ANXIETY DISORDERS

INTRODUCTION

Anxiety Disorders involve a state of distressing chronic but fluctuating nervousness that is inappropriately severe for the person's circumstances.

Anxiety is a normal response to a threat or to psychological stress and is experienced occasionally by everyone. Normal anxiety has its root in fear and serves an important survival function. When someone is faced with a dangerous situation, anxiety induces the fight-or-flight response. With this response, a variety of physical changes, such as increased blood flow to the heart and muscles, provide the body with the necessary energy and strength to deal with life-threatening situations, such as running from an aggressive animal or fighting off an attacker. However, when anxiety occurs at inappropriate times, occurs frequently, or is so intense and long-lasting that it interferes with a person's normal activities, then it is considered a disorder.

Anxiety Disorders are more common than any other category of mental health disorder and are believed to affect about 15% of adults in the world. However, Anxiety Disorders often are not recognized by people who have them or by health care professionals and consequently are seldom treated.

Causes

The causes of Anxiety Disorders are not fully known, but both physical and psychological factors are involved. Because Anxiety Disorders are prevalent in some families, heredity probably plays a role. Anxiety is viewed at a psychological level as a response to environmental stresses, such as the break up of a significant relationship or exposure to a life-threatening disaster. When a person's response to stresses is improper or a person is overwhelmed by events, an anxiety disorder can arise. For example, some people find speaking before a group exhilarating, while others dread it, becoming anxious with symptoms such as sweating, fear, rapid heart rate, and tremor.

Anxiety Disorders may also be caused by a physical disorder or the use of a drug. For example, an overactive thyroid gland, use of prescribed corticosteroids, or illicit use of cocaine may produce symptoms of an anxiety disorder.

Symptoms and Diagnosis

Anxiety can arise suddenly, as in panic, or gradually over minutes, hours, or days. The anxiety itself can last for any length of time, from a few seconds to years. Anxiety ranges in intensity from barely noticeable qualms to full-blown panic attack, during which a person may experience shortness of breath, dizziness, and increased heart rate.

Anxiety Disorders can be so distressing and interfere so much with a person's life that they can lead to depression. Sometimes depression develops first and an anxiety disorder develops later.

The diagnosis of an anxiety disorder is based largely on its symptoms. The ability to tolerate anxiety varies, and determining what constitutes abnormal anxiety can be difficult. A family history of an anxiety disorder (except posttraumatic stress disorder) may help a doctor make the diagnosis.

Treatment

Accurate diagnosis is important, since treatment varies from one anxiety disorder to another. Additionally, Anxiety Disorders must be distinguished from anxiety that occurs in many other mental health disorders, for which different treatment approaches are used. Depending on the anxiety disorder, drug therapy or psychotherapy (such as behaviour therapy), alone or in combination, can significantly relieve the distress and dysfunction for most people.

ACUTE STRESS DISORDER

Acute stress disorder is similar to posttraumatic stress disorder, except that it begins within 4 weeks of the traumatic event and lasts only 2 days to 4 weeks.

A person with acute stress disorder has been exposed to a terrifying event. The person mentally re-experiences the traumatic event, avoids things that remind him of it, and has increased anxiety. The person also has three or more of the following symptoms:

- A sense of numbing, detachment, or lack of emotional responsiveness
- Reduced awareness of surroundings (for example, being dazed)
- A feeling that things are not real
- A feeling that he himself is not real
- An inability to remember an important part of the traumatic event.

The number of people with acute stress disorder is unknown. The likelihood of developing acute stress disorder is greater when traumatic events are severe.

Treatment

Many people recover from acute stress disorder once they are removed from the traumatic situation and given appropriate support in the form of understanding, empathy for their distress, and an opportunity to describe what happened and their reaction to it. Some people benefit from describing their experience several times.

ANXIETY INDUCED BY DRUGS OR MEDICAL PROBLEMS

Anxiety can be caused by a medical disorder or the use or discontinuation of a drug. Examples of medical disorders that may cause anxiety include neurological disorders, such as a head injury, brain infection, or inner ear disorder; cardiovascular disorders, such as heart failure and abnormal heart rhythms (arrhythmias); endocrine disorders, such as an overactive adrenal or thyroid gland; and respiratory disorders, such as asthma and chronic obstructive pulmonary disease. Even fever can cause anxiety.

Drugs that can induce anxiety include alcohol, stimulants, caffeine, cocaine, and many prescription drugs, such as ephedrine (used, for example, in decongestants) and theophylline (used, for example, to treat asthma). Some over-the-counter weight-loss products contain both ephedrine and caffeine. Drugs that can induce anxiety when discontinued include benzodiazepines.

Anxiety may occur in dying people as a result of fear of death, pain, and difficulty breathing.

Treatment

A doctor aims to treat the primary causes rather than the secondary anxiety symptoms. Anxiety should subside after the medical disorder is treated or the drug has been discontinued long enough for any withdrawal symptoms to abate. A doctor can treat any remaining anxiety with appropriate anti-anxiety drugs or psychotherapy (such as behaviour therapy). For people who are dying, strong analgesics with potent anti-anxiety effects, such as morphine are often appropriate. No dying person should have to experience intense anxiety.

GENERALIZED ANXIETY DISORDER

Generalized anxiety disorder consists of excessive, usually daily, nervousness and worry (lasting 6 months or longer) about a variety of activities or events.

Generalized anxiety disorder is common; about 3% of adults have it during any 12-month period. Women are twice as likely as men to have the disorder. It often begins in childhood or adolescence but may start at any age. For most people, the disorder fluctuates, worsening at times (especially during times of stress), and persists over many years.

People with generalized anxiety disorder constantly feel worried or distressed and find it difficult to control these feelings. The severity, frequency, or duration of the worries is disproportionately greater than the situation warrants. Worries are general in nature; common worries include work responsibilities, money, health, safety, car repairs, and chores. The focus of worry may shift from one topic to another over time.

For a doctor to make a diagnosis of generalized anxiety disorder, a person must experience worry or anxiety and three or more of the following symptoms: restlessness, easy fatigue, difficulty concentrating, irritability, muscle tension, and disturbed sleep.

Treatment

Optimal management is best achieved with a combination of some form of counselling and drug therapy. Counselling can address the root causes of anxiety and ways to cope.

Anti-anxiety drugs such as benzodiazepines are usually prescribed. However, because long-term use of benzodiazepines can lead to drug dependence, the drug, if discontinued, must be tapered off slowly rather than stopped abruptly. The relief that benzodiazepines bring usually outweighs any mild side effects and the possibility of drug dependence.

Buspirone is another anti-anxiety drug effective for some people with generalized anxiety disorder. Its use does not lead to drug dependence. However, Buspirone may take 2 weeks or longer to start working, in contrast to benzodiazepines, which begin to work within an hour.

Some antidepressants, such as Venlafaxine, Paroxetine, and other selective serotonin reuptake inhibitors, are also effective for treatment of generalized anxiety disorder. These antidepressants start to relieve anxiety quickly, sometimes after a few days.

Herbal products such as Kava and Valerian appear to have anti-anxiety effects, although their effectiveness for treating Anxiety Disorders such as generalized anxiety disorder requires further study.

Cognitive-behaviour therapy has been shown to be beneficial for generalized anxiety disorder. Relaxation, yoga, meditation, exercise, and biofeedback techniques may also be of some help

OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder is characterized by the presence of recurring, unwanted, intrusive ideas, images, or impulses that may even seem silly, weird, nasty, or horrible (obsessions) to the person experiencing them, accompanied by urges to do something that will relieve the discomfort caused by the obsession (compulsions).

Obsessive-compulsive disorder occurs about equally in men and women and affects about 1.5% of the population during any 6-month period.

The obsessions are usually related to a sense of harm, risk, or danger. Common obsessions include concerns about contamination (for example, worrying that touching doorknobs will cause disease), doubts (for example, worrying that the front door was not locked), fear of loss, and fear of physically injuring someone.

More than 95% of people with obsessive-compulsive disorder feel compelled to perform rituals—repetitive, purposeful, intentional acts. Rituals used to control an obsession include washing or cleaning to be rid of contamination, checking to allay doubt, hoarding to prevent loss, and avoiding the people who might become objects of aggression. Most rituals, such as excessive hand washing or repeated checking to make sure a door has been locked, can be observed. Other rituals, such as repetitive counting or making statements intended to diminish danger, cannot be observed. Obsessions are not always accompanied by compulsions.

Most people with obsessive-compulsive disorder are aware that their obsessive thoughts do not reflect actual risks and that their compulsive behaviours are ineffective. Obsessive-compulsive disorder, therefore, differs from psychotic disorders, in which people lose contact with reality. Obsessive-

compulsive disorder also differs from obsessive-compulsive personality disorder in which specific personality traits are defined (for example, being a perfectionist). Because people with obsessive-compulsive disorder are aware that their compulsive behaviours are excessive to the point of being bizarre and are afraid they will be embarrassed or stigmatized, they often perform their rituals secretly, even though the rituals may occupy several hours each day.

About one third of people with obsessive-compulsive disorder are depressed at the time the disorder is diagnosed. Altogether, two thirds become depressed at some point.

Treatment

Exposure therapy is effective in treating obsessive-compulsive disorder. Exposure therapy involves exposing the person to the situations or people that trigger obsessions, rituals, or discomfort. The person's discomfort or anxiety will gradually diminish if he prevents himself from performing the ritual during repeated exposure to the provocative stimulus. In this way, the person learns that rituals are unnecessary for decreasing discomfort. The improvement usually persists for years, probably because people who have mastered this self-help approach continue to practice it as a way of life without much effort after formal treatment has ended.

Selective serotonin reuptake inhibitors and Clomipramine, a Tricyclic antidepressant, are effective. Certain other antidepressant drugs are also used, but much less often. Many experts believe that a combination of behaviour therapy and drug therapy is the best treatment for people with obsessive-compulsive disorder.

Psychodynamic psychotherapy and psychoanalysis have generally not been effective for people with obsessive-compulsive disorder.

PANIC ATTACKS AND PANIC DISORDER

Panic is acute, short-lived, extreme anxiety with accompanying physical symptoms.

Panic attacks may occur in any anxiety disorder, usually in response to a specific situation tied to the main characteristic of the disorder. For example, a person with a phobia of snakes may panic when encountering a snake. However, these situational panic attacks differ from the spontaneous, unprovoked ones that define a person's problem as panic disorder.

Panic attacks are common, occurring in more than one third of adults each year. Women are 2 to 3 times more likely than men to have panic attacks and panic disorder. Most people recover from panic attacks without treatment; a few develop panic disorder. Panic disorder is present in 2% of the population during any 12-month period. Panic disorder usually begins in late adolescence or early adulthood.

A panic attack involves the sudden appearance of at least four of the following symptoms:

- Chest pain or discomfort
- Choking

- Dizziness, unsteadiness, or faintness
- Fear of dying
- Fear of "going crazy" or of losing control
- Feelings of unreality, strangeness, or detachment from the environment
- Flushes or chills
- Nausea, stomach ache, or diarrhoea
- Numbness or tingling sensations
- Palpitations or accelerated heart rate
- Shortness of breath or sense of being smothered
- Sweating
- Trembling or shaking.

Symptoms peak within 10 minutes and usually dissipate within minutes, leaving little for a doctor to observe except the person's fear of another terrifying attack. Since panic attacks sometimes are unexpected or occur for no apparent reason, especially when people experience them as part of panic disorder, people who have them frequently anticipate and worry about another attack—a condition called anticipatory anxiety—and try to avoid places where they have previously panicked.

Because symptoms of a panic attack involve many vital organs, people often worry that they have a dangerous medical problem involving the heart, lungs, or brain and seek help from a doctor or hospital emergency department. However, the correct diagnosis may not be made, leading to the additional worry that the medical problem is going untreated. Although panic attacks are uncomfortable—at times extremely so—they are not dangerous.

A diagnosis of panic disorder is made when a person experiences at least two unprovoked and unexpected panic attacks, which are followed by at least 1 month of fear that another attack will occur. The frequency of attacks can vary greatly; some people have weekly or even daily attacks that occur for months, whereas others have several daily attacks followed by weeks or months of remission.

<u>Treatment</u>

People who experience panic attacks as part of an anxiety disorder other than panic disorder and some people with panic disorder who have recurring panic attacks, anticipatory anxiety, and avoidance recover without formal treatment. For others, panic disorder follows a waxing and waning course over years.

People with panic disorder are more receptive to treatment if they understand that the disorder involves both physical and psychological processes and that treatment must address both. Drug therapy and behaviour therapy can generally control the symptoms.

Drugs that are used to treat panic disorder include antidepressants and anti-anxiety drugs such as benzodiazepines. Most types of antidepressants—Tricyclics, Monoamine Oxidase inhibitors (MAOIs), and Selective Serotonin Reuptake Inhibitors (SSRIs)—are effective. Benzodiazepines work faster than antidepressants but can cause drug dependence and are probably more likely to cause sleepiness, impaired coordination, and slowed reaction time. SSRIs are preferred to other antidepressants and benzodiazepines because they are equally effective but have fewer side effects, especially considerably less sleepiness, and do not cause drug dependence.

When a drug is effective, it prevents or greatly reduces the number of panic attacks. A drug may have to be taken for a long time, because panic attacks often return once the drug is discontinued.

Supportive psychotherapy, which includes education and counselling, is beneficial because a therapist can provide general information about the disorder, its treatment, realistic hope for improvement, and the support that comes from a trusting relationship.

PHOBIC DISORDERS

Phobias involve persistent, unrealistic, intense anxiety and fear in response to specific external situations.

People who have a phobia avoid situations that trigger their anxiety and fear, or they endure them with great distress. However, they recognize that their anxiety is excessive and therefore are aware that they have a problem.

AGORAPHOBIA

Agoraphobia is characterized by anxiety about or avoidance of being trapped in situations or places with no way to escape easily if anxiety or panic develops.

Agoraphobia is diagnosed in about 4% of women and 2% of men during any 12-month period. Most people with this disorder develop it in their early 20s; agoraphobia rarely develops after age 40.

Although agoraphobia literally means "fear of the marketplace," the term more specifically describes the fear of being trapped, often in a busy place filled with people, without a graceful and easy way to leave if anxiety becomes severe. Typical situations that are difficult for people with agoraphobia include standing in line at a bank or supermarket, sitting in the middle of a long row in a theatre or classroom, and riding on a bus or airplane. Some people develop agoraphobia after experiencing a panic attack in one of these situations. Other people simply feel uncomfortable in these settings and may never, or only later, develop panic attacks. Agoraphobia often interferes with daily living, sometimes so drastically that it leaves the person housebound.

Treatment

If agoraphobia is not treated, it usually waxes and wanes in severity and may even disappear without formal treatment, possibly because the person has conducted some personal form of behaviour therapy.

Exposure therapy, a type of behaviour therapy in which the person is exposed repeatedly to the anxiety-provoking situation, is the best treatment for agoraphobia, helping more than 90% of people who practice this therapy faithfully.

People with agoraphobia who are deeply depressed may need to take an antidepressant. Substances that depress the central nervous system, such as alcohol or large doses of anti-anxiety drugs, may interfere with behaviour therapy and are tapered off before therapy is begun.

SOCIAL PHOBIA

Social phobia (social anxiety disorder) is characterized by significant anxiety induced by exposure to certain social or performance situations, often resulting in avoidance.

Humans are social animals, and their ability to relate comfortably in social situations affects many important aspects of their lives, including family, education, work, leisure, dating, and mating.

Although some anxiety in social situations is normal, people with social phobia have so much anxiety that they either avoid social situations or endure them with distress. About 13% of people have social phobia sometime in their lives; the disorder affects about 9% of women and 7% of men during any 12-month period. Men are more likely than women to have the most severe form of social anxiety, avoidant personality disorders. Some people are shy by nature and show timidity early in life that later develops into social phobia. Others first experience anxiety in social situations around the time of puberty.

Some social phobias are tied to specific performance situations, producing anxiety only when the person must perform a particular activity in public. The same activity performed alone produces no anxiety. Situations that commonly trigger anxiety among people with social phobia include public speaking; performing publicly, such as reading in church or playing a musical instrument; eating with others; signing a document before witnesses; and using a public bathroom. People with social phobia are concerned that their performance or actions will seem inappropriate. Often they worry that their anxiety will be obvious—that they will sweat, blush, vomit, or tremble or that their voice will quaver; that they will lose their train of thought; or that they will not be able to find the words to express themselves.

A more general type of social phobia is characterized by anxiety in many social situations. In both types of social phobia, the person's anxiety comes from the belief that if his performance falls short of expectations, he will feel humiliated and embarrassed.

Treatment

Social phobia often persists if left untreated, causing many people to avoid activities in which they would otherwise like to participate.

Exposure therapy, a type of behaviour therapy in which the person is exposed repeatedly to the anxiety-provoking situation, is effective, but arranging for exposure to last long enough to permit getting used to the anxiety-provoking situation and growing comfortable in that situation may not be easy. For example, a person who is afraid of speaking in front of his boss may not be able to arrange a series of speaking sessions in front of that boss. Substitute situations may help, such as joining Toastmasters (an organization for those who have anxiety about speaking in front of an audience) or reading a book to nursing home residents.

Antidepressants, such as selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs), and anti-anxiety drugs can often help people with social phobia. Many people use alcohol as a social lubricant; for some people, however, alcohol abuse and dependence can result. Beta-blockers are commonly used to reduce the increased heart rate, tremor, and sweating experienced by people who are distressed by performing in public.

SPECIFIC PHOBIA

A specific phobia is an irrational fear of specific objects or situations.

Specific phobias, as a group, are among the most common Anxiety Disorders but are often less troubling than other Anxiety Disorders. During any 12-month period, about 13% of women and 4% of men have a specific phobia.

Some specific phobias cause little inconvenience, while others severely interfere with functioning. For example, a city dweller who is afraid of snakes may have no trouble avoiding them. However, a city dweller who fears small, closed places such as elevators will have a problem working on an upper floor in a skyscraper.

Some specific phobias, such as fear of large animals, the dark, or strangers, begin early in life. Many phobias stop as the person gets older. Other phobias, such as fear of rodents, insects, storms, water, heights, flying, or enclosed places, typically develop later in life.

At least 5% of people are to some degree phobic about blood, injections, or injury. These people can actually faint due to a decrease in heart rate and blood pressure, which does not happen with other phobias and Anxiety Disorders. In contrast, many people with other phobias and Anxiety Disorders hyperventilate, which can cause them to feel as though they might faint, although they virtually never faint.

<u>Treatment</u>

A person can often cope with a specific phobia by avoiding the feared object or situation. When treatment is needed, exposure therapy is the treatment of choice. A therapist can help ensure that the therapy is carried out properly, although it can be done without a therapist. Even people with a phobia of blood or needles respond well to exposure therapy. For example, a person who faints while blood is

drawn can have a needle brought close to a vein and then removed when the heart rate begins to slow down. Repeating this process allows the heart rate to return to normal. Eventually, the person should be able to have blood drawn without fainting.

Drug therapy is not very useful in helping people overcome specific phobias. However, benzodiazepines (anti-anxiety drugs) may give a person short-term control over a phobia, such as the fear of flying.

POST-TRAUMATIC STRESS DISORDER

Posttraumatic stress disorder is an anxiety disorder caused by exposure to an overwhelming traumatic event, in which the person later repeatedly re-experiences the event.

Experiences that threaten death or serious injury can affect people long after the experience is over. Intense fear, helplessness, or horror can haunt a person.

Traumatic events may involve having been threatened with death or serious injury or witnessing violence against another person. Examples include engaging in military combat, experiencing or witnessing sexual or physical assault, or being affected by a disaster, either natural (for example, a hurricane) or man-made (for example, a severe automobile accident). Sometimes symptoms do not begin until many months or even years after the traumatic event took place (delayed onset). If posttraumatic stress disorder has been present for 3 months or longer, it is considered chronic.

Posttraumatic stress disorder affects at least 8% of people sometime during their life, including childhood. Many people who undergo or witness traumatic events, such as combat veterans and victims of rape or other violent acts, experience posttraumatic stress disorder.

In posttraumatic stress disorder, the traumatic situation is re-experienced repeatedly, usually in nightmares or flashbacks. Intense distress often occurs when the person is exposed to an event or situation that reminds him of the original trauma. Examples of such reminders are anniversaries of the traumatic event; seeing a gun after being pistol-whipped during a robbery; and being in a small boat after a near-drowning accident.

The person persistently avoids things that are reminders of the trauma. He may also attempt to avoid thoughts, feelings, or conversations about the traumatic event and avoid activities, situations, or people who serve as reminders. Avoidance may also include memory loss (amnesia) for a particular aspect of the traumatic event. The person has a numbing or deadening of emotional responsiveness and symptoms of increased arousal (such as difficulty falling asleep or being easily startled). Symptoms of depression are common, and the person shows less interest in previously enjoyed activities. Feelings of guilt are also common.

Treatment

Treatment of posttraumatic stress disorder involves psychotherapy (including exposure therapy) and drug therapy. Because of the often intense anxiety associated with traumatic memories, supportive

psychotherapy plays an especially important role in treatment. The therapist is openly empathic and sympathetic in recognizing the person's psychological pain. The therapist reassures the person that his response is valid but encourages him to face his memories (as a form of exposure therapy). The person also is taught ways to control anxiety, which helps to modulate and integrate the painful memories into his personality.

Insight-oriented psychotherapy can help people with feelings of guilt understand why they are punishing themselves and help rid them of guilty feelings.

Antidepressants appear to provide some benefit, especially selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, and monoamine oxidase inhibitors (MAOIs).

Chronic posttraumatic stress disorder may not disappear but often becomes less intense over time even without treatment. Nevertheless, some people remain severely handicapped by the disorder.