# ANXIETY DISORDERS

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**Anxiety** is probably one of the most distressing human emotions. It can impact on the functioning of people at various levels, and so prevent them from reaching their full potential. It is important to remember that anxiety is an experience (like pain) that is not necessarily pathological and, indeed, that is an important survival mechanism. Anxiety warns people about danger, and so plays an important role in encouraging necessary defense measures. It is therefore important to differentiate between normal and pathological anxiety. Pathological anxiety can be viewed as an inappropriate anxiety response (in terms of intensity or duration) to a stimulus.

The following **anxiety disorders** are listed in the DSM-IV:

- Panic disorder with or without agoraphobia
- Agoraphobia without panic disorder
- Specific phobia
- Social phobia (also termed social anxiety disorder)
- Obsessive-compulsive disorder
- Posttraumatic stress disorder
- Acute stress disorder
- Generalised anxiety disorder
- Anxiety disorder due to general medical condition
- Substance induced anxiety disorder
- Anxiety disorder not otherwise specified

# PANIC DISORDER AND AGORAPHOBIA

**Panic disorder** is characterised by recurrent, spontaneous, and unexpected panic attacks.

**Panic attacks** are discrete periods of intense anxiety, associated with physical symptoms like trembling or shaking, sweating, palpitations, and shortness of breath. Panic attacks occur in panic disorder, but may also be seen in various other psychiatric disorders, for example social phobia and major depressive disorder, as well as in conditions like substance intoxication- and withdrawal. Panic disorder is often accompanied by agoraphobia.

**Agoraphobia** is an irrational fear of places or situations where help may not be available, or where escape is difficult. The person who suffers from this condition is aware of the fact that this fear is unfounded and irrational. Agoraphobia often leads to avoidance of places from where escape is difficult or where help may not be available, for example supermarkets, churches, freeways, et cetera. It curtails the life of the sufferer on various levels, including work and social functioning.

**Clinical presentation:**

**i) Panic attacks:**

The first panic attack is usually spontaneous, although it may occur after exercise or emotional trauma.

During a panic attack there is a rapid escalation of symptoms over approximately ten minutes. The psychological symptoms are severe, intense anxiety and a feeling that something terrible will happen. This is accompanied by multiple physical symptoms, which may include some, or all of the following:

- Shortness of breath
- Tachycardia (fast heartbeat)

- Dizziness, light-headedness
- Paresthesia
- Chest pain or discomfort
- Feeling of choking
- Fainting, unsteadiness
- Sweating
- Tremor
- Hot or cold flushes
- Derealisation/depersonalisation
- Urge to urinate/defecate
- Dry mouth
- Nausea
- Muscle tension
- Visual disturbances
- The person feels he/she's going to die/ is losing control/ "is going crazy".

As the panic worsens, most people will try to escape from the situation or get help, hoping that this will cause the panic to stop. It is a frightening experience and, although patients realise, after suffering multiple panic attacks, that they won't die, panic attacks continue to be extremely unpleasant.

**ii) Agoraphobia:**

People with this condition anticipate the possibility that they may have another panic attack, and therefore avoid situations where it is difficult to escape or to get help. They also prefer to be accompanied by family and friends when they visit places like the church, shopping centres, confined places like lifts and even when travelling in a motor car on a freeway. Some patients become totally housebound.

**iii) Other symptoms:**

Panic disorder has been suggested to be a risk factor for suicide in several studies. The consequences of panic disorder disrupt the patient's life on various levels, which include social and work functioning, as well as the risk of drug abuse through patients trying to medicate themselves.

**Treatment:**

The treatment of panic disorder consists of a combination of pharmacotherapy and psychotherapy.

## GENERALISED ANXIETY DISORDER

**Generalised anxiety disorder (GAD)** is defined as excessive and pervasive worry, associated with various somatic symptoms, which causes meaningful reduction in social and/ or work functioning, or marked subjective distress.

**Clinical presentation:**

These patients do not usually present primarily to a psychiatrist, but would typically first consult a general practitioner or specialist physician, often with somatic complaints (e.g., palpitations/diarrhoea).

The typical symptom complex presents as follows:

Anxiety and increased vigilance, associated with motor tension and autonomic hyperactivity.

Lasts at least six months.

The anxiety is excessive and interferes with the person's normal functioning.

The anxiety is associated with some (at least 3) of the following:

- Restlessness/ a feeling of tension
- Inability to concentrate
- Exhaustibility

- Irritability
- Muscle tension
- Sleep disturbance

**Management:**

Treatment comprises a combination of pharmaco- and psychotherapy.

## SOCIAL PHOBIA (SOCIAL ANXIETY DISORDER) AND SPECIFIC PHOBIAS

### What is social phobia (social anxiety disorder)?

A degree of discomfort during person-to-person or person-to-group interaction can be normal. This social discomfort or anxiety is often described as “shyness”. Severe degrees of shyness are also regularly made out to be “part of the patient’s personality”. Social phobia, or otherwise known as social anxiety disorder, is characterised by a disproportionate fear of negative evaluation (humiliation/ embarrassment) by other persons in social- or performance-bound situations. These situations will then be avoided, if possible. The person recognises that his/her fears are excessive. Nevertheless, the fear and avoidance limit the functioning of the individual.

### What are specific phobias?

A specific phobia is a disproportionate fear of a specific object or situation. The fear is not of negative evaluation by other people, and can therefore be distinguished from social phobia. The fear is provoked through mere anticipation or exposure to the object or situation. The fear-response may take the form of a panic-attack. As in social phobia, avoidance and functional impairment occur.[1]

Five types occur:

Fear for:

a) an animal;

b) the natural environment (e.g., storms or heights);

c) blood, injections and injuries;

d) specific situations (e.g., flying, using of elevators);

e) diverse group which includes choking, vomiting and contracting an illness.

**Aetiology (causality):**

Both environmental and genetic factors may contribute to the pathogenesis of social phobia. Environmental factors in social phobia include overprotective parents (perhaps in response to an already sensitive child), parents who are rejecting and less caring, as well as socially phobic patterns of parents. Major life experiences may sometimes trigger phobias. Inherited factors include a 3 times increased risk for first degree family members to develop social phobia.

**Treatment:**

Optimal treatment requires individualisation of interventions. Available treatment modalities are pharmacotherapy and psychotherapy.

## OBSESSIVE-COMPULSIVE DISORDER

In everyday language, the terms "obsessive" and "compulsive" are used to refer to a wide range of repetitive thoughts and behaviours, including such things as unusual neatness or a strong interest in sport. In medical practice, however, obsessions and compulsions in different patients are surprisingly uniform, often involving intrusive thoughts about possible harm, and repetitive responses (e.g., hand-washing, checking, etc.) to these thoughts.

*Obsessions* are recurrent and persistent thoughts that are experienced as intrusive and inappropriate, that cause marked anxiety or distress, and which the person tries to ignore or suppress.
*Compulsions* are repetitive and excessive behaviours or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

**Presentation:**

**i) Presentation by the family:**

A typical example of this is childhood OCD. It turns out that OCD often begins in childhood. Indeed, it is striking that compulsions in childhood are often extremely similar to those in adulthood.

**ii) Presentation with depression and/or anxiety:**

Patients with OCD often become extremely demoralised about their symptoms, and may develop the symptoms of a major depression. The symptoms of OCD are often extremely anxiety provoking, so that patients may also present with complaints of anxiety.

**iii) Presentation with medical sequelae:**

OCD patients may present to dermatologists with dermatitis from repetitive washing. Patients with exaggerated thoughts that they are ugly (body dysmorphic disorder) may present to plastic surgeons for cosmetic surgery.

**iv) Presentation with neurological disorders:**

OCD patients may present with the symptoms of a neurological disorder. Tourette's disorder, for example, is characterised by motor and vocal tics. However, many of patients with Tourette's disorder also have OCD symptoms.

**Treatment:**

Two treatments are known to be effective for OCD. The first is pharmacotherapy.

The second known treatment of OCD is behaviour therapy. Behaviour therapy employs specific techniques to decrease OCD symptoms. These primarily relate to exposure and response prevention. Thus patients are encouraged to come into contact with the feared stimulus (e.g., placing their hands into dirt) and to prevent their usual response (e.g., washing the dirt off). While this raises anxiety levels in the short-term, it ultimately often proves very successful. It is often a good idea to combine pharmacotherapy and behaviour therapy. During this time, the patient and family should also be educated about the illness.

Research on OCD continues to advance rapidly, and more detailed knowledge about its neurobiology and management should be forthcoming in future years.

## ACUTE STRESS AND POSTTRAUMATIC STRESS DISORDER

**Acute stress disorder** is an anxiety disorder that arises in response to a terrifying or traumatic event. Common symptoms that individuals with acute stress disorder are: numbing; detachment; de-realization; depersonalization or dissociative amnesia; continued re-experiencing of the traumatic event by such ways as thoughts, dreams or nightmares, and flashbacks; and avoidance of anything that reminds them of the event. During this time, they have symptoms of anxiety, and significant impairment in at least one essential area of functioning, like work or in their social relationships. Symptoms last for a minimum of 2 days, and a maximum of 4 weeks, and occur within 4 weeks of the event. This disorder may resolve itself

with time. However, if the symptoms continue, the person may be given a new diagnosis of post-traumatic stress disorder. Acute stress disorder and PTSD (described below) are similar conditions however, the time of onset and the duration of the conditions differ.

A diagnosis of **posttraumatic stress disorder** (PTSD) requires exposure to a psychologically traumatising event (extreme stressor) and a characteristic set of symptoms that have lasted at least 1 month. PTSD characteristically develops in a person who has experienced an extremely traumatic event that involves experiencing, witnessing, or being confronted with actual or threatened death, serious physical injury, or a threat to one's physical integrity. The person's response to the exposure involves intense fear, helplessness, or horror.

Extreme stressors that can give rise to PTSD include:

- Rape or criminal assault
- Serious accident or natural disaster (floods, fires, etc.)
- Combat exposure
- Child sexual/physical abuse or severe neglect
- Hostage/imprisonment/torture/displacement
- Witnessing a trauma
- Sudden, unexpected death of a loved one

Rates of trauma exposure in the community are considerably higher than rates of PTSD, indicating that many individuals who have experienced a trauma do not go on to develop PTSD.

Risk factors for developing PTSD include:

a) greater extent and severity of trauma
b) female gender (women are twice as likely to have PTSD than men)
c) presence of childhood trauma
d) family history of anxiety/depression

e) preexisting personality disorder

f) preexisting anxiety or depressive disorder

g) parental PTSD

h) lack of appropriate or available social support.

**Clinical Features:**

**The core symptoms of PTSD are:**

a) Re-experiencing of the traumatic event via intrusive memories, dreams, and flashbacks.

b) Physical or emotional avoidance of stimuli associated with the trauma or a numbing of emotions.

c) Persisting symptoms of increased arousal.

These symptoms may only develop months or years after the event.

**Comorbidity and PTSD:**

Because PTSD often co-occurs with the disorders listed below, it is useful to screen for them in any patient with PTSD, and to take them into account when planning treatment. Patients with PTSD with comorbid disorders are likely to have a worse long-term outcome than those without, and may require longer-term maintenance therapy. The most common comorbid conditions in a patient with PTSD are:

a) major depressive disorder

b) alcohol/drug abuse or dependence

c) other anxiety disorders: panic disorder/agoraphobia, generalised anxiety disorder, obsessive-compulsive disorder, social phobia.

**Course and prognosis:**

When PTSD was first recognised as a diagnostic entity, it was considered to be a chronic and recurring condition without the possibility of spontaneous remission. Individuals with PTSD, and even some clinicians, had low expectations of a favourable treatment outcome, and complete remission was seen as unattainable in many instances. These expectations have changed with recent research studies that have indicated efficacy with the SSRI's and cognitive- behaviour therapies. Remission (to be free of most symptoms) is now accepted as a realistic treatment goal for many patients.

**Treatment:**

Both psychotherapy and pharmacotherapy are of value in the treatment of PTSD. Some patients recover from psychotherapy alone, while others need medication, or a combination of these treatments.

## ANXIETY DISORDER DUE TO KNOWN GENERAL MEDICAL CONDITION

These disorders are predominantly characterized by prominent anxiety, panic attacks, or obsessions or compulsions. For this diagnosis to be made, there should be evidence from the history, physical examination or laboratory findings that the symptoms are the direct physiological consequence of a general medical condition (which should be named). These general medical conditions may include, for example, neurologic disorders (e.g., brain trauma, infections, inner ear disorders), cardiovascular disorders (e.g., heart failure, arrhythmias), endocrine disorders (e.g., overactive adrenal or thyroid glands), and respiratory disorders (e.g., asthma). The disturbance must cause clinically significant distress and/or functional impairment to be diagnosed. When the diagnosis of an anxiety disorder due to a general medical condition is made, it should be specified whether it presents with generalized anxiety (i.e. if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation), or with panic attacks (i.e. if panic attacks predominate) or with obsessive-compulsive symptomatology (i.e. if obsessions or compulsions predominate).

## SUBSTANCE INDUCED ANXIETY DISORDER

The essential features of substance-induced anxiety disorder include prominent and persistent feelings of anxiety that are judged to be due to the direct physiological effects of intoxication or withdrawal from a substance (drug) such as marijuana, alcohol, cocaine or some other psychoactive substance(-s). Prominent anxiety, panic Attacks, or obsessions or compulsions predominate in the clinical picture.

## ANXIETY DISORDER NOT OTHERWISE SPECIFIED

Anxiety disorder NOS is diagnosed when there is extreme anxiety and/or debilitating phobic avoidance that does not meet the criteria for any other specific anxiety disorder, adjustment disorder with anxiety, or adjustment disorder with mixed anxiety and depressed mood in the diagnostic manuals.