

Generalised anxiety disorder
and panic disorder (with or
without agoraphobia) in adults

Clinical case scenarios for generalised anxiety disorder for use in primary care

2011

These clinical case scenarios accompany the clinical guideline: 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care' (available online at: www.nice.org.uk/guidance/CG113).

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It is not NICE guidance.

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Introduction

These clinical case scenarios are an educational resource that can be used in individual or group learning situations. They illustrate the application of the recommendations on generalised anxiety disorder (GAD) in the clinical guideline 'Generalised anxiety and panic disorder (with or without agoraphobia) in adults' (NICE clinical guideline 113) to the care of people presenting with symptoms of generalised anxiety disorder in primary care.

Five scenarios are outlined. Each scenario includes details of the person's initial presentation, their past medical history and the clinician's summary of the situation after examination. The clinical decisions surrounding diagnosis and management are then examined using a question and answer approach.

Each question should be considered by the individual or group before referring to the answers. You will need to look at the NICE guideline (available from www.nice.org.uk/guidance/CG113) to help you decide what you need to do to diagnose and manage each case scenario, so make sure that copies of the recommendations from the NICE guideline are available. The clinical case scenarios are also presented in a PowerPoint presentation for use with groups.

It is acknowledged that in reality people will present in primary care with a variety of symptoms and needs that will necessitate the diagnosis and management of other conditions in addition to generalised anxiety disorder. However, in order to illustrate the application of the guideline, the scenarios outlined here focus primarily on the symptoms, diagnosis and management of generalised anxiety disorder.

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.

Next steps for diagnosis

Question 1: You suspect GAD – what would you do to confirm this?

Answer:

1.2.3 Consider the diagnosis of GAD in people presenting with anxiety or 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.

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.

Question 2: You confirm GAD – what would you do next?

Answer:

Start with step 1 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, including the 'Understanding NICE guidance' booklet*
- monitor the person's symptoms and functioning (known as active monitoring).

This is because education and active monitoring may improve less severe presentations and avoid the need for further interventions.

*NICE has also produced a 'Guide to self-help resources for GAD' that lists online resources that will help people with GAD to manage their symptoms. The guide is available from <http://guidance.nice.org.uk/CG113/SelfHelp>

1.2.10 Discuss the use of over-the-counter medications and preparations with people with GAD. Explain the potential for interactions with other prescribed and over-the-counter medications and the lack of evidence to support their safe use.

Refer to recommendations 1.1.1 to 1.1.6 for details of information and support that should be provided for all people presenting with GAD, their families and carers.

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?

Answer:

Move up to step 2 interventions and discuss the options with Mary.

1.2.11 For people with GAD whose symptoms have not improved after education and active 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.

See recommendations 1.2.12 to 1.2.15 for more details about these interventions.

Case scenario 2: Blossom

Presentation

Blossom is a 20-year-old telesales operator who feels that she is 'going mad' with anxiety.

Past history

Blossom has no significant past medical or mental health history.

On examination

Blossom describes feeling anxious much of time. The problem started when she was studying for her GCSEs, when she describes being incapacitated with anxiety. Despite wanting to enter higher education she felt that she would be unable to cope with the pressure and left school aged 16. Her family was disappointed about this. Blossom describes not being able to make decisions as she worries too much about what would happen if she made the wrong decision. She also describes a low mood but has no suicidal thoughts.

Next steps for diagnosis

Question 1 You suspect GAD – what would you do to confirm this?

Answer:

1.2.3 Consider the diagnosis of GAD in people presenting with anxiety or 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.

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.

Question 2 *You confirm GAD and moderate depression, with GAD being the more severe condition – what would you do next?*

Answer:

Start with step 1 interventions for GAD as this is the primary disorder.

1.2.7 For people with GAD and a comorbid depressive or other anxiety disorder, treat the primary disorder first (that is, the one that is more severe and in which it is more likely that treatment will improve overall functioning).

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, including the 'Understanding NICE guidance' booklet*
- monitor the person's symptoms and functioning (known as active monitoring).

This is because education and active monitoring may improve less severe presentations and avoid the need for further interventions.

*NICE has also produced a 'Guide to self-help resources for GAD' that lists online resources that will help people with GAD to manage their symptoms. The guide is available from <http://guidance.nice.org.uk/CG113/SelfHelp>

1.2.10 Discuss the use of over-the-counter medications and preparations with people with GAD. Explain the potential for interactions with other prescribed and over-the-counter medications and the lack of evidence to support their safe use.

Refer to recommendations 1.1.1 to 1.1.6 for details of information and support that should be provided for all people presenting with GAD, their families and carers.

Question 3 What are the next steps for management?

Blossom's symptoms have not improved after 4 weeks of active monitoring and education. What are the next steps?

Answer:

Discuss the options for step 2 interventions. Blossom's preference is to attend a psychoeducational group as she feels she would benefit from meeting people who have similar problems.

1.2.11 For people with GAD whose symptoms have not improved after education and active 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.

See recommendations 1.2.12 to 1.2.15 for more details about these interventions.

Case scenario 3: 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 fortnightly 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?

Answer:

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 (see 1.2.17 to 1.2.21)
 - or**
 - drug treatment (see 1.2.22 to 1.2.32).

Provide verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes.

Base the choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better.

Refer to recommendations 1.1.1 to 1.1.6 for details of information and support that should be provided for all people presenting with GAD, their families and carers.

After a discussion of the options, Paul chooses a psychological intervention and shows a preference for individual cognitive behavioural therapy (CBT).

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:

- have regular supervision to monitor fidelity to the treatment model, using audio or video recording of treatment sessions if possible and if the person consents
- use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment.

Case scenario 4: Ashraf

Presentation

Ashraf is a 29-year-old single man who has come to see his GP regarding feeling stressed and exhausted all of the time, sleeping badly, having frequent headaches and persistent worries about his work situation.

Past history

Ashraf describes himself as someone who has been 'easily stressed' all his life. He had seen a counsellor at college for a few sessions when he became very anxious about his exams and had found this helpful. Apart from this he has had no previous treatment for mental health difficulties.

On examination

Ashraf said that things had become significantly worse over the past 6 months when there had been threats of redundancies in his workplace. He describes being unable to relax, constantly thinking about mistakes he might have made, colleagues he might have upset and what might happen in the future. He has noticed himself getting more wound up than usual about everyday events outside work as well. Recently he has been so exhausted and anxious that he has taken days off work, which worries him more and has prompted him to see his GP.

Next steps for diagnosis

Question1 *You suspect GAD – what would you do to confirm this?*

Answer:

1.2.3 Consider the diagnosis of GAD in people presenting with anxiety or 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.

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.

Question 2 *You confirm GAD – what would you do next?*

Answer:

Start with step 1 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, including the 'Understanding NICE guidance' booklet*
- monitor the person's symptoms and functioning (known as active monitoring).

This is because education and active monitoring may improve less severe presentations and avoid the need for further interventions.

*NICE has also produced a 'Guide to self-help resources for GAD' that lists online resources that will help people with GAD to manage their symptoms. The guide is available from <http://guidance.nice.org.uk/CG113/SelfHelp>

1.2.10 Discuss the use of over-the-counter medications and preparations with people with GAD. Explain the potential for interactions with other prescribed and over-the-counter medications and the lack of evidence to support their safe use.

Refer to recommendations 1.1.1 to 1.1.6 for details of information and support that should be provided for all people presenting with GAD, their families and carers.

Question 3 What are the next steps for management?

After discussing the nature of GAD and talking about treatment options, Ashraf is keen to start treatment straight away. What are the next steps?

Answer:

Offer a step 2 intervention.

1.2.11 For people with GAD whose symptoms have not improved after education and active 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.

See recommendations 1.2.12 to 1.2.15 for more details about these interventions.

After considering the options, Ashraf decides that he would prefer individual guided self-help.

1.2.13 Individual guided self-help for people with GAD should:

- include written or electronic materials of a suitable reading age (or alternative media)
- be supported by a trained practitioner, who facilitates the self-help programme and reviews progress and outcome usually consist of five to seven weekly or fortnightly face-to-face or telephone sessions, each lasting 20–30 minutes.

Question 4 Ashraf continues to present with symptoms of GAD. What would you do next?

After completion of the individual guided self-help sessions there is only minor improvement and Ashraf's symptoms remain very troubling. He continues to have frequent days off work. What would you do next?

Answer:

Discuss the options available at step 3.

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 (see 1.2.17 to 1.2.21) or
- drug treatment (see 1.2.22 to 1.2.32).

Provide verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes.

Base the choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better.

Ashraf is not keen on a psychological intervention because of his concerns about taking time off work so he decides to try drug treatment. You prescribe sertraline*.

See recommendations 1.2.22 to 1.2.32 about drug treatment at step 3.

* refer to recommendation 1.2.22 for details of issues to consider when prescribing sertraline.

Question 5 What are the options if Ashraf still has symptoms of GAD?

Ashraf takes sertraline for 6 weeks. He tolerates the medication well.

However, his symptoms are only minimally improved and he continues to take time off work because of anxiety-related symptoms. What are the possible options?

Answer:

Inadequate response to step 3 interventions

- 1.2.33 If a person's GAD has not responded to a full course of a high-intensity psychological intervention, offer a drug treatment (see 1.2.22–1.2.32).
- 1.2.34 If a person's GAD has not responded to drug treatment, offer either a high-intensity psychological intervention (see 1.2.17–1.2.21) or an alternative drug treatment (see 1.2.23–1.2.24).
- 1.2.35 If a person's GAD has partially responded to drug treatment, consider offering a high-intensity psychological intervention in addition to drug treatment.

Ashraf is still not keen on further psychological treatment and wishes to try another drug. You withdraw the sertraline and start venlafaxine.

See recommendations 1.2.22 to 1.2.32 about drug treatment at step 3.

Case scenario 5: Jill

Presentation

Jill is a 50-year-old woman who lives with her husband and two children (aged 20 and 18). She has come to see her GP with worries about a number of health problems including extreme tiredness, agitation and pains in her chest.

Past history

Jill has been a frequent attender at the practice over the years, often with concerns about her or her children's health. She has a history of GAD and has been on and off antidepressants for the past 30 years. When she was 23 she took an overdose following the break-up of a relationship. She had some sessions of counselling about 10 years ago that she found helpful. She was referred to a primary care mental health worker in the practice 2 years ago for help with anxiety and low mood. She had some sessions of individual guided self-help, but she found that this made no difference. She was put in touch with a voluntary sector self-help group for people with anxiety around this time – but did not pursue this.

On examination

Jill says she has always been a very 'nervy' person who finds dealing with everyday stresses difficult. She worries a lot about herself and her family and easily gets 'in a state' and assumes 'the worst' – for example, if family members are unwell or if they are late coming home. Sometimes things get so bad that she needs someone around her constantly to reassure her and feels that she can't be left on her own. The intensity of these problems has varied over the years, but has become worse again during the past 8 months following her husband's diagnosis of heart problems. She has been drinking wine most evenings to try to calm herself down. More recently things have become so bad that she has sometimes felt that if she were left on her own she might harm herself. Her family has been very supportive and stayed with her during these periods until she calmed down, but is now finding this difficult to manage.

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

Answer:

As GAD is markedly interfering with Jill's functioning and her symptoms have not previously responded to 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 (see 1.2.17 to 1.2.21)
- or**
- drug treatment (see 1.2.22 to 1.2.32).

Provide verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes.

Base the choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better.

Refer to paragraphs 1.1.1 to 1.1.6 for details of information and support that should be provided for all people presenting with GAD, their families and carers.

You also need to consider Jill's alcohol intake.

1.2.8 For people with GAD who misuse substances, be aware that:

- substance misuse can be a complication of GAD
- non-harmful substance use should not be a contraindication to the treatment of GAD
- harmful and dependent substance misuse should be treated first as this may lead to significant improvement in the symptoms of GAD.

As Jill's alcohol intake is considered to be non-harmful, she is offered a step 3 intervention. She is not keen on taking any more drugs and so decides to try a psychological intervention, with individual CBT her preferred option.

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:

- have regular supervision to monitor fidelity to the treatment model, using audio or video recording of treatment sessions if possible and if the person consents
- use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment.

Question 2 – Jill continues to have symptoms of GAD. What would you do next?

After 15 sessions of CBT, Jill continues to have significant symptoms of anxiety. She is finding it increasingly difficult to manage everyday tasks and is very agitated and frightened a lot of the time. Her family says that she is now unable to be left on her own without threatening to take an overdose and the family is finding this very difficult to deal with. Although Jill denies feeling suicidal when she is seen in the surgery she is worried about the increase in frequency of her suicidal thoughts when she gets very anxious. Her alcohol intake has increased and she is now drinking several glasses of wine each evening. She says she finds it very difficult to put into practice the strategies that she learnt in the CBT sessions.

Answer:

As Jill has not responded to a step 3 intervention, her anxiety is severe, her alcohol intake has increased to harmful levels and she has marked functional impairment and a risk of self-harm, she is offered assessment and treatment at step 4.

1.2.36 Consider referral to step 4 if the person with GAD has severe anxiety with marked functional impairment in conjunction with:

- a risk of self-harm or suicide **or**
- significant comorbidity, such as substance misuse, personality disorder or complex physical health problems **or**
- self-neglect **or**
- an inadequate response to step 3 interventions.

Refer to recommendations 1.2.37 to 1.2.43 for the details of assessment and treatment at step 4.

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