with GAD, how frequently do you typically follow-up? How do you assess response to treatment? Do you have a particular method for escalating treatment if response has been inadequate or is it patient-specific? In your experience, are there particular features that suggest a patient will require more intensive intervention?

6. Identifying and managing anxiety in patients who are pregnant and in the post-partum period is particularly important. It may often be detected incidentally, e.g. during a consultation for another reason, or when the mother attends the practice with their infant. Can you share any experiences you have had with this?

7. In your experience, do patients with GAD typically require life-long treatment, or do most reach a point where they can self-manage their condition? What is your approach to discontinuing antidepressants? Do you find that many patients relapse after stopping treatment for GAD? What strategies have you found effective for patients who experience a relapse of symptoms?