Anxiety Disorders — Diagnosis & Stepped Care

Differentiate the type first; CBT first-line for all

CLINICAL PATHWAY

Differentiate the type of anxiety first — treatment varies. CBT is commonly first-line across all anxiety disorders; SSRIs are the best-supported drug class. Don't miss comorbid depression (around half of patients) and start SSRIs LOW — anxiety can transiently worsen in the first 1–2 weeks.

DIFFERENTIATING THE 5 MAIN DISORDERS

Type	Feature & first screen
GAD	Excessive worry across multiple domains ≥6 months — **GAD-7**; CBT, often plus an SSRI/SNRI
Panic	Recurrent unexpected panic attacks + fear of further attacks — **PDSS**; CBT + SSRI (start very low)
Social	Fear of scrutiny/negative judgment in social settings — **LSAS / Mini-SPIN**; CBT, often plus sertraline or escitalopram
OCD	Intrusive thoughts + compulsive behaviours/rituals — **Y-BOCS**; CBT (ERP) + high-dose SSRI
PTSD	Re-experiencing + avoidance + hyperarousal after trauma — **PCL-5**; trauma-focused CBT/EMDR, often plus an SSRI

Stepped care by severity (GAD-7)

1	**Mild (5–9)** — psychoeducation, lifestyle measures, online CBT, watchful wait
2	**Moderate (10–14)** — Mental Health Treatment Plan + CBT (Better Access); avoid benzodiazepines as monotherapy
3	**Moderate–severe** — MHTP + CBT + SSRI, started low; review response at 4–6 weeks
4	**Severe / treatment-resistant** — switch SSRI or trial an SNRI; psychiatry input

SSRI CHOICE — START LOW, GO SLOW

- **Start at roughly half the usual depression starting dose** — anxiety can transiently worsen in weeks 1–2
- **Escitalopram or sertraline** — commonly well-tolerated first choices for GAD, panic and social anxiety
- **Fluoxetine** — an option for OCD, which typically needs a higher dose toward the top of the SSRI range
- Confirm exact starting/target doses in the AMH or eTG

COMORBIDITY & SCREENING

- Screen for depression (PHQ-9) and substance use (AUDIT-C) at every assessment — high overlap with anxiety
- Anxiety can mimic cardiac, thyroid, or GI conditions — exclude organic causes first
- Consider OSA screening if hypersomnia/snoring — untreated OSA can worsen anxiety

BENZODIAZEPINE STEWARDSHIP

Not first-line — CBT and SSRIs treat the disorder; benzodiazepines don't. Reserve for short-term use (commonly ≤2–4 weeks) in acute crisis or while an SSRI takes effect, at the lowest effective dose. Tolerance can develop within 4–6 weeks. If tapering after longer use, individualise the pace — current guidance favours slow, patient-centred reductions, which can take many months for long-term use.

■ SAFETY

- Anxiety can transiently worsen in weeks 1–2 of an SSRI — warn the patient before starting
- Avoid benzodiazepines as monotherapy in moderate–severe anxiety
- Avoid benzodiazepines in the elderly — falls, confusion, fracture and dementia risk
- Screen for suicidality at every review, especially with comorbid depression

■ RED FLAGS / REFER

- Treatment-resistant — failed two SSRIs at adequate dose/duration; OCD not responding to high-dose SSRI
- Severe PTSD needing specialist trauma therapy (EMDR, prolonged exposure) or complex PTSD
- Suicidal ideation with plan or intent
- Significant functional impairment despite an adequate treatment trial

For health-professional use. Stepped care adapted from RACGP psychological strategies and beyondblue/NICE-aligned principles.
SSRI choice & benzo stewardship — confirm current dosing at the AMH; deprescribing guidance evolving — see psychotropic.tg.org.au.