Editorials

Generalised anxiety disorder:

the importance of life context and social factors

In this issue of the *BJGP*, Sherina and colleagues provide us with a reminder that generalised anxiety disorder (GAD) is common among primary care patients.[1] GAD is one of the most frequent of all psychiatric disorders seen in primary care — second only to depression — but women are twice as likely as men to have this disorder.[2] Compared with other patient groups, patients with GAD have higher rates of medical appointments and clinical investigations.[3] GAD therefore incurs a substantial burden not only on patients and their families but also on healthcare resources.

Primary care is where most patients with GAD present and receive care. Therefore, GPs have a vital role to play in identifying and managing generalised anxiety, together with its primary cause, among their patients. Recognising and treating patients with GAD in primary care is challenging, which is often due to its complex presentation.

AN UNMET NEED

GAD can easily be missed due to the wide range of clinical presentations and co-occurrence with other psychiatric disorders, somatic complaints, and physical medical conditions. These coexisting associations are important clinically. Patients who have comorbid anxiety and depressive disorders or medical conditions have an extended clinical course and poorer long-term outcomes than patients with 'pure' GAD.

To complicate matters further, primary care patients report substantial levels of anxiety that do not always automatically meet diagnostic criteria, but the symptoms result in a substantial degree of suffering and disability. However, it is only recently that evidence-based guidelines have been introduced that are helpful in guiding management and treatment decisions in primary care patients with GAD.

UPDATED GAD GUIDELINES

A partial update of the National Institute for Health and Clinical Excellence[4] guideline for the management of GAD in primary, secondary, and community care has recently been published. The update continues with the familiar stepped-care model of treatment based on the triad of the bio-psychosocial model. The emphasis, however, is very much focused on the psychological and the biological treatments of GAD. In this issue of the *BJGP*, the study by Sherina *et al* brings the impact of social factors in GAD back to the fore.

IMPORTANCE OF LIFE CONTEXT AND SOCIAL FACTORS

The research of Sherina and colleagues reminds us of the importance of taking life context and social factors into account in patients presenting with anxiety symptoms, particularly family and social background. The researchers found that familiar stressful life events, such as loss, unemployment, and work-related, family, and housing problems, were associated with anxiety in primary care patients.

Moreover, two main factors associated with anxiety in women were being afraid of, and being humiliated by, a partner or ex-partner. These are important findings as there is evidence of a strong association between women reporting fear of their partner and having experienced partner abuse.[5] There is also good evidence that stressful life events such as loss, humiliation, and danger are strongly linked to the onset of GAD.[6]

The issue of sex should be considered in managing mental illness in primary care, as the development of depression and anxiety disorders in women are strongly associated with partner abuse. Moreover, women are affected disproportionately by partner abuse. Thus, viewing mental health symptoms in isolation from a person's life context, by offering psychological or medical treatment without considering social aspects, can limit efforts to decrease symptoms and improve quality of life and functioning. Greater awareness of the impact of partner abuse on psychological and physical health — which is substantial — would allow better targeting of health care and support for women attending primary care with symptoms of GAD who may also be experiencing partner abuse.

GPs are ideally placed to offer a holistic assessment for a patient presenting with GAD. This will necessarily involve an assessment of the social situation. Sherina *et al* 's study suggests that this assessment should include enquiry into the possibility of partner abuse or, at the very least, the cultivation of a higher index of suspicion that partner abuse may have triggered GAD.

SCREENING FOR PARTNER ABUSE

There have been calls for universal screening programmes for partner abuse. However, a systematic review of studies relevant to UK National Screening Committee (NSC) criteria for screening programmes concluded that there was insufficient evidence to meet the NSC criteria.[7] It is important to differentiate between screening and routine enquiry, where the latter allows a more sensitive and individualised approach to enquiring into partner abuse with all women experiencing GAD.

ROUTINE ENQUIRY FOR PARTNER ABUSE

Routine enquiry for identifying partner abuse appears to be on the NHS agenda. However, before introducing routine enquiry in general practice, several issues need to be addressed. Asking questions about partner abuse raises potential problems about the consequences after disclosure, with the safety of women of primary concern, as well as ensuring that such questioning is acceptable to women and does not deter them from seeking medical care. First, there needs to be good research evidence that interventions are beneficial and, second, that effective support, training, and community resources are available for routine questioning to make a difference.

Guidelines to clarify local procedures for dealing with suspected partner abuse would be helpful for all healthcare professionals. This guidance would help to clarify professional responsibility, alleviate concerns about routine enquiry, and

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intervening effectively. Even when guidance becomes available, concerns about responding appropriately, scarcity of time, fear of offending patients, and a fear of 'opening pandora's box' may prevent some practitioners from pursuing this line of investigation.

In addition, women are more likely to disclose partner abuse to supportive, non-judgmental health professionals who ask questions in a sensitive manner.[8] Furthermore, women may need to be asked several times about partner abuse before they feel able to make a disclosure.[8] Asking appropriate questions about partner abuse and providing effective care would need to be addressed by tailored education programmes and coordinated training.

DEPARTMENT OF HEALTH RESPONSE

Current policy and published guidance emphasise the importance of an appropriate response from health services to respond effectively to the issue of partner abuse.[9] However, it has been recognised that the health response to partner abuse needs to improve. The Department of Health has pledged to fund the Royal College of General Practitioners (RCGP) to develop and deliver, in partnership with experts in the field and the voluntary sector, an e-learning course specifically for GPs on violence against women and children.[9]

PROGRAMME WHERE ROUTINE QUESTIONING HAS WORKED

Routine questioning about partner abuse is already operational in some areas of health care. Research indicates that pregnant women may be at greater risk for partner abuse than non-pregnant women.[10] Moreover, there is evidence that many pregnant women are not offended by routine enquiry for partner abuse.[11] The confidential enquiry into maternal death in the UK recommends that partner abuse is assessed routinely in obstetric clinics as part of the antenatal booking-in process.[12]

An opportunistic assessment conducted in the obstetric setting obviously only focuses on those women who become pregnant. It has not yet become routine in general practice to ask women about partner abuse, although some practices have set up well-women clinics so that routine enquiries about partner abuse can be made in a safe environment.[13]

CONCLUSION

Early recognition and effective treatment of GAD are essential to reducing the burden associated with this chronic and prevalent condition. Treating this complex and often chronic disorder requires considerable expertise and management within a collaborative stepped-care approach. Further investigations into the association between GAD and partner abuse as well as improving the current approach to the recognition of the importance of life context and social factors are also necessary.

We are in no way underestimating the difficulties of enquiring about partner abuse. However, failure to consider that partner abuse may be closely linked to GAD could result in the omission of important information about the underlying cause of the presenting anxiety disorder for women patients in primary care. Opportunities may be missed to improve women's mental health. Moreover, when the connection between partner abuse and anxiety is missed, the risk of unsatisfactory treatment response, repeat victimisation, other health problems, and repeated use of healthcare services are all increased.

All GPs need to be familiar with the services that are available locally. The RCGP has published a position statement that discusses the role of GPs in cases of partner abuse, which can be found at: http://www.rcgp.org.uk/policy/position_statements/domestic_violence-the_gps_role.aspx

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