ABC of mental health

Anxiety

Anthony S Hale

Although there is considerable overlap between the various anxiety disorders, it is important to make a diagnosis as they have different optimal treatments

Anxiety is an unpleasant emotional state characterised by fearfulness and unwanted and distressing physical symptoms. It is a normal and appropriate response to stress but becomes pathological when it is disproportionate to the severity of the stress, continues after the stressor has gone, or occurs in the absence of any external stressor. Neurotic disorders with anxiety as a prominent symptom are common: a recent British survey found that 16% of the population suffered from some form of pathological anxiety.

Anxiety disorders should be differentiated from stress reactions, in which anxiety may be a prominent feature. These include acute stress reactions—a rapid response (in minutes or hours) to sudden stressful life events, leading to anxiety with autonomic arousal and some disorientation—and adjustment reactions—slower responses to life events (such as loss of job, moving house, or divorce) that occur days or weeks later as symptoms of anxiety, irritability, and depression (without biological symptoms). These are generally self limiting and are helped by reassurance, ventilation, and problem solving. A more profound stress reaction, post-traumatic stress disorder, is described below.

Until recently, the commonest response to a presentation of anxiety has been to prescribe a benzodiazepine. This has been much criticised and alternatives have been evaluated, including almost all the available antidepressants and psychological treatments, especially cognitive behaviour therapy. For most general practitioners, constraints on resources are likely to mean that drugs remain the mainstay of treatment.

Prevalence of anxiety disorders in adult population*

Disorder	Percentage of population		
	Female	Male	Total
Generalised anxiety disorder	5	4	5
Phobic disorders	2	1	2
Panic disorder	1	1	1
Obsessive-compulsive disorder	2	1	2
Mixed anxiety and depression	10	5	8

*Data from OPCS 1995 household survey

Classification of anxiety disorders*

F40 Phobic anxiety disorder

- F40.0 Agoraphobia (with or without panic disorder)
- F40.1 Social phobias
- F40.2 Specific (isolated) phobias

F41 Other anxiety disorders

- F41.0 Panic disorder
- F41.1 Generalised anxiety disorder
- F41.2 Mixed anxiety and depressive disorder

F42 Obsessive-compulsive disorder

*ICD-10 (international classification of diseases, 10th edition)

F43 Reaction to severe stress and adjustment disorders

- F43.0 Acute stress reaction
- F43.1 Post-traumatic stress disorder
- F43.2 Adjustment reaction

F44 Dissociative (conversion) disorders

F45 Somatoform disorders

F48 Other neurotic disorders

Includes neurasthenia and depersonalisation or derealisation

Generalised anxiety disorder

This affects 2-5% of the general population, with a slight female preponderance, but accounts for almost 30% of "psychiatric" consultations in general practice. Its onset is usually in early adulthood and its course may be chronic, with a worse prognosis in females. Some genetic predisposition is present, childhood traumas such as separations may confer vulnerability, and it may be triggered and maintained by stressful life events.

This is now regarded as distinct from panic disorder. It is characterised by irrational worries, motor tension, hypervigilance, and somatic symptoms. For most sufferers, it tends to be mild, but in severe cases it may be very disabling.

Diagnosis of generalised anxiety disorder

- Persistent (> 6 months) "free floating" anxiety or apprehension
- Disturbed sleep (early and middle insomnia, not restful)
- Muscle tension, tremor, restlessness
- Autonomic overactivity (sweating, tachycardia, epigastric discomfort)
- May be secondary to other psychiatric disorders such as depression or schizophrenia
- Exclude physical disorders which may mimic anxiety:

Excessive caffeine use	Phaeochromocytoma, carcinoid
Thyrotoxicosis, parathyroid disease	syndrome
Hypoglycaemia	Cardiac dysrhythmias, mitral valve disease
Drug or alcohol withdrawal	

Management

Drug treatment

Drugs have been the mainstay of treatment, but the disorder itself is generally chronic, so the potential for tolerance, dependence, and relapse limits the value of anxiolytics to the short term.

Benzodiazepines show a fast onset of action, but tolerance develops with chronic use, leading to increased dose with acute withdrawal reactions on cessation in 30% of cases and chronic reactions in 10%. Side effects include sedation and amnesia and possibly also anxiety and depression: there is substantial potential for misuse and an interaction with alcohol.

Buspirone—Although dependence has not been seen with buspirone, many patients are dubious about its efficacy, perhaps because of its slow onset of action. For chronic anxiety, this is not such a drawback. A trial of up to eight weeks' treatment with at least 30 mg buspirone daily, after gradually increasing the dose for the first two weeks, is often successful.

Antidepressants—Patients who have previously taken benzodiazepines may miss the sedative and acute anxiolytic effects when switched to buspirone, and in such cases a six to eight week trial of antidepressants might be worth while. Antidepressants can produce an initial exacerbation of anxiety, which may be prevented with a benzodiazepine over the first seven to 10 days with little risk of dependence.

The required duration of drug treatments is uncertain, and a common practice is to treat for a similar duration to that offered in depression—six to nine months in the first instance.

Psychological treatments

These are designed to teach skills in managing the cognitive and somatic components of anxiety and are as effective as drugs but with fewer drawbacks. Specialist psychological treatments may be impractical for most patients in primary care, but brief counselling and structured problem solving techniques are effective and may be delivered in general practice. A good outcome after behaviour therapy is predicted by low initial severity of anxiety, while a perception of the outside world as threatening predicts a good response to cognitive-behaviour therapy.

Agoraphobia (with or without panic disorder)

Agoraphobia tends to start between the ages of 15 and 35 and is twice as common in women as in men. Patients suffer acute anxiety attacks when they are in, or anticipate being in, places where escape might be difficult or help might not be available. They have an intense desire to be somewhere else, and their anxiety may be accompanied by the autonomic symptoms of panic disorder. Anxiety inducing situations are avoided, and just thinking about going into such situations may produce anticipatory anxiety.

Management

The efficacy of behavioural techniques such as exposure therapy is well established, and in the long term these may be more effective than benzodiazepines.

Social phobia

Social phobia is a persistent fear of performing in social situations, especially where strangers are present or where the person fears embarrassment. Patients fear that others will think them stupid, weak, or crazy, and exposure to the feared situation

The efficacy of all treatments for generalised anxiety disorder is best described as modest

Management of generalised anxiety disorder

Drug treatment

- **Benzodiazepines**
Usually short term use (but watch for tolerance or addiction)
Long term use in small subgroup of patients (chronic anxiety and long exposure to benzodiazepines)
- **Antidepressants**
Tricyclics (not addictive but many side effects)
Selective serotonin reuptake inhibitors (may exacerbate anxiety initially)
- **Buspirone** (delayed onset but no dependence)
- **β Blockers** (block peripheral manifestations of anxiety, especially cardiac)

Psychological treatment

- **Reassurance**, especially from general practitioner in person
- **Counselling and problem solving**
- **Psychotherapy**
Cognitive-behaviour therapy
Insight oriented therapy
Anxiety management (relaxation, breathing exercises, distraction)

Some patients—especially those with chronic anxiety, a tendency to self treat with alcohol, and a long history of benzodiazepine use—are difficult to manage except with benzodiazepines. When benzodiazepines are used, those with a slower onset of action (not the same as half life), such as oxazepam, may cause less dependence and withdrawal symptoms than diazepam or lorazepam

Agoraphobia

Diagnosis

- Anxiety in situations where escape is difficult or help unavailable
- Fear of specific situations, such as
Alone at home
Crowds
Public transport
Bridges, lifts
- Active avoidance of feared situation, or exposure leads to severe anxiety
- Limitation of functioning (such as shopping, work, social life)

Management

Drug treatment

- **Benzodiazepines** (short term only)
- **Antidepressants** (longer term, may exacerbate anxiety initially)
Tricyclics
Selective serotonin reuptake inhibitors

Psychological treatment

- **Behaviour therapy** (especially exposure therapy)
- **Group therapy** (including self support groups)

provokes an immediate anxiety attack. Patients recognise that their fear is excessive, but their anxiety and avoidance behaviour may markedly interfere with their daily routine, work, or social life. Blushing is common, and patients may avoid eating, drinking, or writing in public.

There is some genetic predisposition, onset may follow a particular stressful or embarrassing experience or be insidious, and the disorder usually follows a chronic course. Symptoms often start in adolescence or even childhood and may be associated with poor social or academic performance. The incidence of social phobia is about 2%, but lifetime prevalence ranges from 3% to 13%. In some community studies social phobia is more common in women than men, but the sexes are equally represented in clinical samples.

Management

Only phenelzine and moclobemide have well established efficacy in treating social phobia. Moclobemide is probably the drug of choice, but high doses may be required and treatment should continue for a minimum of three months.

Treatments combining imaginary and actual exposure produce modest gains but seem as effective as more complex regimens. Cognitive-behaviour therapy is promising, either alone or in combination with an antidepressant, but seems most effective in the third of cases with circumscribed social phobias.

Specific (isolated) phobias

This is a circumscribed fear of specific objects or situations. Some community samples have shown an annual prevalence as high as 9% in the general population. Most phobias start in childhood, but situational phobias have a second peak of onset among people in their middle 20s. Particular types of phobias seem to aggregate in families, with some evidence of biological predisposition. Other predisposing factors include traumatic events that affected the patient or were observed in others, and repeated warnings from others about situations. Phobias that persist into adult life usually have a chronic course.

Management

Successful treatment is almost exclusively with behaviour therapy. Drugs are of little use.

Panic disorder

Panic may occur as part of several conditions. However, panic disorder is characterised by unpredictable attacks of severe anxiety with pronounced autonomic symptoms not related to any particular situation. Common features are shortness of breath, fear of dying or of going crazy, and an urgent desire to flee regardless of the consequences.

One year prevalence of panic disorder is 1-2%, with a lifetime prevalence of 1.5-3.5%. Onset is commonest in adolescents or in people in their mid-30s, while onset after 45 is rare. The course of the disorder is variable—sometimes chronic but waxing and waning in severity, or, rarely, it may be episodic. There is evidence of genetic transmission, with first degree relatives of patients at four to seven times greater risk than the general population.

Management

Drug treatment

The choice is between a fast acting benzodiazepine (despite concerns about dependence and withdrawal) and antidepressants, which are well tolerated but have a much slower onset of action. Benzodiazepines are rapidly effective, but

Social phobias

Diagnosis

- Extreme, persistent fear of social situations
- Fear of humiliation or embarrassment
- Exposure provokes extreme anxiety
- Fear recognised as excessive or unreasonable
- Avoidance of situations
- Anxious anticipation

Management

Drug treatment

- Moclobemide (drug of choice) or phenelzine for at least 12 weeks
- Selective serotonin reuptake inhibitors yet to be proved
- β Blockers used occasionally

Psychological treatment

- Behaviour therapy
 - Exposure (in imagination or actual)
 - Desensitisation
 - Flooding (extreme form of exposure)
 - Modelling (therapist demonstrates appropriate behaviour)
- Cognitive-behaviour therapy

Specific (isolated) phobias

Diagnosis

- Extreme, persistent, and unreasonable fear
- Cued by appearance or anticipation of specific object or situation
- Specific objects include
 - Animals (spiders, snakes)
 - Natural environment (heights, water, storms)
 - Blood, injections, injury (may provoke particularly strong vasovagal response with fainting)
- Specific situations—Driving, flying, tunnels, lifts, bridges, enclosed spaces
- Avoidance of situation often with secondary fear of the phobia itself (phobophobia)

Management

- Drug treatment—Minimal response to drug treatment alone
- Psychological treatment
 - Behaviour therapy—Exposure, systematic desensitisation, flooding, and modelling (with benzodiazepine treatment if necessary)
 - Psychodynamic psychotherapy

Panic attacks

Characterised by acute development of several of the following, reaching peak severity within 10 minutes:

- Escalating subjective tension
- Chest pain or discomfort, palpitations, "pounding heart," tachycardia
- Sweating, chills, or hot flushes
- Tremor or "shakes"
- Feeling of choking, smothering, or shortness of breath
- Nausea, "butterflies," or abdominal distress
- Dizziness, feeling light headed or faint
- Derealisation, depersonalisation
- Paraesthesias
- Fear of dying, loss of control, or "going crazy"

panic symptoms commonly recur after withdrawal, even with slow tapered discontinuation.

Several older tricyclic antidepressants (such as amitriptyline, clomipramine, and desipramine) and all of the selective serotonin reuptake inhibitors have been found useful in panic disorder at doses similar to those used in depression. Antidepressants often produce an initial increase in anxiety in the first few weeks of treatment before therapeutic benefits appear, leading to poor compliance. This may be overcome by explanation, starting with a low dose with slow increase to therapeutic dose, and coprescription of benzodiazepines for the first one to two weeks.

Monoamine oxidase inhibitors are also effective (for example, phenelzine at doses up to 105 mg/day), and moclobemide may be better tolerated than older drugs. Neither trazodone or buspirone seem to be effective in panic disorder.

Psychological treatment

Cognitive-behaviour therapy and other forms of psychotherapy seem effective against some or all symptoms of panic disorder, with or without exposure treatment. Response to psychotherapy seems to be enhanced by a period of drug treatment to control symptoms. Relaxation therapy also seems to have most benefit when combined with other treatments.

Post-traumatic stress disorder

Anxiety and other symptoms may follow a severe trauma such as an assault or a serious accident. Although formal diagnosis requires an extremely severe stress to occur, similar features are often seen after milder stresses. The relation between the stressor and factors affecting vulnerability, such as personality, is unclear. There is considerable comorbidity with depression and suicide, anxiety states, and other psychosomatic syndromes.

Management

Many treatments have been advocated for post-traumatic stress disorder but with little supporting evidence. Immediate and brief (a few days) treatment with a benzodiazepine may minimise sleep disturbance and mental rehearsal and reduce the chance of chronicity. This should be combined with early debriefing for all concerned. Prolonged symptoms may respond to antidepressants or psychotherapy, or both. One interesting new development for treating flashbacks is eye movement desensitisation and reprocessing (EMDR).

The artwork is by Brad Sherri and reproduced with permission of the Stock Illustration Source.

Anthony S Hale is professor of psychiatry at the University of Sheffield, Sheffield.

The ABC of mental health is edited by Teifion Davies, senior lecturer in community psychiatry, United Medical and Dental Schools, St Thomas's Hospital, London, and honorary consultant psychiatrist, Lambeth Healthcare NHS Trust, and T K J Craig, professor of community psychiatry, United Medical and Dental Schools, St Thomas's Hospital.

Further reading

- Clark DM, Salkovskis PM, Hackmann A, Middleton H, Anastasiades P, Gelder M. A comparison of cognitive therapy, applied relaxation and imipramine in the treatment of panic disorder. *Br J Psychiatry* 1994;164:759-69
- Hunt C, Singh M. Generalized anxiety disorder. *Int Rev Psychiatry* 1991;3:215-30
- Murray M. *Prevention of anxiety and depression in vulnerable groups*. London: Royal College of Psychiatrists, 1995

Panic disorder

Diagnosis

- Recurrent unexpected panic attacks (that is, no specific stimulus)
- Concern about additional attacks (phobophobia)
- Worry about implications of attack (loss of control, "going crazy")
- Change in behaviour related to attacks.

Exclude the following:

- Acute intoxication with or withdrawal from alcohol, caffeine, or illicit drugs (amphetamines, cannabis, cocaine)
- Epilepsy

Management

- Drug treatment
 - Fast acting benzodiazepine (alprazolam) in short term
 - Tricyclic antidepressants (may exacerbate anxiety initially)
 - Selective serotonin reuptake inhibitors (may exacerbate anxiety initially)
- Psychological treatment
 - Cognitive-behaviour therapy
 - Exposure
 - Relaxation is helpful as part of wider treatment plan
- Combination therapy—Ideally, drug treatment should be timed to produce "window" of receptiveness to psychological intervention

Post-traumatic stress disorder

Diagnosis

- Exceptional stressor
- Emotional numbness, detachment initially
- Intrusive flashbacks, vivid memories, recurring dreams
- Distress on re-exposure, leading to avoidance of similar circumstances
- Hypervigilance and hyperarousal
- Psychogenic amnesia, insomnia, irritability, poor concentration, distractible, diminished interests, pessimistic mood

Severity affected by

- Premorbid mental or psychological problems
- Repeated similar stress
- Human agency—More severe if stressor caused by another person

Management

Drug treatment

- Benzodiazepines (immediate, short course)
- Antidepressants
- Specialist treatment include
 - Carbamazepine
 - Clonidine
 - Lithium

Psychological treatment

- Debriefing as soon as possible
- Counselling
- Anxiety management (for non-specific symptoms)
- Cognitive-behaviour therapy (especially where intrusive imagery and avoidance)
- Stress inoculation
- Assertiveness training
- Eye movement desensitisation and reprocessing (EMDR)
- Group psychotherapy
- Psychodynamic approaches not generally helpful except in cases such as sexual abuse