Generalized Anxiety Disorder (GAD)

1. Purpose

- To establish a standardized protocol for the identification, assessment, diagnosis, treatment, referral, and follow-up of patients presenting with Generalized Anxiety Disorder (GAD) in a general hospital setting.

2. Scope

This SOP applies to:

- Emergency Department (ED)
- Outpatient Department (OPD)
- Inpatient Wards
- Psychiatry Department
- Primary Care Physicians
- Nursing Staff
- Clinical Psychologists
- Medical Social Workers

3. Definition

- Generalized Anxiety Disorder (GAD) is characterized by excessive anxiety and worry occurring more days than not for at least 6 months, about various events or activities, that is difficult to control and causes clinically significant distress or impairment.

4. Diagnostic Criteria (As per DSM-5-TR guidelines)

A. Excessive anxiety and worry occurring more days than not for at least 6 months

B. Difficulty controlling the worry

C. Associated with ≥3 of the following:

- Restlessness
- Fatigue
- Difficulty concentrating
- Irritability
- Muscle tension
- Sleep disturbance

D. Causes functional impairment

E. Not due to substance/medical condition

5. Responsibilities

5.1 Medical Officer / Primary Physician

- Initial screening and assessment
- Rule out medical causes
- Initiate first-line management
- Refer to Psychiatry when required

5.2 Psychiatrist

- Confirm diagnosis
- Risk assessment (suicidal ideation, comorbidities)
- Pharmacological management
- Ongoing supervision

5.3 Clinical Psychologist

- Conduct structured assessments
- Provide CBT and other psychotherapies
- Monitor psychological progress

5.4 Nursing Staff

- Monitor vital signs

- Medication compliance
- Provide supportive care
- Document behavioral observations

6. Procedure

6.1 Screening

- Use standardized tools:
- GAD-7 Scale
- HAM-A (if required)
- Identify red flags:
- Panic attacks
- Suicidal thoughts
- Substance abuse

6.2 Clinical Assessment

- Detailed psychiatric history
- Medical history (thyroid disorders, anemia, cardiac issues)
- Substance use history
- Family psychiatric history
- Mental Status Examination (MSE)

6.3 Investigations (If indicated)

- CBC
- Thyroid Function Test (TFT)
- Blood sugar
- ECG (before certain medications)
- Vitamin B12 (if indicated)

6.4 Risk Assessment

- Suicidal ideation
- Self-harm risk
- Severe functional impairment
- Psychosis or severe depression

If high risk → Immediate psychiatric referral/admission.

7. Management

7.1 Non-Pharmacological Management

- Psychoeducation
- Cognitive Behavioral Therapy (CBT)
- Relaxation techniques
- Breathing exercises
- Sleep hygiene counseling
- Lifestyle modification (exercise, caffeine reduction)

7.2 Pharmacological Management

First-line:

- SSRIs (e.g., Escitalopram, Sertraline)
- SNRIs (e.g., Venlafaxine)

Short-term (if severe anxiety):

- Benzodiazepines (short course only, 2–4 weeks max)

Alternatives:

- Buspirone
- Pregabalin (if indicated)

7.3 Emergency Management

If patient presents with:

- Severe agitation
- Panic with autonomic instability
- Suicidal ideation

→ Stabilize in ED

→ Psychiatric consultation

→ Consider admission

8. Follow-Up Protocol

- First follow-up: 2 weeks after initiation
- Subsequent visits: Every 4–6 weeks
- Monitor:
- Symptom improvement
- Side effects
- Medication adherence
- Functional recovery

Minimum treatment duration: 6–12 months after remission.

9. Referral Criteria

Refer to higher center or specialist if:

- Treatment resistance (no response after 8–12 weeks)
- Severe comorbid psychiatric disorders

- Active suicidality
- Diagnostic uncertainty

10. Documentation

Maintain:

- GAD-7 scores
- Medication chart
- Progress notes
- Risk assessment record
- Consent for treatment