Editorials

Improving the detection and management of anxiety disorders in primary care

ANXIETY IS UNDER-DIAGNOSED IN PRIMARY CARE

There has been considerable emphasis on encouraging GPs to improve their skills in the diagnosis and management of depression, yet anxiety disorders have been relatively neglected. Anxiety symptoms are more common than those of depression in the community, and may be accompanied by significant morbidity. The 2007 UK Adult Psychiatric Morbidity Survey reported a 9% prevalence of mixed anxiety and depression in their doorstep community survey, while generalised anxiety disorder (GAD) affected 4.4% of the population, other anxiety disorders 3.6%, and only 2.3% reported depressive disorders.[1]

Despite this, there has been much less research to assess outcomes in anxiety than depressive disorders, and most of the research comes from the US or Europe. Studies suggests that anxiety disorders are often more chronic than other common mental disorders, presumably because anxiety is often left untreated and it is frequently comorbid with depressive disorders or chronic physical health problems.[2,3] Such comorbidity is associated with poor quality of life, substance misuse, disability, and high health and social costs.[4]

GP rates of diagnosis and treatment of anxiety disorders are much lower than expected, given their prevalence.[5] This may be due to both patient and practitioner factors. Patients may have symptoms of anxiety, worry, tension, irritability, or tiredness, which they are unsure about presenting to their GP; whereas GPs may dismiss such symptoms or attribute them to general malaise or a potentially physical condition requiring investigation, and not specifically consider or ask about anxiety symptoms. In addition, many people present with the somatic symptoms associated with their anxiety, possibly thinking that these are more medically legitimate.

Those with anxiety disorders may be frequent users of both primary and secondary care services, but if their anxiety is not detected they may not receive appropriate treatment and can also undergo unnecessary, potentially dangerous, and costly investigations. Some patients with anxiety symptoms may have an underlying problem with alcohol use that can obscure the presentation.

Both patients and primary care practitioners may consider anxiety symptoms to be 'part of normal living' and be concerned about medicalising this problem. It is important to recognise that, when persistent, these symptoms can cause significant distress and limitation to daily activities. Self-help groups, such as Anxiety UK, are keen to raise the profile of these disorders among GPs and to improve both their detection and management in primary care.[6]

Some clinicians consider both anxiety and depression to be part of a continuum of common mental disorders, and that identifying people as having one or other disorder is less important than assessing the severity of symptoms and their impact on people's lives. This may be a valid perspective, particularly in primary care where people often present with mixed or comorbid disorders, but it is important to distinguish which symptoms are most prominent or severe in order to know how to focus any explanations, treatments offered, or referrals made.

ARE THERE EFFECTIVE TREATMENTS FOR ANXIETY?

One of the arguments given for low detection rates for anxiety disorders in primary care has been the poor availability in many areas of psychological therapies, such as cognitive behavioural therapy (CBT), and the reluctance of many patients to take, and practitioners to prescribe, antidepressant medication such as selective serotonin receptor inhibitors for the treatment of anxiety disorders. The Improving Access to Psychological Therapies initiative[7] has greatly improved national availability of talking treatments, and this should improve further following the UK government's October 2010 Spending Review if commissioners agree this is an important provision.

A recent meta-analysis indicated that brief CBT administered in primary care for anxiety (mostly GAD and panic disorder) had an equivalent impact to longer-length treatments, unlike for depression where brief CBT had a smaller effect on clinical outcomes.[8]

In previous guidelines for depression and GAD from the National Institute for Health and Clinical Excellence, the advice was always to focus initially on treating any depression if it co-existed with an anxiety disorder, but both guidelines now state that the more severe problem should be treated first. Both also advocate a stepped-care approach to the management of these disorders, aiming to find the least intrusive but effective intervention.[9,10]

The steps are not dissimilar across both guidelines, with initial education about the disorder and 'active monitoring' as the first step. If patients remain symptomatic, the step 2 recommendation is for a low-intensity intervention which could be non-facilitated self-help, guided self-help, or psycho-educational groups. Interestingly, unlike in depression, non-facilitated self-help (providing patients with written, audio-recorded, or computerised self-help materials based on CBT to make use of themselves without further guidance) does appear to be effective for GAD, and is recommended for this level of stepped care.[10] Reasons for this difference are not clear, but it may be difficult for people who are significantly depressed to motivate themselves to use self-help materials on their own.

If someone still has significant symptoms after receiving an appropriate low-intensity intervention, they should be stepped up to a high-intensity one. Step 3 may involve one of the psychological therapies with a good evidence base in this condition (CBT, applied relaxation, or pharmacotherapy). Where evidence is similar for different interventions at the same step (for example, between CBT and pharmacological treatment at step 3), patient choice should

> *"Primary care clinicians should be aware of the possibility of anxiety symptoms causing physical distress or being comorbid with depression or chronic physical disease."*

determine which is offered, providing that the intervention is available and not contraindicated. If people don't respond to the first step 3 intervention offered, another may be tried before considering referral to a specialist step 4 service.

Although GAD is the most common anxiety disorder found in the community, it is important for GPs to be able to identify and know how to treat other anxiety disorders, such as panic disorder, social phobia, and post-traumatic stress disorder (PTSD). There is no formal stepped-care approach formulated for these conditions, and the evidence is probably strongest for psychological therapies in all of these, although the components may vary.

HOW CAN DETECTION OF ANXIETY BE IMPROVED IN PRIMARY CARE?

The Patient Health Questionnaire (PHQ-9) has become part of routine primary care practice at initial assessment and in the follow-up of patients diagnosed as depressed, not least because its use is rewarded under the Quality and Outcomes Framework (QOF). Recent studies indicate that patients do not object to completing such questionnaires nearly as much as was initially feared by many GPs, so this may be one way of improving detection rates of anxiety disorders; although there is some evidence that GPs may find using such schedules problematic within a consultation.[11] The equivalent questionnaire for GAD — the Generalised Anxiety Disorder Assessment, or 'GAD-7' — is not rewarded under QOF and is much less frequently used in UK primary care. Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and specificity of 82% for GAD, but these rates are lower if screening for panic disorder, social phobia, and PTSD.[12]

Suggesting the use of another case-finding measure does not negate the fact that primary care clinicians should be aware of the possibility of anxiety symptoms causing physical distress or being comorbid with depression or chronic physical disease. The importance of taking a careful history, exploring the patient's views of their problem, and preferred management cannot be under-estimated. Third sector groups, such as Anxiety UK (http://www.anxietyuk.org.uk/), also provide services for patients with anxiety and should be part of the discussion about treatment options.

Marta Joanna Buszewicz,
University College London Medical School, Research Department of Primary Care and Population Health, London, UK.

Carolyn Chew-Graham,
University of Manchester, School of Community Based Medicine, Manchester, UK.

Acknowledgements
We would like to thank Professor John Cape for his helpful comments on an earlier version of this editorial. Marta Buszewicz, Carolyn Chew-Graham, and John Cape were all members of the NICE Guidelines Development Group responsible for the recent updating of the generalised anxiety disorder and panic disorder guideline (Clinical guideline 113).

Provenance
Freely submitted; not externally peer reviewed.

DOI: 10.3399/bjgp11X588259

ADDRESS FOR CORRESPONDENCE

Marta Joanna Buszewicz
University College London Medical School, Research Department of Primary Care and Population Health, Upper 3rd floor, Hampstead Campus, Rowland Hill Street, London, NW3 2PF.

E-mail: m.buszewicz@ucl.ac.uk

REFERENCES

1. McManus S, Meltzer H, Brugha,T, *et al. Adult psychiatric morbidity in England, 2007: Results of a household survey.* Leeds: The NHS Information Centre for Health and Social Care, 2009.
2. Tyrer P, Baldwin D. Generalised anxiety disorder. *Lancet* 2006; **368(9553):** 2156–2166.
3. Sareen J, Jacobi F, Cox B, *et al.* Disability and poor quality of life associated with comorbid anxiety disorders and physical conditions. *Arch Intern Med* 2006; **166(19):** 2109–2116.
4. Simon G, Ormel J, VonKorff M, Barlow W. Health care costs associated with depressive and anxiety disorders in primary care. *Am J Psychiatry* 1995; **152(3):** 352–357.
5. Wittchen H-U, Jacobi F. Size and burden of mental disorders in Europe — a critical review and appraisal of 27 studies. *Eur Neuropsychopharmacol* 2005; **15(4):** 357–376.
6. Anxiety UK. *Anxious times: ensuring the needs of anxiety sufferers are met in the next decade.* Manchester: Anxiety UK, 2009.
7. Improving Access to Psychological Therapies. www.iapt.nhs.uk (accessed 4 Jul 2011).
8. Cape J, Whittington C, Buszewicz M, *et al.* Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. *BMC Med* 2010; **8:** 38.
9. NICE. *Depression: the treatment and management of depression in adults (update). (Clinical guideline 90).* London: National Institute for Health and Clinical Excellence, 2009. www.nice.org.uk/CG90 (accessed 4 Jul 2011).
10. NICE. *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care.* (Clinical guideline 113). London: National Institute for Health and Clinical Excellence, 2011. http://guidance.nice.org.uk/CG113 (accessed 4 Jul 2011).
11. Leydon G, Dowrick C, Mc Bride A, *et al.* Questionnaire severity measures for depression: a threat to the doctor-patient relationship? *Br J Gen Pract* 2011; **61(583):** 117–123.
12. Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. The GAD-7. *Arch Intern Med* 2006; **166(10):** 1092–1097.