

Pharmacotherapy In Generalized Anxiety Disorder (GAD) Dan Egli, PhD

This article summarizes the author's impressions (based on clinical experience, review of the literature, clinical supervision, and CE/CME) of what is currently being done when psychopharmacologic interventions are used in the treatment of generalized anxiety disorder (GAD).

This article, although focusing exclusively on the pharmacotherapeutic interventions with GAD, presumes that this is being done in the context of psychotherapy, probably a more "CBT-like" form of treatment. In other words, although focusing on the medications, I am coming from a "both-and" perspective rather than an "either-or" perspective. In many cases, 1+1=3. That is to say, it may be that the combination approach may be better than either approach by itself.

I will not take the time to review the DSM-IV criteria for GAD in this article and will simply lead into the pharmacologic interventions by suggesting the following:

- » the prevalence of GAD is ~2-5% of the population (women more than men and older more than younger)
- » there is a high degree of co-morbidity (especially major depression and substance abuse [so-called "self-medicating"]).

Tables 1 to 5

DSM-IV requires at least a 6-month duration, with significant symptoms of worry, fatigue, insomnia, muscle tension, decreased concentration, and irritability).

- » GAD is a chronic illness
- » relapse rates are high
- » diagnostically, many clinicians see GAD as a possible obsessive-compulsive (O-C) spectrum variant, similar in some ways to hypochondriasis, given the ruminative focus, the cognitive style, the behavioral avoidance, and the rituals surrounding the GAD obsession (often the body, illness, health, etc.).
- » in the initial work-up, it is very important to rule out intoxication or withdrawal (e.g. from benzodiazepines) as a contributing factor. Intoxication could be something as simple as excessive caffeine usage.

This author, for the psychotherapeutic intervention, uses a CBT-like intervention that focuses primarily on anxiety-provoking, therapist-assisted, out-of-office, in-vivo exposure protocol. In general, this author does not use pharmacotherapeutic interventions in mild-to moderate GAD and tends to use pharmacotherapeutic interventions in a high percentage of moderate-to-severe GAD.

As with all Axis I anxiety disorders, before starting pharmacotherapy (in conjunction with the psychotherapy of choice), the clinician needs to first rule out:

- » a causative medical problem presenting as symptoms of GAD
- » a prescription medication presenting as symptoms of GAD (an iatrogenic cause)
- » rule out substance abuse (drug and/or alcohol).

Having ruled out the above three concerns, and assuming a moderate-to-severe degree of GAD, the informed prescriber (as with any other Axis I disorder) will try to find a first-line agent that is effective, at the lowest possible dose, with the fewest side-effects.

Some of the factors that influence this choice include:

- » age (pediatric/geriatric might affect dose, medically compromised, etc.)
- » co-morbid psychiatric/psychological conditions (Axis I, II [particularly Cluster C, the "anxious-fearful" cluster])
- » concurrent prescription (psychotropic or otherwise) medication (rule out activating or stimulating effects)
- » concurrent OTC (including "herbal"/organic) products (rule out activation. e.g. ephedrine)
- » co-morbid medical conditions (Axis III "hyper-" or "hypo-" conditions that have similar-to-GAD presentations)
- » personal or family history of response (positive or negative) to a particular class of medication (possible genetic predisposition to preferential response?)
- » personal or family history of response (positive or negative) to a particular agent within a particular class of medication
- » personal bias (positive or negative) about a particular class or medication within that class concurrent substance abuse/history of addiction (avoid benzodiazepines)
- » cultural, religious beliefs/values about the use of medication

As with all prescription trials, the first-line agent (especially if not just being used on a p.r.n. [as needed] basis) needs to be geared to doing an adequate trial. An adequate trial is defined as an adequate dose for an adequate duration of time. Most of the patients this author has seen in consultation for so-called "treatment-resistant GAD" have been on many medications but have literally never had an adequate trial of a single medication based on the above definition. An exception to that would be the patient who was clearly compliant with the pharmacologic recommendations but had unremitting and severe side-effects. Obviously the most important clinical intervention in such a case is to discontinue the drug and try something else. This would neither be non-compliance nor false treatment-resistance.

Tables 1 to 5

REFERENCES

Goodman, Wayne K. Selecting Pharmacotherapy for GAD. *Journal of Clinical Psychiatry*, 2004, 65, (Supplement 13), 8-13.

Van Meter, S.A. & Doraiswamy, P.M. Anxiety Disorders. In: Rakel, R.E., Bope, E.T. (eds.). *Conn's Current Therapy*. Philadelphia, PA: W.B. Saunders Co., 2001, 1137-1142.

Dr. Egli is in full-time solo clinical practice in Williamsport, PA. Comments and questions can be directed to him at: sixeggs@suscom.net.