



## **Role of Primary Care Physician in Management of Generalized Anxiety Disorder**

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## 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 characterized 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 practice guidelines advocate pharmacological (e.g., SSRIs and venlafaxine) or cognitive behavior 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.

*Keywords: Behavioural therapy; anxiety disorder; pathophysiological; mental disorder.*

## 1. 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 linked to medical conditions such as heart disease, GI issues, and chronic pain. Such connections are clinically significant because people with mental or medical comorbidities have a longer clinical course and worse outcomes than people 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 psychological and pharmaceutical therapies are the same. For instance, investigation has also shown that perceptions of treatment need, assistance behavior, care delivery, and recognition and treatment of mental disorders by healthcare professionals differ across common mental disorders, potentially affecting the likelihood of receiving potentially adequate treatments [1,10–14].

## 2. ETIOLOGY AND PATHOPHYSIOLOGY

Several etiological explanations for GAD have been proposed, 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
- Comorbidities include medical conditions such as diabetes and other comorbidities such as depression.
- 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. Many believe that decreased serotonin system activity and increased noradrenergic system activity are responsible for its development. As a result, serotonin reuptake inhibitors (SSRI) and serotonin-norepinephrine reuptake inhibitors (SNRI) are the first-line treatments for it [16].

## 3. EPIDEMIOLOGY

As shown in a 6-month prevalence estimates accepted for publication by World Health

Organization (WHO) research in 14 countries, including the U.s, more than 8% of patients visiting a general practitioner had GAD. The lifetime prevalence of the illness is estimated to be around 5%–6% using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria, though the European Study of the Epidemiology of Mental Disorders (ESEMeD) provides a lower estimate of 2.8 percent. While the incidence estimates in the ESEMeD questionnaires are typically comparable to other studies, it's been suggested that several incidence rate may be underestimated due to ESEMeD research methods, such as the way analytic interviews were conducted. GAD affects twice as many women as men and is more common in middle age, with incidence rates starting to rise after the ages of 35 for women and 45 for men. GAD is thought to be common among the elderly, with various estimates 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].

## 4. 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 phenomena that can encourage people to finish work and escape harmful circumstances 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].

The key diagnostic criteria for GAD are excessive anxiety and concern, as well as at least three symptoms from a list of six

(restlessness, irritability, problems concentrating, muscle tension, sleep disruptions, and being easily fatigued) and a 6-month duration of the disorder. Manifestations are unpleasant or disabling and could be adequately explained by another disorder. The clinical definition in the International Classification of Diseases' Tenth Edition place a greater emphasis on the existence of somatic complaints, which would be reflected in the GAD Algorithm established by the International Psychopharmacology Algorithm Project (IPAP), as somatic symptoms are frequently the prove detrimental. The DSM task group is debating whether GAD and major depressive disorders are distinct manifestations of the same condition, closely related disorders, or distantly related disorders based on the most recent genetic, epidemiologic, and other study results. Furthermore, 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 being taken into account [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].

## 5. MANAGEMENT

The plan for treatment includes managing the following: The severity of the condition, the presence of concurrent medical illness, complications such as substance abuse or the risk of suicide, the outcomes of any previous treatments, cost issues, the 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, 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].

The selective serotonin reuptake inhibitor (SSRI) and serotonin-norepinephrine reuptake inhibitor (SNRI) groups of medications are first-line treatments, with response rates ranging from 30% to 50%. This class of drugs includes escitalopram (Lexapro), duloxetine (Cymbalta), venlafaxine (Effexor XR), and paroxetine (Paxil, Pexeva). In one investigation, children with anxiety problems improved in 81 percent of instances were given a combination of sertraline hydrochloride and CBT [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 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 help cooperative and compliant people who are aware that their symptoms have a psychological basis. Due to the risk of overuse and dependency, patients with a history of drinking or drug addiction are not suitable candidates for this therapy [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 helps, gradually raise the dose and keep it up for at least four weeks. After the symptoms have been controlled, the medications must be continued for at least 12 months before being gradually tapered off. Patients must be continuously monitored because all drugs have side effects such as weight gain, hyperlipidemia, and diabetes [16]. Recovery involves not just symptomatic relief as well as the return of patients to their peak functional ability, including the return to work, family, social, and action roles. In some lifelong cases of GAD, however, recovery can result in a level of well-being far superior to the premorbid baseline. Patients suffering from GAD are more likely to demand sleep aid, which can have a significant impact on quality of life and work performance. While immediate symptom relief is beneficial, it is more important to remind patients that they must adhere to their therapy in order to reap the most benefits and long-term improvement in their disease. It is possible that remission will take 4-6 months after beginning therapy [27].

## 6. 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 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.

## DISCLAIMER

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.

## CONSENT AND ETHICAL APPROVAL

It is not applicable.

## COMPETING INTERESTS

Authors have declared that no competing interests exist.

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