ANXIETY DISORDERS

FOR PATIENTS AND FAMILIES

Anxiety disorders are a group of disorders that have different causes but share many symptoms. Anxiety disorders are the most common of the psychiatric illnesses. The core symptoms of anxiety disorders are nervousness, worry, and fear. The patient's symptoms may cause distress and result in some functional impairment. In the spectrum of anxiety disorders, anxieties may be triggered by excessive fear of certain objects or situations (**phobias**), episodes of sudden, inexplicable terror (**panic attacks**), or persistent thoughts and behaviors (**obsessive-compulsive disorder**, or **OCD**). For others, their disorder is characterized by chronic anxiety and worry (**generalized anxiety disorder**, or **GAD**) without a specific identifiable cause like phobic disorder, panic disorder, or OCD. The anxiety disorders include agoraphobia (fear of open space and leaving familiar surroundings), social phobia, generalized anxiety disorder (GAD), panic disorder (with or without agoraphobia), phobic disorders, and OCD. For a discussion of OCD, refer to the handout *Information About Obsessive-Compulsive Disorder (OCD) for Patients and Families* (Form 2–6).

GENERALIZED ANXIETY DISORDER (GAD)

Without the specific symptoms that characterized panic or phobic disorder, generalized anxiety disorder is marked by persistent apprehension, worry, and anxiety that cause distress and result in physical symptoms. People with GAD worry not just some of the time, but incessantly and excessively about life circumstances, including their health, finances, job, family, and potentially hazardous situations (e.g., driving a car). However, persons with GAD do not have episodes of panic attacks typically seen with panic disorders. The usual clinical symptoms of GAD include restlessness or edginess, becoming easily fatigued, difficulty concentrating, irritability, and sleep disturbance. Anxiety may trigger physical symptoms, such as sweating, rapid heartbeat, dry mouth, frequent urination, lightheadedness, and stomach upset. To make the diagnosis of GAD, the physician must eliminate other causes of anxiety, such as substance abuse, medications, medical conditions (e.g. hyperthyroidism), or other psychiatric disorders (e.g., depression).

Generalized anxiety disorder is a relatively common disorder, afflicting approximately 4%–7% of people in the United States. The incidence of GAD may be higher in women, African Americans, and persons under 30 years of age. The treatment for GAD may consist of medications (anti-anxiety agents), psychotherapy, and behavior therapy.

POSTTRAUMATIC STRESS DISORDER (PTSD)

The concept of PTSD was recognized long before the term was introduced in 1980. It was recognized early on that some soldiers suffered from an emotional disorder following the aftermath of war ("shell shock"). Posttraumatic stress disorder, as the diagnosis implies, occurs following a trauma that was either experienced or witnessed by the person. The traumatic experience may leave the person feeling vulnerable, anxious, helpless, depressed, and emotionally numbed. A person may develop PTSD after a physical or sexual assault, experiencing a near-fatal accident or natural disaster, or witnessing violence and death. Following the aftermath of the traumatic experience, the person may continue to develop psychological reactions related to the fright-

ening experience. The essential clinical features of PTSD include having recurrent, intrusive, and distressing recollections of the event, having recurrent distressing dreams of the event (particularly with children), reliving the experience through flashbacks or hallucinations, and developing intense psychological distress and physical symptoms (e.g., sweating, rapid heartbeat) when exposed to cues that trigger recollection of the traumatic event.

The onset of PTSD may begin within hours or days following the traumatic experience, or it may be delayed for months or years. Without treatment the disorder has a chronic course and may last for years. Many patients with PTSD also develop major depression and other anxiety disorders. Furthermore, patients with PTSD are at risk for substance and alcohol abuse.

Clinical management of PTSD involves treating the underlying symptoms with medications and treating the cause of the illness through psychotherapy. The benzodiazepines are the most widely prescribed tranquilizers used for treating anxiety. Depression is a common aftermath of traumatic stress, and an antidepressant medication may be needed to treat depressive symptoms. Antidepressants may help to reduce nightmares and flashbacks and to improve sleep.

Psychotherapy in the form of supportive intervention may be beneficial initially in helping the patient overcome the traumatic experience. Group and family therapy may be helpful in bringing out painful thoughts and emotions, especially guilt, anger, or fear that have been internalized. Other approaches of psychotherapy may involve behavioral techniques for helping the patient overcome phobias or anxiety related to or associated with the traumatic situation. A gradual process of exposing and confronting the patient to the object or situation that evokes the phobia and anxiety may be achieved though desensitization. Another approach is through cognitive-behavior therapy, with which the patient can learn skills to block intrusive thoughts (e.g., flashback) when they occur and learn relaxation and breathing techniques to overcome anxiety.

PANIC DISORDER AND AGORAPHOBIA

Individuals with panic disorder have unexpected, recurrent anxiety (or panic) attacks that trigger a chain of frightening physical reactions. They may be caught totally off guard while engaged in routine activities, when suddenly their heart begins to pound. They have difficulty breathing, feeling as though they are being smothered or choked; they feel lightheaded, dizzy, or faint; they may complain of nausea and abdominal distress. The panic attack leaves them sweating, trembling, and shaking. The initial reaction is that they are having a heart attack and dying. The attacks are sudden, and usually there is no precipitating cause before the onset of a panic attack. Most attacks lasts about 10 minutes. Panic attacks are overwhelmingly frightening, and these patients live in dread of the next attack.

Agoraphobia is a condition in which individuals become frightened when separated from home and family, their source of security. Agoraphobia often accompanies panic disorder.

People with agoraphobia have a fear of leaving home, being in crowded places, or being away from home alone where they cannot suddenly leave if they have a panic attack. They are usually housebound, and they cannot travel any distance alone away from home without feeling anxious and fearful. They are only able to leave their house or travel when accompanied with someone.

Many experts believe that panic disorder and agoraphobia are a single illness rather than separate disorders. A significant number of persons with panic disorder develop some symptoms of agoraphobia. Panic disorder is classified with or without agoraphobia. Individuals with panic disorder may develop agoraphobia because they fear having a panic attack in a public place where they may not be in control of the situation and feel they may embarrass themselves, or being away from home where they cannot seek help. In some cases, agoraphobia may persist even in the absence of a recent panic attack because these individuals are so preoccupied with fears of another panic attack that they are frightened when separated from their secure surroundings.

The cause of panic disorder has been extensively studied. The etiology of the disorder is associated to an area of the brain stem (**locus coeruleus**) that regulates alertness. Disturbance in this area of the brain stem is the most plausible explanation for causing panic attacks. Therefore, panic disorder is a biological rather than a psychological disturbance that underlies the disorder.

Treatment of panic disorder has the greatest success when a combination of medications and psychotherapy is used. Antidepressants, including the **selective serotonin reuptake inhibitors** (SSRIs), **tricyclic antidepressants** (TCAs), and **monoamine oxidase inhibitors** (MAOIs), are effective for treating panic attacks and agoraphobia in up to 80% of patients. The SSRIs and newer antidepressants have essentially replaced the TCAs and MAOIs because they are better tolerated and safer. For a discussion of these antidepressants, refer to the handouts on SSRIs (Form 3–14), TCAs (Form 3–15), and MAOIs (Form 3–12).

Benzodiazepines (e.g., Valium) are also very effective in blocking panic attacks, but higher doses are required than for treating anxiety disorder. The concern with chronic use of benzodiazepines at high doses is the potential for habituation. Benzodiazepines are also effective for treating the anxiety of panic disorder and agoraphobia, for which they may be prescribed in lower doses than for panic attacks.

Propranolol (Inderal), an adrenergic-blocking agent, may be useful in treating panic attacks for some patients, but it is much less effective than antidepressants or benzodiazepines. Panic disorder may be associated with excessive activity of the adrenergic neurotransmitter system (e.g., norepinephrine). Propranolol antagonizes the adrenergic action of the neurotransmitter and attenuates the symptoms of panic attacks. For example, propranolol may diminish palpitations, rapid heartbeat, sweating, trembling or shaking, and chills or hot flashes during a panic attack.

Psychotherapy in the form of cognitive-behavioral therapy has been effective for treating patients with panic disorder, particularly those with agoraphobia. Cognitive-behavioral therapy usually involves the patient with distraction and breathing exercises and teaches him or her to gain control at the onset of distressing symptoms. With such cognitive-behavioral treatment, along with education, the patient can better understand the illness.

PHOBIC DISORDERS

A *phobia* is defined as an irrational, intense, and persistent fear of an object, place, or situation. A person with a phobia will go to great lengths to avoid the object of fear. What separates normal and usual fear from phobias is that phobic fears are irrational and excessive. Phobias are the most common type of anxiety disorders. There are three types of phobias: agoraphobia, social phobia, and specific phobia. Agoraphobia was discussed earlier in this handout.

Individuals with **social phobia** (also called **social anxiety disorder**) are fearful and anxious when they are in situations around other people where they may be observed or embarrassed. As a result, social anxiety disorder interferes and limits social relationships. These individuals commonly avoid public places where there are crowds.

Specific phobias are extreme fears of animals, objects, places, or situations. The most common types of phobias are fear of snakes, insects, closed spaces (claustrophobia), and heights (acrophobia).

Most individuals with phobias do not seek treatment and only do so when the disorder becomes so incapacitating as to disrupt normal function. Most people circumvent their phobias by avoiding the thing they fear. When individuals with social phobia seek medical attention, a combination of medication and behavior therapy has proved to be the most effective treatment. Antidepressants are effective for treating phobic disorders, and the SSRIs are the commonly prescribed antidepressants because they are well tolerated and generally safe.

Behavior therapy is very effective in the treatment of phobic disorders, both social and specific phobias, using the techniques of exposure and desensitization and flooding. Through the technique of exposure and

desensitization, patients are gradually exposed to their fearful situations until they become desensitized to their fears. For example, patients with phobia of snakes may be shown pictures of snakes, and as their fears decrease gradually, they may be asked to visit snakes at the zoo. In the technique of flooding, patients are expected to confront their fears by total exposure to the situation. For example, patients with social phobias may be asked to enter into a situation (e.g., engage a conversation with a stranger) and stay with the situation until their anxiety subsides. With each subsequent encounter, their anxiety becomes less intense.

If you have any questions about this handout, please consult your physician.

ADVOCACY AND SUPPORT GROUPS

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