Anxiety Disorders

(Also see specific entries on Obsessive Compulsive Disorder and Post Traumatic Stress Disorder)

Description of the Disability

Anxiety Disorders are a disruption of the brain's threat warning system, making relatively safe and normal situations seem very threatening and dangerous. Although many people have difficulty with anxiety and worry, individuals with anxiety disorders experience these to a degree that seriously interferes with their lives and ability to function. For these individuals, the anxiety and fears are persistent and overwhelming.

The diagnosis of a specific anxiety disorder for a person should be thought of as a general hint about the things that person experiences rather than a definitive prediction. The characteristics and consequences of the different anxiety disorders overlap quite a bit. A person with obsessive-compulsive disorder, for example, may also show features of social phobia disorder at times.

Panic attacks are a significant feature of most anxiety disorders. These attacks are intense and uncomfortable episodes that occur swiftly, usually peaking within 10 minutes of their start. They usually involve a sense of impending doom and of an inability to escape. Other possible symptoms include sweating, racing heart, trembling, shaking, "jelly legs", shortness of breath (hyperventilation), a choking feeling, chest pains, nausea, dizziness, tingling or prickling of the skin, and depersonalization. People who experience panic attacks often say they thought they were having a heart attack, were about to die, or were going crazy. They usually have an intense urge to get away from the situation where the attack is happening. After the attack, the person usually has an intense fear of future ones. For some people, the panic attacks are associated with specific situations, events, or objects. These are called **Situationally Bound Panic Attacks** or **Cued Panic Attacks**.

Following panic attacks, the fear of a recurrence can sometimes cause the anxiety disorder to develop into Agoraphobia – a generalized fear of being away from home alone. Agoraphobia is rooted in the fear that a panic attack may happen where others will see it and embarrass the person. This leads to a pervasive fear of being outside of home alone, including avoidance of crowds, of traveling in cars or airplanes, of using elevators, etc. Alternatively, the person may fear being home alone. However, a central part of agoraphobia is the fear of being alone and without help when the panic attack happens. The individual usually does not have a problem traveling outside if someone is with them.

Researchers do not know what causes anxiety disorders, but it appears to be a combination of genetic predisposition, neurological factors, and environmental factors (experiences). Magnetic imaging suggests that the disorders involve widespread changes in the brain. Research currently points to two parts of the brain in particular as playing important roles in anxiety disorders: the Amygdala and the Hippocampus. The Amygdala acts as a sort of communications hub between the different signal processing centers of the brain and may help identify threats in the environment. The Hippocampus also plays a role in identifying threats and traumatic stimuli, and

Copyright 2001, Curators of the University of Missouri & RCEP7

helps the brain encode memories. It appears to be smaller in people who have experienced severe stress. On the other hand, the often-positive response of anxiety disorders to treatment with drugs targeted at the neurotransmitter Serotonin suggests that neurotransmitter changes are also be involved.

Anxiety disorders often coexist with depression, substance abuse, or eating disorders.

Anxiety disorders can be classified in several ways, but they are usually grouped into six specific disorders:

- **Panic Disorder**
- **Social Phobia (or Social Anxiety Disorder)**
- **Specific Phobias**
- **Generalized Anxiety Disorder**
- **Obsessive-Compulsive Disorder**
- **Post-Traumatic Stress Disorder**

(Note: The DSM IV subdivides Panic Disorder into 1) Panic Disorder With Agoraphobia, 2) Panic Disorder Without Agoraphobia, and 3) Agoraphobia Without Panic Disorder. It also adds Anxiety Due To A Medical Condition, Anxiety Due To Substance Abuse, and Acute Stress Disorder (basically PTSD lasting less than a month). Other sources sometimes combine Social Phobia and Specific Phobias into one item)

Panic Disorder

The central feature of panic disorder is recurrent, unexpected panic attacks. Most individuals with panic disorder have a mixture of situationally cued panic attacks and unpredictable panic attacks. The attacks may show a very regular, consistent frequency – once a week or so, for example – or they may come in cluster patterns, with clusters separated by months or years. Not surprisingly, individuals with panic disorder also report a lot of free floating anxiety about health, the safety of loved ones, etc. Many fixate on the idea that they have an undiagnosed illness, such as heart disease or schizophrenia, which is causing the symptoms of the attacks.

The symptoms may increase during times of stress in personal relationships. More than half of people with panic disorder also experience depression.

Fortunately, panic disorder is one of the most treatable of all the anxiety disorders. Most individuals respond well to medication, targeted psychotherapy, or both.

- 2.4 million adults in the US have panic disorder
- It is diagnosed in women twice as often as in men

Copyright 2001, Curators of the University of Missouri & RCEP7

Social Phobia

People with social phobia have an intense fear of being watched and judged by others or of being embarrassed by their behavior in front of others. The fear comes from intense anxiety or actual panic attacks triggered by social situations or by public speaking/performing. Because of the anxiety or panic attacks, the person dreads being in that situation again and will worry for days or weeks ahead about an upcoming situation. They worry that other people will think they are stupid, "crazy", weak, or anxious. They may worry that others will notice that their hands shake or their voice trembles. They often have hypersensitivity to criticism, low self-esteem, poor eye contact, and difficulty being assertive. Blushing and confusion are common symptoms, in addition to the other possible symptoms of panic attacks (see above). It should be noted that social phobia is much more intense and debilitating than common fears of embarrassment or of public speaking.

There can also be a vicious cycle of intense anxiety in anticipation of the social situation, escalating the anxiety when the moment arrives, leading to poor social performance (or the self-perception of poor performance) and embarrassment. This in turn feeds into the next round of anticipation.

Typically, the person will know their fear is irrational and out of proportion to the real situation, but the anxiety remains. Although both are marked by a fear of the judgment of other people, social phobia is different from agoraphobia in that the presence of another person does not relieve the fear and anxiety.

- 5.3 million adults in the US experience social phobia
- Equal numbers of men and women experience social phobia
- 80% of people with social phobia report that they have the symptoms under control through therapy and/or medical treatment
- Adults with social phobia may wait as long as 10 years before seeking help

Specific Phobias

A person with specific phobias experiences anxiety or panic attacks in response to specific things or places that pose little actual danger. If they experience panic attacks, the attacks are, by definition, situationally cued. In addition, the person will usually show intense avoidance behavior of the thing or place. The fear/anxiety is so intense that often just thinking about the thing or place can trigger it.

The phobia can be linked to a variety of objects, but the most common seem to be certain types of animals, including snakes, spiders, and dogs. Some of the other, more common phobias involve closed-in places, heights, escalators, tunnels, highway driving, water, flying, and injuries involving blood. The phobia usually centers around being hurt, "loosing control", panicking, or

Copyright 2001, Curators of the University of Missouri & RCEP7

passing out. In some cases, the only difference between a diagnosis for social phobia and specific phobia will be the nature of the perceived threat – embarrassment versus physical harm.

It is important to note that these are not just extreme fears; they are irrational, immobilizing fears that significantly impact the person's life. As with other anxiety disorder, the person often knows the fear is irrational. The intensity of the response may vary from time to time, so that someone who is afraid of height may have a panic attack on a particular bridge one time but only experience acute anxiety another time.

Risk factors for phobias include experiencing a traumatic event involving the object, repeated parental warnings about how dangerous the object is, and witnessing others becoming intensely afraid of the object.

- 6.3 million people in the US have specific phobias
- Twice as many women as men have specific phobias

Generalized Anxiety Disorder (GAD)

People with Generalized Anxiety Disorder have their days filled with worry. They are always worrying about disaster, money, health, family, work, being late for appointments, etc. Just the thought of getting through the day can make them nervous.

In some ways, generalized anxiety disorder is like an extended, low-grade panic attack. The person feels that they cannot control the worry, that they worry all the time, and sometimes they don't even know exactly what they are worried about – just a sense of impending disaster. In addition, they may experience fatigue, headaches, muscle tension, abdominal cramps, difficulty swallowing, irritability, sweating, hot flashes, difficulty sleeping, or nausea.

Unlike other anxiety disorders, people with generalized anxiety disorder do not usually associate the fear with any particular place, object, or situation. So they do not show the avoidance behavior seen in other disorders.

- 4 million adults in the US experience generalized anxiety disorder
- Twice as many women as men experience the disorder

Obsessive Compulsive Disorder (brief overview)

(Also see separate entry on Obsessive Compulsive Disorder)

People with Obsessive Compulsive Disorder find themselves caught between intrusive, obsessive thoughts and compulsions to perform repetitive or ritualized actions. The intrusive, repetitive thoughts are often focused on worrying, but can also be disturbingly violent or graphic thoughts. Resisting the thoughts takes an effort and but giving in just increases the person's

Copyright 2001, Curators of the University of Missouri & RCEP7

anxiety. The compulsions can include a variety of activities, often related to the kind of obsessive thoughts the person is experiencing. For example, people obsessing about cleanliness may have hand-washing compulsions; people obsessing about doubts ('Did I turn off the oven?') may have a compulsion of checking. Resisting the compulsions also takes effort. Curiously, giving in to the compulsions also bring relief from the obsessive thoughts, at least while performing the compulsive acts. So the compulsions may be used to control the obsessive thoughts.

Some people are able to control their compulsions to private times, making the disorder invisible to others but still disruptive in the person's life. Panic attacks are not usually part of the disorder.

- 3.3 million adults in the US experience OCD
- An equal number of men and women experience it
- Average age of onset is 20 years

Post-Traumatic Stress Disorder (brief overview)

(Also see separate entry on Post-Traumatic Stress Disorder)

Post Traumatic Stress Disorder is a set of typical symptoms that develop after a person sees, is involved in, or hears of an "extreme traumatic stressor". The person reacts to this experience with panic attacks, persistently reliving the event with accompanying feelings of fear and helplessness. To avoid the panic attacks, the person tries to avoid anything that may remind them of the event, including topics of conversations, particular places or situations, and certain thoughts.

Although most people think of PTSD being caused by a "single blow" event, it can also be caused by long-term exposure to "chronic traumas" such as witnessing childhood abuse, living in a high crime area, experiencing domestic abuse, or living in extreme poverty. Trauma is a subjective experience: events that are traumatic to one person and cause PTSD may not be especially traumatic to others who witness the same event.

- 5.2 million adults in the US experience PTSD
- Twice as many women as men are diagnosed with PTSD
- Among rape victims, 65% of men and 45.9% of women who had been raped develop PTSD

Common Treatments, Medications, and Side Effects

The recommended treatment for anxiety disorders is medication, cognitive-behavioral, or a combination of the two.

Copyright 2001, Curators of the University of Missouri & RCEP7

Medications

Antidepressants seem to be effective in reducing the symptoms of anxiety disorders. They reduce the number of panic attacks and allow individuals to feel a sense of control over their anxieties. Physicians prescribe both SSRIs (Selective Serotonin Reuptake Inhibitors) and Tricyclic antidepressants for treating anxiety disorders (see Drug Entries for side effects).

In addition, there are some specific anti-anxiety drugs available. The most common are the high-potency benzodiazepines, which act quickly and have few side effects. However, individuals can build up tolerance to the drugs and dosages may have to be periodically increased. Alternatively, a newer anti-anxiety drug called Buspirone is sometimes used for Generalized Anxiety Disorder. It is slower acting that the benzodiazepines, but does not show tolerance issues. (See Drug Entries for side effects)

Cognitive-Behavioral Therapy

The most effective psychotherapy for anxiety disorders appears to be some of the Cognitive-Behavioral Therapies (CBT). These approaches focus on helping the person control their reactions to anxiety triggers and stress in general. Even gaining partial control of their own response helps people feel less helpless and fearful about their anxieties. The therapies most useful for anxiety disorders include:

- Cognitive Therapy: Focuses on recognizing and then altering the thoughts that produce and maintain the anxiety. By changing the thoughts, the person can begin to change their response to anxiety and possibly eliminate the anxious response entirely.
- Systematic Desensitization: Focuses on relaxation techniques and their use during gradual exposure to the anxiety-provoking object or situation. The exposure starts with a mildly stressful exposure and gradually moves to more stressful situations.
- Exposure & Response Therapy: Focuses on repeated exposure to the anxiety-provoking object or situation until the person grows accustomed to the anxiety. In contrast to systematic desensitization, this begins with the most stressful exposure possible. In a sense, this approach wears the person down (with their permission) until they get used to the anxiety. There are two versions of exposure and response therapy: Flooding, in which starts with one or two hours of exposure; and Graduated, which lets the person choose the length and frequency of the exposure.
- Modeling Treatment: Focuses on watching someone else model an anxiety-free encounter the object or situation. The person with the anxiety can begin to learn a new set of behaviors and responses to the trigger.
- Breathing Retraining: Focuses on reducing some of the alarming symptoms of panic attacks by controlling the hyperventilation feature of the attacks, often the source of other physical symptoms. The symptoms caused by hyperventilation include chest pains, dizziness, tingling of the mouth and fingers, and fainting. Breathing retraining is typically used in combination with some of the other exposure therapies, and not alone.

Research comparing drug therapy alone to CBT treatment alone suggests that the success rates are similar but the results of psychotherapy tend to last longer after the end of treatment. A

Copyright 2001, Curators of the University of Missouri & RCEP7

combination of the two is especially powerful. Some other types of psychotherapy can also be useful, including group therapy, attention intervention, and emotionally supportive therapy.

Possible Functional Issues

- Unwillingness to be in certain situations
- Difficulty concentrating
- Social withdrawal
- Drowsiness (from lack of sleep)
- Panic attacks
- Irritability
- Agitation

Initial Interview Considerations

Initial Questions

- What are the major symptoms of their anxiety disorder? What happens when they have an attack?
- What places or situations that they need to avoid?
- Are there social situations that they need to avoid? Crowds, for instance? Or being alone?
- How often do episodes happen? Several times a day? Several times a month?
- What helps them recover from the episodes?
- Are they taking any medications? Are there any side effects?
- How often do they use alcohol or drugs, if at all?
- How often do they have difficulty sleeping? How often do they feel sleepy during the day?
- How well do they get along with other people? Do they get into disagreements or fights often?
- What if any coexisting conditions do they have?
- What hobbies do they have?
- What do they do on a typical weekend? (gets at other interests)
- How well are they able to keep to schedules? Some individuals may be obsessed with time, others may find their anxiety delays them.
- How well are they able to drive?
- Do they have any trouble going out in public, either alone or with someone else?

Copyright 2001, Curators of the University of Missouri & RCEP7

It may be helpful to talk to family members, if the individual approves, to ask about social skills, avoidance behaviors, and general comfort level.

Initial Observations

- Do they appear tired?
- Is there any indication they are self medicating?
- Do they appear agitated or jittery?
- Were they on time to the interview? If not, ask why. This may indicate a problem with keeping on schedule.

Possible Accommodations and Assistive Technology

- Flexible work schedule
- Safe haven at work site in case of panic attack
- Removal of any potential triggers from work environment (triggers will vary from person to person)

Career Planning Issues

- Social skills may or may not be an issue
- Much will depend on what kinds of situations the individual has to avoid
- Learning skills should not be affected, so training or higher education may be an option
- Dexterity, mobility, and strength should not be affected
- Cognitive skills should not be affected
- If they prefer to be alone, home-based employment or self-employment may be an option
- Discuss carefully with the client any jobs in which they would have to "meet the public" (receptionist, sales, guide, customer service, etc.) to make sure they are willing to handle the range of encounters that might be involved. This does not mean to avoid such jobs - they may work out very well. But the client should agree to the level of risk, if any.

Emerging Issues

- Treatment options, including exposure therapy and medication

Additional Information Resources

- National Mental Health Association (NMHA): www.nmha.org
- National Institute of Mental Health: www.nimh.nih.gov/anxiety/anxietymenu
- The Anxiety Disorders Association of America: www.adaa.org

Copyright 2001, Curators of the University of Missouri & RCEP7