

The pressing need for new pharmacological treatments in anxiety disorders

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The 'ideal' drug for treating patients with anxiety disorders would be effective in all disorders, across all symptom domains, across the range of severity, in achieving remission, in preventing relapse and in treating comorbid conditions, and would have a rapid onset of action and be cost-effective in clinical practice. In addition, it would be suitable for once-daily dosage, have minimal adverse effects, cause minimal interference with daily life, would not be associated with the development of tolerance during use or discontinuation symptoms once treatment is stopped, would be suitable for use in physically ill patients and free from interactions with other medications, and be safe in overdose.

Clearly, the 'ideal' drug is not currently available. Response rates to initial treatment are disappointing; it is not possible to reliably predict the likelihood of response in an individual patient; a substantial proportion will experience unwanted effects during treatment; many others will relapse despite adhering to treatment; there are many uncertainties about subsequent management after initial non-response; and discontinuation symptoms can be troublesome. Hence there is considerable room for improvement, in the development of novel treatments with enhanced effectiveness and greater acceptability, when compared to existing medications: particularly in identifying which patients are most likely to benefit from which treatment, in having medications with an earlier onset of clinical effect, in achieving superior efficacy in reducing symptom severity, in optimising dosage for maximal effectiveness and tolerability, and in combining treatments to enhance efficacy in patients that have made little response to first-line interventions.

Current evidence-based guidelines for pharmacological management of patients with anxiety disorders tend to recommend initial treatment with either a selective serotonin reuptake inhibitor (SSRI) or a serotonin-noradrenaline reuptake inhibitor (SNRI). There have been comparatively few studies of the further management of patients who do not respond to initial treatment and there is a clear need for further randomised controlled trials, in patients who do not respond to an SSRI, SNRI or other treatment. Increasing the dosage of an SSRI may be helpful in panic disorder, and higher doses of pregabalin may be beneficial in generalized anxiety disorder. There is good evidence for augmentation with antipsychotic drugs after an initial limited response to SSRI or SNRI treatment in patients with obsessive-compulsive disorder, but only limited evidence for this in patients with other anxiety disorders. The combination of pharmacological with psychological treatments is common in clinical practice, though without proven additional efficacy in some disorders.

Future treatment guidelines will be influenced by emerging data with both established and novel pharmacological interventions, but achieving a 'step-change' improvement in clinical outcomes is only likely through better identification of patient sub-groups that are likely to respond preferentially to particular interventions, or with new treatments, probably based on novel pharmacological targets.