

1. Introduction

This document is the *complete* version of the CPG for treatment patients with anxiety disorders in Primary Care. The CPG is structured into chapters which respond to the questions that appear at the start of each one. A summary of the evidence and recommendations are presented at the end of each chapter. The right margin will include an indication of the type of study and the possibility of bias of the bibliography reviewed.

The material that provides a detailed description of the methodological process applied for the CPG (description of the techniques used in qualitative research, search strategy for each clinical question, guideline table) is available at the *GuiaSalud* website, as well as in the *UETS*, the Health Technology Assessment Unit of the Agencia Laín Entralgo. These websites also include the *Methodology Manual for CPG preparation*, which covers the general methodology used ¹. There is also a *summarized* version of the CPG, which is shorter and includes the main appendices of the *complete* CPG, a *quick* guideline with the main algorithms and recommendations and an informational *brochure* for patients. These versions are available on both the aforementioned websites as well as in the printed edition.

Prevalence of anxiety and associated burdens

Mental health, as an indivisible part of health, contributes significantly to quality of life and full social participation. Mental disorders constitute a significant social and economic burden due to their frequency, coexistence, and comorbidity, in addition to the disability that they generate. Mental illness is the second leading cause of illness in societies with market economies, with these figures expected to increase considerably ² with few prospects for control.

In our context, it has been confirmed to be one of the categories of causes that most contribute to the loss of illness-free years of life, using the DALY rate (Disability-Adjusted Life Years)³ as the measure of the burden of illness. For this reason, mental health has required special attention by the agents involved, reflected by the broad lines of action in the document “*Mental Health Strategy for the National Health System*”⁴: healthcare for patients, coordination amongst institutions, scientific societies, and associations, training of healthcare personnel, promotion of research and systems of information and evaluation.

With mental health problems, *anxiety disorders* are associated with significant levels of disability ⁵. This dysfunctionality has a considerable impact on personal well-being, on social relations, and on productivity on the job, with the aggravating factor that its prevalence and the recurrent or even chronic nature of many of these disorders makes them as debilitating as any other chronic physical illness.

Anxiety disorders, along with mood disorders, are the disorders that contribute most to morbid-mortality through the suffering that they generate and are the ones that have the biggest repercussions on national economies ⁶⁻⁸. Pathological panic-anxiety makes it difficult for the subject to function anywhere, limiting autonomy, and leaving the person trapped and threatened by the panic itself.

In our context, most studies put the prevalence of mental illness in the general population at between 10% and 20%^{9,10}. Figures from the Eurobarometer give an estimated prevalence for any mental disorder in Spain of 17.6%, higher in women (20.8%) than in men (14.2%)¹¹. The most frequent disorders are normally anxiety, followed by depression, or vice-versa, depending on the classification used and whether or not the analysis includes phobias.

The international prevalence of anxiety disorders varies widely among the different epidemiological studies published, although the variability associated with anxiety disorders considered overall is significantly lower than the variability associated with the disorders considered individually. There are several factors that explain the heterogeneity of the percentages in these studies, such as the diagnostic criteria for inclusion, the diagnostic instruments, the size of the sample, the country covered by the study, and the response percentage. The estimated percentages of prevalence-year and prevalence-life for anxiety disorders were 10.6% and 16.6% respectively¹². If the studies are done among users who visit Primary Care facilities, the prevalence increases, varying between 20% and 40%^{5,6,10,13,14}. Anxiety disorders in and of themselves or associated with other pathologies are one of the most frequent causes of Primary Care visits and represent one of the main health problems in Spain. In the context of Spain, the prevalence of anxiety disorders in the community, with the precision difficulties mentioned before, varies around 2.3%-8.9%⁹, reaching figures between 9% and 19.5%^{5,8,10,14} when we talk about patients who visit a healthcare centre because they have the perception that they do not feel good.

Women have a higher risk than men of suffering anxiety disorders^{11,15}, and the prevalence of most of the anxiety disorders in the case of women is double the prevalence for men, except in the case of social phobia, in which the differences are smaller. The age at which anxiety disorders start is lower than for depression disorders. This appears to indicate that many people who show signs of anxiety disorders during childhood, adolescence, and early years of adulthood, have a higher risk of developing a depression disorder later in life. This means that a therapeutic approach to anxiety disorders could prevent the later appearance of depression disorders^{11,15} (See tables 1-3).

Table 1. Prevalence-year of anxiety disorders following the criteria DSM-IV (data weighted for the Spanish population). 2001 - 2002

Anxiety disorders						
	Total		Men		Women	
	Prev (%)	CI 95%	Prev (%)	CI 95%	Prev (%)	CI 95%
Generalized anxiety	0.50	(0.30-0.70)	0.44	(0.11-0.78)	1.18	(0.81-1.56)
Social phobia	0.60	(0.33-0.87)	0.57	(0.13-1.00)	0.64	(0.32-0.95)
Specific phobia	3.60	(2.82-4.38)	1.19	(0.68-1.70)	4.20	(3.23-5.16)
Post-traumatic stress disorder	0.50	(0.30-0.70)	0.25	(0.02-0.48)	0.94	(0.50-1.39)
Agoraphobia	0.30	(0.10-0.50)	0.15	(0.02-0.29)	0.60	(0.26-0.95)
Panic disorder	0.60	(0.40-0.80)	0.38	(0.14-0.63)	0.98	(0.60-1.36)
Any anxiety disorder	6.20	(4.63-7.77)	2.53	(1.74-3.31)	7.61	(6.41-8.80)

CI: confidence interval.

Source¹⁵: Study ESEMeD-España.

Table 2. Prevalence-life of anxiety disorders following the criteria DSM-IV (data weighted for the Spanish population). 2001 - 2002

Anxiety disorders						
	Total		Men		Women	
	Prev (%)	CI 95%	Prev (%)	CI 95%	Prev (%)	CI 95%
Generalized anxiety	1.89	(1.49-2.29)	1.15	(0.64-1.66)	2.57	(1.49-3.16)
Social phobia	1.17	(0.81-1.54)	1.06	(0.51-1.61)	1.28	(0.83-1.73)
Specific phobia	4.52	(3.82-5.23)	2.32	(1.60-3.05)	6.54	(5.38-7.69)
Post-traumatic stress disorder	1.95	(1.18-2.73)	1.06	(0.00-2.2)	2.79	(1.71-3.87)
Agoraphobia	0.62	(0.36-0.89)	0.47	(0.08-0.86)	0.76	(0.39-1.14)
Panic disorder	1.70	(1.32-2.09)	0.95	(0.53-1.37)	2.39	(1.76-3.02)
Any anxiety disorder	9.39	(8.41-10.37)	5.71	(4.57-6.85)	12.76	(11.24-14.29)

CI: confidence interval.

Source¹⁵: Study ESEMeD-España.

Table 3. Prevalence-year of anxiety disorders classified according to DSM-IV by age group in the Spanish population. 2001 - 2002

Age	Any mental disorder	Anxiety disorder
	Prevalence (CI 95%)	Prevalence (CI 95%)
18-24 years old	10.1 (7.3-12.9)	7.8 (5.3-10.4)
25-34 years old	8.5 (6.3-10.8)	4.2 (2.9-5.6)
35-49 years old	8.4 (6.6-10.2)	4.5 (3.2-5.8)
50-64 years old	9.1 (6.8-11.3)	6 (4.3-7.7)
Over 65 years old	6.6 (5.1-8.1)	3.9 (2.8-5.0)

CI: confidence interval.

Source¹⁵: Study ESEMeD-España.

Variability in clinical practice

Patients with mental disorders or chronic psychosocial conflicts repeatedly visit the different healthcare facilities, especially at the level of primary care, mainly due to quick access and the longitudinality of the care ^{5,8,16,17}.

In general, mental health problems are normally treated initially in Primary Care facilities, and a significant number of the requests generated by these pathologies are resolved at this level ^{18,19}.

Family physicians are the healthcare professionals, due to their position in the healthcare network, can detect the first psychiatric symptoms earlier in patients who visit their offices with an anxiety disorder. Some of the studies done in our context indicate a low level of detection of psychiatric disorders, with the prevalence of the detected disorders ranging between 18%-27% versus 36%-47% of probable pathology ^{9,13,14}. The lack of a common pattern in the presentation of different anxiety disorders, somatization and association with chronic illnesses, as well as the limitation of time in family medicine facilities are some of the reasons that complicate diagnosis within the scope of Primary care ^{20,21}.

Anxiety and panic are very frequent symptoms in doctor visits, and they are very often un-specific and can be masked somatically. This makes the treatment of patients with anxiety disorders complex, especially if we take into account the difficulty of differential diagnosis, the need for specific therapeutic treatment that at time is extended over time for each form of the illness, as well as the need at time for referral to Specialized Care when the etiology, disorder, or manifestations of the illness require it.

All of these factors generate a certain degree of variability in the treatment of anxiety disorders. A study done in Spain, with data from three regions, evaluates the main factors that influence the therapeutic attitudes of doctors in connection with anxiety disorders and the variability in how they are approached. The type of anxiety disorder was the determining variable for the type of therapy selected the referral criteria. The probability of referring patients increased when there was a prior diagnosis of anxiety. Patients with phobic anxiety, panic, or mixed anxiety were more than twice as likely to be referred as patients with generalized anxiety. In general, pharmacological treatment was done with appropriate and specific drugs, with a high degree of variability that depended mainly on the type and other characteristics of the process, the patient, and the professional ²².

The variability in the approaches to anxiety disorders is also the result of an enormous variability in training. Different studies have identified a significant need for continuous training in mental health for Primary Care doctors, particularly in the field of psychiatric interviews and the knowledge, abilities, and attitudes to provide “psychological assistance”, especially in regard to somatization disorder, psychosexual problems, treatment of stress ^{17,23-28}.

In terms of the use of non-medication treatments, these are covered in a minimal number of studies, although the low use of psychological actions with proven effectiveness is significant ⁶. There are even fewer studies evaluating the work done by Primary Care social workers and nursing staff. These professionals play a very important role in the therapeutic treatment of anxiety disorders at the primary care level, providing both individual and group therapy, with techniques that can be implemented in Primary Care provided that the professionals involved have received the necessary training.

The search for a common pattern for the detection and treatment of pathological anxiety in a Primary Care facility is not a simple task. This is due in part to the wide variety of official diagnostic categories that exist, the relatively short duration of office visits, the frequent somatization

and association of this type of disorders with other chronic illnesses. For this reason, many studies have concluded that one of the basic needs is to provide general practitioners with clear, practical clinical guides based on scientific criteria to assist them in effectively detecting and treating anxiety disorders, offering the ideal therapeutic alternatives in each process, at the care level in which they are available ^{7,8,29}.

This guideline is therefore intended to be a useful tool for all professionals who work at the Primary Care level and for patients with these anxiety disorders, including an appendix with specific information for patients that was prepared with input from patients.