ANXIETY DISORDERS: AN INTEGRATIVE APPROACH

COURSE DESCRIPTION

Anxiety disorders are the third most commonly occurring mental disorders, manifested by disturbances of mood, thinking, behavior, and physiological activity. The five major types of anxiety disorders include generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), social phobia disorder (or social anxiety disorder), and panic disorder.

The goal/outcome of this course is for the learner to provide an overview of the types of anxiety disorders, describe conventional treatment modalities, and examine integrative treatment approaches.

LEARNING COURSE OBJECTIVES

Upon completion of this course, you will be able to do the following:

1. Describe the extent of anxiety disorders in the United States.
2. Explain the pathophysiology of anxiety.
3. Describe the characteristics of generalized anxiety disorder.
4. Describe the characteristics of obsessive-compulsive disorder.
5. Describe the characteristics of panic disorder.
6. Describe the characteristics of post-traumatic stress disorder.
7. Describe the characteristics of social phobia disorder.
8. Explain the importance of the differential diagnosis process for anxiety disorders.
9. Compare the types of conventional treatment approaches for anxiety disorders.
10. Explain the types of integrative treatment approaches to anxiety.
INTRODUCTION

Anxiety can be a normal response to stress, but it can become a pathologic disorder when it is excessive and uncontrollable, requires no specific external stimulus to elicit, and manifests in a wide range of physical and psychological symptoms as well as changes in behavior and cognition. Anxiety is considered a normal response to stimuli when it helps the individual, for example, deal with a tense situation in the office, study harder for an exam, or stay focused on an important speech. In general, anxiety can help one cope with a stressful situation, but when it becomes an excessive, irrational dread of everyday situations, it becomes a disabling disorder (National Institutes of Mental Health [NIMH], 2014).

Anxiety disorders are serious medical conditions that affect approximately 19 million American adults. Anxiety disorders cause overwhelming, even debilitating worry, apprehension, and fear. If left untreated, these disorders can become life threatening (NIMH, 2014).

Anxiety disorders are the third most common mental disorder, behind depression and substance abuse. Almost one-third of the total mental health care costs in the United States are spent on treatments for individuals with anxiety disorders (Lake, 2007).

Anxiety disorders appear to be caused by an interaction between biopsychosocial factors, including genetic vulnerability. These factors cause a response to situations, stressors, or traumas and produce clinically significant anxiety syndromes. Genetic factors significantly influence the risk for many anxiety disorders. Environmental factors, such as early childhood trauma, can also contribute to the risk for anxiety disorders that develop later in life (Medscape, 2011).

PATHOPHYSIOLOGY

The etiology of anxiety is multi-factorial and includes the interaction of neurobiological, physiological, and environmental factors.

Neurobiological Factors

While definitive pathophysiologic mechanisms have not yet been identified, anxiety symptoms and the resulting disorders are believed to be due to a disruption in the
modulation of central nervous system neurotransmitters. Physical and emotional symptoms of this disrupted modulation result from various degrees of heightened sympathetic arousal (Domschke & Zwanzger, 2008; Medscape, 2011; Rowney, Hermida, & Malone, 2011).

Several neurotransmitter systems have been implicated in this disruption. In the central nervous system (CNS), the major mediators of the symptoms of anxiety disorders appear to be norepinephrine, serotonin, gamma-aminobutyric acid (GABA), dopamine, corticotrophin-releasing hormone (CRH), and cholecystokinin (CCK):

- **Norepinephrine** is both a hormone and neurotransmitter, secreted by the adrenal medulla and the nerve endings of the sympathetic nervous system to cause vasoconstriction and increases in heart rate, blood pressure, and the sugar level of the blood.
- **Serotonin** is an inhibitory neurotransmitter that quiets the body’s stress response.
- **Gamma-aminobutyric acid (GABA)** is the brain's calming chemical. It reduces stress and anxiety and increases mental focus. GABA is usually deficient in individuals with anxiety disorder.
- **Dopamine** increases the body’s stress response, heart rate, and blood pressure.
- **Corticotrophin-releasing hormone (CRH)** increases anxiety and depression symptoms.
- **Cholecystokinin (CCK)** increases anxiety and panic-like symptoms.

There is a delicate balance between these neurotransmitters; a change in one invariably elicits a change in another, including their extensive feedback mechanisms (Domschke & Zwanzger, 2008; Medscape, 2011; Rowney, Hermida, & Malone, 2011).

Corticosteroid regulation is also related to symptoms of fear and anxiety. Corticosteroids (produced by the adrenal cortex located outer portion of the adrenal glands) are involved in the stress response as well as the immune response, the regulation of inflammation, carbohydrate metabolism, protein catabolism, electrolyte levels, and
behavior. Corticosteroids play a role in increasing or decreasing the activity of certain neural pathways, affecting not only behavior under stress but also the brain's processing of fear-inducing stimuli (Lydiard, 2003; Nemeroff, 2003; Rowney, Hermida, & Malone, 2011).

Research also suggests that deficiencies of amino acids may contribute to anxiety symptoms. Amino acids are the smallest units of protein and the precursors of brain neurotransmitters (NIMH, 2014).

**Physiological Factors**

Research has shown that individuals suffering from anxiety are generally more sensitive to physiologic changes in their bodies than non-anxious individuals, and panic disorder sufferers are even more sensitive to these changes than individuals with generalized anxiety disorders. This heightened sensitivity leads to diminished autonomic flexibility, which may be the result of faulty central information processing in anxiety-prone persons. Genetic factors, such as a familial history of anxiety disorders, also significantly influence the risk for many anxiety disorders (Rowney, Hermida, & Malone, 2011).

**Environmental Factors**

Environmental stressors (e.g., stress, abuse, a chaotic home life) clearly play a role in the development of anxiety disorders or the elicitation of anxiety symptoms to varying degrees. All of the disorders are affected in some way by external stimuli and how they are processed (NIMH, 2014).

**TYPES OF ANXIETY DISORDERS**

There are five major types of anxiety disorders (NIMH, 2014):

- Generalized anxiety disorder (GAD)
- Obsessive-compulsive disorder (OCD)
- Panic disorder
- Post-traumatic stress disorder (PTSD)
- Social phobia disorder (also called social anxiety disorder)

**Generalized Anxiety Disorder (GAD)**

Generalized anxiety disorder (GAD) affects about 6.8 million American adults and is twice as common in women as in men. The disorder develops gradually and can begin at any point in the life cycle, although the years of highest risk are between childhood and middle age. There is evidence that genes play a modest role in the development of GAD (Anxiety Disorders Association of America [ADAA], 2014; NIMH, 2014).
GAD is characterized by the following (Lake, 2007; Mental Health America [MHA], 2014; NIMH, 2014):

- Chronic anxiety
- Exaggerated worry and tension, even when there is little or nothing to provoke the anxiety and worry
- Anticipation of disaster
- Excessive concern about health issues, money, family problems, or difficulties at work
- Difficulty relaxing
- Startling easily
- Difficulty concentrating
- Trouble falling asleep
- Trouble staying asleep

Sometimes just the thought of making it through the day produces anxiety in the person.

When the anxiety level is mild, people with GAD can function socially and effectively hold down a job. Although people don’t usually avoid certain situations as a result of their disorder, people with severe GAD can have difficulty carrying out the simplest daily activities (ADAA, 2014).

GAD rarely occurs alone and the individual suffering from GAD may have additional co-morbidities such as other anxiety disorders, depression, or substance abuse issues. GAD is commonly treated with medication or cognitive-behavioral therapy, but co-morbid conditions must also be treated using the appropriate therapies.
**Symptoms**

Symptoms of generalized anxiety vary widely, especially among individuals from different cultural and socioeconomic backgrounds. The individual with GAD typically experiences a changing pattern of core symptoms over time, including the following (Lake, 2007; NIMH, 2014):

- Depressed mood
- Obsessions
- Sleep disturbances
- Panic attacks

Physical symptoms that often accompany the anxiety include the following (Lake, 2007; NIMH, 2014):

- Fatigue
- Headaches
- Muscle tension
- Muscle aches
- Difficulty swallowing
- Trembling
- Twitching
- Irritability
- Sweating
- Nausea
- Lightheadedness
- A desire to go to the bathroom frequently
- Feeling out of breath
- Hot flashes

Diagnostic criteria for GAD also include excessive or unrealistic worry about a variety of events or activities. Individuals with GAD have trouble ridding themselves of their concerns and worries, even though they often realize that their anxiety is more intense than the situation warrants (American Psychiatric Association [APA], 2013).

The anxiety and worry of GAD are associated with at least three of the following six symptoms during the previous 6 months (APA, 2013):

- Restlessness or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or a feeling of the “mind going blank”
- Irritability
- Muscle tension
- Sleep disturbances
Obsessive-compulsive disorder (OCD) affects about 2.2 million American adults, and it can be accompanied by eating disorders, other anxiety disorders, or depression. It strikes men and women in roughly equal numbers and usually appears in childhood, adolescence, or early adulthood. One-third of adults with OCD develop symptoms as children, and research indicates that OCD might have a familial component (NIMH, 2014).

The causes of OCD are not known but genetic factors, infections, stress, difficult or challenging interpersonal relationships, and neurological conditions have been shown to be relevant. Brain imaging studies using positron emission tomography (PET) have compared people with and without OCD; those with OCD demonstrate patterns of brain activity that differ from people with other mental illnesses or people with no mental illness at all (Medscape, 2011).

OCD is an anxiety disorder characterized by intrusive, irrational, unreasonable thoughts and fears (obsessions) that lead a person to do repetitive, ritualized behaviors (compulsions). With obsessive-compulsive disorder, individuals may realize that their obsessions aren’t reasonable, and they may try to ignore or stop them, but that only increases the distress and anxiety they experience. The obsessions typically intrude when the individual tries to think of or do other things. Ultimately, the individual feels driven to perform compulsive acts in an effort to ease his or her stressful, anxious feelings (Lake, 2007; Mayo Clinic, 2013; NIMH, 2014).

People with OCD may be preoccupied with order and symmetry, have difficulty throwing things away (so they accumulate items), or hoard unneeded items. Obsessive-compulsive disorders often center around themes, such as a fear of being contaminated by germs. To ease contamination fears, for example, individuals may compulsively wash their hands until they hurt and become chapped (Lake, 2007; Mayo Clinic, 2013; NIMH, 2014).

Common obsessions include persistent concerns about germs, frequent thoughts of violence and harming loved ones, persistent thinking about performing sexual acts the person dislikes, or having thoughts that are prohibited by religious beliefs. Even with
effort, thoughts of obsessive-compulsive behavior keep coming back, leading to more ritualistic behavior and a vicious cycle characteristic of obsessive-compulsive disorder (Lake, 2007; Mayo Clinic, 2013; NIMH, 2014).

Healthy people also have rituals, such as checking to see if the stove is off a couple of times before leaving the house. The difference is that people with OCD perform their rituals (such as repeatedly checking things, touching things in a particular sequence, or counting things) even though doing so interferes with daily life and they find the repetition distressing. Performing these rituals provides only temporary relief, and not performing them increases anxiety. Although most adults with OCD recognize that what they are doing is senseless, some adults and most children may not realize that their behavior is out of the ordinary (MHA, 2014).

OCD usually responds well to treatment with certain medications and/or exposure-based psychotherapy, in which people face situations that cause fear or anxiety and become less sensitive (desensitized) to them. The National Institutes of Mental Health (NIMH) is supporting research into new treatment approaches for people whose OCD does not respond well to the usual therapies. These approaches include combination and augmentation (add-on) treatments, as well as modern techniques such as deep brain stimulation (NIMH, 2014).

**Symptoms**

The course of OCD is often quite varied. Symptoms may come and go, ease over time, or get worse. If OCD becomes severe, it can keep a person from working or carrying out normal responsibilities at home. People with OCD may try to help themselves by avoiding situations that trigger their obsessions, or they may use alcohol or drugs to calm themselves. The diagnostic criteria for OCD include the following (APA, 2013):

**Obsessions**

- The individual experiences recurrent and persistent thoughts, impulses, or images as intrusive and inappropriate, causing anxiety or distress.
- The thoughts, impulses, or images are more than excessive worries about real-life problems.
- The person attempts to ignore or suppress such thoughts, impulses, or images or to neutralize them with some other thought or action.
- The person recognizes that the obsessive
- Thoughts, impulses, or images are a product of his or her own mind.

**Compulsions**

- The individual experiences repetitive behaviors or mental acts that he/she feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
• The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation.
• The behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or they are clearly excessive.

**Obsessive-compulsive disorder**

• At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.
• The obsessions or compulsions cause marked distress; take up more than 1 hour a day; or significantly interfere with the person's normal routine, occupation, or usual social activities.

**Panic Disorder**

Panic disorder appears to be a genetically inherited neurochemical dysfunction and can be successfully treated. Panic disorder affects about 6 million American adults and is twice as common in women as in men. People with panic disorder experience unexpected and repeated panic attacks. A person with panic disorder experiences panic attacks but not every person who experiences panic attacks develops a panic disorder (ADAA, 2014; American Psychological Association [APA], 2014; NIMH, 2014).

Panic disorder is frightening because of the associated panic attacks and because it often leads to other complications such as phobias, depression, substance abuse, medical complications, and even suicide. The effects of panic disorder can range from mild work or social impairment to a total inability to face the outside world (ADAA, 2014; APA, 2014; Mayo Clinic, 2012; NIMH, 2014).

Some people’s lives become so restricted by a panic disorder that they avoid normal activities, such as grocery shopping or driving. About one-third become housebound or able to confront a feared situation only when accompanied by a spouse or other trusted person. When the condition progresses this far, it is called *agoraphobia*, or fear of open spaces (Mayo Clinic, 2012).
People who have a panic disorder can become very disabled by their condition and should seek treatment before they start avoiding places or situations where panic attacks occur. For example, if a panic attack happened in an elevator, someone with panic disorder might develop a fear of elevators that could affect the choice of a job, an apartment, a medical provider, or entertainment.

All ethnic groups are vulnerable to panic disorder. People with panic disorder sometimes go from doctor to doctor for years and visit the emergency room repeatedly before someone correctly diagnoses their condition. This is unfortunate, because panic disorder is one of the most treatable of all the anxiety disorders, responding well to medication and/or certain kinds of cognitive psychotherapy (ADAA, 2014; APA, 2014; Lake, 2007; Mayo Clinic, 2012; NIMH, 2014).

**Symptoms**

Panic disorder is characterized primarily by panic attacks: sudden episodes of terror and intense fear accompanied by a sense of unreality, a fear of impending doom, or a fear of losing control. A panic attack usually develops for no apparent reason and often begins in late adolescence or early adulthood. Many people have just one panic attack and never have another. A panic attack is not dangerous, but it can be terrifying, because the individual feels out of control and may think he or she is having a heart attack or even dying.

A panic attack is a period of intense fear or discomfort, developing abruptly and peaking within 10 minutes, and requiring at least four of the following symptoms for diagnosis (APA, 2013):

- Chest pain or discomfort
- Chills or hot flushes
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control
- Feeling dizzy, unsteady, lightheaded, or faint
- Feeling of choking
- Nausea or abdominal distress
- Palpitations or tachycardia
- Paresthesias (a sensation of tingling or numbness of the skin)
- Sensations of shortness of breath or smothering
- Sense of impending doom
- Sweating
- Trembling or shaking

There is considerable variation in the duration and severity of symptoms during panic attacks. The same individual may experience different symptoms during subsequent panic attacks (Medscape 2011; NIMH, 2014).
Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) affects approximately 8 million American adults, and it can occur at any age, including childhood. Women are more likely to develop PTSD than men, and there is some evidence that susceptibility to the disorder may run in families. PTSD is often accompanied by depression, substance abuse, or one or more of the other anxiety disorders (ADAA, 2014; NIMH, 2014).

PTSD usually develops after exposure to severe psychological or physical trauma. PTSD can be caused by experiencing, witnessing, or being confronted with an event involving injury, death, or threat of physical harm to the individual or another person, along with a response involving helplessness and/or intense fear or horror. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers. The trauma may be a single event, a repeated event, or a prolonged situation that causes severe stress and falls outside the range of normal events (ADAA, 2014; Lake, 2007; Medscape, 2011).

PTSD was first brought to public attention in relation to war veterans, but it can also result from a variety of traumatic incidents, such as muggings, sexual assaults, torture episodes, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods, tornadoes, or earthquakes. People with PTSD may startle easily, become emotionally numb (especially in relation to people with whom they used to be close), lose interest in things they used to enjoy, have trouble feeling affectionate, be irritable, become more aggressive, or even become violent. They avoid situations that remind them of the original incident, and anniversaries of the incident are often very difficult (APA, 2011; NIMH, 2014).

**Symptoms**

PTSD symptoms seem to be worse if the event that triggered them was deliberately initiated by another person, such as a mugging or kidnapping. Most people with PTSD repeatedly relive the trauma in their thoughts during the day and in nightmares when
they sleep. These flashbacks may consist of images, sounds, smells, or feelings associated with the event and are often triggered by ordinary occurrences, such as an odor, a door slamming, or a car backfiring on the street. A person having a flashback may lose touch with reality and believe that the traumatic incident is happening all over again. Individuals with PTSD may also struggle with emotional numbness, which occurs when they avoid places, people, and activities that remind them of the trauma. Other symptoms include increased arousal, difficulty sleeping and concentrating, feeling jumpy, and being easily irritated and angered (ADAA, 2014; APA, 2011; NIMH, 2014).

Not every traumatized person develops full-blown or even minor PTSD. Symptoms usually begin within 3 months of the incident but occasionally emerge years afterward. Symptoms must last more than a month to be considered PTSD. The course of the illness varies. Some people recover within 6 months, while others have symptoms that last much longer. In some people, the condition becomes chronic (NIMH, 2014).

Diagnostic criteria for PTSD includes the following four areas (APA, 2013):

1. The person has been exposed to a traumatic event in which both of the following were present:
   - The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury or a threat to the physical integrity of him- or herself or others.
   - The person's response involved intense fear, helplessness, or horror.

2. The traumatic event is persistently re-experienced in at least one of the following ways:
   - Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
   - Recurrent distressing dreams of the event
   - Acting or feeling as if the traumatic event were recurring, including a sense of reliving the experience, illusions, hallucinations, and flashback episodes
   - Intense psychological distress at exposure to cues that symbolize an aspect of the traumatic event
   - Physiologic reactivity when exposed to cues that symbolize or resemble an aspect of the traumatic event

3. The person persistently avoids stimuli associated with the trauma and has numbing of general responsiveness including at least three of the following:
   - Efforts to avoid thoughts, feelings, or conversations associated with the trauma
   - Efforts to avoid activities, places, or people that arouse recollections of the trauma
   - Inability to recall an important aspect of the trauma
   - Markedly diminished interest or participation in significant activities
• Feeling of detachment or estrangement from others
• Restricted range of affect

4. Persistent symptoms of increased arousal are indicated by at least two of the following for a duration of more than 1 month:

• Difficulty falling or staying asleep
• Irritability or outbursts of anger
• Difficulty concentrating
• Hypervigilance
• Exaggerated startle response

Social Phobia Disorder (also called Social Anxiety Disorder)

In social phobia disorder, also called social anxiety disorder, a person has an excessive and unreasonable fear of social situations and of being scrutinized and judged by others in social or performance situations. The resulting anxiety (intense nervousness) and self-consciousness may become so severe that they interfere with work, school, and other ordinary activities and can make it difficult for the person to make and keep friends (ADAA, 2014; WebMD, 2014).

Approximately 15 million American adults have social phobia disorder. The typical age of onset is 13 years of age. Approximately 36% of people with social phobia report symptoms for 10 years or more before seeking help (ADAA, 2014).

Social phobia disorder appears to be an interaction between biological and genetic factors and environmental events. Family and twin studies indicate that genetic factors seem to play an especially critical role in the development of this disorder.

While many people with social phobia disorder realize that their fears about being with people are excessive or unreasonable, they are unable to overcome them. Even if they manage to confront their fears and be around others, they are usually anxious
beforehand, intensely uncomfortable throughout the encounter, and worried about how they were judged for hours afterward (NIMH, 2014).

Social phobia can be limited to one situation (such as talking to people, eating or drinking, or writing on a blackboard in front of others) or it may be so broad (such as in generalized social phobia) that the person experiences anxiety around almost anyone other than his or her family (NIMH, 2014).

An individual with social phobia disorder may also have a specific phobia: an intense, irrational fear of something that poses little or no actual danger. Some of the more common specific phobias include the following (NIMH, 2014):

- Claustrophobia: Fear of closed-in places
- Acrophobia: Fear of heights, escalators
- Escalaphobia: Fear of escalators
- Ophidiophobia: Fear of snakes
- Apiophobia: Fear of bees
- Hydrophobia: Fear of water
- Aviatophobia: Fear of flying
- Cynophobia: Fear of dogs
- Hematophobia: Fear of injuries involving blood

Specific phobias aren’t just extreme fear; they are an irrational fear of a particular thing. Someone may be able to easily ski the world’s tallest mountains but be unable to go above the fifth floor of an office building. While adults with phobias realize that these fears are irrational, they often find that facing, or even thinking about facing, the feared object or situation brings on a panic attack or severe anxiety (NIMH, 2014).

**Symptoms**

Social phobia disorder (social anxiety disorder) is diagnosed when people become overwhelmingly anxious and excessively self-conscious in everyday social situations. This disorder is frequently associated with other anxiety disorders, depression, chronic psychosis, substance abuse, and other cognitive or affective symptoms. Affected individuals can worry for days or weeks before a dreaded situation (ADAA, 2014; Lake, 2007; Medscape, 2011; NIMH, 2014).

Physical symptoms that often accompany social phobia include blushing, profuse sweating, trembling, nausea, and difficulty talking. When these symptoms occur, people with social phobia feel as though all eyes are focused on them. Social phobia can be successfully treated with certain kinds of psychotherapy or medications (MHA, 2014; NIMH, 2014).

Diagnostic criteria for social phobia include the following (APA, 2013):
• A fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others and feels he or she will act in an embarrassing manner.
• Exposure to the feared social situation provokes anxiety, which can take the form of a panic attack.
• The person recognizes that the fear is excessive or unreasonable.
• The feared social or performance situations are avoided or are endured with distress.
• Avoidance, anxious anticipation, or distress in the feared situation interferes significantly with the person's normal routine, occupational functioning, or social interactions.
• The condition is not better accounted for by another mental disorder, substance use, or general medical condition.
• If a general medical condition or another mental disorder is present, the fear is unrelated to it.
• The phobia may be considered generalized if it includes most social situations.

DIFFERENTIAL DIAGNOSES

Many different disorders can be confused with anxiety disorders. Even within the five major anxiety disorders, there are many overlapping symptoms. Performing a thorough medical workup when initially assessing the individual with anxiety symptoms helps clarify which disorder(s) is/are affecting the individual. Anxiety can be the result of many factors. An effective differential diagnosis must exclude specific organic causes, such as the following (Rowney, Hermida, & Malone, 2011):

• Endocrine dysfunction
• Intoxication or withdrawal
• Hypoxia
• Metabolic abnormalities
• Neurologic disorders
The effective differential diagnosis also rules out other co-morbid psychiatric disorders such as these (Rowney, Hermida, & Malone, 2011):

- Severe depression
- Bipolar disorder
- Prodromal schizophrenia
- Delusional disorder
- Adjustment disorder
- Substance abuse

Many organic causes can be ruled out by a comprehensive medical, social, emotional, and spiritual history as well as basic laboratory work, including thyroid-stimulating hormone test, urine toxicology, electrocardiogram, complete blood count, and metabolic panel. Anxiety disorders are common, however, and often involve co-morbid conditions that must be treated effectively along with the anxiety disorder for the patient to experience the most positive and lasting clinical outcome (Rowney, Hermida, & Malone, 2011).

CONVENTIONAL TREATMENT APPROACHES TO ANXIETY DISORDER

After ruling out any co-morbid conditions, the next step in treatment is developing a working alliance with the individual and his or her family. This provides a basis for ongoing management and prevents inappropriate and ineffective use of the medical system, which could delay treatment (Rowney, Hermida, & Malone, 2011).

When approaching the topic of therapy, the clinician should reassure the individual that effective treatment is available but patience may be necessary until the right combination of treatment options is found. Most individuals have an improved outcome with appropriate treatment. Response rates improve when there are few (or no) co-morbid conditions. Individuals with an earlier onset of symptoms (childhood or adolescence) can generally expect a more chronic disease process and may be more difficult to treat. In some disorders (such as PTSD or panic disorder), individuals sometimes have spontaneous remission or can function despite the symptoms. However, when effective treatment is provided, symptoms resolve more quickly and the individual’s daily functioning is greatly improved (NIMH, 2014; Rowney, Hermida, & Malone, 2011).

An important part of any intervention for an individual with an anxiety disorder is education, which should involve the patient’s family or partners as well. Many patients, family members, and friends are confused by the symptoms and behaviors of anxiety disorders and are reassured by knowing they are “not alone” and that there are effective therapies for the disorder (Rowney, Hermida, & Malone, 2011).

In general, anxiety disorders are treated with specific types of medication, psychotherapy, or both. People with anxiety disorders who have already received treatment should tell their current physician about that treatment in detail.
• If they received psychotherapy, they should describe the type of therapy, how often they attended sessions, and whether the therapy was useful.
• If they received medication, they should tell their physician which medication was used, the dosage at the beginning of treatment, whether the dosage was increased or decreased during treatment, any side effects that may have occurred, and whether the treatment helped them become less anxious (NIMH, 2014).

Often people believe that they have “failed” at treatment or that the treatment didn’t work for them when, in fact, it was not given for an adequate length of time or was administered incorrectly. Sometimes, people must try several different treatments or combinations of treatment before they find one that works for them.

Medication

Medication will not cure anxiety disorders but it can minimize or eliminate symptoms while the person receives psychotherapy. Medication must be prescribed by physicians, usually psychiatrists, who can either offer psychotherapy themselves or work as a team with psychologists, social workers, or counselors to provide concurrent psychotherapy. The principal medications used for anxiety disorders are antidepressants, anti-anxiety drugs, and beta blockers. With proper treatment, many people with anxiety disorders can lead normal, fulfilling lives (NIMH, 2014).

Antidepressants

Antidepressants were originally developed to treat depression but are also effective in treating anxiety disorders. Although antidepressants begin to alter brain chemistry and reduce symptoms after the very first dose, their full effect usually appears within 4 to 6 weeks of therapy. Patients need to be educated about the importance of taking antidepressants as prescribed and long enough to become effective (NIMH, 2014).
Several types of antidepressants are effective for anxiety disorder, including selective serotonin reuptake inhibitors (SSRIs), tricyclics, and monoamine oxidase inhibitors (MAOIs).

**Serotonin Reuptake Inhibitors (SSRIs)**

Some of the most effective antidepressants used for anxiety disorders are called selective serotonin reuptake inhibitors, or SSRIs. They relieve symptoms by blocking the reabsorption of serotonin (ADA, 2011; NIMH, 2014).

Venlafaxine (Effexor), a drug closely related to SSRIs, is used to treat GAD. Fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), and citalopram (Celexa) are some of the SSRIs commonly prescribed for OCD, panic disorder, PTSD, and social phobia disorder or any combination of these disorders (NIMH, 2014).

Symptoms usually improve within 3 or 4 weeks, and the dose can be increased if no improvement is seen. OCD symptoms may take 8 to 12 weeks to respond to treatment and these patients often require higher doses to experience relief. It is rare to achieve absolute resolution of symptoms in OCD but a reduction of symptoms is typical for most patients. SSRIs should be started at the lowest clinical dose and gradually titrated to higher doses to avoid an initial exacerbation of anxiety (Rowney, Hermida, & Malone, 2011).

SSRIs have fewer side effects than older antidepressants, but they sometimes produce slight nausea or jitteriness when people first begin therapy. These symptoms usually fade with time. Some people also experience sexual dysfunction with SSRIs. This side effect may be helped by adjusting the dosage or switching to another SSRI (Rowney, Hermida, & Malone, 2011).

**Tricyclics**

Tricyclics were developed prior to the development of SSRIs and work as well as SSRIs for most anxiety disorders except OCD (ADAA, 2014; NIMH, 2014).

Tricyclics include imipramine (Tofranil), which is prescribed for panic disorder and GAD, and clomipramine (Anafranil), which is the only tricyclic antidepressant useful for treating OCD (NIMH, 2014).

Tricyclics should be prescribed at the lowest clinical doses and gradually titrated to higher doses to avoid an initial exacerbation of anxiety. Side effects include dizziness, drowsiness, constipation, urinary retention, dry mouth, and weight gain. These can usually be corrected by changing the dosage or switching to another tricyclic medication (ADAA, 2014; NIMH, 2014).
Monoamine Oxidase Inhibitors (MAOIs)

Monoamine oxidase inhibitors (MAOIs) are the oldest class of antidepressant medications. The MAOIs most commonly prescribed for anxiety disorders are phenelzine (Nardil), tranylcypromine (Parnate), and isocarboxazid (Marplan).

MAOIs can react with SSRIs to produce a serious condition called “serotonin syndrome,” which can cause confusion, hallucinations, increased sweating, muscle stiffness, seizures, changes in blood pressure or heart rhythm, and other potentially life-threatening conditions (NIMH, 2014).

One of the contraindications for MAOIs includes the inability to eat a variety of foods and beverages (including cheese and red wine) that contain tyramine. In addition, MAOIs interact with certain medications including some types of birth control pills, pain relievers (such as Advil, Motrin, or Tylenol), cold and allergy medications, and herbal supplements and may cause dangerous increases in blood pressure. The development of a new MAOI skin patch may help lessen these risks (NIMH, 2014).

Anti-Anxiety Drugs

Anti-anxiety drugs are more easily tolerated and less addictive than other anxiety medications, making them more desirable for the long-term management of these disorders. Benzodiazepines, a common class of anti-anxiety drugs, have been used commonly in the past to treat anxiety disorders, and they continue to be useful in the short-term management of anxiety symptoms until the patient achieves an acceptable reduction of symptoms with an SSRI or psychotherapy. Benzodiazepines are fast acting and work well for patients who need quick relief of moderate or severe symptoms.

High-potency benzodiazepines combat anxiety and have few side effects other than drowsiness. Because habituation occurs easily, individuals may need ever-increasing doses to achieve the same clinical effect. Thus, benzodiazepines are generally prescribed for short periods of time, especially for people who have abused drugs or alcohol and who become dependent on medication easily. One exception to this rule is people with panic disorder, who can often take benzodiazepines for up to a year without serious side effects (ADAA, 2014; NIMH, 2014).

Because of the risk for rebound anxiety when withdrawing from short-acting benzodiazepines, such as alprazolam (Xanax), many psychiatrists prefer the longer-acting benzodiazepines, such as clonazepam (Klonopin) (ADAA, 2014; NIMH, 2014).

Some people experience withdrawal symptoms if they stop taking benzodiazepines abruptly instead of tapering off, and anxiety can return once the medication is stopped. These potential problems have led some physicians to shy away from using these drugs or to use them in inadequate doses (NIMH, 2014).
Beta Blockers

Beta blockers, such as propranolol (Inderol), which is used to treat heart conditions, can prevent the physical symptoms that accompany certain anxiety disorders, particularly social phobia disorder. When a feared situation (such as giving a speech) can be predicted, a doctor may prescribe a beta blocker to keep physical symptoms of anxiety under control. The side effects of beta blockers may include lightheadedness, sleepiness, nausea, and an unusually slow pulse rate. Beta blockers are contraindicated for individuals with asthma or diabetes, as they may worsen the symptoms (NIMH, 2014).

Psychotherapy

Psychotherapy involves talking with a trained mental health professional, such as a psychiatrist, psychologist, social worker, or counselor, to discover what is causing, or contributing to, an anxiety disorder and exploring how to deal with its symptoms. The most common types of psychotherapy for anxiety disorders are cognitive-behavioral therapy (CBT), exposure-based behavioral therapy, and dialectical behavioral therapy (DBT).

Cognitive-Behavioral Therapy (CBT)

The most common and effective form of psychotherapy for anxiety disorders is cognitive-behavioral therapy (CBT). This form has the strongest support among health care professionals of all the psychotherapies but it often requires an extensive commitment to treatment (usually at least 12 weeks) on the part of the individual. Its efficacy is contingent on the skill, education, experience, and ability of the therapist as well as the concurrent use of appropriate medications for the specific disorder. Patients treated with a combination of CBT and medication experienced nearly twice the remission rate of those individuals who used only medication, even when the CBT was
administered by someone with minimal to no CBT experience (Rowney, Hermida, & Malone, 2011). There is some evidence that the benefits of CBT last longer than those of medication for people with panic disorder, OCD, PTSD, and social phobia (NIMH, 2014).

Cognitive behavioral treatments include the retraining and reconditioning of an individual to relieve his or her anxiety. CBT involves the following (NIMH, 2014):

- Intensive education about the disorder and the body's physiological reaction to stress and threat
- Desensitization to the various physical sensations or triggers of panic by exposing the person to the actual object, situation, or thought
- Education about relaxation, breathing, and stress management techniques
- Restructuring dysfunctional thoughts and patterns

Other beneficial strategies that can be included in CBT may involve the study and practice of yoga, qi gong, meditation, massage, acupuncture, and nutritional and herbal medicine.

CBT can incorporate unique strategies for specific disorders. The following are examples of how CBT can be utilized (NIMH, 2014):

- CBT can help people with panic disorder learn that their panic attacks are not really heart attacks. When people are ready to confront their fears, they are shown how to use exposure techniques to desensitize themselves to situations that trigger their anxieties.
- People with OCD who fear dirt and germs are encouraged to get their hands dirty and wait increasing amounts of time before washing them. The therapist helps the person cope with the anxiety that waiting produces. After the exercise has been repeated a number of times, the anxiety often diminishes.
- People with social phobia disorder may be encouraged to spend time in feared social situations (resisting the urge to flee) and to make small social blunders while observing how people respond to them. Since the response is usually far less harsh than the person fears, the anxieties often decrease.
- People with PTSD may be supported through recalling their traumatic event in a safe situation, which helps reduce the fear it produces. CBT therapists also teach deep breathing and other types of exercises to relieve anxiety and encourage relaxation.

CBT is undertaken when people decide they are ready for it and with their permission and cooperation. To be effective, the therapy must be directed at the person’s specific anxieties and must be tailored to his or her needs. There are no side effects other than the temporary discomfort of increased anxiety.

CBT or behavioral therapy may be conducted individually or with a group of people who have similar problems. Group therapy is particularly effective for individuals struggling
with social phobia disorder. “Homework” is often assigned for participants to complete between sessions. If a disorder recurs at a later date, the same therapy can be used to treat it successfully a second time (NIMH, 2014).

Exposure-based Behavioral Therapy

Exposure-based behavioral therapy, a form of CBT, has been used for many years to treat specific phobias. In this type of therapy, individuals gradually encounter the feared object or situation, perhaps at first only through pictures or tapes. Later, they encounter the object or situation in real life and face to face. Often the therapist accompanies the person to a feared situation to provide support and guidance (ADAA, 2014).

Dialectical Behavioral Therapy (DBT)

Dialectical behavioral therapy (DBT) integrates cognitive-behavioral techniques with concepts from Eastern meditation. DBT involves individual and group therapy and includes education and support in mindfulness meditation, as well as support for individuals as they develop skills in interpersonal effectiveness, tolerating distress, and regulating emotions (ADAA, 2014).

INTEGRATIVE TREATMENT APPROACHES TO ANXIETY

Anxiety disorders are difficult to treat because of significant individual differences in the type and severity of symptoms and complex medical, psychological, social, and cultural factors that cause or exacerbate anxiety symptoms. There has been substantial research on integrative treatments for generalized anxiety but less research on general anxiety disorder, PTSD, panic disorders, phobias, obsessions, and compulsions (ADAA, 2014; Lake, 2007).

The following sections provide information on integrative approaches to anxiety disorders. These integrative approaches offer a variety of additional therapeutic modalities to conventional treatment methods that can reduce the physical and psychological symptoms associated with anxiety disorders.

Kava Kava (Piper methysticum)

As a treatment for general anxiety symptoms, kava is the most researched remedy for anxiety. Found in the South Pacific, kava is derived from the pulverized lateral roots of a subspecies of a pepper plant. Kava, in doses ranging from 70 to 240 mg/day, is as effective as conventional drugs for generalized anxiety; however, its association with hepatotoxicity is a significant concern. Kava should be avoided in pregnant or breastfeeding women and in individuals taking benzodiazepines (ADAA, 2014; Lake, 2007; Medscape, 2008; Rakel, 2012).
L-theanine

L-theanine, an amino acid, effectively alleviates anxiety symptoms. The recommended dosage for moderate anxiety is 50–200 mg/day; the recommended dosage for severe anxiety is 800 mg/day (in divided doses). L-theanine does not cause drowsiness and there is no evidence of adverse or toxic interactions with other biological treatments (both conventional and unconventional). The anti-anxiety effect of L-theanine is achieved through enhanced brainwave activity and increased synthesis of GABA, producing a feeling of calmness within 30 to 40 minutes after ingestion. There is no risk of dependence with L-theanine; however, more research is needed (Lake, 2007).

Relaxation Techniques and Guided Imagery

Relaxation is as effective as conventional therapy for the management of moderate generalized anxiety and panic disorder. Relaxation techniques include deep breathing, yoga, meditation, and progressive muscle relaxation (which is accomplished by tensing one muscle at a time and then completely releasing the tension until every muscle in the body is relaxed). Guided imagery is beneficial for generalized anxiety, panic attacks, and traumatic memories (Lake, 2007; Mayo Clinic 2012).

Yoga

The regular practice of yoga has been linked to improvements in mood and the reduction of many anxiety symptoms. Yoga brings together physical and mental disciplines to achieve peacefulness of body and mind, enabling individuals to relax and more effectively manage stress and anxiety.

Regular, specific yogic postures or breathing methods result in calmer physical and mental states due to sustained changes in brain activation and neurotransmitter activity (ADAA, 2014; Lake, 2007; Mayo Clinic, 2014; Natural Standard, 2011).
The modulation of brain and neurotransmitter activity decreases physiological arousal. The result is a reduction in heart rate and blood pressure and more relaxed respiration. There is also evidence that yoga practices help increase heart rate variability, an indicator of the body's ability to more flexibly respond to stress. There are still questions about exactly how yoga works to improve mood, but preliminary evidence suggests its benefit is similar to that of exercise and relaxation techniques. In one study, greater improvements in mood and anxiety were reported in a yoga group than a walking group. Further research is needed to confirm these findings (Harvard Health Publications, 2011).

There are no contraindications to the practice of yoga or breathing exercises. However, those with cardiovascular disease, chronic pain syndromes, or other physical impairments should consult with their physician before undertaking yoga techniques (ADAA, 2014; Lake, 2007; Mayo Clinic, 2013; Natural Standard, 2011).

**Meditation**

Meditation practices are used in many cultures to reduce anxiety, and meditation has been studied extensively for the reduction of anxiety. There are many types of meditation, which involve focusing of attention. The object of focus can be an image, a word, a phrase, one's breath, etc. The psychological benefits of meditation include decreased oxygen consumption, respiratory rate, and blood pressure (Lake, 2007; Mennin, 2006; Weil, 2014).

Mindfulness-based stress reduction (MBSR) is an integrative practice that reduces the physical, emotional, and cognitive effects of chronic stress. Mindfulness meditation helps clients become more aware or “mindful” of what is going on in their mind and body at any given moment.
When individuals feel stressed or anxious, mindfulness meditation encourages them to stop, take a moment to become aware of how they feel, and then permit feelings to emerge. The feelings are observed in an objective manner and then allowed to “float away.” Meditating on a regular basis can result in the significant, long-term reduction of anxiety (Lake, 2007; Mennin, 2006; Weil, 2014).

**Breathing Exercises**

Breathing exercises are probably one of the single most effective anti-anxiety measures available. Many individuals experiencing anxiety tend to hold their breath or hyperventilate without being conscious of their actions. Controlled breathing and breath work can offer an immediate reduction in anxious feelings, which provides a sense of empowerment.

One of the most valuable aspects of breathing exercises is that they are available to anyone at any time. No prescriptions or therapists are needed; the individual only has to stop momentarily and take a long, slow, deep breath to experience the benefits. The yogic relaxing breath is perhaps the best tool for addressing generalized anxiety disorder (Weil, 2014).

**Dietary Changes**

In an effort to treat anxiety, health care professionals are counseling clients about the benefits of a healthy diet, including the avoidance of caffeine; evaluating clients for hypoglycemia; and encouraging clients to eat foods that contain tryptophan (an amino acid that increases serotonin levels) (Lake, 2007).
Most individuals can consume one to two cups of coffee a day without any effect on mood. However, some individuals experience increased anxiety with this amount of caffeine and for these individuals caffeine should be discontinued (Rakel, 2012).

Dietary changes that can help reduce feelings of anxiety include eating small, frequent meals to help stabilize blood sugar; avoiding foods to which one is sensitive or allergic; and staying hydrated (Hall-Flavin, 2014).

**Physical Activity**

Engaging in regular aerobic exercise (at least 30 minutes a day) and strength training reduces symptoms of generalized anxiety and may reduce the frequency and severity of panic attacks.

Physical activity does not need to be vigorous to be effective. Brisk walking or gardening can reduce stress and provide a healthy distraction from negative thoughts. The regular practice of qi gong or Tai Chi may also reduce symptoms of generalized anxiety and promote overall emotional health, although research about these two practices is limited (Lake, 2007; Weil, 2014).

**Massage**
**Massage** is a broad term encompassing a variety of approaches to the manipulation of soft tissue to achieve health benefits. Massage techniques have been practiced for thousands of years in many cultures. Research suggests that massage and relaxation therapy may be quite effective at reducing anxiety by evoking feelings of deep relaxation, improving emotional resilience, and enhancing feelings of general well-being (Lake, 2007; Natural Standard, 2014).

**Music and Sound**

[Image of musical notes]

Music has been used for therapeutic purposes since ancient times. Music and sound are also used in many cultures and healing traditions for reducing anxiety. Music therapy may involve both performing and listening to music. Soothing music and binaural sound positively influence emotional and physical well-being, improve one’s quality of life, and reduce the symptoms of generalized anxiety. Certain binaural beats have also been shown to consistently induce a calm, relaxed state (Lake, 2007; Natural Standard, 2014).

**Acupuncture**

The practice of acupuncture originated in China 5,000 years ago. Today, acupuncture is widely used throughout the world and is one of the main pillars of traditional Chinese medicine (TCM). Acupuncture has been widely used to treat the symptoms of anxiety, especially for symptoms of generalized anxiety and panic attacks. There is increasing clinical evidence that acupuncture is effective in treating anxiety disorders (ADAA, 2014; Medscape, 2008; Natural Standard, 2014).

**Aromatherapy**

Aromatherapy involves the psychological, physiological, and pharmacological benefits of essential oils introduced by means of inhalation, olfaction, and dermal application. For example, lavender and rosemary essential oils may reduce generalized anxiety symptoms when applied to the skin during massage. Lavender aromatherapy may produce relaxed, drowsy feelings, while rosemary promotes a relaxed alert state. Although other essential oil preparations are sometimes used to treat anxiety, there is not enough current evidence to support their use (Lake, 2007; Medscape, 2008).
Healing Touch and Therapeutic Touch

Healing Touch (HT) and Therapeutic Touch (TT) may reduce the symptoms of stress and generalized anxiety in several medical conditions. In a research study conducted with cardiac patients, Healing Touch was shown to reduce anxiety when used prior to a hospital procedure. In another study, women undergoing radiation treatment who used HT showed more improvements in their anxiety levels than a group that received a pseudo-healing session for anxiety (Healing Touch International, 2014). By improving the individual's energy flow, Therapeutic Touch is also thought to stimulate healing and help treat a range of health conditions, including anxiety (Wong, 2013).

SUMMARY

Anxiety disorders are real, serious, and treatable. Conventional treatment approaches include psychotherapy and medication, while integrative treatment approaches include kava, L-theanine, relaxation and guided imagery, yoga, meditation, breathing exercises, dietary changes, physical activity, massage, music and sound, acupuncture, aromatherapy, and Healing Touch and Therapeutic Touch. A combination of conventional and integrative treatment approaches is often the best way to effectively manage the symptoms of anxiety disorder.
REFERENCES


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