An Overview of Anxiety Disorders

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Fear and anxiety are a normal part of life, even adaptive in many conditions. Who among us has not studied for a test without some anxiety -- and scored better for it? Who has not walked down a dark street in a high crime district without mounting fear? Normal anxiety keeps us alert: it makes us question whether we really have to walk down that street after all.

Mental health professionals are not concerned with normal anxiety. Rather, they attend to fear and anxiety that has somehow gone awry; that inexplicably reaches overwhelming levels; that dramatically reduces or eliminates productivity and significantly intrudes on an individual's quality of life; and for which friends, family and even the patient can find no obvious cause.

Clinicians recognize about 12 relatively distinct subtypes of anxiety disorder: Panic Disorder, with and without Agoraphobia; Agoraphobia Without a History of Panic Disorder; Specific Phobia; Social Phobia; Obsessive-Compulsive Disorder; Post-traumatic Stress Disorder; Acute Stress Disorder; Generalized Anxiety Disorder; Anxiety Disorder Due to a General Medical Condition; Substance-Induced Anxiety Disorder; and Anxiety Disorder Not Otherwise Specified.

Frequently, these disorders are made more complex and difficult to treat because they are accompanied by depression, substance abuse and suicidal thoughts. Full definitions of each subtype may be found in The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV),American Psychiatric Association, 1994, but the primary distinguishing features will be mentioned briefly here:

Panic Disorder -- Within 10 minutes, escalating fear develops into a discrete period of intense discomfort accompanied by at least four of 13 somatic or cognitive symptoms. The afflicted individual believes that he or she is having a heart attack and dying and often presents to a hospital emergency room with this complaint.

With Agoraphobia -- Often recurrent panic attacks become associated with the places in which they occur. As the person attempts to avoid these places, either in the hope of not triggering an attack or not having help available or being unable to escape, their freedom of movement and lifestyle may become severely restricted.

Without Agoraphobia -- Panic attacks occur, but without the consequence of avoidant behavior.

Agoraphobia Without a History of Panic Disorder -- Persons with limited Symptom Panic Attacks or some other symptom(s) that may be incapacitating or embarrassing (e.g., loss of bladder control) may lead to a pervasive avoidance of a variety of situations. Common agoraphobic situations include being in a crowd, crossing a bridge, or leaving home alone. If the person forces exposure to the feared situation, it is only considerable dread.

Specific Phobia -- Excessive fear upon exposure to a specific object or situation (but not of a panic attack or being embarrassed in a social situation) is the hallmark of a Specific Phobia. When confronted by such objects or events as elevators, funerals, lightening storms, insects, or furry animals, phobic individuals become extremely fearful. Specific phobias may also involve fear of losing control, panicking, and fainting when confronted with feared object. Adolescents or adults recognize the fear as unreasonable, but can do little to stop it. Often the individual can lead a relatively normal life by simple avoidance, and the diagnosis not made.

Social Phobia -- Social Phobics have a persistent fear of exposure to possible scrutiny by others. They fear that they will do something or act in a way that will be humiliating or embarrassing. While it is normal to have some anxiety before an encounter with the boss or before giving a speech, most people are not incapacitated and manage to get through the ordeal. This diagnosis is only made if the consequent avoidant behavior interferes with functioning at work or in usual social situations or if the person is markedly distressed about the problem.

Obsessive-Compulsive Disorder (OCD) --Recurrent, distressful obsessions (thoughts) or compulsions can significantly interfere with normal marital, social or work routines. The person usually recognizes the unreasonableness of the behavior, and this fact adds to the distress. However, resisting the obsession or compulsion means that the anxiety will escalate rapidly to intolerable levels. It is easier to give into the intrusive thought or to execute the behavior.

Post-traumatic Stress Disorder (PTSD) -- This clinical condition can be traced to a definable, traumatic event in the individual's life. It might have occurred in war-time or after witnessing a shooting, being a rape or street crime victim, or living through some natural disaster. The experience must have produced intense fear, helplessness or horror. Either shortly thereafter or at some later date, the person may experience flashbacks, recurrent and intrusive recollections of the event, feelings of detachment, guilt, sleep problems and a variety of somatic symptoms.

Acute Stress Disorder – Symptoms similar to PTSD, that develop within a month after exposure to an extreme traumatic stressor and are time- limited between 2 days and 4weeks, define this disorder.

Generalized Anxiety Disorder (GAD) -- The individual presenting with GAD reports uncontrollable excessive anxiety and worry, more days than not, for at least a 6-month period. They are likely to feel constantly "on edge" and tired, they complain of muscle tenseness, they may be irritable and unable to concentrate, and their sleep pattern is

disturbed. The more life circumstances about which the individual worries, the more likely the diagnosis.

Anxiety Disorder Due to a General Medical Condition -- Anxiety symptoms can include those of GAD, panic attacks, or OCD, and these must be directly linked to a general medical condition by the person's history, physical examination or laboratory findings. The anxiety symptoms likely to be atypical for age of onset, course, and family history.

Substance-Induced Anxiety Disorder -- The clinical presentation of this condition may resemble Panic Disorder, GAD, Phobia, or OCD, but the full set of diagnostic criteria for even one of these disorders does not have to be met. However, it is essential that the anxiety symptoms be due to the direct physiological effects of a drug of abuse, medication, or exposure to a toxin.

Anxiety Disorder Not Otherwise Specified -- A fair number of people may be expected to fit this category. For example, the DSM-IV clinical trials found a number of people with Mixed Anxiety-Depression (i.e., not meeting full diagnostic criteria for either). Others who fit this category might be persons with symptoms of Social Phobia who also have dermatological conditions, stuttering problems and Body Dysmorphic Disorder.

The prevalence of these disorders is startling. At sometime during their lives, nearly a quarter (24.9%) of the adult population in the United States will have an anxiety disorder. Only substance-related disorders are more common (26.6%). The National Comorbidity Survey shows that the percentage is greatest for social and simple phobias (13.3% and 11.3%) and less for Agoraphobia (5.3%), GAD (5.1%) and Panic Disorder (3.5%) (Kessler et al., 1994). The lifetime prevalence of OCD is 2.56%, according to the National Institute of Mental Health (NIMH) - Epidemiological Catchment Area Study (Robins and Regier, 1991).

What is especially striking is how many times one or more of these anxiety disorders occur with each other and with other mental disorders, such as depression and substance abuse (Maser and Cloninger, 1990; Regier, et al., 1990). Nearly 60% of patients who are diagnosed with OCD are later diagnosed with depression (Robins and Regier, 1991). Panic attacks are even found to co-occur frequently in schizophrenic patients (Boyd, et al., 1984), although they are usually overlooked by clinicians.

It is important that clinicians and patients recognize that effective treatments are available. Phobias can be treated by behavioral methods, while panic disorder can be treated with medication, cognitive-behavioral therapy or both (see Wolfe and Maser, 1994). Obsessive-Compulsive and Post-traumatic Stress Disorders are difficult but hardly impossible to treat, and the symptoms can be markedly reduced, if not eliminated. When the anxiety disorder is effectively dealt with, drug abuse and secondary depression will also usually decline.

Every year the NIMH spends many millions of dollars on research on the causes and treatments of the anxiety disorders. As understanding of the causes has grown, effective treatments have

been developed. Treatment allows afflicted individuals to return to relatively normal, productive lives. Recognition that something is wrong is what brings people to this site on National Anxiety Disorders Screening Day. They need to know that once identified, anxiety disorders can be treated.

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TREATMENT FOR ANXIETY DISORDERS

Anxiety disorders are treatable medical illnesses. Therapy for anxiety disorders often involves medication or specific forms of psychotherapy.

Medications, although not cures, can be very effective at relieving anxiety symptoms. Today, thanks to research by scientists at the National Institute of Mental Health and other research institutions, there are more medications available than ever before to treat anxiety disorders. So if one drug is not successful, there are usually others to try. In addition, new medications to treat anxiety symptoms are under development.

For most of the medications that are prescribed to treat anxiety disorders, the doctor usually starts the patient on a low dose and gradually increases it to the full dose. Every medication has side effects, but they usually become tolerated or diminish with time. If side effects become a problem, the doctor may advise that patient to stop taking the medication and to wait a week or longer, for certain drugs - before trying another one. When treatment is near an end, the doctor will taper the dosage gradually.

Research has also shown that behavioral therapy and cognitive-behavioral therapy can be effective for treating several of the anxiety disorders. **Behavioral therapy** focuses on changing specific actions and uses several techniques to decrease or stop unwanted behavior. For example, one technique trains patients in **diaphragmatic breathing**, a special breathing exercise involving slow, deep breaths to reduce anxiety. This is necessary because people who are anxious often hyperventilate, taking rapid shallow breaths that can trigger rapid heartbeat, lightheadedness, and other symptoms. Another technique - **exposure therapy** - gradually exposes patient to what frightens them and helps them cope with their fears.

Like behavioral therapy, **cognitive-behavioral therapy** teaches patients to react differently to the situations and bodily sensations that trigger panic attacks and other anxiety symptoms. However, patients also learn to understand how their thinking patterns contribute to their symptoms and how to change their thoughts so that symptoms are less likely to occur. This awareness of thinking patterns is combined with exposure and other behavioral techniques to help people confront their feared situations. For example, someone who becomes lightheaded during a panic attack and fears he is going to die can be helped with the following approach used in cognitive-behavioral therapy. The therapist asks him to spin in a circle until he becomes dizzy. When he becomes alarmed and starts thinking, "I'm going to die," he learns to replace that thought with a more appropriate one, such as, "It's just a little dizziness - I can handle it."

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