Anxiety Disorders: An Overview

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Anxiety is a term used to describe uncomfortable feelings of nervousness, worry, and tension**.** It affects our thoughts, physical reactions, moods and behaviours.[1] Fear and anxiety in appropriate situations are adaptive and helpful emotions that help keep us safe, avoid threat and danger and adapt to the environment. Problems arise when people's anxiety is out of proportion to the danger of the situation, or when there is no actual danger present. When anxiety becomes excessive or debilitating, it is considered an anxiety disorder. [2]

The term "anxiety disorder" refers to specific psychiatric disorders that involve extreme fear or worry, and includes generalised anxiety disorders (GAD), panic disorders and panic attacks, agoraphobia, social anxiety disorder, selective mutism, separation anxiety, and specific phobias. Some symptoms overlap across many of these disorders, and others are more specific to a single disorder. In general, however, all anxiety-related disorders feature worry, nervousness, or fear that is ongoing, and excessive to the extent that it causes an individual significant distress, or impairs their ability to function in important facets of life such as work, school, or relationships. [4] Obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) are closely related to anxiety disorders, however are no longer classed as anxiety disorders in the DSM-5. [6]

Anxiety disorders are the most prevalent psychiatric disorders and associated with a high burden of illness.[3] Along with depression, anxiety disorders are the most common mental health problem affecting the population of Ireland and Europe.[2] They account for a similar level of stress and disability within society as cancer or heart disease. The most common are specific phobias, which affect nearly 12%, and social anxiety disorder, which affects 10%. Phobias mainly affect people between the ages of 15 and 35, and become less common after age 55. Rates appear to be higher in the United States and Europe.[5]

According to the World Health Organization (WHO), 1 in 13 individuals globally have anxiety. There are no accurate figures detailing the prevalence of anxiety disorders in Ireland, however it is estimated that one in nine individuals will experience a primary anxiety disorder over their lifetime.[2] It is also likely that individuals do not seek help for significant levels of anxiety, and many remain without diagnosis or treatment. The WHO reports that anxiety disorders are the most common mental disorders worldwide with specific phobia, major depressive disorder and social phobia being the most common. About 12% of people are affected by an anxiety disorder in a given year, and between 5% and 30% are affected over a lifetime. Women are 1.5 to two times more likely than men to receive a diagnosis of anxiety disorder and generally begin before age 25 years.[3]

Anxiety disorders can affect anyone and are not age-specific. The age of onset is quite variable, ranging from childhood and adolescence to adulthood. Frequently, anxiety disorders are associated with other anxiety disorders, for example agoraphobia combined with panic disorder. There is also the association between anxiety disorders and other disorders, such as

depression, substance abuse and alcohol misuse.[2] There are many potential risk factors for anxiety disorders, and most people experience different combinations of risk factors, such as genetic markers, neurobiological, neuropsychological, environmental factors and life experiences. However, no single risk factor is definitive - many people may have a risk factor for a disorder, and never develop that disorder. [3, 4]

Genetic risk factors have been well documented for all anxiety disorders. Clinical studies indicate that heritability estimates for anxiety disorders range from 30-67%. Anxiety and depression can also be caused by alcohol abuse, which in most cases improves with prolonged abstinence. Even moderate, sustained alcohol use may increase anxiety levels in some individuals. Caffeine, alcohol, and benzodiazepine dependence can worsen or cause anxiety and panic attacks. Cannabis use is associated with anxiety disorders, however, the precise relationship between cannabis use and anxiety still needs to be established. Occasionally, an anxiety disorder may be a side-effect of an underlying endocrine disorder that causes nervous system hyperactivity, such as pheochromocytoma or hyperthyroidism. [1, 4]

Anxiety disorders increase one's chances of being affected by other medical illnesses, such as cardiovascular disorders, obesity, heart disease and diabetes. More specifically, increased body weight, abdominal fat, high blood pressure, and increased levels of cholesterol, triglycerides and glucose have all been linked to anxiety. While it is still unclear what causes the high co-morbidity between anxiety and poor physical health outcomes, research suggests that changes in underlying biology characteristic of anxiety may also facilitate the emergence for physical health outcomes over time. For example, changes in stress hormones, autonomic responses and heightened systemic inflammation are all associated with anxiety disorders and negative health outcomes. These shared physiological states suggest a shared underlying biology and that anxiety may be a whole-body condition. [5]

Generalized anxiety disorder (GAD)

Generalized anxiety disorder (GAD) is a common disorder, characterized by long-lasting anxiety which is not focused on any one object or situation. It is the most common anxiety disorder to affect older adults. Those affected by GAD experience non-specific persistent fear and worry, and become overly concerned with everyday matters. Generalized anxiety disorder is characterized by chronic excessive worry accompanied by three or more of the following symptoms: restlessness, fatigue, lack of concentration, irritability, muscle tension, and sleep disturbance. A diagnosis of GAD is made when a person has been excessively worried about an everyday problem for six months or more. A person may find that they have problems making daily decisions and remembering commitments as a result of lack of concentration or preoccupation with worry. Before a diagnosis of anxiety disorder is made, drug-induced anxiety and other medical causes must be ruled out. In children GAD may be associated with headaches, restlessness, abdominal pain, and heart palpitations. Typically it begins around 8 to 9 years of age. [4, 6]

Specific Phobia

Specific phobias affects up to 12% of people at some point in their life. A specific phobia is an unreasonable or irrational fear related to exposure to specific objects or situations. As a result, the affected person tends to avoid contact with objects or situations, and in severe cases any mention or depiction of them. The fear or anxiety may be triggered both by the presence or anticipation of the specific object or situation. The person logically knows that the fear is unreasonable but still find it difficult to control the anxiety which in some cases can result in a panic attack. [7]

Panic disorder

Panic disorder affects about 2.5% of people at some point in their life. It usually begins during adolescence or early adulthood but any age can be affected. Women are more often affected than men and it is less common in children and older people. [5] Panic disorder is an anxiety disorder characterized by reoccurring unexpected panic attacks; sudden periods of intense fear that may include palpitations, sweating, shaking, shortness of breath, numbness, or a feeling that something terrible is going to happen.

The cause of panic disorder is unknown and often runs in families. Risk factors include smoking, psychological stress and a history of child abuse. Diagnosis involves ruling out other potential causes of anxiety including other mental disorders, medical conditions such as heart disease or hyperthyroidism, and drug use. [8]

Panic disorder is usually treated with counselling and medications. Cognitive behavioural therapy (CBT) is especially useful as a first-line treatment for panic disorder and is effective in more than half of cases. Medications used include antidepressants, SSRIs and SNRIs and occasionally benzodiazepines or beta blockers. [8]

Agoraphobia

DSM-5 classifies agoraphobia as a phobia along with specific and social phobia. It is an anxiety disorder characterized by symptoms of anxiety in situations where the person perceives their environment to be unsafe with no easy way to escape.

Situations include open spaces, public transport, shopping centers, or anywhere outside their home. Being in these situations may result in the person experiencing a panic attack. Symptoms occur nearly every time the situation is encountered. In severe cases people may become completely unable to leave their home. [5, 9] Agoraphobia is thought to be due to a combination of genetic and environmental factors. The condition often runs in families, and stressful or traumatic events may be a trigger. It is uncommon for agoraphobia to resolve without treatment. Treatment is usually with cognitive behavioural therapy (CBT) which is effective for about half of cases treated. Agoraphobia affects about 1.7% of adults. The condition which is rare in children often begins in early adulthood and becomes less common in old age. Women are affected twice as often as men. [9]

Social anxiety disorder

Social anxiety disorder (SAD) is also known as social phobia. It can be defined as the persistent fear of one or more social or performance situations in which one is exposed to unfamiliar people or to possible scrutiny by others, and where exposure to such situations provokes intense anxiety. It affects approximately 13.7% of Irish adults at any one time, which is 1 in 8 people. [10]

Symptoms often include excessive blushing, sweating, trembling, palpitations, and nausea. Stammering and rapid speech may be present and panic attacks can also occur under intense fear and discomfort. Individuals who experience social anxiety typically have a stronger than usual desire to make a good social impression. They often believe that other people think poorly of them, and are judging them in a critical fashion or that they are behaving in ways that others find unacceptable. This leads to intense feelings of shame, self-consciousness and embarrassment and the urge is to hide or escape the social situation. [10]

Individuals with social anxiety tend to either avoid or endure severe anxiety with these much-feared situations. Because the anxiety is so intense and distressing, it is much easier just to stay away from social situations and avoid other people altogether. Individuals can isolate themselves to such an extent that they give up work and remain at home. [10]

The first line of treatment for social anxiety disorder is cognitive behavioural therapy (CBT). Medications such as SSRIs are effective for social phobia especially paroxetine. Other commonly used medications include beta blockers and benzodiazepines. CBT is effective in treating the disorder and can be delivered individually or in a group setting. The cognitive and behavioural components seek to change thought patterns and physical reactions to anxiety-inducing situations. [11]

Separation anxiety disorder (**SAD**)

The American Psychiatric Association (APA), describes separation anxiety disorder as an excessive display of fear and distress when faced with situations of separation from the home or from a specific attachment figure. The anxiety expressed is atypical of the expected developmental level and age and the severity of the symptoms ranges from uneasiness to full-blown anxiety about separation. [6] It is most common in infants and small children, typically between the ages of six to seven months to three years, although it may manifest itself in older children, adolescents and adults. Separation anxiety is a natural part of the developmental process but unlike SAD, which causes significant negative effects within areas of social and emotional functioning, family life, and physical health, normal separation anxiety indicates healthy advancements in a child's cognitive maturation and should not be considered a developing behavioural problem. [12] The duration of the condition must persist for at least four weeks and present itself before a child is eighteen years of age to be diagnosed as separation anxiety disorder in children. It can also be diagnosed in adults with a duration typically lasting six months as specified by the DSM-5. [6]

Non-medication based treatments are the first choice when treating individuals diagnosed with separation anxiety disorder. Cognitive behavioural therapy is very effective in mild to moderate cases, however, in more severe cases medication may be indicated.

Situational anxiety

Situational anxiety is very common and caused by new situations or changing events. Often, an individual will experience panic attacks or extreme anxiety in specific situations. Situations that causes one individual to experience anxiety may not affect another individual. [4,5]

Selective mutism (**SM**)

Children and adults with selective mutism are fully capable of speech and understanding language but are physically unable to speak in certain situations. Selective mutism usually co-exists with shyness or social anxiety. A child with selective mutism may be completely silent at school for years but speak quite freely or even excessively at home. [13] DSM-5 defines selective mutism by the following criteria; Consistent failure to speak in specific social situations despite speaking in others: The disturbance interferes with educational or occupational achievement or with social communication: The duration of the disturbance is at least 1 month (not limited to the first month of school): The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation: The disturbance is not better accounted for by a communication disorder and does not occur exclusively in people with autism spectrum disorders, or psychotic disorders such as schizophrenia. [6]

Selective mutism does not necessarily improve with age. Effective treatment is necessary for a child to develop properly and if not addressed it tends to be self-reinforcing and can contribute to chronic depression, further anxiety, and other social and emotional problems. The exact treatment depends on the person's age, any comorbid mental illnesses, and a number of other factors. Stimulus fading is typically used with younger children because older children and teenagers recognise the situation as an attempt to make them speak, and older people with this condition and people with depression are more likely to need medication. [13]

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) once considered an anxiety disorder is now classed as a *trauma- and stressor-related disorders* in DSM-5. PTSD can result from an extreme situation or a serious accident. It can also result from long-term (chronic) exposure to a severe stressor. Common symptoms include hypervigilance, flashbacks, avoidant behaviours, anxiety, anger, sleep disturbance and depression. There are a number of treatments that form the basis of the care for those affected with PTSD, including CBT, psychotherapy and support from family and friends. [3, 6]

Obsessive–compulsive disorder

Obsessive-compulsive disorder (OCD) is no longer classified as an anxiety disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). It has become a flagship disorder of the new category of *Obsessive Compulsive and Related Disorders*

(OCRDs) – a group of five disorders linked together by the core symptom of repetitive thoughts and behaviours and phenomenological and neurobiological similarity to OCD. Body dysmorphic disorder, hoarding disorder, trichotillomania, and skin picking disorder are the other disorders included in this group. In the eleventh edition of the International Classification of Diseases (ICD)-11, which is due to come into effect in 2022, the World Health Organization (WHO) is planning to introduce similar changes to its own classification of OCD, further recommending the inclusion of olfactory reference disorder and hypochondriasis, in addition to the disorders listed in the DSM-5. [14]

OCD is a condition where the person has obsessions (distressing, persistent, and intrusive thoughts or images) and compulsions (urges to repeatedly perform specific acts or rituals), that are not caused by drugs or other medical conditions, and which cause distress or social dysfunction. The compulsive rituals are followed to relieve the anxiety. It affects approximately 2–3% of the general population and is present in all cultures worldwide. The disorder typically begins early in life, affects males and females equally, and has a bimodal age of onset with peaks in early childhood and young adulthood. [5, 6, 14]

People with OCD know that their symptoms are unreasonable and struggle against both the thoughts and the behaviour. It is not known exactly why some people have OCD, but behavioural, cognitive, genetic, and neurobiological factors are thought to be involved. Risk factors include family history, being single, and higher socioeconomic class or not being in paid employment. Treatment involves counselling, such as CBT, and sometimes antidepressants such as selective serotonin reuptake inhibitors (SSRIs) or clomipramine. Approximately 20% of people with OCD will overcome it, and symptoms will reduce over time for a further 50%. [14]

The prevalence of mental health difficulties in Ireland

Ireland has one of the highest rates of mental health illness in Europe costing the Irish economy over € 8.2 billion a year. The Healthy Ireland framework reports the economic cost of mental health problems in Ireland as €11 billion per year, much of which is related to loss of productivity. Youth mental health service 'Jigsaw' who run counselling services for people aged between 12 and 25 years, reports an increase in the number of young people presenting with anxiety. Problems with anxiety are the most common mental health difficulty among young people who used the organisation's services. The charity says problems with relationships, family breakdowns, bullying and exam stress are common factors behind the mental health problems young people are presenting with and high expectations of self are one key driver of anxiety which can be compounded by the expectations of parents, teachers and society at large. [15]

The prevalence of mental health difficulties in Ireland is significant. The 2016 census data showed that the percentage of people with a psychological or emotional condition increased by almost 30%, between 2011 and 2016. The Healthy Ireland survey reports that almost 10% of the Irish population over age 15 has a 'probable mental health problem' (PMHP) at any one time. The situation is more severe for children and young people, with almost 20% of young people aged 19-24 years having had a mental health disorder and 15% of children aged 11-13 years also having experienced a mental health disorder. [16]

Despite growing demand for mental health supports at all levels of the system, services continue to struggle to operate within existing resources. At the beginning of 2018 there were almost 8,000 people on the waiting list for primary care psychology, of which almost 30% were waiting more than 12 months to be seen. [16] More than 7,000 children with mental health concerns were on waiting lists for community and psychology supports in 2019 and in addition, some 2,250 children are waiting for specialist mental health treatment. The lack of availability of direct mental health services for adults and children has far reaching consequences across all domains of society. [16, 17]

The high burden of disease attributed to mental health difficulties highlights the need for adequate investment in mental health. Without investment and major change the level of care provided to vulnerable and distressed individuals will continue to be unsafe and substandard. It is imperative that mental health is afforded financial parity in the wider health budget to reflect its significance in contributing to the burden of disease. Investment must include resourcing services at all levels of the system, from prevention to community supports to primary care and through to specialist mental health services.

References:

1. CPI (2018) Anxiety Disorders. College of Psychiatrists of Ireland. Available online at https://www.irishpsychiatry.ie/external-affairs-policy/public-information/mental-health-problems/what-is-an-anxiety-disorder/

2. St Patricks Mental Health Service (2019). Anxiety. Available online at https://www.stpatricks.ie/mental-health/anxiety

3. Bandelow B, Michaelis S, Wedekind D. Treatment of anxiety disorders. *Dialogues Clin Neurosci*. 2017; 19(2):93–107. Available online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5573566/

4. ADAA (2019). Understanding the Facts: Anxiety and Depression. Anxiety and Depression Association of America. Available online at https://adaa.org/understanding-anxiety

5. *Craske, MG; Stein, MB (24 June 2016). "Anxiety". Lancet. 388 (10063): 3048–3059. doi:10.1016/S0140-6736(16)30381-6. PMID 27349358.*

6. *American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders, fifth edition. Arlington, VA: American Psychiatric Association. ISBN 978-0890425558.*

7. WebMD (2013). Specific Phobias. Available online at http://www.webmd.com/anxiety-panic/specific-phobias

8. NIMH (2016). Panic Disorder: When Fear Overwhelms. National Institute of Mental Health. NIH Publication No. 19-MH-8077. Available online at https://www.nimh.nih.gov/health/publications/panic-disorder-when-fear-overwhelms/index.shtml

9. Mayo Clinic (2019). Agoraphobia. Available online at https://www.mayoclinic.org/diseases-conditions/agoraphobia/diagnosis-treatment/drc-20355993

10. Social Anxiety Ireland (2019). Social Anxiety. Available online at http://socialanxietyireland.com/social-anxiety/social-anxiety-ireland/

11. *Blanco, C.; Bragdon, L. B.; Schneier, F. R.; Liebowitz, M. R. (2012). "The evidence-based pharmacotherapy of social anxiety disorder". The International Journal of Neuropsychopharmacology.* ***16*** *(1): 235–249. doi:10.1017/S1461145712000119. PMID 22436306*

12. Dryden-Edwards, R., MD. (2014). Separation Anxiety Disorder (M. C. Stoppler, MD, Ed.). Available online at http://www.medicinenet.com/separation_anxiety/article.htm

13. *Viana, A. G.; Beidel, D. C.; Rabian, B. (2009). "Selective mutism: A review and integration of the last 15 years". Clinical Psychology Review.* ***29*** *(1): 57–67.*

14. Krzanowska, E., Kuleta, M. (2017). From anxiety to compulsivity – a review of changes to OCD classification in DSM-5 and ICD-11. Archives of Psychiatry and Psychotherapy, 2017; 3: 7–15.

15. The Irish Times (Aug 7, 2018). Rise in reported anxiety levels among young people, figures show. Available online at https://www.irishtimes.com/news/social-affairs/rise-in-reported-anxiety-levels-among-young-people-figures-show-1.3588823

16. Mental Health Reform (2018). Promoting improved mental health services. Available online at https://www.mentalhealthreform.ie/wp-content/uploads/2018/08/Mental-Health-Reform-Pre-Budget-2019-Submission.pdf

17. Children's Rights Alliance (2019). Report Card 2019. Available at https://www.childrensrights.ie/content/report-card-2019