Generalized Anxiety Disorder

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Definition and Criteria

People with GAD have excessive anxiety and worry that is difficult to control. According to DSM-IV, symptoms must be present for more days than not for a six-month period, and the patient must not meet criteria for another anxiety disorder. Worrying is associated with at least three of the following: restlessness or feeling keyed up or on edge, easy fatigability, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance. Women with GAD worry excessively about multiple areas of life such as school or work performance, marriage, social acceptance, finances, and health. Like any psychiatric diagnosis, these symptoms must impair a person's ability to function in order to meet the diagnostic criteria. Medical causes and substance-induced disorders must be ruled out.

Epidemiology and Impact on Society

GAD is the most recently defined anxiety disorder. It was first included in the DSM-III in 1980. However, the most current epidemiologic data is available using DSM-III-R criteria because diagnostic criteria changed with subsequent editions of DSM. This data shows a lifetime prevalence rate of 6.6% and a one year prevalence rate of 4.3% in women. These rates are approximately twice those found in men (Kessler 1992).

GAD is a chronic disorder with periodic exacerbations. Symptoms tend to worsen during times of stress, and lessen when the stressful period has passed. Limited data suggests that anxiety symptoms also worsen premenstrualy and postpartum. The disorder is more common in unmarried people, racial-ethnic minorities, and people of low socioeconomic status (Howell 2001).

Despite the chronic course associated with GAD, there are very few studies that investigate long-term outcomes. The available data shows that half of patients still have moderate symptoms at 4-20 year follow-up. Since the mean age of onset is late teens and early twenties, GAD may persist for a large portion of a woman's life (Rickels 1990).

Women with GAD are more likely than men to have comorbid psychiatric disorders (Howell 2001). One study found the most common comorbid diagnoses were panic disorder with agoraphobia (41%), major depression (37%), and social phobia (32%) (Yonkers 1996). Alcohol dependence is another common comorbidity (Howell 2001). GAD can be especially difficult to diagnose in this setting since GAD and alcohol withdrawal have similar symptoms. In addition, women are often secretive about their alcohol use and reluctant to tell their physician.

Treatment

Venlafaxine and buspirone have the most clinical evidence to support their use. One study comparing the two medications found both superior to placebo, and venlafaxine superior to buspirone (Davidson 1999). Buspirone may be especially useful since it lacks sexual side effects. To achieve maximal response, a dose of 30mg/day is recommended (Brawman-Mintzer 2001).

Benzodiazapines are effective, especially in relieving symptoms acutely. Studies show a superior efficacy of benzodiazepines in the initial treatment period, however paroxitine, tricyclic antidepressants (TCA), buspirone and trazadone reached comparable efficacy within several weeks (Rickels 1993, Rocca 1997, Lydiard 2000). Due to the relapsing and non-remitting nature of the disease, chronic use of benzodiazepines should be avoided. Alcohol dependent disorders are common in patients with GAD, and alcohol and benzodiazepines have

additive central nervous system effects. If needed, benzodiazepines should only be used for short periods when symptoms have worsened due to life stressors.

Paroxitine is an effective treatment and is the only selective seritonin reuptake inhibitor (SSRI) to be studied in a large multicenter placebo-controlled trial. Symptomatic improvement was dose dependent (Bellew 2000). Although no other SSRIs have been studied in large trials, mental health providers believe there is a general class response to all SSRIs and are increasingly prescribing them (Brawman-Mintzer 2001). TCAs are also effective, but are not usually first line therapy due to their side effects.

Non-pharmacologic therapy for GAD is also beneficial. Studies show cognitive behavioral therapy and cognitive therapy to be superior to placebo with 40-60% improvement. The studies that have compared medications (benzodiazepines and TCAs) to psychotherapy have found that medications show more immediate relief, but cognitive behavioral therapy achieves more long-term results. Studies are limited, however, and more research is needed before definitive conclusions can be made (Falsetti 2001).

Bibliography

GAD

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