

ANXIETY SYMPTOMS and ANXIETY DISORDERS

What is anxiety?

Anxiety is part of the normal response to stress and is usually short-lived and controllable. It probably allows someone to respond better to a perceived threat or danger (and is sometimes called the '*fight-or-flight*' response). Anxiety symptoms are important when they are particularly severe, last longer than expected, occur in the absence of stress and impair everyday life. Anxiety symptoms can be physical (or 'somatic') and due to over-arousal (such as shortness of breath, a racing heart and excessive sweating), or psychological, such as feeling frightened, troublesome worrying or being irritable.

Doctors can diagnose anxiety disorders when a patient has had a certain number of symptoms for more than a specified time, providing these symptoms cause much distress and impair everyday life. There are several different anxiety disorders, which share many psychological and physical symptoms but each disorder has its own characteristic features. For example, recurrent unexpected 'panic attacks' occur in panic disorder, whilst recurring troublesome ruminations and repeated checking habits occur in obsessive-compulsive disorder.

Who should be treated, for anxiety?

Many people have anxiety symptoms that are mild, short-lived and linked to stressful events or situations; these will often improve without treatment. But anxiety disorders usually last a long time and reduce everyday function. Most patients with troublesome and long-lasting symptoms are likely to benefit from some form of treatment - whether this is psychological (a 'talking treatment') or pharmacological (a medication). Psychological and pharmacological treatments are similar in how effective they are in reducing the severity of symptoms and in helping people get back to normal function. The current evidence is for careful prescription of a drug treatment known as a 'selective serotonin reuptake inhibitor (SSRI) or for a talking treatment known as cognitive behaviour therapy (CBT), delivered by trained and supervised staff. Choosing which treatment is most appropriate should take account of patient preferences and what services are available locally. Guidelines for the treatment of anxiety

were published by the British Association for Psychopharmacology in 2005¹ (www.bap.org.uk/pdfs/Anxiety_Disorder_Guidelines.pdf) and will be updated in 2011.

Worried about treatment?

Many patients worry about starting a medication or a talking treatment for an anxiety disorder. Some people fear potential problems such as being drowsy and others worry about a risk of becoming dependent on prescribed medication (often erroneously thinking they are “addictive”) or the psychotherapist. Some patients find it hard to commit to talking treatments that can have a limited availability, are difficult to undertake and often quite time-consuming. But all patients should be told that anxiety symptoms can worsen in the early stages of drug or talking treatment and that prolonged efforts are needed to consolidate and maintain a good early response.

Is anxiety linked to depression?

Depressive symptoms - such as feeling low in mood and losing motivation - often develop in individuals with anxiety disorders and about one-third of people with anxiety disorders also fulfil the diagnostic criteria for depression. Treating the depression will usually relieve anxiety symptoms when depression is the primary problem but if depression started after the anxiety disorder, each condition usually needs its own treatment.

Treatment of Generalized Anxiety Disorder (GAD)

GAD is characterised by excessive worrying that is not simply linked to particular circumstances and which has lasted longer than several months. Other common symptoms include feeling tense and having difficulty when concentrating, together with physical symptoms such as dry mouth and excessive perspiration. The most important distinction is with depressive illness, so patients should be asked about symptoms such as reduced interest, loss of weight and suicidal thoughts.

Psychological and pharmacological treatments have similar efficacy. First-line pharmacological treatment usually involves an SSRI, given for at least 12 months. Other medications can also be beneficial but are normally reserved for patients who have not responded to an SSRI. Problem-solving treatment, applied relaxation and anxiety

management training can be helpful, but relapse rates are lower with CBT than with other psychological treatments.

Treatment of Panic Disorder

Panic disorder is characterised by recurrent unexpected 'panic attacks' (spells of severe anxiety, lasting less than 30 minutes) with relative freedom from anxiety between attacks. Many people with panic disorder attend emergency departments, believing they are having a 'heart attack'. Panic disorder can sometimes occur with 'agoraphobia' (anxiety in feared situations from which escape might prove difficult or embarrassing) and this can cause people to become housebound.

Treatment aims to prevent panic attacks, resolve the fear of having an attack and reduce agoraphobia. A panic attack can be shortened by re-breathing exhaled air into and out of a paper bag, over a few minutes, but many people find this very difficult. CBT is the most often used psychological treatment. SSRIs are the usual first-line drug treatment, as they cause less drowsiness than benzodiazepines and will also treat depressive symptoms.

Treatment of Specific (or Simple) Phobia

Specific fears of objects, animals or situations (such as flying in a plane or visiting the dentist) are very common but only a minority of people with specific phobias ask for treatment. Most individuals with these very specific fears will respond fully to a few sessions of psychological treatment, based on gradual exposure techniques. SSRIs are sometimes used in patients who have not responded to exposure therapy.

Treatment of Social Phobia/Social Anxiety Disorder

Social phobia (also known as 'social anxiety disorder') is characterised by intense and long-lasting fears of being scrutinized or evaluated negatively by others, in social or performance situations. Extreme embarrassment (disabling shyness) is the core symptom of social phobia, but people who are just shy generally have minimal anxiety and usually function well at home and work. People with social phobia feel they will behave ridiculously and so be humiliated, which is why they avoid many social situations. Many individuals with social

anxiety drink alcohol excessively, to try to reduce anxiety symptoms before feared social events.

As with GAD and panic disorder, the usual first-line treatment is with an SSRI or with CBT. Other effective medications include other antidepressants, some benzodiazepines and some anticonvulsants. A good response should be followed by at least 12 months of further treatment, to prevent a relapse of symptoms. GPs often prescribe 'beta-blockers' to reduce physical symptoms of anxiety, but these do not work in generalised social phobia.

Treatment of Post-Traumatic Stress Disorder (PTSD)

Most people experience unpleasant and potentially life-threatening traumatic events but only some will develop 'post-traumatic' psychological symptoms. The diagnosis of PTSD rests on the history of trauma and its response of intense fear, helplessness or horror, together with other symptoms such as 'flashbacks', nightmares and hyper-arousal.

It should in theory be possible to prevent the emergence of distressing symptoms in people after major trauma. But at present there is no clear evidence that medication can do this and routine prescription of benzodiazepines or 'debriefing' may be counter-productive. In established PTSD, some SSRIs and other antidepressants can be beneficial, as can trauma-focused CBT. Patients who respond to medication should continue with it for at least 12 months to reduce the risk of symptoms returning.

Obsessive-Compulsive Disorder (OCD)

OCD usually starts early in life and tends to run a chronic course, fluctuating in severity, over many years. The theme of obsessional thoughts varies relatively little between countries and cultures, and often centres on fears of contamination, of being indiscreet or the need for 'everything to be in the right place'. Some people with OCD are seen in hospital settings; for example, unfounded concerns about HIV infection can cause repeated attendance at genitourinary clinics and ruminations about imagined faults in appearance can lead to frustrating encounters with cosmetic surgeons.

The antidepressant clomipramine or an SSRI can be beneficial, as can CBT or ‘behaviour therapy’ based on gradual exposure techniques. Combining medication with behaviour therapy may be a little better than either treatment given alone. Medication should continue for at least 12 months in patients who have improved after initial treatment. Some antipsychotic drugs (more commonly used in patients with schizophrenia) can boost the response, when patients have not benefited fully from an SSRI.

Key points

1	Anxiety disorders are common, often chronic, and life-impairing medical conditions
2	Anxiety disorders often come before the later development of depression
3	Asking direct questions about characteristic symptoms can help doctors recognise symptoms and make an accurate diagnosis
4	Evidence-based guidelines for treatment of patients with anxiety symptoms and anxiety disorders are available – put link here
5	SSRIs and CBT are similar in terms of reducing symptoms in acute treatment
6	Medication treatment should be continued for at least 12 months, after a patient has made a good initial response
7	Antipsychotic drugs can boost the response to SSRI treatment in patients with OCD
8	Benzodiazepines should be reserved for people with severe and long-lasting anxiety symptoms, who have not responded to other treatments

¹ Baldwin DS *et al* (2005) Evidence-based guidelines for the pharmacological treatment of anxiety disorders: recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology* 19: 567-596