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Clinical practice

Guidelines for the management of patients with generalised anxiety

A group of interested people met for two days last year in order to attempt to reach a consensus on good practice in the management of patients with generalised anxiety. The result of their efforts is published below.

Most patients presenting with anxiety, whether acute or chronic, mild or severe, were until recently treated with tranquillisers. Recognition that these drugs can cause dependence in some patients has prompted a re-evaluation of the pharmacological management of anxiety and the value of non-pharmacological treatments is now recognised. Uncertainty remains among many doctors about the efficacy of the whole range of current therapies and the place of the new classes of drugs for anxiety. However, research findings are now accruing which indicate the relative merits of these various therapies, and clarify the principles on which they are based.

The following guidelines are a consensus of the views of interested and experienced psychiatrists, general practitioners and clinical psychologists (list at end) on today's management of patients with generalised anxiety. They are not intended as rules which dictate clinical practice by as a description of the possible alternatives and their place in a balanced management plan.

It is recognised that the availability of services varies throughout the country and that local circumstances and limitations on resources often determine what treatments can realistically be offered. Nonetheless, we believe it is desirable at this time to suggest a management plan which includes the optimal treatments for people with generalised anxiety.

Description of generalised anxiety

A range of disorders come under the heading of Anxiety Disorders (see Table 1). We concentrate on the commonest, Generalised Anxiety Disorder.

These guidelines focus on the management of generalised anxiety which is defined as 'apprehensive expectation about two or more life circumstances.' Worry is the main symptom and somatic, affective, cognitive and behavioural symptoms of anxiety vary according to person and context. Bodily symptoms are often prominent and may greatly alarm the patient, magnifying the anxiety. Generalised anxiety disorder is persistent with secondary characteristics which may include depression, low self-confidence, demoralisation and social anxiety. These may increase if the anxiety is untreated. Common reactions to the problem include counter-productive ways of minimising symptoms, such as avoidance, over-dependence on others and hypochondriasis, which contribute to the maintenance of the problem. Secondary depression often resolves when the anxiety is successfully treated but primary depression requires specific treatment.

Generalised anxiety disorder is a fluctuating condition which may co-exist with, or develop into, other types of anxiety such as phobias or panic disorder for which specific methods of treatment are available; when more than one type of anxiety is present the disorders should be separately treated.

TABLE I.
Types of anxiety disorders

1. *Generalised anxiety disorder*. Unrealistic or excessive anxiety and worry about life circumstances, usually for no good reason. Many symptoms are usually present and include trembling, tension, restlessness, fatiguability, autonomic hyperactivity (such as sweating, palpitations, dry mouth, dysphagia), feeling keyed up, exaggerated startle response, difficulty concentrating because of anxiety, trouble falling asleep and irritability.
2. *Panic disorder*. Panic attacks occur which are unexpected and comprise a range of severe bodily symptoms such as dizziness and trembling. Fear of dying, going mad or losing control is a cardinal feature. The minimum frequency to diagnose the disorder is three attacks in three weeks.
3. *Agoraphobic disorder*. Fear of being in places or situations from which escape may be difficult or help unavailable if a panic attack were to occur. Avoidance such as inability to enter a shop usually develops. Some patients develop phobic avoidance without a history of panics.
4. *Social phobia*. A persistent fear of situations in which the person is subject to possible scrutiny by others and fears that he or she may act in a humiliating or embarrassing way. Examples are eating in a restaurant or public-speaking.
5. *Simple phobia*. A persistent fear of specific objects such as snakes, spiders, or blood. Avoidance may interfere with the person's daily activities.
6. *Post-traumatic stress disorder*. A highly stressful event has been experienced, such as an earthquake or personal violence. The experience is relived in the form of intrusive recollections, recurrent distressing dreams, or intense psychological distress at some aspects of the event such as anniversaries. Stimuli reminiscent of the event are persistently avoided, usually with abnormal feelings of mental numbness such as a feeling of estrangement from others. Other symptoms include insomnia, irritability, difficulty concentrating and exaggerated startle response.

(Based on Diagnostic Criteria from DSM-III-R of the American Psychiatric Association, 1987).

The borderline between 'normal' and 'pathological' anxiety is not easily definable, and people generally seek advice when the problem causes significant distress or interferes with everyday life to an unacceptable extent. It is important to remember that some degree of anxiety may be a normal and necessary part of human experience so treatment cannot eliminate it entirely.

The aim of treatment is to help people cope with their symptoms of anxiety effectively. The first step is to help them recognise and understand the nature of their problem by providing an explanation of anxiety and of its symptoms. In addition, treatment should encourage people to develop and draw on their own resources so as to build up an adequate level of coping. The severity and duration of the presenting problem determine which of the stages outlined below is the most appropriate starting point in individual cases.

Epidemiology

Generalised anxiety is the most common of the anxiety disorders. Community surveys suggest that about 3% of the adult population are suffering from generalised anxiety disorder at any one time. A much higher proportion of patients attending GP surgeries are 'anxious' (around 15%) so that this condition places a heavy demand on GP services.

Management of anxiety

Anxiety is normally a self-limiting condition which should be treated when it becomes subjectively intolerable or unrealistic, or interferes with normal function. Reduction of anxiety is a helpful part of treatment when the symptoms occur in the context of real problems such as unemployment, marital breakdown, physical disease or bereavement.

Pharmacological and psychological treatment may be used alone or in combination. However, when patients are treated with medication alone, they may become passive participants in treatment and this may discourage them in their efforts to cope with anxiety in other ways.

Psychological therapies

This term includes recognised psychological therapies such as anxiety management and cognitive therapy; counselling; and self-help techniques like 'relaxation'. However, it excludes certain complementary techniques such as yoga and hypnotism which, though potentially useful, have undergone less intensive scientific scrutiny. A brief explanation of the main techniques is provided in Table II.

All psychological therapies require collaboration between the therapist and the patient. These techniques may not be suitable for all patients. The range of therapies available depends on local circumstances. Trained clinical psychologists and nurse behaviour therapists are in short supply nationally; the services offered by community psychiatric nurses vary between districts; and some counselling services are offered in the private sector whose quality is uncertain. However, the simpler techniques ought to be available in every practice. This shortage of resources could be alleviated if the services of clinical psychologists and nurse behaviour therapists were more widely available or if they were encouraged to advise or instruct other health professionals, such as

TABLE II.
Psychological management of generalised anxiety

Anxiety management and cognitive therapy have been shown to be effective treatments, specifically for generalised anxiety. Both of them make use of a variety of techniques which are held together by a theoretical rationale, and thus differ from single techniques such as relaxation or exposure. These treatments will therefore be described first.

Anxiety management. This is an active therapy based on the rationale that anxiety can be managed by breaking into the vicious circles that keep the problem going. Essential components include an explanation of anxiety and its causes and consequences (including triggers, avoidance and loss of confidence); identifying and encouraging present methods of coping that are likely to be helpful such as trying to relax, discouraging methods of coping that could maintain the problem, such as avoidance, and constant seeking of reassurance, and teaching additional new ways of coping, including distraction and simplified cognitive techniques.

Cognitive therapy. This is based on the idea that thoughts and feelings are related. Thus anxious thinking (including attitudes, beliefs and images) provokes or maintains the problem. Anxiety is controlled by learning how to recognise and re-examine anxious thinking so as to find out whether there are alternative, and more helpful, ways of thinking. The patients then learn how to test their new ideas out in practice. Cognitive therapy also aims to identify and modify the dysfunctional assumptions or beliefs which underlie anxious thinking.

Psychological techniques widely used either alone or in combination

Applied relaxation. The client is taught progressively to relax, for example, by alternately tensing and relaxing groups of muscles while lying or sitting in a comfortable position. The client then practises relaxing more and more quickly, and finally learns to apply this method of reducing anxiety while involved in daily activities and when feeling anxious.

Exposure. The way in which avoidance maintains anxiety is explained and demonstrated in the client's particular case. The client is then encouraged to face rather than avoid those things that provoke anxiety. If this is difficult, the client is encouraged to do this in a graded way, tackling easier situations first, and repeating the practice before taking on harder ones.

Assertiveness training. The therapist's interventions are aimed at eliciting inhibited responses in interpersonal relationships. A range of methods from role-play to systematic desensitisation are used to enable the client to express his/her basic feelings and emotions without anxiety.

Other forms of psychological treatment

Non-directive counselling. This therapy is termed 'client-centred', as the client is in control of what is discussed in sessions. The counsellor helps the client to deal with problems by listening, trying to understand, asking questions and reflecting back salient points in a warm, empathic way.

Directive counselling. Specific anxiety-provoking issues in the client's life are identified. The client is encouraged to face up to these issues and helped to alter his or her life style, personal relationships and attitudes to problems. The therapist may give advice about specific issues or may limit his or her intervention to general help about decision-making, problem solving, and daily routine.

Psychotherapy. In brief, focal psychotherapy, the therapist focuses on a previously selected, specific problem and sets an agenda and time limits at the beginning of treatment. The client is encouraged to talk freely, but the therapist interprets the content to reveal a deeper meaning which can be understood and accepted by the client.

practice nurses, in specific techniques. In particular we recommend that they should contribute to the training of GPs who seek to develop these skills.

Drugs

Several classes of drugs are available (see Table III for details). Anti-anxiety drugs (tranquillisers) suppress the symptoms of anxiety to a varying extent, but they do not necessarily correct causative factors. Anxiety related to depression is best treated with antidepressants, adding psychological therapies as appropriate.

The role of anti-anxiety drugs alone is usually limited to occasional use, when anxiety is clearly associated with an infrequent but unavoidable event (for example, air travel for holidays, in cases where psychological therapies are not expedient), or briefly to overcome symptoms so severe that they obstruct the initiation of other more appropriate treatment. For patients acutely disabled by severe anxiety drug therapy for up to four weeks may be not only appropriate but essential. Even under these circumstances though, additional counselling, self-help or support is recommended.

The chronic use of anti-anxiety drugs should generally be avoided, although evidence is emerging that antidepressants and possibly buspirone may have a role in the longer-term management of severe persistent forms of anxiety. For patients already dependent on benzodiazepines after long-term use, further benzodiazepine prescriptions may be the only realistic immediate option.

Management plan

Four 'stages' are outlined below, distinguished by the complexity of treatment offered. It is not intended, though, that patients should routinely progress from

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TABLE III.
Drugs used to treat anxiety

Benzodiazepines: effective short-term; long-term effectiveness disputed; rapid onset of action; sedative side effects with impairment of psychomotor, cognitive and memory functions; interactions with alcohol and other psychotropic drugs; risk of dependence with physical withdrawal syndrome on discontinuing long-term use; definite abuse potential. Longer-acting compounds such as diazepam now generally preferred.
Buspirone: effective short-term with progressive onset of action; diminished efficacy in previous benzodiazepine users; side effects of dizziness, headache and nausea; minimal sedation and psychological impairment; no interactions with alcohol or other psychotropic drugs; low or absent risk of dependence or abuse.
Beta-adrenoceptor antagonists: effective in situational or acute stress-related anxiety; effective in patients with some somatic symptoms; side-effects of tiredness and occasionally nightmares and depression; no sedation, psychological impairment, dependence or abuse potential.
Antidepressants: effective in anxiety, panic, and phobic disorders but marked differences among members of this group. Dosages for these indications are unclear. Slow onset of action. Risk of relapse when drug is stopped. Clomipramine and some MAOIs usually preferred but wide range of side-effects which lessen compliance; sedative compounds may impair memory function, in particular autonomic rebound on withdrawal but probably no true dependence or abuse potential. The new selective serotonin re-uptake inhibitors are often better tolerated than standard tricyclics.
Antipsychotics: used in low dose to some effect; side-effects of akathisia (restlessness) and autonomic symptoms may mimic anxiety; low risk of tardive dyskinesia on long-term use; sedative compounds impair psychological functioning; some rebound on withdrawal but probably no true dependence or abuse potential.
Antihistamines: efficacy not firmly established; often very sedative; minimal dependence or abuse potential.

one stage to another. Depending on the severity and nature of functional impairment, they may initially need the type of treatment described in any stage and move in either direction, according to their needs. Therapies from more than one stage should be combined as necessary.

At Stages Two to Four, it is essential to discuss with the patient, rather than dictate a management plan, although the term 'contract' is intimidating for some patients. The plan may or may not be finite; it may set out nothing more than an 'open door' policy, or suitable intervals between appointments (which will reduce the risk that the patient may become dependent on repeated reassurance), or it may embody patients' commitment to take an active role in their therapy. This process alone can be therapeutic to some extent.

It is essential to agree reasonable goals, for example, understanding and controlling symptoms rather than an out-and-out 'cure'. It is important that the patients's wishes are taken into account; imposing what appears to be the best treatment is counter-productive if the patient is inimical to it. This is especially relevant to the use of drugs, and benzodiazepines in particular. Thus in both cases efforts must be made to secure the patient's co-operation.

Stage One: Initial intervention

Most patients suffering from generalised anxiety are treated in the primary care setting. Even though a GP's time is limited, a series of four or five 15-minute consultations over several weeks will often clarify the nature of an apparently difficult problem. At times, GPs may need to consult specialists at an early stage, particularly if anxiety is only one of several relevant clinical factors.

Physical causes of anxiety symptoms (e.g. thyrotoxicosis) should be excluded, although many (e.g. phaeochromocytoma) are sufficiently rare for other investigations not to be cost-effective as a routine. It is important not to 'medicalise' anxiety by asking the patient to undergo more and more investigations. History-taking should also explore the use of alcohol, caffeine and illicit drugs, as well as family and social history, and any association with possible precipitating events. The diagnosis of an anxiety disorder is usually easier when the patient presents with predominantly psychological than with predominantly somatic features. Patients with anxiety who are already taking a benzodiazepine on a long-term basis or attempting to withdraw from it need particularly thorough assessment: an informant should also be interviewed and specialist advice may be needed from an early stage. Nevertheless, the treatment of most of these patients can be based in primary care.

The effectiveness of counselling during the initial consultation with the GP, even if it is brief, should not be underestimated. At this stage, patients are likely to be susceptible to influences which will determine their perception of anxiety as a potentially soluble 'problem' and their own role in its management. Appropriate management at this stage should involve clear definition of the particular problem, information about anxiety and attempts to encourage patients to adopt an active problem-solving rather than passive approach to their difficulty. Bland reassurance may be misunderstood. Such management may prevent a chronic problem.

Counselling should include the provision of self-help materials such as books, tapes or leaflets, followed by discussion to reinforce the counselling

message. A wide range of materials is available although few have been evaluated. Many are popular with patients and some suggestions are included below.

Stage Two: Psychological management

Patients with more complicated or resistant problems may benefit from more formal psychological therapy and support from the GP or practice nurse or one of the psychological therapies available from a clinical psychologist, behavioural nurse therapist or psychiatrist, according to local circumstances. The range of appropriate techniques includes directive and non-directive counselling, assertiveness training, relaxation, psychotherapy, anxiety management, and cognitive therapy. There is good evidence that anxiety management and cognitive therapy are capable of achieving clinically useful and lasting change and that a cognitive approach conducted by an *experienced* therapist may be more effective than others. A brief explanation of each technique is provided in the accompanying notes. Nevertheless, medication may be needed in severe cases to tide the patient over, while the psychological therapies are instituted.

Not all techniques are helpful for all patients: some require significant effort by the patient, including homework assignments. Patients should be told that the course of improvement is sometimes marked by temporary setbacks as anxiety levels continue to fluctuate, but that this is normal.

The patient can learn some of the simpler techniques involved in relaxation, stress or anxiety management, or can join a local self-help group. Again, there is a range of materials for patients, much of which has not been evaluated. Relaxation tapes recorded by the therapist who is working with the patient ensure better quality, can be adapted to suit the particular needs, and act as a reminder of techniques learned in the clinic.

The selection of a psychological therapy should be made on the advice of the therapist concerned (who may be a psychiatrist, clinical psychologist or other professional) bearing in mind the patients's own preferences. More than one technique (e.g. relaxation plus cognitive therapy) may be used at a time. The techniques can be used in group settings, although they are supposedly most effective when adapted to individual needs.

Stage Three: The use of medication

Psychological therapies are not effective in all patients and those who do not respond to them should be re-assessed to ensure that an underlying disease or other mood disorder (particularly depression) has not been missed. In some patients, a combination of drug and psychological therapies may help (though the benzodiazepines may impair the effectiveness of psychological therapies); other patients may require long-term therapy or support.

Patients who are acutely disabled by severe anxiety may need a brief course of treatment with a benzodiazepine. This should be monitored closely, and patients who apparently still need treatment after two to three weeks may need referral to a specialist. The selection of appropriate drug treatment depends on the individual needs of the patient and likely duration of therapy. If depression is present, an antidepressant is then the best choice; antidepressants may also be useful when anxiety is chronic. Some patients tolerate new selective serotonin re-uptake inhibitors better than they do the tricyclics. Buspirone is suitable for the short-term management of severe anxiety when a rapid onset of effect is not essential and for the treatment of anxious patients with histories of dependence on alcohol or sedative/hypnotics. Beta-adrenoceptor antagonists are often effective in situational anxiety especially when bodily symptoms predominate.

The benzodiazepines are still the first choice when a rapid anxiolytic effect is needed. However, the GP must tell the patient that the supply will be restricted to one or two small prescriptions; that drugs are only one part of the management plan; that they are an aid not a solution to the problem of anxiety; that performance of skilled tasks and driving may be impaired; and that interactions with drugs and alcohol are potentially dangerous. The dose and duration of treatment should be the minimum effective to relieve symptoms.

A brief course of benzodiazepines can also be helpful in patients with combined anxiety and depression pending the onset of the effect of antidepressants, though in general polypharmacy is best avoided.

The risks of benzodiazepines used intermittently and infrequently to control situational anxiety are unknown, but probably small. However, there is a risk of 'kindling' a reliance on the drugs, which may develop gradually into more frequent chronic use. Benzodiazepines are usually inappropriate for bereaved patients and may impair the adjustment to grief.

Stage Four: Specialist care

Patients may be referred to hospital services when primary care is inappropriate or unsuccessful. The hospital specialist will expect to reassess the patient, and to take a new medical and psychiatric history. However, other than excluding thyrotoxicosis, medical investigations to identify a possible physical cause are not cost-effective unless there are positive indications of physical illness, e.g. the possibility of alcoholism, or sudden unexplained onset of anxiety

in a middle-aged or elderly person. Psychometric assessment is occasionally informative, for example, to exclude a dementing process.

Few patients need to be admitted for the treatment of anxiety. Most should be treated as out-patients or perhaps day patients with the close co-operation of all those involved including the GP, consultant psychiatrist, clinical psychologist and other relevant staff.

It is essential that communication between those involved is frequent and explicit: GPs should state clearly their reasons for referral (for advice, reassessment, or to take over patient care) and hospital specialists should inform the GP about the management plan and who is to be responsible for particular aspects, e.g. for prescribing. It is also important to inform the patient of treatment plans to reinforce the collaborative element of the enterprise. One way to address this problem is to provide specialist services in the primary care setting by using mobile clinics or community-based teams. Domiciliary visits by specialists may also have a role.

An appropriate management plan will depend on both the outcome of the reassessment and on the treatment the patient has already undergone. The specialist's treatment options are similar to those used in the community, though there will probably be a wider range of expertise available and the experience with new psychological and pharmacological treatments is likely to be greater at this level.

Self-help books

GILLIAN BUTLER. *Managing Anxiety*. Department of Psychiatry, Warneford Hospital. Oxford.

CLAIRE WEEKES. *More Self-help for your Nerves*. Angus & Robertson.

BOB WHITMORE. *Living with Stress and Anxiety*. Manchester University Press.

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