Role of Primary Care Physician in management of generalized anxiety disorder

Abstract:

Individual survival would be impossible without anxiety, which is a natural and important emotion. Anxiety is considered a disease that requires treatment when it occurs in the absence of a threat, or in a disproportionate proportion to a threat, as well as when it prevents the affected individual from leading a normal life. Generalized Anxiety Disorder (GAD) is a widespread mental disorder characterised by excessive and difficult-to-control anxiety and concerns. as well as a variety of psychological and physical symptoms. Patients with GAD frequently visit primary care, and it is widely acknowledged that the majority of patients should be treated in this environment. Clinical practise guidelines advocate pharmacological (e.g., SSRIs and venlafaxine) or cognitive behaviour therapy as first-line therapies for GAD. There are several proposed etiological explanations for GAD, including Freud's psychoanalytic theory, Stack's interpersonal theory, and the Stress Diathesis Model. The exact pathophysiological process of the disease is not fully understood. Patients with GAD frequently visit primary care, and it is widely acknowledged that the majority of patients should be treated in this environment. Clinical practice guidelines advocate pharmacological (e.g., SSRIs and venlafaxine) or cognitive behavior therapy as first-line therapies for GAD. In this article, we'll be discussing GAD epidemiology, etiology, evaluation, and treatment.

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Introduction:

Generalized Anxiety Disorder (GAD) is a widespread mental disorder characterized by excessive and difficult-to-control anxiety and concerns, as well as a variety of psychological and physical symptoms. GAD frequently has a long-term course, with a lifetime prevalence rate of around 6% for DSM-IV criteria. People with GAD have major problems at work, in their social and familial lives, and in their health-related quality of life. There is also mounting evidence of GAD's economic impact in terms of missed job productivity and medical expenditures resulting from excessive use of medical services. GAD is strongly linked to

concomitant mental diseases, the most common of which is major depressive disorder, as well as comorbid physical sickness. [1–7]

GAD has also been related to medical conditions like heart disease, gastrointestinal problems, and chronic pain. These links are significant from a clinical standpoint, because individuals with mental or medical comorbidities have a longer clinical course and worse results than those with GAD alone. The presence of pain has been found in the PCAP to have a negative impact on the progression of anxiety disorders. In a subset of GAD patients, the occurrence of back pain was linked to a lower risk of remission. Patients with comorbidities have a larger therapeutic challenge, necessitating the use of innovative medicines or a mix of treatments, such as polypharmacy with pharmaceuticals from other classes or extra nonpharmacologic techniques. [8]

Individual survival would be impossible without anxiety, which is a natural and important emotion. Anxiety disorders, as well as most other kinds of mental disease, can cause pathologically heightened anxiety. Anxiety can also be a symptom of potential threat in cases of somatic disorders. A complete psychological and somatic assessment is required for any patient presenting with pathologically heightened anxiety in order to rule out an underlying lung, cardiovascular, neurological, or endocrine condition. Anxiety reactions are important indicators of a possible threat to homeostasis; anxiety is considered a disease that requires treatment when it occurs in the absence of a threat, or in a disproportionate proportion to a threat, as well as when it prevents the affected individual from leading a normal life. [9]

Patients with GAD frequently visit primary care, and it is widely acknowledged that the majority of patients should be treated in this environment. Clinical practice guidelines advocate pharmacological (e.g., SSRIs and venlafaxine) or cognitive behavior therapy as first-line therapies for GAD, with long-term therapy being necessary to avoid recurrence. In epidemiological surveys in Canada, the United States, Spain, and Australia, treatment adequacy rates for patients with GAD ranged from 24.6 percent to 42.5 percent, and from 44.2 percent to 43.8 percent in clinical trials in the United States, and 49.5 percent in a primary care sample in the Netherlands. While GAD has certain similarities to other anxiety disorders, we cannot assume that the determinants of potentially effective

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psychological and pharmaceutical therapies are the same. For example, research has shown that perceptions of treatment need, help-seeking behavior, service utilization, and recognition and treatment of common mental disorders by healthcare professionals differ across common mental disorders, which could affect the likelihood of receiving potentially adequate treatments. [1,10–14]

Etiology and pathophysiology:

There are several proposed etiological explanations for GAD, including Freud's psychoanalytic theory, which states that anxiety is caused by intrapsychic conflict between the id and superego; Stack's interpersonal theory, which states that anxiety is caused by unmet interpersonal needs; the Stress Diathesis Model; personality factors; and neurobiological factors. [15]

The following factors may have a role in the etiology:

- Stress
- medical condition, such as diabetes, or other comorbidities, such as depression, are examples of comorbidities.
- Generalized anxiety disorder (GAD) among first-degree relatives (25 percent)
- Factors in the environment, such as child abuse
- Abuse of drugs and alcohol [16]

The specific process isn't well understood. Anxiety in kids is a common occurrence. Stranger anxiety appears between the ages of seven and nine months. The body's response to stress appears to be influenced by noradrenergic, serotonergic, and other neurotransmitter systems. The serotonin and noradrenergic systems are two major pathways that have a role in anxiety. Its development, according to many, is caused by decreased serotonin system activity and increased noradrenergic system activity. As a result, the first-line treatment for it is selective serotonin reuptake inhibitors (SSRI) and serotonin-norepinephrine reuptake inhibitors (SNRI). [16]

Epidemiology:

According to a 6-month prevalence rate published by World Health Organization (WHO) research in 14 countries, including the United States, over 8% of patients attending a primary care physician had GAD. Using the Diagnostic and Statistical

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Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria, the lifetime prevalence of the illness is estimated to be around 5%–6%, though the European Study of the Epidemiology of Mental Disorders (ESEMeD) offers a lower estimate of 2.8 percent.Whereas the prevalence estimates in the ESEMeD surveys are typically similar to other research, it has been claimed that some prevalence rates may have been underestimated due to ESEMeD methodological aspects, such as the way diagnostic interviews were done. GAD is twice as frequent in women as it is in men and is more common in middle age, with prevalence rates rising after the age of 35 for women and 45 for men. GAD is thought to be common in the elderly, with estimates ranging as high as 7.3%.[8,17–22]

Delaying therapy can lead to long-term psychosocial and professional dysfunction, as well as an increased risk of suicide, medical and mental comorbidities, and a significant financial load on the healthcare system. Recurrence of symptoms is more probable without early treatment, and remission may be more difficult to achieve. In the United States, the yearly cost of GAD disability is projected to be $42 billion. [15]

Evaluation:

Excessive anxiety can cause headaches, dizziness, irritability, muscle tension, heart palpitations, chest pain, tachycardia, sweating, and shortness of breath. While anxiety is a universal phenomenon that can motivate people to complete tasks and avoid dangerous situations through "fight or flight," it can also cause decreased concentration, insomnia, daytime fatigue, distorted perceptions of reality, increased performance errors, headaches, dizziness, irritability, muscle tension, heart palpitations, and anxiety. disorders. According to the DSM-IV-TR, these symptoms coexist with many physical diseases such as agoraphobia, panic disorder, specific and social phobias, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), acute distress disorder, and GAD, the last being the most common anxiety disorder encountered in primary care. [15]

Excessive anxiety and worry that is difficult to control, as well as at least three symptoms from a list of six (restlessness, irritability, difficulty concentrating, muscle tension, sleep disturbances, and being easily fatigued) and a 6-month duration of the disorder, are the main diagnostic criteria for GAD. Symptoms must be unpleasant or disabling and cannot be explained effectively by another

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disorder. The diagnostic criteria in the Tenth Edition of the International Classification of Diseases, on the other hand, place a greater emphasis on the presence of somatic symptoms, which is reflected in the GAD Algorithm developed by the International Psychopharmacology Algorithm Project (IPAP), as somatic symptoms are frequently the presenting complaint. Based on the most recent genetic, epidemiologic, and other study results, the task group of the DSM is debating whether GAD and major depressive disorders are distinct manifestations of the same condition, closely related disorders, or distantly related disorders. In addition, the number of symptoms included in the criteria, as well as the criterion for 6 months' duration of symptoms and the predominance of continuous worry, are also being considered. [8]

Fear and worry are common symptoms of all anxiety disorders. Worry is a sense of anxiety, a sense of discomfort in response to an unknown threat, whereas fear is a response to a recognized threat. The fundamental symptoms of GAD include dread and worry, as well as poor concentration, disrupted sleep, irritability, muscular tension, exhaustion, and sensations of arousal. Patients with GAD, according to the DSM-IV-TR, have these symptoms more days than not for at least 6 months. [15]

Management:

The plan for treatment includes managing the following: Predominant symptoms, severity of the condition, presence of concomitant medical illness, complications such as substance abuse or the risk of suicide, outcomes of any previous treatments, cost issues, availability of treatment in a given area, and patient preferences should all be considered in the treatment plan for GAD. The treatment's overall goals are fourfold: (1) to reduce GAD's core symptoms (both psychic and somatic), including sleep restoration; (2) to improve patient function and quality of life; (3) to treat comorbid disorders, both those present at the time of diagnosis and those that develop over time; and (4) to continue treatment long enough to produce remission and, where possible, prevent relapse.

Pharmacotherapy, psychotherapy, or a combination of both are the most common treatment options for GAD. Due to the persistent and severe nature of GAD, some people may not respond completely to first-line therapy. As a result,

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patients may require a series of therapies or the use of combination therapies. [16]

Cognitive behavioural therapy (CBT) is the form of psychotherapy with the most evidence and the highest degree of recommendation for all sorts of anxiety disorders. The therapeutic effectiveness of psychodynamic therapy, such as in social phobia, has been proven in preliminary randomised controlled studies. Despite this, psychodynamic therapy is given evidence level IIa in the current German guidelines due to the incomplete state of data from clinical trials, as well as the recommendation that it be used if cognitive behavioural therapy has been ineffective or is unavailable, or if an informed patient expresses a preference for it. The specifics of cognitive behavioural therapy differ based on the anxiety condition being treated, but the patient must have the experience that his or her situationally produced fear is unjustified and the situation is truly safe. This is best accomplished by exposure under the supervision of a therapist, during which the patient must become accustomed to the anxiety reaction, therefore refuting the primary fear that underpins it. Virtual reality exposure is becoming more common in cognitive-behavioral therapy methods. [9,23–26]

First-line medicines include the selective serotonin reuptake inhibitor (SSRI) and serotonin-norepinephrine reuptake inhibitor (SNRI) classes, which have a response rate of 30% to 50%. Escitalopram (Lexapro), duloxetine (Cymbalta), venlafaxine (Effexor XR), and paroxetine are examples of this family of medicines (Paxil, Pexeva). In one study, children with anxiety disorders who were given a combination of sertraline hydrochloride and CBT improved in 81 percent of cases.[16]

Some individuals, particularly those with accompanying behavioural difficulties, may benefit from antipsychotics.

In clinical practise, a recurrent question is how long medication therapy should be continued to avoid recurrence. Although response rates are typically high (about 80%), premature withdrawal of therapy is linked to significant recurrence rates. For example, 15–50% of people with panic disorder relapse within 6–12 months of stopping tricyclic antidepressants, SSRIs, or venlafaxine.As a result, it is suggested that SSRI or SNRI maintenance medication be continued for at least 6–12 months following the end of the acute period, at the effective last dose

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achieved. Any attempt to stop taking medicine should be done gradually, such as over a period of 12 weeks if you've been on it for 40 weeks. [9]

Benzodiazepines: Long-acting medicines such as diazepam and clonazepam are examples. When a quick decrease in symptoms is sought or a short-term therapy is required, these medicines are utilised. Benzodiazepines are more likely to work for cooperative and compliant individuals who are aware that their symptoms have a psychological foundation. Patients with a history of drinking or drug addiction are not suitable candidates for this therapy due to the risk of overuse and dependency. [16]

Buspirone is not a benzodiazepine and does not create addiction. It also has a lower sedative effect than benzodiazepines and does not cause tolerance at therapeutic levels. The therapeutic lag in effectiveness of this drug is two to three weeks, which limits its usage.

To see if a medicine works, it should be gradually increased and maintained for at least four weeks. The drugs must be used for at least 12 months after the symptoms have been controlled before being gradually tapered off. Because all medications have side effects such as weight gain, hyperlipidemia, and diabetes, patients must be closely watched. [16]

Recovery entails not only the relief of symptoms but also the return of patients to their previous high level of functioning, including the resumption of family, social, and work-related roles. However, in some lifelong cases of GAD, recovery can result in a level of well-being that is far superior to the premorbid baseline. Patients with GAD are more likely to require assistance with sleeplessness, which can have a significant impact on quality of life and work performance. While immediate symptom alleviation is helpful, it is more crucial to remind patients that they must stick with their therapy in order to gain maximal benefit and long-term improvement in their disease. Remission may take 4-6 months after starting therapy. [27]

Conclusion:

Generalized Anxiety Disorder (GAD) is one of the important disorders presented at the primary care. Anxiety is important reaction for human survival, however when it’s pathological it causes serious impact on patient’s health and quality of

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life. Most of guideline agrees on 2 methods of treatment one of which is cognitive behavior therapy and the other being pharmacological drugs such as SSRI, or benzodiazepines, or combination between non-pharmacological and pharmacological treatments. treatment's overall goals are (1) to reduce GAD's core symptoms (2) to improve patient function and quality of life; (3) to treat comorbid disorders (4) and to prevent relapse.

COMPETING INTERESTS DISCLAIMER:

Authors have declared that no competing interests exist. The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

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