ANXIETY DISORDERS

CHI Formulary Development Project

مجلس الضمان الصحي
Council of Health Insurance

INDICATION UPDATE

ADDENDUM- December 2023

To the CHI Original Anxiety Disorders Clinical Guidance- Issued 2020

Contents

Related Documents 4

List of Tables 4

Abbreviations 5

Executive Summary 6

Section 1.0 Summary of Reviewed Clinical Guidelines and Evidence 10

1.1 Revised Guidelines 10

1.1.1 National Institute for Health and Care Excellence (NICE) Guideline on the Management of Generalized Anxiety Disorder and Panic Disorder in Adults (Published 2011, Updated 2020) 11

1.2 Additional Guidelines 24

1.2.1 Saudi Ministry of Health Protocols for the Management of Anxiety Disorders: Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder (2021) 25

1.2.2 Australian Guidelines for the Prevention and Treatment of Posttraumatic Stress Disorder: Updates in the Third Edition (2022) 31

1.2.3 Department of Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder (2023) 35

Section 2.0 Drug Therapy 42

2.1 Additions 42

2.2 Modifications 42

2.3 Delisting 42

Section 3.0 Key Recommendations Synthesis 42

Section 4.0 Conclusion 43

Section 5.0 References 44

Section 6.0 Appendices 46

Appendix A. Prescribing Edits 46

Appendix B. Level of Evidence Adopted 48

Appendix C. PubMed Search 49

Appendix D. Protocol Overview (Saudi Guidelines) 52

Appendix E. Summary of Guideline Recommendations for Children and Adolescents Exposed to Trauma 53

Appendix F. Summary of Guideline Recommendations for Children and Adolescents Exposed to Trauma 54
Appendix G. Summary of Guideline Recommendations for Adults Exposed to Trauma 55
Appendix H. Scope 56

Related Documents

Related SOPs

- IDF-FR-P-02-01-IndicationsReview&IDFUpdates
- IDF-FR-P-05-01-UpdatedIndicationReview&IDFUpdates

Related WI:

- IDF-FR-WI-01-01SearchMethodologyGuideForNewIndications

List of Tables

Abbreviations

AD	Anxiety Disorder
AP	Agoraphobia
ASD	Acute Stress Disorder
BAI	Beck Anxiety Inventory
CBT	Cognitive Behavioral Therapy
CFTSI	Child and Family Traumatic Stress Intervention
CHI	Council of Health Insurance
CPG	Clinical Practice Guideline
CPT	Cognitive Processing Therapy
CT	Cognitive Therapy
DASS	Depression Anxiety Stress Scale
DSM	Diagnostic and Statistical Manual of Mental Disorders
EMDR	Eye Movement Desensitization and Reprocessing
GAD	Generalized Anxiety Disorder
ICD	International Classification of Diseases
IDF	Insurance Drug Formulary
MAOI	Monoamine Oxidase Inhibitor
NHMRC	National Health and Medical Research Council
PD	Panic Disorder
PE	Prolonged Exposure
PTSD	Posttraumatic Stress Disorder
SAD	Social Anxiety Disorder
SGA	Second-Generation Antipsychotics
SIT	Stress Inoculation Training
SNRI	Serotonin Noradrenaline Reuptake Inhibitor
SP	Specific Phobia
SSRI	Selective Serotonin Reuptake Inhibitor
TCA	Tricyclic Antidepressant
TF-CBT	Trauma Focused Cognitive Behavioral Therapy

Executive Summary

Anxiety disorders (AD) are a group of mental disorders characterized by anxiety and fear. The most common specific ADs are generalized anxiety disorder (GAD), panic disorder (PD), social anxiety disorder (SAD), agoraphobia (AP) and specific phobias (SPs).

GAD is characterized by long-lasting anxiety not associated with specific objects or situations; PD is characterized by attacks of intense panic lasting minutes to hours that are associated with strong physical symptoms such as trembling, confusion, difficulty breathing, and others; SAD is characterized by fear of public embarrassment or social interaction; AP constitutes a specific fear of being in places from which one cannot easily escape; and SPs are characterized by fear that is triggered by specific stimuli or situations such as, for example, flying, heights, or spider[1].

ADs are among the most prevalent and disabling psychiatric disorders in the United States[2,3]. Approximately one in four adults will suffer from an AD at some point in their lives[4]. According to the World Health Organization, there are about 264 million people globally who suffer from anxiety disorders, representing a 15% increase since 2005[5]. In a national survey in Saudi Arabia, panic disorder was found to be prevalent by 1.6%, GAD was found to have a prevalence rate of 1.9%, and social anxiety disorder was found to be prevalent by 5.6%[6].

ADs are one of the leading causes of disease burden worldwide. According to the global burden of disease study, approximately 275 million individuals are affected by AD, and approximately 42 million incident cases occur per year worldwide[7]. They place a substantial financial and emotional strain on patients and their families[8]. Literature has shown that patients with various anxiety and associated disorders have a lower quality of life[9,10]. Anxiety also has a significant economic effect on society, as it is linked to increased use of healthcare services[11,12] and worse productivity at work[11,13].

Currently available first-line treatments for anxiety disorders include selective serotonin reuptake inhibitors (SSRIs) and serotonin noradrenaline reuptake inhibitors (SNRIs) medication, with benzodiazepines best suited for short-term and adjunctive anxiolytic treatment. Tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) are effective, but tolerability issues limit their use[4]. While there continues to be expansive research in posttraumatic stress disorder (PTSD), depression and schizophrenia, there is a relative dearth of novel medications under investigation for anxiety disorders[14].

According to the relevant sources, this report gathers all the clinical and economic evidence pertaining to anxiety. Anxiety and related disorders considered herein include panic disorder, social anxiety disorder, generalized anxiety disorder and posttraumatic stress disorder. The primary goal of the Council of Health Insurance (CHI) in issuing Anxiety guidelines is to incorporate the most up-to-date clinical

and economic evidence regarding drug therapies into the IDF (CHI Drug Formulary). This objective aims to ensure that patients with anxiety disorders in Saudi Arabia have timely and secure access to appropriate treatments while prioritizing their safety. The focus of the review was on Saudi, North American, European and international guidelines issued within the last three years.

All recommendations are well supported by reference guidelines, Grade of Recommendation (GoR), Level of Evidence (LoE) and Strength of Agreement (SoA) reflecting specific drug class role in the management of anxiety disorders.

This report functions as an addendum to the prior CHI anxiety disorders report and seeks to offer guidance for the effective management of anxiety disorders.

Regarding the management of anxiety and related disorders, compounds currently in clinical development for ADs include new monoaminergic agents and second-generation antipsychotics (SGAs). Encouragingly, mechanistically novel compounds targeting glutamate, neuropeptide and endocannabinoid systems are also in development[4].

Below is a table summarizing the major changes based on the different anxiety and related disorders guidelines used to issue this report:

Table 1. General Recommendations for the Management of Anxiety and Related Disorders

Management of Anxiety Disorders		
General Recommendations	**Level of Evidence/Grade of Recommendation**	**Reference**
All patients with anxiety disorders should be educated on their disorder, the efficacy (including the expected time for therapeutic effects to appear) and tolerability of treatment options, aggravating factors, and relapse symptoms.	**Not Graded**	Saudi MOH Protocols for the Management of Anxiety Disorders: Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder, 2021
During the acute treatment period and while medication was continued, a meta-analysis of 21 trials indicated that combining psychotherapy with antidepressant medications was greater than Cognitive Behavior Therapy (CBT) or pharmacotherapy alone.	Not Graded	Saudi MOH Protocols for the Management of Anxiety Disorders: Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder, 2021

Several studies showed the efficacy of CBT in treating anxiety disorder, especially in panic disorder.	Not Graded	Saudi MOH Protocols for the Management of Anxiety Disorders: Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder, 2021
First-line drug therapy includes: I. Selective serotonin reuptake inhibitor (SSRI) II. Serotonin-norepinephrine reuptake Inhibitor (SNRI)	Not Graded	Saudi MOH Protocols for the Management of Anxiety Disorders: Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder, 2021
For the prevention of PTSD among individuals who have been exposed to trauma, there is insufficient evidence to recommend for or against psychotherapy or pharmacotherapy in the immediate post-trauma period.	Not Graded	VA/DoD Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder, Department of Veterans Affairs Department of Defense, 2023
For the prevention of PTSD among patients diagnosed with acute stress disorder, we suggest trauma-focused cognitive behavioral psychotherapy.	Weak recommendation	VA/DoD Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder, Department of Veterans Affairs Department of Defense, 2023
Individual psychotherapies are recommended over pharmacologic interventions for the treatment of PTSD.	Strong recommendation	VA/DoD Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder, Department of Veterans Affairs Department of Defense, 2023

Paroxetine, sertraline, or venlafaxine are recommended for the treatment of PTSD	Strong recommendation	VA/DoD Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder, Department of Veterans Affairs Department of Defense, 2023
We suggest against divalproex, guanfacine, ketamine, prazosin, risperidone, tiagabine, or vortioxetine for the treatment of PTSD	Strong against	VA/DoD Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder, Department of Veterans Affairs Department of Defense, 2023
We recommend against benzodiazepines for the treatment of PTSD.	Strong against	VA/DoD Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder, Department of Veterans Affairs Department of Defense, 2023

Section 3 lists the key recommendations synthesis for generalized anxiety disorders (GAD) treatment.

Section 1.0 Summary of Reviewed Clinical Guidelines and Evidence

This section is divided into two parts: the first includes recommendations from **updated versions of guidelines** mentioned in the previous CHI anxiety disorders report, and the second includes **newly added guidelines** that have helped generate this report.

1.1 Revised Guidelines

This part contains the updated versions of the guidelines mentioned in the 2020 CHI Anxiety disorder report and the corresponding recommendations.

Table 2. Guidelines Requiring Revision

Guidelines requiring revision	
Old versions	**Updated versions**
National Institute for Health and Care Excellence (**NICE**) Guideline on the Management of Generalized Anxiety Disorder and Panic Disorder in Adults (Published: 26 January 2011, Updated **2019**)	National Institute for Health and Care Excellence (**NICE**) Guideline on the Management of Generalized Anxiety Disorder and Panic Disorder in Adults (Published: 26 January 2011, Updated June **2020**)
NICE Guidelines on the Recognition, Assessment, and Treatment of Social Anxiety Disorder (Published: 22 May 2013, Updated **2017**)	N/A*
NICE Guideline on Post-Traumatic Stress Disorder (Published: 5 December **2018**)	N/A*
Canadian Anxiety Disorders Guidelines Initiative: Clinical Practice Guidelines for the Management of Anxiety, Posttraumatic Stress and Obsessive-Compulsive Disorders (**2014**)	N/A*
American Academy of Child and Adolescent Psychiatry Practice Parameter for the Assessment and Treatment of Children and Adolescents with Obsessive-Compulsive Disorder (**2012**)	N/A*

British Association for Psychopharmacology Evidence-Based Pharmacological Treatment of Anxiety Disorders, Post-Traumatic Stress Disorder and Obsessive-Compulsive Disorder: A Revision of the 2005 Guidelines (**2014**)	N/A*

**: No updated version available: the existing version is the most recent one and no further updates or revisions have been made or released.*

1.1.1 National Institute for Health and Care Excellence (NICE) Guideline on the Management of Generalized Anxiety Disorder and Panic Disorder in Adults (Published 2011, Updated 2020)

Generalized anxiety disorder (GAD) is 1 of a range of anxiety disorders that includes panic disorder (with and without agoraphobia), post-traumatic stress disorder, obsessive–compulsive disorder, social phobia, specific phobias (for example, of spiders) and acute stress disorder.

Anxiety disorders can exist in isolation but more commonly occur with other anxiety and depressive disorders.

This guideline covers both 'pure' GAD, in which no comorbidities are present, and the more typical presentation of GAD comorbid with other anxiety and depressive disorders in which GAD is the primary diagnosis[15].

AD and panic disorder vary in severity and complexity, and this has implications for response to treatment. Therefore, it is important to consider symptom severity, duration, degree of distress, functional impairment, personal history, and comorbidities when undertaking a diagnostic assessment.

Practice recommendations

The following recommendations have been identified as priorities for implementation. They have been chosen from the updated recommendations on the management of generalized anxiety disorder (GAD).

Step 1: All known and suspected presentations of GAD

Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly. [2011]

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. [2011]

Assessment and education: 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. [2011]

As part of the comprehensive assessment, consider how the following factors might have affected the development, course, and severity of the person's GAD:

1 Any comorbid depressive disorder or other anxiety disorder

2 Any comorbid substance misuse

3 Any comorbid medical condition

4 A history of mental health disorders

5 Past experience of, and response to, treatments

Be aware when prescribing selective serotonin reuptake inhibitors (SSRIs) of the need to ask about cocaine use when considering drug–drug interactions, and the need to avoid concurrent use of multiple serotonergic drugs [2011, amended 2020].

For people with GAD and a comorbid depressive or other anxiety disorder, treat the primary disorder first (that is, the 1 that is more severe and in which it is more likely that treatment will improve overall functioning).

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.
- When prescribing SSRIs, there is a need to ask about cocaine use when considering drug–drug interactions, and the need to avoid concurrent use of multiple serotonergic drugs. [2011, amended 2020].

Explain the potential for interactions with other prescribed and over-the-counter medications and the lack of evidence to support their safe use. [2011]

Step 2: Diagnosed GAD that has not improved after step 1 interventions

Low-intensity psychological interventions for GAD: For people with GAD whose symptoms have not improved after education and active monitoring in step 1.

Offer 1 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. [2011]

Individual non-facilitated self-help for people with GAD should:

- Include written or electronic materials of a suitable reading age (or alternative media)
- Be based on the treatment principles of cognitive behavioral therapy (CBT)
- Include instructions for the person to work systematically through the materials over a period of at least 6 weeks
- Usually involve minimal therapist contact, for example an occasional short telephone call of no more than 5 minutes. [2011]

Individual guided self-help for people with GAD should:

- Be based on the treatment principles of CBT
- Include written or electronic materials of a suitable reading age (or alternative media)
- Be supported by a trained practitioner, who facilitates the self-help program and reviews progress and outcome
- Usually consist of 5 to 7 weekly or fortnightly face-to-face or telephone sessions, each lasting 20 to 30 minutes. [2011, amended 2018]

Psychoeducational groups for people with GAD should:

- Be based on CBT principles, have an interactive design and encourage observational learning
- Include presentations and self-help manuals
- Be conducted by trained practitioners
- Have a ratio of 1 therapist to about 12 participants
- Usually consist of 6 weekly sessions, each lasting 2 hours. [2011]

Practitioners providing guided self-help and/or psychoeducational groups should:

- Receive regular high-quality supervision
- Use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment. [2011]

Step 3: GAD with marked functional impairment or that has not improved after step 2 interventions

Treatment Options

For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions: Offer an individual high-intensity psychological intervention or drug treatment.

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. [2011]

If a person with GAD chooses a high-intensity psychological intervention, offer either cognitive behavioral therapy (CBT) or applied relaxation. [2011]

CBT for people with GAD should be based on the treatment manuals used in the clinical trials of CBT for GAD and delivered by trained and competent practitioners.

It usually consists of 12 to 15 weekly sessions (fewer if the person recovers sooner; more if clinically required), each lasting 1 hour. [2011]

Applied relaxation for people with GAD should be based on the treatment manuals used in the clinical trials of applied relaxation for GAD and delivered by trained and competent practitioners, and usually consist of 12 to 15 weekly sessions (fewer if the person recovers sooner; more if clinically required), each lasting 1 hour. [2011]

If a person with GAD chooses drug treatment, offer a **selective serotonin reuptake inhibitor** (SSRI). Monitor the person carefully for adverse reactions. [2011]

If SSRIs are ineffective, offer a **serotonin–noradrenaline reuptake inhibitor** (SNRI), taking into account the following factors:

- Tendency to produce a withdrawal syndrome (especially with paroxetine and venlafaxine)
- Side-effect profile and the potential for drug interactions
- The risk of suicide and likelihood of toxicity in overdose (especially with venlafaxine)
- The person's prior experience of treatment with individual drugs (particularly adherence, effectiveness, side effects, experience of withdrawal syndrome and the person's preference). [2011, amended 2020]

If the person cannot tolerate SSRIs or SNRIs, consider offering **pregabalin**.

Evaluate patients carefully for a history of drug abuse before prescribing and observe patients for development of signs of abuse and dependence [2011, amended 2020]

Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. [2011]

Do not offer an antipsychotic for the treatment of GAD in primary care. [2011, amended 2020].

Before prescribing any medication, discuss the treatment options and any concerns the person with GAD has about taking medication.

Explain fully the reasons for prescribing and provide written and verbal information on:

- The likely benefits of different treatments

- The different propensities of each drug for side effects, withdrawal syndromes and drug interactions (consult the interactions section of the BNF)
- The risk of activation with SSRIs and SNRIs, with symptoms such as increased anxiety, agitation and problems sleeping
- The gradual development, over 1 week or more, of the full anxiolytic effect
- The importance of taking medication as prescribed and the need to continue treatment after remission to avoid relapse. [2011, amended 2020]

Take into account the increased risk of bleeding associated with SSRIs, particularly for older people or people taking other drugs that can damage the gastrointestinal mucosa or interfere with clotting (for example, non-steroidal anti-inflammatory drugs [NSAIDS] or aspirin).

Consider prescribing a gastroprotective drug in these circumstances. [2011]

For people aged under 30 who are offered an SSRI or SNRI: warn them that these drugs are associated with an increased risk of suicidal thinking and self-harm in a minority of people under 30 and

See them within 1 week of first prescribing and monitor the risk of suicidal thinking and self-harm weekly for the first month. [2011]

For people who develop side effects soon after starting drug treatment, provide information and consider monitoring the person's symptoms closely (if the side effects are mild and acceptable to the person) or reducing the dose of the drug or stopping the drug.

According to the person's preference, consider offering either an alternative drug or a high-intensity psychological intervention [2011]

Review the effectiveness and side effects of the drug every 2 to 4 weeks during the first 3 months of treatment and every 3 months thereafter. [2011]

If the drug is effective, advise the person to continue taking it for at least a year as the likelihood of relapse is high. [2011]

Inadequate response to step 3 interventions

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. [2011]

Step 4: Complex, treatment-refractory GAD and very marked functional impairment or high risk of self-harm

Normally refers to community mental health teams but may include specialist services and specialist practitioners in primary care.

Offer the person with GAD a specialist assessment of needs and risks, including:

- Duration and severity of symptoms, functional impairment, comorbidities, risk to self and self-neglect.
- A formal review of current and past treatments, including adherence to previously prescribed drug treatments and the fidelity of prior psychological interventions, and their impact on symptoms and functional impairment
- Home environment
- Support in the community
- Relationships with and impact on families and carers. [2011]

Advise carers about their right to carer assessment, and assessment for respite care and other support [2011, amended 2020]

Develop a comprehensive care plan in collaboration with the person with GAD that addresses needs, risks and functional impairment and has a clear treatment plan. [2011]

Treatment

Inform people with GAD who have not been offered or have refused the interventions in steps 1 to 3 about the potential benefits of these interventions and offer them any they have not tried. [2011]

Consider offering combinations of psychological and drug treatments, combinations of antidepressants or augmentation of antidepressants with other drugs, but exercise caution and be aware that evidence for the effectiveness of combination treatments is lacking and side effects and interactions are more likely when combining and augmenting antidepressants. [2011]

Combination treatments should be undertaken only by practitioners with expertise in the psychological and drug treatment of complex, treatment refractory anxiety disorders and after full discussion with the person about the likely advantages and disadvantages of the treatments suggested. [2011]

When treating people with complex and treatment-refractory GAD, inform them of relevant clinical research in which they may wish to participate, working within local and national ethical guidelines at all times. [2011]

Principles of care for people with generalized anxiety disorder (GAD)

When working with people with GAD:

- Build a relationship and work in an open, engaging and non-judgmental manner
- Explore the person's worries in order to jointly understand the impact of GAD
- Explore treatment options collaboratively with the person, indicating that decision making is a shared process
- Ensure that discussion takes place in settings in which confidentiality, privacy and dignity are respected. [2011]

When families and carers are involved in supporting a person with GAD, consider:

- Providing information, including contact details, about family and carer support groups and voluntary organizations, and helping families or carers to access these
- Negotiating between the person with GAD and their family or carers about confidentiality and the sharing of information
- Providing written and verbal information on GAD and its management, including how families and carers can support the person
- Providing contact numbers and information about what to do and who to contact in a crisis.

Stepped care for people with GAD

A stepped-care model (described in table 3) is used to organize the provision of services and to help people with GAD, their families, carers, and practitioners to choose the most effective interventions. [2011]

Table 3. The Stepped-Care Model (Adapted from the NICE 2020 Guidelines)

Focus of the intervention	Nature of the intervention
STEP 4: Complex treatment-refractory generalized anxiety disorder (GAD) and very marked functional impairment, such as self-neglect or a high risk of self-harm.	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care.
STEP 3: GAD with an inadequate response to step 2 interventions or marked functional impairment.	Choice of a high-intensity psychological intervention (cognitive behavioral therapy [CBT]/applied relaxation) or a drug treatment.

STEP 2: Diagnosed GAD that has not improved after education and active monitoring in primary care.	Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups.
STEP 1: All known and suspected presentations of GAD.	Identification and assessment; education about GAD and treatment options; active monitoring.

Individual non-facilitated self-help: this is a self-administered intervention intended to treat GAD involving written or electronic self-help materials (usually a book or workbook).

It is similar to individual guided self-help but usually with minimal therapist contact, for example an occasional short telephone call of no more than 5 minutes.

PRINCIPLES OF CARE FOR PEOPLE WITH PANIC DISORDER

General management for panic disorder

People who have panic disorder and their families and carers need comprehensive information, presented in clear and understandable language, about the nature of their condition and the treatment options available.

In addition, given the emotional, social, and economic costs panic disorder usually entails, people with panic disorder and their families and carers may need help in contacting support and self-help groups.

Support groups can also promote understanding and collaboration between people who have panic disorder, their families and carers, and healthcare professionals at all levels of primary and secondary care.

Shared decision making and information provision

Shared decision making between the individual and healthcare professionals should take place during the process of diagnosis and in all phases of care. [2004]

People with panic disorder and, when appropriate, families and carers should be provided with information on the nature, course, and treatment of panic disorder, including information on the use and likely side-effect profile of medication. [2004]

To facilitate shared decision making, evidence-based information about treatments should be available and discussion of the possible options.

People's preference and the experience and outcome of previous treatment(s) should be considered in determining the choice of treatment. [2004]

Common concerns about taking medication, such as fears of addiction, should be addressed. [2004]

In addition to being provided with high-quality information, people with panic disorder and their families and carers should be informed of self-help groups and

support groups and be encouraged to participate in such programs where appropriate. [2004]

Language

When talking to people with panic disorder and their families and carers, healthcare professionals should use every day, jargon-free language. If technical terms are used, they should be explained to the person. [2004]

Where appropriate, all services should provide written material in the language of the person, and appropriate interpreters should be sought for people whose preferred language is not English. [2004]

Where available, consideration should be given to providing psychotherapies in the person's own language if this is not English. [2004]

Stepped care for people with panic disorder

The guideline provides recommendations for care at different stages of the person's journey, represented as different steps:

- Step 1 – recognition and diagnosis
- Step 2 – treatment in primary care
- Step 3 – review and consideration of alternative treatments
- Step 4 – review and referral to specialist mental health services
- Step 5 – care in specialist mental health services.

Step 1: Recognition and diagnosis of panic disorder

All healthcare professionals involved in diagnosis and management should have a demonstrably high standard of consultation skills so that a structured approach can be taken to the diagnosis and subsequent management plan for panic disorder. [2004, amended 2020]

The accurate diagnosis of panic disorder is central to the effective management of this condition.

It is acknowledged that frequently there are other conditions present, such as depression, that can make the presentation and diagnosis confusing.

The diagnostic process should elicit necessary relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. [2004]

The clinician should be alert to the common clinical situation of comorbidity, in particular, panic disorder with depression and panic disorder with substance misuse.

Be aware when prescribing SSRIs of the need to ask about cocaine use when considering drug–drug interactions, and the need to avoid concurrent use of multiple serotonergic drugs. [2004, amended 2020]

Step 2 for people with panic disorder: offer treatment in primary care

Psychological therapy, medication and self-help have all been shown to be effective.

The choice of treatment will be a consequence of the assessment process and shared decision making.

For people with mild to moderate panic disorder, offer or refer for 1 of the following low-intensity interventions:

- Individual non-facilitated self-help
- Individual facilitated self-help.

The benefits of exercise as part of good general health should be discussed with all people with panic disorders as appropriate. [2004]

Step 3 for people with panic disorder: review and offer alternative treatment if appropriate

For people with moderate to severe panic disorder (with or without agoraphobia), consider referral for: CBT or an antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological intervention.

Psychological interventions

CBT should be used. [2004]

CBT should be delivered only by suitably trained and supervised people who can demonstrate that they adhere closely to empirically grounded treatment protocols. [2004]

CBT in the optimal range of duration (7 to 14 hours in total) should be offered. [2004]

For most people, CBT should take the form of weekly sessions of 1 to 2 hours and should be completed within a maximum of 4 months of commencement. [2004]

Briefer CBT should be supplemented with appropriate focused information and tasks. [2004]

Where briefer CBT is used, it should be around 7 hours and designed to integrate with structured self-help materials. [2004]

For a few people, more intensive CBT over a very short period of time might be appropriate. [2004]

Pharmacological interventions

Benzodiazepines are associated with a less good outcome in the **long term** and should not be prescribed for the treatment of individuals with panic disorder. [2004]

Sedating antihistamines or antipsychotics should not be prescribed for the treatment of panic disorder. [2004]

Antidepressants should be the only pharmacological intervention used in the longer-term management of panic disorder.

The classes of antidepressants that have an evidence base for effectiveness are SSRIs, SNRIs, and TCAs.

The following must be taken into account when deciding which medication to offer:

- The age of the person
- Previous treatment response.
- Risks: the likelihood of accidental overdose by the person being treated and by other family members if appropriate and the likelihood of deliberate self-harm, by overdose or otherwise (the highest risk is with TCAs)
- Tolerability
- The possibility of interactions with concomitant medication (consult the interactions section of the BNF)
- The preference of the person being treated
- Cost, where equal effectiveness is demonstrated. [2004, amended 2020]

All people who are prescribed antidepressants should be informed, at the time that treatment is initiated, of potential side effects (including transient increase in anxiety at the start of treatment) and of the risk of discontinuation/withdrawal symptoms if the treatment is stopped abruptly or in some instances if a dose is missed or, occasionally, on reducing the dose of the drug. [2004, amended 2020].

People started on antidepressants should be informed about the delay in onset of effect, the time course of treatment, the need to take medication as prescribed, and possible discontinuation/withdrawal symptoms. Written information appropriate to the person's needs should be made available. [2004]

Unless otherwise indicated, an SSRI licensed for panic disorder should be offered. [2004]

If an SSRI is not suitable or there is no improvement after a 12-week course and if a further medication is appropriate, imipramine or clomipramine may be considered. [2004, amended 2020]

When prescribing an antidepressant, the healthcare professional should consider the following:

- Side effects on the initiation of antidepressants may be minimized by starting at a low dose and increasing the dose slowly until a satisfactory therapeutic response is achieved.
- In some instances, doses at the upper end of the indicated dose range may be necessary and should be offered if needed.
- Long-term treatment may be necessary for some people and should be offered if needed.
- If the person is showing improvement on treatment with an antidepressant, the medication should be continued for at least 6 months after the optimal dose is reached, after which the dose can be tapered. [2004]

If there is no improvement after a 12-week course, an antidepressant from the alternative class (if another medication is appropriate) or another form of therapy should be offered. [2004]

Stopping antidepressants abruptly can cause discontinuation/withdrawal symptoms.

To minimize the risk of discontinuation/withdrawal symptoms when stopping antidepressants, the dose should be reduced gradually over an extended period. [2004]

All people prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/ withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly. [2004]

Healthcare professionals should inform people that the most experienced discontinuation/withdrawal symptoms are dizziness, numbness and tingling, gastrointestinal disturbances (particularly nausea and vomiting), headache, sweating, anxiety and sleep disturbances. [2004]

Healthcare professionals should inform people that they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms. [2004]

If discontinuation/withdrawal symptoms are mild, the practitioner should reassure the person and monitor symptoms. If severe symptoms are experienced after discontinuing an antidepressant, the practitioner should consider reintroducing it (or prescribing another from the same class that has a longer half-life) and gradually reducing the dose while monitoring symptoms. [2004]

Step 4 for people with panic disorder: review and offer referral from primary care if appropriate

In most instances, if there have been 2 interventions provided (any combination of psychological intervention, medication, or bibliotherapy) and the person still has significant symptoms, then referral to specialist mental health services should be offered. [2004]

Step 5 for people with panic disorder: care in specialist mental health services

Specialist mental health services should conduct a thorough, holistic reassessment of the individual, their environment, and social circumstances. This reassessment should include evaluation of:

- Previous treatments, including effectiveness and concordance
- Any substance use, including nicotine, alcohol, caffeine and recreational drugs
- comorbidities
- Day-to-day functioning
- Social networks
- Continuing chronic stressors
- The role of agoraphobic and other avoidant symptoms.

A comprehensive risk assessment should be undertaken, and an appropriate risk management plan developed.

When prescribing SSRIs there is a need to ask about cocaine use when considering drug–drug interactions, and the need to avoid concurrent use of multiple serotonergic drugs. [2004, amended 2020]

Care and management should be based on the individual's circumstances and shared decisions made. Options include:

- Treatment of comorbid conditions
- CBT with an experienced therapist if not offered already, including homebased CBT if attendance at clinic is difficult
- Full exploration of pharmacotherapy
- Day support to relieve carers and family members
- Referral for advice, assessment, or management to tertiary centres. [2004]

There should be accurate and effective communication between all healthcare professionals involved in the care of any person with panic disorder, and particularly between primary care clinicians (GP and teams) and secondary care clinicians (community mental health teams) if there are existing physical health conditions that also require active management. [2004]

Monitoring and follow-up for individuals with panic disorder

Psychological interventions: There should be a process within each practice to assess the progress of a person undergoing CBT. The nature of that process should be determined on a case-by-case basis. [2004]

Pharmacological interventions: When a new medication is started, the efficacy and side-effects should be reviewed within 2 weeks of starting treatment and again at 4, 6 and 12 weeks.

Follow the summary of product characteristics with respect to all other monitoring required. [2004]

At the end of 12 weeks, an assessment of the effectiveness of the treatment should be made, and a decision made as to whether to continue or consider an alternative intervention. [2004]

If medication is to be continued beyond 12 weeks, the individual should be reviewed at 8- to 12-week intervals, depending on clinical progress and individual circumstances. [2004]

Self-help: Individuals receiving self-help interventions should be offered contact with primary healthcare professionals, so that progress can be monitored, and alternative interventions considered if appropriate.

The frequency of such contact should be determined on a case-by-case basis but is likely to be between every 4 and 8 weeks. [2004]

Outcome measures: Short, self-completed questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible. [2004]

1.2 Additional Guidelines

This part includes the added guidelines to the previous CHI anxiety disorders report, along with their recommendations.

Table 4. List of Additional Guidelines

Additional Guidelines
Saudi Ministry of Health Protocols for the Management of Anxiety Disorders: Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder (**2021**)
Australian Guidelines for the Prevention and Treatment of Posttraumatic Stress Disorder: Updates in the Third Edition (**2022**)
Department of Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder (**2023**)

1.2.1 Saudi Ministry of Health Protocols for the Management of Anxiety Disorders: Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder (2021)

Anxiety and related disorders are prevalent in clinical practice, and they are commonly associated with other psychiatric and medical conditions. A thorough grasp of pharmacological and psychological treatments' efficacy and side effect profiles is required for optimal management.

These protocols aim to deliver evidence-based recommendations on the nonpharmacological and pharmacological management of some common anxiety disorders, specifically generalized anxiety disorder, panic disorder, and social anxiety disorder for adult patients[16].

Other anxiety disorders, for example, simple phobic disorder, secondary anxiety disorder, and other anxiety disorders mentioned in DSM-5 and ICD-11 were not addressed in this protocol.

GENERAL PRINCIPLES IN ASSESSMENT AND MANAGEMENT OF ANXIETY DISORDER

Assessment:

Those who fulfil the diagnostic criteria for any of the anxiety disorders (generalized anxiety disorder, panic disorder, agoraphobia, and social anxiety disorder) using DSM-5 or ICD-11 diagnostic criteria, taking into consideration that anxiety disorders have similar causes and management, so protocols for one disorder will be similar to protocols for related disorders.

Consider GAD as a differential diagnosis in persons who have anxiety or a lot of worries, and those who go to the doctor a lot who:

- Suffer from a long-term physical health issue.
- Are seeking comfort about somatic symptoms but do not suffer from a physical health issue (especially the elderly and people from minority ethnic groups).
- Are preoccupied with a variety of topics on a regular basis.

The following are the main components of anxiety assessment:

1- Screen for the anxiety and related symptoms.

2- Perform a differential diagnosis (consider severity, impairment, and comorbidity).

3- Determine whether the patient has specific anxiety or associated disorder.

4- Psychological and/or pharmacological treatment.

5- Carry out follow-up.

GAD-7, Beck Anxiety Inventory (BAI), Depression Anxiety Stress Scale (DASS), Social phobia scale and panic disorder severity scale are some of the scales that can be used to assist with screening and severity measurement.

Management

All patients should be educated on their disorder, the efficacy (including the expected time for therapeutic effects to appear) and tolerability of treatment options, aggravating factors, and relapse symptoms.

Combined Psychological and Pharmacological Treatment (First-line Treatment):

During the acute treatment period and while medication was continued, a meta-analysis of 21 trials indicated that combining psychotherapy with antidepressant medications was greater than CBT or pharmacotherapy alone.

Combined therapy was more effective than pharmacotherapy alone after treatment ended, and it was as effective as psychotherapy.

Similar findings have been found in previous meta-analyses, implying that CBT alone or in combination with pharmacotherapy should be recommended as a first-line treatment.

Non-Pharmacological Management:

Several studies showed the efficacy of CBT in treating anxiety disorder, especially in panic disorder.

Minimal intervention formats, such as self-help books, treatment via telephone/videoconferencing, and internet-based CBT (ICBT) have been shown to be more effective than wait-list or relaxation controls.

Non-pharmacological treatment includes the following:

1- Psychotherapy, mainly cognitive-behavioral therapy (CBT).

2- Individual non-facilitated self-help.

3- Individual guided self-help.

4- Psychoeducational groups.

Pharmacological management - first-line drug therapy includes:

- Selective serotonin reuptake inhibitor (SSRI)
- Serotonin-norepinephrine reuptake Inhibitor (SNRI)

To treat depression, start with half the normal starting dose and gradually increase the dose into the normal antidepressant dosage range as tolerated (initial worsening of anxiety may be seen when treatment is started.

The optimal duration of treatment should be at least one year.

Effective treatment of GAD may prevent the development of major depression.

Benzodiazepine can be used in crisis intervention and for short term, 2-4 weeks with close observation and caution for the possibility of addiction.

GENERALIZED ANXIETY DISORDER

Generalized anxiety disorder (GAD) is a common and debilitating disorder.

This is exacerbated further by the high prevalence of comorbidity with various psychiatric disorders and general medical issues, both of which contribute to a complicated clinical presentation.

Clinical pearls:

- Worry that is extreme and uncontrollable.
- Agitation, irritation, and motor tension.
- Physical (somatic) symptoms (e.g., hyperventilation, tachycardia, and sweating)
- GAD is usually associated with major depression, panic disorder, or obsessive-compulsive disorder (OCD).

Table 4. Pharmacological Treatment of Generalized Anxiety Disorder

Maintenance Treatment	Category	Drug Options	Comments
1rst line treatment option	SSRIs	Fluoxetine 20-80 mg/day Escitalopram 10-20mg/day	- Keep in mind that citalopram and all other medications that cause QTc prolongation have a relative contraindication and should be used with caution and close monitoring to avoid arrythmia and Torsades de pointes. - SSRIs may aggravate symptoms at first. Therefore, it is suggested that patients begin with a smaller dose.
	SNRIs	Venlafaxine 75-225mg/day Duloxetine 60-120 mg/day	- SNRI may aggravate symptoms at first. It is suggested that patients begin with a smaller dose.

			- Venlafaxine has a short half-life. Therefore, the patient should be educated about withdrawal symptoms.
Second-line drug treatment (less well tolerated or weak evidence base)	TCAs	Imipramine 75-300 mg/day Amitriptyline100-300mg/day	TCA has a strong anticholinergic effect. TCA can prolong QTc
	Beta-Blocker e.g., propranolol	Initiates at 40mg and titrate dose up to effect if needed.	It's suitable for somatic symptoms, especially tachycardia
	Mirtazapine	15-45mg/day	Mirtazapine may induce morning sedation, which usually improves with sustained treatment, as well as an increase in appetite or weight gain.
Third line treatment option *These medications are supported by studies, but Not FDA approved. (off-label)	Valproic acid	500-2250 mg / day	Only one double-blind, placebo controlled randomized study that investigated the effectiveness of valproate in the treatment of anxiety disorders in 68 patients with generalized anxiety disorder reported that valproate significantly reduced anxiety symptoms compared to placebo
	Quetiapine	50-300 mg /day	Antipsychotics have an adverse side effect profile (metabolic syndrome, extrapyramidal side effects and NMS), making them less favorable
	Risperidone	0.5-1.5 mg / day	Antipsychotics have an adverse side effect profile (metabolic syndrome, extrapyramidal side effects and NMS), making them less favorable

PANIC DISORDER

Panic attack is a sudden bout of acute terror that results in extreme physical reactions when there is no real risk or apparent reason.

Although panic attacks are not life-threatening, they can be terrifying and substantially impact on one's quality of life. Yet, treatment for panic attacks can be very effective.

To fulfill the diagnosis of panic disorder, patients must experience recurring panic attacks, with one or more attacks followed by at least one month of fear of another panic attack or severe maladaptive behavior related to the attack.

Clinical pearls:

- Sudden and unexpected bouts of extreme anxiety, generally lasting 30–45 minutes.
- Breathing problems and other autonomic symptoms.
- Fear of suffocation or death.
- Desire to escape as soon as possible.

Table 5. Pharmacological Treatment of Panic Disorder

Maintenance Treatment	Category	Drug Options	Comments
1rst line treatment option	SSRIs	Fluoxetine 20-80 mg/day Escitalopram 10-20mg/day	-Keep in mind that citalopram and all other medications that cause QTc prolongation have a relative contraindication and should be used with caution and close monitoring to avoid arrythmia and Torsades de pointes. -SSRIs may aggravate symptoms at first. Therefore, it is suggested that patients begin with a smaller dose.
	SNRIs	Venlafaxine 75-225mg/day Duloxetine 60-120 mg/day	Venlafaxine has a short half-life. Therefore, the patient should be educated about withdrawal symptoms.
Second-line drug treatment	TCAs	Clomipramine 25 250mg/day	TCA has a strong anticholinergic effect. TCA can prolong QTc

(less well tolerated or weak evidence base)		Imipramine 25–300mg/day	
	Atypical antidepressant	Mirtazapine 15-60mg/day	Although a meta-analysis reveals mirtazapine does not aid with panic symptoms, it does help with the anxiety that comes with this disorder.

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

The fear of embarrassment and humiliation is a defining feature of social anxiety disorder.

While normal social anxiety can help focus attention and prevent inappropriate behavior, the severe symptoms of social anxiety disorder can make it difficult to function or cause significant distress. In some social circumstances, it's natural to feel anxious.

However, ordinary encounters create severe anxiety, self-consciousness, and shame for people with social anxiety disorder because they are afraid of being assessed negatively by others.

Clinical pearls:

- Extreme aversion to social circumstances, such as eating in public or giving a public speech.
- Afraid of being humiliated or embarrassed.
- Avoidant conduct, such as refusing to eat in restaurants.
- Anxiety expectation, such as feeling ill when entering a restaurant.

Table 6. Pharmacological Treatment of Social Phobia

Maintenance Treatment	Category	Drug Options	Comments
1rst line treatment option	SSRIs	Fluoxetine 20-80 mg/day Escitalopram 10-20mg/day	-Keep in mind that citalopram and all other medications that cause QTc prolongation have a relative contraindication and should be used with caution and close monitoring to avoid arrythmia and Torsades de pointes. -SSRIs may aggravate symptoms at first.

			Therefore, it is suggested that patients begin with a smaller dose.
	SNRIs	Venlafaxine 75-225mg/day Duloxetine 60-120 mg/day	In social phobia, there are open-label trials with the TCAs imipramine and clomipramine, but no RCT.
Second-line drug treatment (less well tolerated or weak evidence base)	TCAs	Clomipramine 25 250mg/day Imipramine 25–300mg/day	In social phobia, there are open-label trials with the tricyclic, showing its superiority in treating social phobia
	Beta-blockers	Atenolol 25–100 mg/ day Propranolol 10-120 mg / day	Propranolol's effectiveness in the long-term treatment of anxiety disorders other than panic disorder is unproven. Propranolol is beneficial for people who have somatic symptoms associated with elevated adrenergic tone.

1.2.2 Australian Guidelines for the Prevention and Treatment of Posttraumatic Stress Disorder: Updates in the Third Edition (2022)

A degree of psychological distress is common in the early aftermath of exposure to one or more traumatic events and can be considered a part of the normal stress response.

However, when an individual's distress is severe, persists and/or interferes with important areas of psychosocial functioning, assessment for a posttraumatic mental health disorder is indicated.

Acute stress disorder (ASD) and PTSD are the focus of the Australian PTSD Guidelines and are both included in the Trauma-and Stressor-Related Disorders category in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013).

These guidelines, based on systematic review of the international literature, are intended to guide decision making for practitioners, service planners, funders and those seeking treatment for trauma related mental health concerns[17].

RECOMMENDATIONS

The section begins with recommendations for children and adolescents, then moves on to recommendations for adults.

For both populations, recommendations are divided into interventions within the first 3 months after exposure to a potentially traumatic event (universal and indicated interventions) and interventions for those with PTSD (psychological, pharmacological, and non-psychological/non-pharmacological).

Recommendations for children and adolescents

Interventions within the first 3 months of trauma: for children with symptoms of PTSD within the first 3 months, a new conditional recommendation is made for Child and Family Traumatic Stress Intervention (CFTSI), in preference to supportive counselling.

CFTSI is a four-session caregiver plus child model that focusses on two PTSD risk factors of poor social or familial support and poor coping skills. It aims to ameliorate these risks by:

- Increasing communication between the affected child and their caregivers about feelings, symptoms, and behaviors with the goal of increasing the caregivers' support of the child
- Teaching specific behavioral skills to both the caregiver and child to assist in coping with symptoms.

Interventions for children and adolescents with clinically relevant symptoms of PTSD: the current Australian PTSD Guidelines made a strong recommendation for TF-CBT for children and adolescents with symptoms of PTSD, upgraded from the Level C recommendation in 2013.

The guidelines also make a new strong recommendation for TF-CBT for the caregiver and the child.

A new conditional recommendation is made for eye movement desensitization and reprocessing (EMDR) where TF-CBT is unavailable or unacceptable.

EMDR was previously not recommended for children and adolescents.

Pharmacological interventions

As was the case in 2013, there was insufficient evidence to recommend pharmacological interventions for children and adolescents with PTSD.

Recommendations for adults

Interventions within the first 3 months of exposure to a traumatic event:

The current guideline suggested that adults exposed to traumatic events be provided with information, emotional support, and practical assistance, consistent with psychological first aid.

Psychological interventions. A new strong recommendation is made for a stepped/collaborative care model, in which individuals receive evidence-based care commensurate with the severity and complexity of their need.

This approach involves ongoing monitoring of symptoms, in order to guide treatment decisions.

Interventions can be stepped up from low intensity and easily delivered interventions such as psychoeducation and problem solving, to more complex interventions such as activity scheduling, as indicated.

Interventions are generally CBT-based, but sometimes based on other psychological approaches (motivational interviewing) and may include components of case management and pharmacological intervention.

The guidelines make a conditional recommendation for TF-CBT (including prolonged exposure, cognitive processing therapy, and cognitive therapy) within the first 3 months following trauma, in preference to no intervention.

A new conditional recommendation is also made for brief EMDR in preference to no intervention within the first 3 months after trauma.

Pharmacological interventions

The systematic review identified RCTs of hydrocortisone, docosahexaenoic acid, escitalopram, oxytocin, propranolol, and gabapentin.

To date there is insufficient evidence to recommend the use of any of these pharmacological agents, however there is emerging evidence for hydrocortisone, a synthetic form of cortisol, and a recommendation is made for further research into the use of hydrocortisone in the prevention of PTSD.

Interventions for adults with PTSD

Psychological interventions: In the current update of the Guidelines there was sufficient evidence to make separate strong recommendations for individual approaches of TF-CBT, specifically, prolonged exposure (PE), cognitive processing therapy (CPT), TF cognitive therapy (CT) as well as the original TF-CBT intervention, comprising a hybrid of PE and cognitive restructuring.

EMDR remained a strong recommendation.

A strong recommendation is made for prolonged exposure (PE).

A strong recommendation for cognitive processing therapy (CPT) is based on four RCTs that showed a large clinically important benefit of CPT for PTSD symptom

severity relative to waitlist or usual treatment (including CBT, psychoeducation, supportive counselling, non-trauma focused symptom management).

A strong recommendation is also made for trauma focused cognitive therapy (CT) with evidence from four RCTs suggesting a large clinically important benefit of CT for PTSD symptom severity relative to waitlist.

The Guidelines make a strong recommendation for TF-CBT, which broadly encompasses the common elements of effective treatments including exposure to trauma related memories, tackling avoidance, and addressing trauma related cognition.

A conditional recommendation is made for guided Internet-based TF-CBT, an online program in which the intervention is guided by a therapist.

A conditional recommendation is made for present-centered therapy (PCT). PCT includes psychoeducation about the impact of PTSD symptoms, the development of effective strategies to deal with day-to-day challenges and homework to practice newly developed skills.

A conditional recommendation is made for stress inoculation training (SIT).

The guidelines make a conditional recommendation for group TF-CBT where individual TF-CBT or EMDR are unavailable or unacceptable.

Pharmacological interventions

Psychological interventions are recommended as first-line in the treatment of PTSD but there are several circumstances when pharmacological interventions should be considered.

These include where the person is unwilling or not in a position to engage in or access recommended psychological therapy, has a comorbid condition or associated symptoms (clinically significant depression and high levels of dissociation), is not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence), has not gained significant benefit from recommended psychological therapy or there is a significant wait time before psychological treatment is available.

In these conditions, the Australian PTSD Guidelines make a conditional recommendation for selective serotonin reuptake inhibitor (SSRIs), specifically, sertraline, paroxetine, or fluoxetine.

Similarly, the Australian PTSD Guidelines make a conditional recommendation for the serotonin noradrenaline reuptake inhibitor (SNRI) venlafaxine in the same circumstances.

There is emerging evidence for two additional pharmacological agents in the treatment of PTSD – ketamine, an antagonist of the glutamate N-methyl-D-aspartate (NMDA) receptor and quetiapine, an atypical antipsychotic that is used for individuals with significant agitation.

1.2.3 Department of Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder (2023)

This clinical practice guideline (CPG) is based on a systematic review (SR) of both clinical and epidemiological evidence.

Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation[18].

Table 7. Evidence-Based Clinical Practice Recommendations with Strength and Category

Topic	Subtopic	Recommendation	Strength	Category
Assessment and Diagnosis of PTSD	When screening for PTSD, we suggest using the Primary Care PTSD Screen for DSM-5.		Weak For	Reviewed, New-replaced
	For confirmation of the diagnosis of PTSD, we suggest using a validated structured clinician-administered interview, such as the Clinician-Administered PTSD Scale or PTSD Symptom Scale - Interview Version		Weak For	Reviewed, New-replaced
	To detect changes in PTSD symptom severity over time, we suggest the use of a validated instrument, such as the PTSD Checklist for DSM-5, or a structured clinician-administered interview, such as the Clinician-Administered PTSD Scale.		Weak For	Reviewed, New-replaced
Prevention of PTSD	Selective prevention	For the prevention of PTSD among individuals who have been exposed to trauma, there is insufficient evidence to recommend for or against psychotherapy or pharmacotherapy in the immediate post-trauma period.	Neither for nor against	Not Reviewed, Amended
	Indicated Prevention	For the prevention of PTSD among patients diagnosed with acute stress disorder, we suggest trauma-focused cognitive behavioral psychotherapy.	Weak For	Reviewed, New-replaced
		For the prevention of PTSD among patients diagnosed with acute stress reaction/acute stress disorder, there is insufficient evidence to recommend for or against any pharmacotherapy	Neither for nor against	Reviewed, New-replaced

Treatment of PTSD	Treatment selection	We recommend individual psychotherapies, over pharmacologic interventions for the treatment of PTSD.	Strong for	Reviewed, New-replaced
	Psychotherapy	We recommend the individual, manualized trauma-focused psychotherapies for the treatment of PTSD: Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, or Prolonged Exposure.	Strong for	Reviewed, New-replaced
		We suggest the following individual, manualized psychotherapies for the treatment of PTSD: Ehlers' Cognitive Therapy for PTSD, Present-Centered Therapy, or Written Exposure Therapy.	Weak for	Reviewed, New-replaced
		There is insufficient evidence to recommend for or against the following individual psychotherapies for the treatment of PTSD: Accelerated Resolution Therapy, Adaptive Disclosure, Acceptance and Commitment Therapy, Brief Eclectic Psychotherapy, Dialectical Behavior Therapy, Emotional Freedom Techniques, Impact on Killing, Interpersonal Psychotherapy, Narrative Exposure Therapy, Prolonged Exposure in Primary Care, psychodynamic therapy, psychoeducation, Reconsolidation of Traumatic Memories, Seeking Safety, Stress Inoculation Training, Skills Training in Affective and Interpersonal Regulation, Skills Training in Affective and Interpersonal Regulation in Primary Care, supportive counseling, Thought Field Therapy,	Neither for nor against	Reviewed, New-replaced

		Trauma-Informed Guilt Reduction, or Trauma Management Therapy.		
		There is insufficient evidence to recommend using individual components of manualized psychotherapy protocols over, or in addition to, the full therapy protocol for the treatment of PTSD.	Neither for nor against	Reviewed, Not Changed
		There is insufficient evidence to recommend for or against any specific manualized group therapy for the treatment of PTSD.	Neither for nor against	Reviewed, New-replaced
		There is insufficient evidence to recommend using group therapy as an adjunct for the primary treatment of PTSD.	Neither for nor against	Reviewed, New-replaced
		There is insufficient evidence to recommend for or against the following couples' therapies for the treatment of PTSD: Behavioral Family Therapy, Structured Approach Therapy, or Cognitive Behavioral Conjoint Therapy.	Neither for nor against	Reviewed, Not Changed
	Pharmacology	We recommend paroxetine, sertraline, or venlafaxine for the treatment of PTSD	Strong for	Reviewed, New-replaced
		There is insufficient evidence to recommend for or against amitriptyline, bupropion, buspirone, citalopram, desvenlafaxine, duloxetine, escitalopram, eszopiclone, fluoxetine, imipramine, mirtazapine, lamotrigine, nefazodone, olanzapine, phenelzine, pregabalin, rivastigmine, topiramate, or quetiapine for the treatment of PTSD.	Neither for not against	Reviewed, New-replaced

		There is insufficient evidence to recommend for or against psilocybin, ayahuasca, dimethyltryptamine, ibogaine, or lysergic acid diethylamide for the treatment of PTSD.	Neither for not against	Reviewed, New-added
		We suggest against divalproex, guanfacine, ketamine, prazosin, risperidone, tiagabine, or vortioxetine for the treatment of PTSD	Weak against	Reviewed, New-replaced
		We recommend against benzodiazepines for the treatment of PTSD.	Strong against	Reviewed, New-replaced
		We recommend against cannabis or cannabis derivatives for the treatment of PTSD.	Strong against	Reviewed, Amended
	Augmentation Therapy	There is insufficient evidence to recommend for or against the combination or augmentation of psychotherapy or medications with any psychotherapy or medication for the treatment of PTSD.	Neither for not against	Reviewed, New-replaced
		We suggest against aripiprazole, asenapine, brexpiprazole, cariprazine, iloperidone, lumateperone, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone for augmentation of medications for the treatment of PTSD.	Weak against	Reviewed, New-replaced
		There is insufficient evidence to recommend for or against 3,4-methylenedioxymethamphetamine assisted psychotherapy for the treatment of PTSD.	Neither for not against	Reviewed, New-added

	Non-pharmacologic Biological Treatments	There is insufficient evidence to recommend for or against the following somatic therapies for the treatment of PTSD: capnometry-assisted respiratory therapy, hyperbaric oxygen therapy, neurofeedback, NightWare©, repetitive transcranial magnetic stimulation, stellate ganglion block, or transcranial direct current stimulation.	Neither for not against	Reviewed, New-replaced
		We suggest against electroconvulsive therapy or vagus nerve stimulation for treatment of PTSD.	Weak against	Reviewed, New-replaced
		We suggest Mindfulness-Based Stress Reduction® for the treatment of PTSD.	Weak for	Reviewed, New-replaced
	Complementary, Integrative, and Alternative Approaches	There is insufficient evidence to recommend for or against the following mind-body interventions for the treatment of PTSD: acupuncture, Cognitively Based Compassion Training Veteran version, creative arts therapies (e.g., music, art, dance), guided imagery, hypnosis or self-hypnosis, Loving Kindness Meditation, Mantram Repetition Program, Mindfulness-Based Cognitive Therapy, other mindfulness trainings (e.g., integrative exercise, Mindfulness-Based Exposure Therapy, brief mindfulness training), relaxation training, somatic experiencing, tai chi or qigong, Transcendental Meditation®, and yoga.	Neither for not against	Reviewed, New-replaced

		There is insufficient evidence to recommend for or against the following interventions for the treatment of PTSD: recreational therapy, aerobic or non-aerobic exercise, animal-assisted therapy (e.g., canine, equine), and nature experiences (e.g., fishing, sailing).	Neither for not against	Reviewed, New-replaced
	Technology-based Treatment	We recommend secure video teleconferencing to deliver treatments when that therapy has been validated for use with video teleconferencing or when other options are unavailable	Strong for	Reviewed, New-replaced
		There is insufficient evidence to recommend for or against mobile apps or other self-help-based interventions for the treatment of PTSD.	Neither for not against	Reviewed, New-added
		There is insufficient evidence to recommend for or against facilitated internet-based cognitive behavioral therapy for the treatment of PTSD	Neither for not against	Reviewed, New-replaced
Treatment of Nightmares		We suggest prazosin for the treatment of nightmares associated with PTSD.	Weak for	Reviewed, Amended
		There is insufficient evidence to recommend for or against the following treatments for nightmares associated with PTSD: Imagery Rehearsal Therapy, Exposure Relaxation and Rescripting Therapy, Imaging Rescripting and Reprocessing Therapy, or NightWare	Neither for not against	Reviewed, New-added
Treatment of PTSD with Co-Occurring Conditions		We suggest that the presence of co-occurring substance use disorder and/or other disorder(s) not preclude treatments for PTSD.	Weak for	Reviewed, New-replaced

Section 2.0 Drug Therapy

2.1 Additions

Several drugs are under review for anxiety disorders and PTSD management. Compounds currently in clinical development include new monoaminergic agents and Second generations antipsychotics. Encouragingly, mechanistically novel compounds targeting glutamate, neuropeptide and endocannabinoid systems are also in development[4].

However, currently only sertraline and paroxetine are approved by the Food and Drug Administration (FDA) for PTSD. From the FDA perspective, all other medication uses are “off label” with differing levels of evidence supporting their use.

2.2 Modifications

For all benzodiazepines and antipsychotic agents listed in the drug summary spreadsheet, the prescribing edit requesting “prior approval (PA)” was removed and replaced with “MD” (to be prescribed by a physician specialized in the treatment of anxiety disorders.

2.3 Delisting

After carefully reviewing the SFDA drug list, it is recommended to delist **lorazepam** and **buspirone** as they are no longer SFDA-registered.

Section 3.0 Key Recommendations Synthesis

Anxiety disorders (AD) are a group of mental disorders characterized by anxiety and fear. The most common specific ADs are generalized anxiety disorder (GAD), panic disorder (PD), social anxiety disorder (SAD), agoraphobia (AP) and specific phobias (SPs).

Anxiety and related disorders considered in this report include panic disorder, social anxiety disorder, generalized anxiety disorder and posttraumatic stress disorder.

Currently available first-line treatments for anxiety disorders include SSRI and SNRI medication, with benzodiazepines best suited for short-term and adjunctive anxiolytic treatment.

TCAs and MAOIs are effective but tolerability issues limit their use.

While there continues to be expansive research in posttraumatic stress disorder (PTSD), depression and schizophrenia, there is a relative dearth of novel medications under investigation for anxiety disorders.

Currently only sertraline and paroxetine are approved by the Food and Drug Administration (FDA) for PTSD. From the FDA perspective, all other medication uses are “off label” with differing levels of evidence supporting their use.

Several drugs are under review for anxiety disorders and PTSD management. Compounds currently in clinical development include new monoaminergic agents and Second generations antipsychotics. Encouragingly, mechanistically novel compounds targeting glutamate, neuropeptide and endocannabinoid systems are also in development.

No changes or modifications were made to existing drugs, but some drugs were withdrawn from Saudi FDA.

Section 4.0 Conclusion

This report serves as **an annex to the previous anxiety disorders (AD) report** and aims to provide recommendations to aid in the management of AD. It is important to note that these recommendations should be utilized to support clinical decision-making and not replace it in the management of individual patients with AD. Health professionals are expected to consider this guidance alongside the specific needs, preferences, and values of their patients when exercising their judgment.

Section 5.0 References

1. Konnopka A, König H. Economic Burden of Anxiety Disorders: A Systematic Review and Meta-Analysis. *Pharmacoeconomics*. 2020;38(1):25-37. doi:10.1007/S40273-019-00849-7
2. Erickson SR, Guthrie S, VanEtten-Lee M, et al. Severity of anxiety and work-related outcomes of patients with anxiety disorders. *Depress Anxiety*. 2009;26(12):1165-1171. doi:10.1002/DA.20624
3. Kessler RC, Wai TC, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):617-627. doi:10.1001/ARCHPSYC.62.6.617
4. Murrough JW, Yaqubi S, Sayed S, Charney DS. Emerging Drugs for the Treatment of Anxiety. *Expert Opin Emerg Drugs*. 2015;20(3):393. doi:10.1517/14728214.2015.1049996
5. Depression and Other Common Mental Disorders. Accessed November 19, 2023. https://www.who.int/publications/i/item/depression-global-health-estimates
6. Al-Subaie AS, Al-Habeeb AH, Altwaijri YA. Overview of the Saudi National Mental Health Survey. *Int J Methods Psychiatr Res*. 2020;29(3). doi:10.1002/MPR.1835
7. Vos T, Abajobir AA, Abbafati C, et al. Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet*. 2017;390(10100):1211-1259. doi:10.1016/S0140-6736(17)32154-2
8. Senaratne R, Van Ameringen M, Mancini C, Patterson B. The burden of anxiety disorders on the family. *J Nerv Ment Dis*. 2010;198(12):876-880. doi:10.1097/NMD.0B013E3181FE7450
9. Barrera TL, Norton PJ. Quality of life impairment in generalized anxiety disorder, social phobia, and panic disorder. *J Anxiety Disord*. 2009;23(8):1086-1090. doi:10.1016/J.JANXDIS.2009.07.011
10. Comer JS, Blanco C, Hasin DS, et al. Health-related quality of life across the anxiety disorders: results from the national epidemiologic survey on alcohol and related conditions (NESARC). *J Clin Psychiatry*. 2011;72(1):43-50. doi:10.4088/JCP.09M05094BLU
11. Wittchen HU. Generalized anxiety disorder: prevalence, burden, and cost to society. *Depress Anxiety*. 2002;16(4):162-171. doi:10.1002/DA.10065
12. Martín-Merino E, Ruigómez A, Wallander MA, Johansson S, García-Rodríguez LA. Prevalence, incidence, morbidity and treatment patterns in a cohort of

patients diagnosed with anxiety in UK primary care. *Fam Pract*. 2010;27(1):9-16. doi:10.1093/FAMPRA/CMP071

13. Waghorn G, Chant D, White P, Whiteford H. Disability, employment and work performance among people with ICD-10 anxiety disorders. *Aust N Z J Psychiatry*. 2005;39(1-2):55-66. doi:10.1080/J.1440-1614.2005.01510.X

14. Garakani A, Murrough JW, Freire RC, et al. Pharmacotherapy of Anxiety Disorders: Current and Emerging Treatment Options. *Front Psychiatry*. 2020;11:595584. doi:10.3389/FPSYT.2020.595584

15. Recommendations | Generalised anxiety disorder and panic disorder in adults: management | Guidance | NICE.

16. *MOH Protocols for the Management of Anxiety Disorders Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder*.

17. Phelps AJ, Lethbridge R, Brennan S, et al. Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition. *Aust N Z J Psychiatry*. 2022;56(3):230-247. doi:10.1177/00048674211041917

18. Lewin Group T. *VA/DoD CLINICAL PRACTICE GUIDELINE FOR MANAGEMENT OF POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER Department of Veterans Affairs Department of Defense QUALIFYING STATEMENTS Management of Posttraumatic Stress Disorder and Acute Stress Disorder Work Group Office of Quality and Patient Safety, Veterans Health Administration and Clinical Quality Improvement Program, Defense Health Agency*.

19. Clair JS. A New Model of Tracheostomy Care: Closing the Research–Practice Gap. In: Henriksen K, Battles JB, Marks ES, et al., editors. Advances in Patient Safety: From Research to Implementation (Volume 3: Implementation Issues). Rockville (MD): Agency fo.

Section 6.0 Appendices

Appendix A. Prescribing Edits

Some covered drugs may have additional requirements, rules, or limits on coverage. These requirements and limits may include:

Prescribing edits Tools	Description
AGE (Age Edit):	Coverage may depend on patient age
CU (Concurrent Use Edit):	Coverage may depend upon concurrent use of another drug
G (Gender Edit):	Coverage may depend on patient gender
MD (Physician Specialty Edit):	Coverage may depend on prescribing physician's specialty or board certification
PA (Prior Authorization):	Requires specific physician request process
QL (Quantity Limit):	Coverage may be limited to specific quantities per prescription and/or time period
ST (Step Therapy):	Coverage may depend on previous use of another Drug
EU (Emergency use only):	This drug status on Formulary is only for Emergency use.
PE (Protocol edit)	Use of drug is dependent on protocol combination, doses and sequence of therapy

Examples:
Age edit: Desmopressin in Nocturnal Enuresis should not be prescribed for children < 5 years.
Concurrent Use Edit: Flavoxate in Nocturnal Enuresis should be used as add on to desmopressin after desmopressin failure and cannot be used alone.
Gender Edit: Exemestane in Endometriosis should be used only by Females.
Physician Specialty Edit: Fentanyl in Endometriosis should be prescribed by a gynecologist or pain management specialist.
Prior Authorization: Desmopressin in Nocturnal Enuresis: The prescriber must check the following before prescribing:

- Failure of combination of behavioral and alarm therapy.

Quantity Limit: Idarubicin in Acute Leukemia: Cumulative dose should not exceed 150 mg/m2. Please note that this Quantity Limit is different than the one based on maximum daily dose as this is not necessary based on Maximum Daily Dose
Step Therapy: Aripiprazole in Social Anxiety: should be used as third line after:
First-line: Escitalopram, fluvoxamine, fluvoxamine CR, paroxetine, paroxetine CR, pregabalin, sertraline, venlafaxine XR
Second-line: Alprazolam, bromazepam, citalopram, clonazepam, gabapentin
Emergency use only: Furosemide IV form in Hypertension is used only in emergency setting.
Protocol edit: Bendamustine Hydrochloride, Cyclophosphamide, Ifosfamide, Dacarbazine should be used in Lymphoma as per the following protocol

- **Adult and Pediatric Quantity Limit?**

This is either the adult or pediatric maximum amount of a drug that can be administered per day based on a maximum daily dose.
If there is no clinical evidence supporting the quantity limit for that relevant indication, this column will be left as Blank.

- **What information are available in the notes?**

"Notes" section provides details of the prescribing edits, extra important drug information and special warning and precautions.

- **Drug interactions**

1.0 A: No known interaction
2.0 B: No action needed
3.0 C: Monitor therapy
4.0 D: Consider therapy modification
5.0 X: Avoid combination

- **Defined Daily Dose**

  The Defined Daily Dose (DDD) is to be set based on the WHO recommendations
  https://www.whocc.no/ddd/definition_and_general_considera/

- **REMS**

  A Risk Evaluation and Mitigation Strategy (REMS) is a drug safety program that the U.S. Food and Drug Administration (FDA) can require for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks.

Appendix B. Level of Evidence Adopted

Grade of research[19]	
A	Strongly recommend; Good evidence
B	Recommend; At least fair evidence
C	No recommendation for or against; Balance of benefits and harms too close to justify a recommendation
D	Recommend against; Fair evidence is ineffective, or harm outweighs the benefit
E	Evidence is insufficient to recommend for or against routinely; Evidence is lacking or of poor quality; Benefits and harms cannot be determined.
Level of evidence	
Level I	Meta-analysis of multiple studies
Level II	Experimental studies
Level III	Well-designed, quasi-experimental studies
Level IV	Well-designed, non-experimental studies
Level V	Case reports and clinical examples

Appendix C. PubMed Search

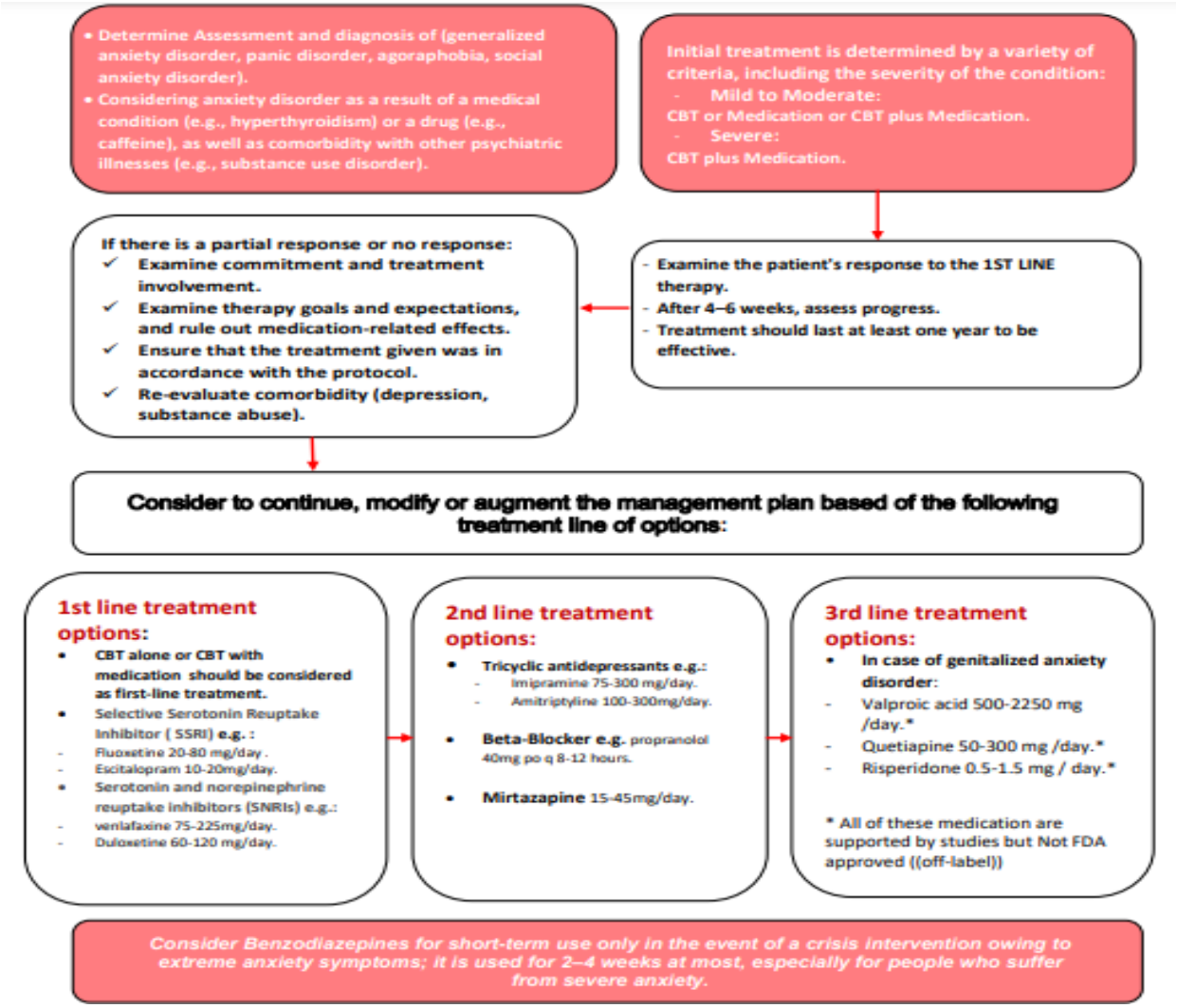
The following is the result of the PubMed search conducted for the anxiety disorders indication:

Query	Filters	Search Details	Results
((social anxiety) AND (general anxiety disorder)) AND (anxirty disorder)	Guideline, in the last 5 years	((social anxiety) AND (general anxiety disorder)),,in the last 5 years,"((""anxiety""[MeSH Terms] OR ""anxiety""[All Fields] OR (""social""[All Fields] AND ""anxiety""[All Fields]) OR ""social anxiety""[All Fields]) AND (""general anxiety disorder""[Supplementary Concept] OR ""general anxiety disorder""[All Fields]) AND (""disease""[MeSH Terms] OR ""disease""[All Fields] OR ""disorder""[All Fields] OR ""disorders""[All Fields] OR ""disorder s""[All Fields] OR ""disordes""[All Fields]))	531
(((PTSD)) OR (post traumatic stress disorder)) OR (traumatic disorders)	Guideline, in the last 5 years	((PTSD)) OR (post traumatic stress disorder)) OR (traumatic disorders),,"Guideline, in the last 5 years","(""stress disorders, post traumatic""[MeSH Terms] OR (""stress""[All Fields] AND ""disorders""[All Fields] AND ""post traumatic""[All Fields]) OR ""post-traumatic stress disorders""[All Fields] OR ""ptsd""[All Fields] OR (""stress disorders, post traumatic""[MeSH Terms] OR (""stress""[All Fields] AND ""disorders""[All Fields] AND ""post traumatic""[All Fields]) OR ""post-traumatic stress disorders""[All Fields] OR (""post""[All Fields] AND ""traumatic""[All Fields] AND ""stress""[All Fields] AND ""disorder""[All Fields]) OR ""post traumatic stress disorder""[All Fields]) OR ((""traumatic""[All Fields] OR ""traumatically""[All Fields] OR ""traumatism""[All Fields] OR ""traumatisms""[All Fields] OR ""traumatization""[All Fields] OR ""traumatizations""[All Fields] OR ""traumatize""[All Fields] OR ""traumatized""[All Fields] OR ""traumatizes""[All Fields] OR ""traumatizing""[All Fields]) AND (""disease""[MeSH Terms] OR	27

		""disease""[All Fields] OR ""disorder""[All Fields] OR ""disorders""[All Fields] OR ""disorder s""[All Fields] OR ""disordes""[All Fields]))) AND ((y_5[Filter]) AND (guideline[Filter]))	
(((PTSD)) OR (post traumatic stress disorder)) OR (traumatic disorders)	Guideline, in the last 5 years	((PTSD)) OR (post traumatic stress disorder)) OR (traumatic disorders),„Guideline,"(""stress disorders, post traumatic""[MeSH Terms] OR (""stress""[All Fields] AND ""disorders""[All Fields] AND ""post traumatic""[All Fields]) OR ""post-traumatic stress disorders""[All Fields] OR ""ptsd""[All Fields] OR (""stress disorders, post traumatic""[MeSH Terms] OR (""stress""[All Fields] AND ""disorders""[All Fields] AND ""post traumatic""[All Fields]) OR ""post-traumatic stress disorders""[All Fields] OR (""post""[All Fields] AND ""traumatic""[All Fields] AND ""stress""[All Fields] AND ""disorder""[All Fields]) OR ""post traumatic stress disorder""[All Fields]) OR (((""traumatic""[All Fields] OR ""traumatically""[All Fields] OR ""traumatism""[All Fields] OR ""traumatisms""[All Fields] OR ""traumatization""[All Fields] OR ""traumatizations""[All Fields] OR ""traumatize""[All Fields] OR ""traumatized""[All Fields] OR ""traumatizes""[All Fields] OR ""traumatizing""[All Fields]) AND (""disease""[MeSH Terms] OR ""disease""[All Fields] OR ""disorder""[All Fields] OR ""disorders""[All Fields] OR ""disorder s""[All Fields] OR ""disordes""[All Fields]))) AND (guideline[Filter])"	134
(((PTSD)) OR (post traumatic stress disorder)) OR (traumatic disorders)	Guideline, in the last 5 years	(((PTSD)) OR (post traumatic stress disorder)) OR (traumatic disorders),,,"""stress disorders, post traumatic""[MeSH Terms] OR (""stress""[All Fields] AND ""disorders""[All Fields] AND ""post traumatic""[All Fields]) OR ""post-traumatic stress disorders""[All Fields] OR ""ptsd""[All Fields] OR (""stress disorders, post traumatic""[MeSH Terms] OR (""stress""[All Fields] AND ""disorders""[All Fields] AND ""post traumatic""[All Fields]) OR ""post-	106,184

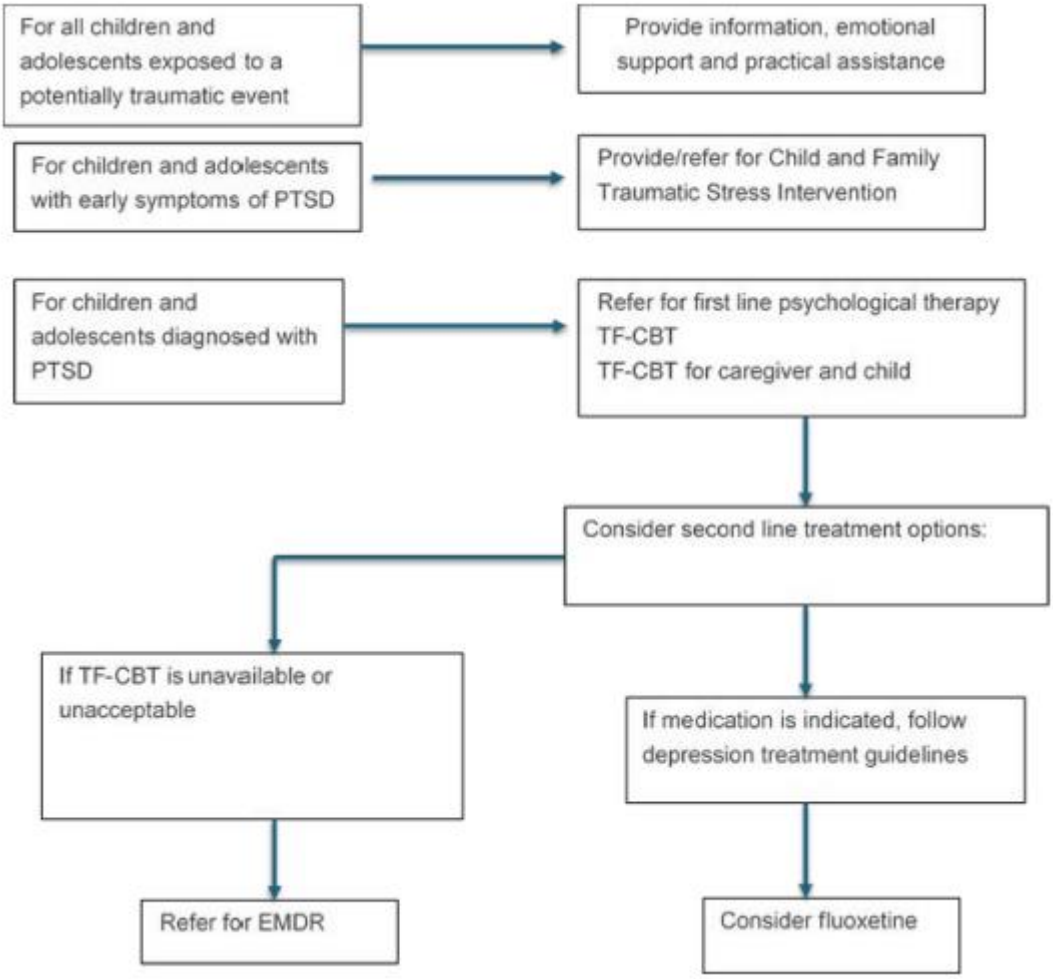
		traumatic stress disorders""[All Fields] OR (""post""[All Fields] AND ""traumatic""[All Fields] AND ""stress""[All Fields] AND ""disorder""[All Fields]) OR ""post traumatic stress disorder""[All Fields]) OR (((""traumatic""[All Fields] OR ""traumatically""[All Fields] OR ""traumatism""[All Fields] OR ""traumatisms""[All Fields] OR ""traumatization""[All Fields] OR ""traumatizations""[All Fields] OR ""traumatize""[All Fields] OR ""traumatized""[All Fields] OR ""traumatizes""[All Fields] OR ""traumatizing""[All Fields]) AND (""disease""[MeSH Terms] OR ""disease""[All Fields] OR ""disorder""[All Fields] OR ""disorders""[All Fields] OR ""disorder s""[All Fields] OR ""disordes""[All Fields]))	
Anxiety	Guideline, in the last 5 years	(""anxiety""[MeSH Terms] OR ""anxiety""[All Fields] OR ""anxieties""[All Fields] OR ""anxiety s""[All Fields]) AND ((y_5[Filter]) AND (guideline[Filter]))	53
general anxiety disorder	Guideline, in the last 5 years	"(""anxiety""[MeSH Terms] OR ""anxiety""[All Fields] OR ""anxieties""[All Fields] OR ""anxiety s""[All Fields]) AND (y_5[Filter])"	113,814
Anxiety	Guideline, in the last 5 years	anxiety""[MeSH Terms] OR ""anxiety""[All Fields] OR ""anxieties""[All Fields] OR ""anxiety s""[All Fields]"	327,649

Appendix D. Protocol Overview (Saudi Guidelines)



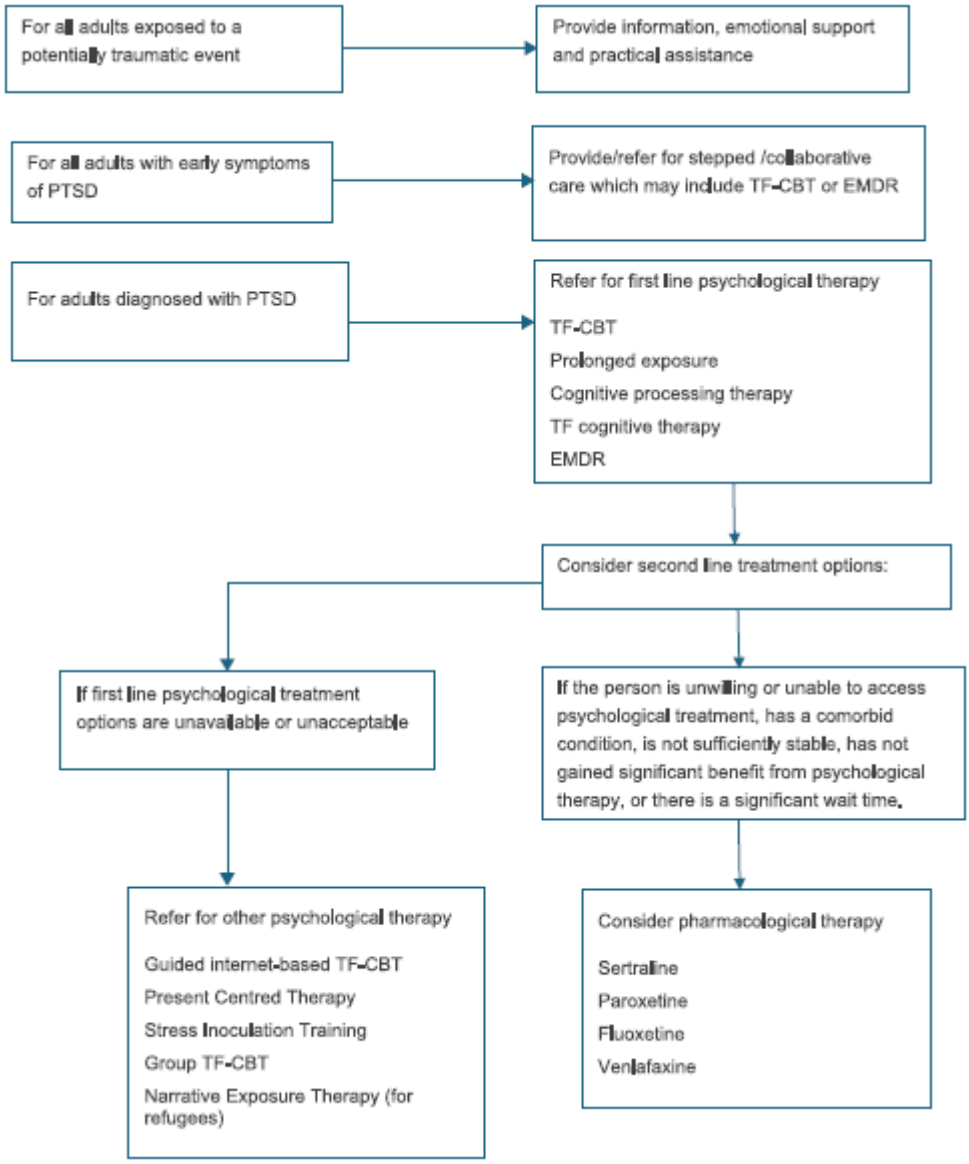
Retrieved from the Saudi MOH Protocols for the Management of Anxiety Disorders Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder[16]

Appendix E. Summary of Guideline Recommendations for Children and Adolescents Exposed to Trauma



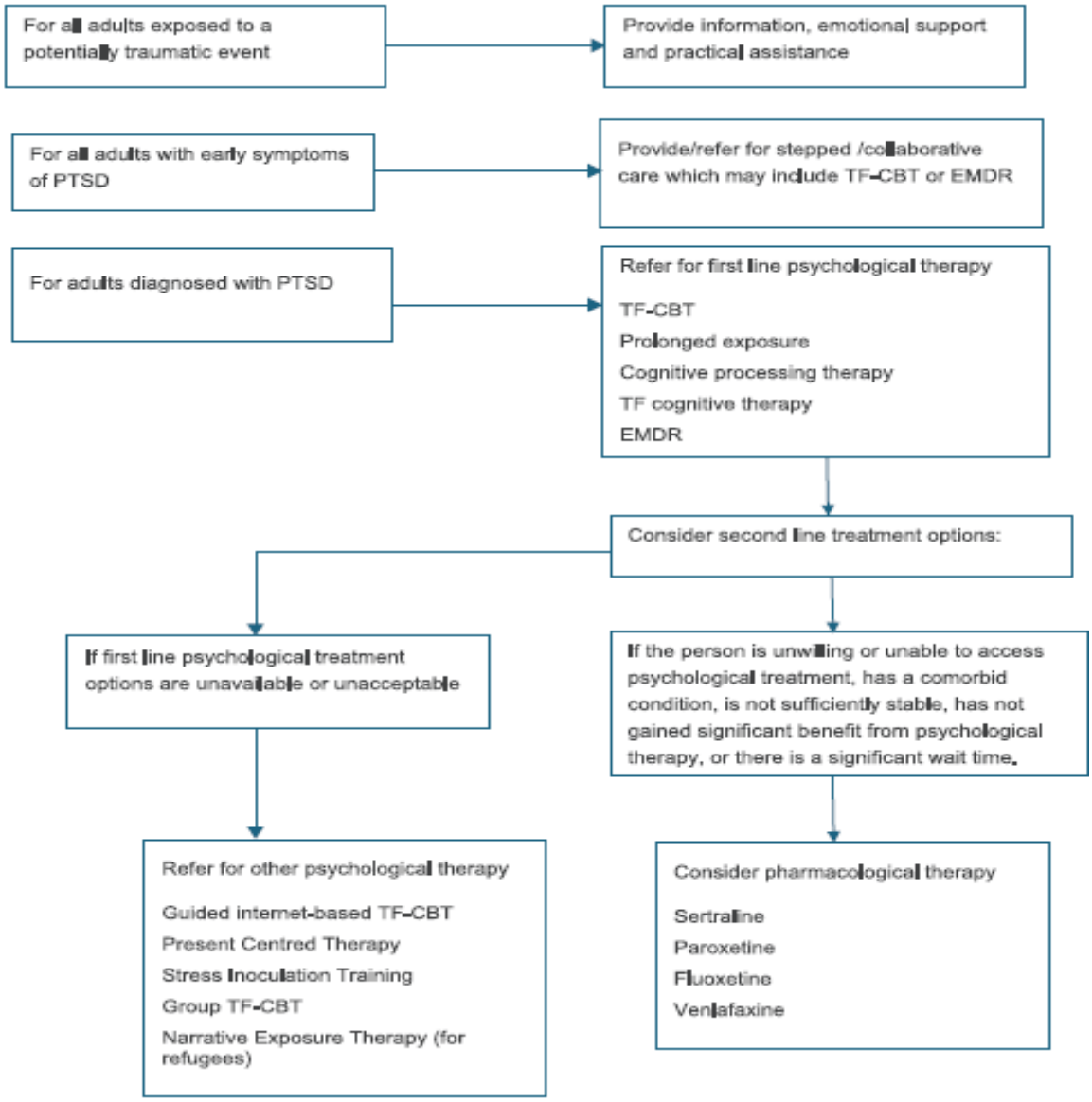
This figure was adapted from the Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition[17]

Appendix F. Summary of Guideline Recommendations for Children and Adolescents Exposed to Trauma



This figure was adapted from the Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition[17]

Appendix G. Summary of Guideline Recommendations for Adults Exposed to Trauma



This figure was adapted from the Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition[17]

Appendix H. Scope

2020 Version	Changes Performed	2023 (Current version)	Rationale/Description
Not available	New section	Scope	Summarize the main changes and updates between the 2020 and 2023 versions
Executive Summary	New section	Background	A general overview covering pathophysiological and epidemiological aspects was added.
Section 1. Anxiety CLINICAL GUIDELINES			
N Generalized anxiety disorder and panic disorder in adults: Management, NICE Clinical guideline Published: 26 January 2011 updated 2019	**Updated**	Generalized anxiety disorder and panic disorder in adults: management Clinical guideline [CG113] Published: 26 January 2011 Last updated: 15 June 2020	Generalized anxiety disorder and panic disorder in adults: management. London: National Institute for Health and Care Excellence (NICE); 2019 Jul. (NICE Clinical Guidelines, No. 113.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK552847/
Not available	New section	VA/DOD clinical practice guideline for management of posttraumatic stress disorder and acute stress disorder, 2023	
Not available	New section	Treatment Guidelines for PTSD: A Systematic Review. J Clin Med. 2021	Martin A, Naunton M, Kosari S, Peterson G, Thomas J, Christenson JK. Treatment Guidelines for PTSD: A Systematic Review. J Clin Med. 2021

			Sep 15;10(18):4175. doi: 10.3390/jcm10184175. PMID: 34575284; PMCID: PMC8471692.
Not available	New section	Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition, 2021	Phelps AJ, Lethbridge R, Brennan S, Bryant RA, Burns P, Cooper JA, Forbes D, Gardiner J, Gee G, Jones K, Kenardy J, Kulkarni J, McDermott B, McFarlane AC, Newman L, Varker T, Worth C, Silove D. Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition. Aust N Z J Psychiatry. 2022 Mar;56(3):230-247. doi: 10.1177/00048674211041917. Epub 2021 Aug 27. PMID: 34448406.
Not available	New section	Saudi MOH Protocols for the Management of Anxiety Disorders: Generalized Anxiety Disorder, Social Anxiety Disorder and Panic Disorder, 2021	
Not existing	**New section**	**Section 4. Key Recommendations Synthesis**	
Not existing	**New section**	**Section 5. Conclusion**	
References	Updated	**Section 6. References**	
Appendices	Updated	**Section 7. Appendices**	