Generalized Anxiety Disorder (GAD)

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Introductions

- Behavioral Health Consultant
- Director of Clinical Training
- Vice Chair of the Interprofessional Education Committee
- Primary Care Progress
- COM/PSYD

Generalized Anxiety Disorder 300.02 (F41.1)

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

- B. The individual finds it difficult to control the worry.

American Psychiatric Association, 2013

- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
  - **Note:** Only one item required in children.

- 1. Restlessness, 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).

American Psychiatric Association, 2013

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

- E. The disturbance is *not attributable to the physiological effects* of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

- F. The disturbance is not better explained by another medical disorder

American Psychiatric Association, 2013

Generalized Anxiety Disorder

- Prevalence
  - 12-month prevalence rate for adolescents and adults in the US is 3.8%-5.1%
  - The lifetime morbid risk is 9%
  - Much more common in the primary care setting
  - More common in individuals of European descent
  - More common in females
    - Female comorbidities→ other anxiety disorders, unipolar depression
    - Male comorbidities→ substance use disorders
- Most frequent anxiety disorder in primary care
  - 22% of primary care patients who complain of anxiety problems
  - The high prevalence rate of GAD in primary care suggests that GAD patients are high users of primary care resources

American Psychiatric Association, 2013; Wittchen, 2002

Generalized Anxiety Disorder

- Exact causes are unknown
  - Biological: serotonin, dopamine, and norepinephrine
- Functional impact
  - The degree of impairment is similar to that of cases with major depression.
  - GAD comorbid with depression usually reveals considerably higher numbers of disability days in the past month than either condition in its pure form.
  - As a result, GAD is associated with a significant economic burden owing to decreased work productivity and increased use of health care services, particularly primary health care.

Wiley-Liss, 2002; Wittchen, 2002

Associated Features of GAD

- Somatic symptoms
- Exaggerated startle response
- Other conditions frequently a/w stress may be present
  - IBS
  - Headaches

American Psychiatric Association, 2013

Risk and Prognostic Factors

- Temperamental:
  - Behavioral inhibition
  - Negative affectivity (neuroticism)
  - Harm avoidance
- Environmental:
  - Childhood adversities
  - Overprotective parents
- Genetic and physiological
  - 1/3 of the risk for GAD is genetic
  - Genetic factors overlap w/ neuroticism and are a/w other anxiety & depressive disorders

Assessments

- Screening Tools

- HAM-D
- https://dcf.psychiatry.ufl.edu/files/2011/05/HAMILTON-ANXIETY.pdf

- GAD-7
- https://www.integration.samhsa.gov/clinical-practice/gad708.19.08cartwright.pdf

Course and Prognostic Indicators

- Chronic with waxing and waning of symptoms
- Full remission is very rare
- Individuals report lifetime of worry, free-floating anxiety
- Earlier onset a/w increased comorbidities
- Earlier onset a/w greater impairment

American Psychiatric Association, 2013

GAD Interventions

Psychosocial

- Active monitoring
- Psychoeducation
- Supportive therapy
- Cognitive behavioral therapy
- Meditation, yoga (increase diaphragmatic breathing, decrease sympathetic arousal)
- Family/therapy

Pharmacological

- SSRIs
- SNRIs
- Pregabalin or buspirone (Buspar)
- NaSSA
- Beta blockers
- (Tricyclics)
- Benzodiazepines

Case scenario 1: Mary

Presentation: Mary is aged 42 years, divorced with two children, employed part time and cares for her mother who has Alzheimer's disease. Past history Mary has no significant past medical history, although she frequently makes appointments with her GP and practice nurse about problems experienced by her and her children.

She was moderately depressed following her divorce 5 years ago and was offered antidepressants but declined them. She was referred for six sessions of counselling, which led to some improvement in her symptoms.

On examination Mary complains of feeling 'stressed' all the time and constantly worries about 'anything and everything'. She describes herself as always having been a 'worrier' but her anxiety has become much worse in the past 12 months since her mother became unwell, and she no longer feels that she can control these thoughts. When worried, Mary feels tension in her shoulders, stomach and legs, her heart races and sometimes she finds it difficult to breathe.

Her sleep is poor with difficulty getting off to sleep due to worrying and frequent wakening. She feels tired and irritable. She does not drink any alcohol.

Question 1: You suspect GAD—what next?

- 1.2.3 Consider the diagnosis of GAD in people presenting with anxiety of significant worry, and in people who attend primary care frequently who:
  - have a chronic physical health problem **OR**
  - do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups) **OR**
  - are repeatedly worrying about a wide range of different issues

- 1.2.4 When a person with known or suspected GAD attends primary care seeking reassurance about a chronic physical health problem or somatic symptoms and/or repeated worrying, consider with the person whether some of their symptoms may be due to GAD.

NICE, 2011

NICE, 2011

Question 1: You suspect GAD—what next?

- 1.2.5 For people who may have GAD, conduct a comprehensive assessment that does not rely solely on the number, severity and duration of symptoms, but also considers the degree of distress and functional impairment.

- 1.2.6 As part of the comprehensive assessment, consider how the following factors might have affected the development, course, and severity of the person's GAD:
  - Any comorbid depressive disorder or other anxiety disorder
  - Any comorbid substance misuse
  - Any comorbid medical condition
  - A history of mental health disorders
  - Past experience of, and response to, treatments.

NICE, 2011

Question 2: You confirm GAD—what next?

- Start with STEP ONE interventions

- 1.2.2 Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly

- 1.2.9 Following assessment and diagnosis of GAD:
  - Provide education about the nature of GAD and the options for treatment
  - Monitor the person's symptoms and functioning (active monitoring)
  - ***Education and active monitoring may improve less severe presentations and avoid the need for further interventions.***

- 1.2.10 Discuss the use of over-the-counter medications and the lack of evidence to support their safe use.

NICE, 2011

Question 3: What are the next steps for management?

- After 4 weeks of education and active monitoring there is minimal improvement in Mary's functioning and distress. What are the next steps?

- Move up to Step 2 interventions and discuss options

- 1.2.11 For people with GAD whose symptoms have not improved after education and monitoring in step 1, offer one or more of the following as a first-line intervention, guided by the person's preference:
  - Individual non-facilitated self-help
  - Individual guided self-help
  - Psychoeducational groups

NICE, 2011

Case scenario 2: Paul

Presentation: Paul is 48 years old and has a 20-year history of GAD. He has not been able to work for the past 8 years due to severe levels of anxiety.
Past history: Paul has tried non-facilitated self-help and was seen by a primary care mental health worker for six sessions. He was given a self-help booklet and twice monthly telephone sessions to support his use of the book. He has also attended an anxiety management group run by the voluntary sector.
Although he feels that the interventions have helped ‘a bit’, he feels he needs more support.

Question 1 You confirm GAD – what would you do next?

As Paul has marked functional impairment that has not improved with a step 2 intervention, offer a step 3 intervention

- 1.2.16 For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions, offer either:
  - An individual high-intensity psychological intervention (CBT)
  - Drug treatment

- 1.2.18 ***CBT*** for people with GAD should:
- be based on the treatment manuals used in the clinical trials of CBT for GAD
- be delivered by trained and competent practitioners usually consist of 12–15 weekly sessions (fewer if the person recovers sooner; more if clinically required), each lasting 1 hour.
- 1.2.20 Practitioners providing high-intensity psychological interventions for GAD should: use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment.

NICE, 2011

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