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MEDICAL MEMO

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What is Anxiety? OCD? PTSD?

The dictionary definitions of anxiety include "a painful or apprehensive uneasiness of mind usually over an anticipated or impending ill" and a "fearful concern or interest". When we speak clinically of excess anxiety or anxiety disorders dictionary definitions are helpful but inadequate. Anxiety becomes a problem when the anxious, nervous, worried, or fearful feelings begin to interfere with everyday life to a frequent and troubling degree. Anxiety can include over-thinking things, over-sensitivity and reactivity including excess irritability when things don't go right or as expected. Some anxiety can be beneficial. Anxiety often helps us to prepare, to plan ahead, to care, to do what is right, and to make sure we have been thorough. Wouldn't you want the neurosurgeon operating on your brain (or lawyer handling your case, or accountant doing your taxes, or mechanic repairing your car) to be somewhat compulsive? Anxiety can be understandable and not excessive such as that which follows news of a tornado watch in your area or what a soldier often feels just before going into battle; as long as it doesn't interfere with preparation or functioning. Anxiety disorders can also be severely disabling.

What surprises many people is that **anxiety disorders are the most common psychiatric disorder**! The percentage of people who will have, at some time, Panic disorder is 1% of the population, Generalized Anxiety is 5%, a Specific Phobia is 11%, Agoraphobia is 5%, Social Phobia is 2.7%, Obsessive-Compulsive disorder is 2%, and Post Traumatic Stress Disorder is about 5%. School Phobia and Separation Anxiety Disorder are also often seen in youth. There is substantial overlap between these various anxiety conditions. Anxiety Disorders are far more frequent than Schizophrenia or Bipolar Disorder (Manic-Depression) and even exceed the frequency of the various types of depression or alcoholism or other substance abuse dependence. Anxiety problems are more common than Attention Deficit Hyperactivity Disorder and Learning Disorders in kids and Alzheimer's Disease in adults. However, in DSM 5 PTSD and OCD are each now in separate categories that brings the incidence and prevalence of Anxiety, Depressive, and Substance Disorders closer in frequency.

It is common to hear a patient say they didn't realize they had been so anxious until those symptoms were diminished by the medication or therapy we had used to treat what had been seen as only depression. They may notice less need to control things so much, more ability to not sweat the little things, more ability to try new things they have always wanted to do but were too nervous about, etc. Their prior oversensitivity and over-reactivity may be lessened, resulting in less irritability and better temper control. Social interactions may be a bit easier or more enjoyable or there may be decreased discomfort in intimacy. Changing habits which may have been compulsive or letting go of obsessive thoughts seem easier. Sensitivity to certain textures, certain clothes, or sounds may be less. They, or others, may note their increased flexibility and decreased irritability. All of these traits are often, in my view, included in the broader anxiety symptom spectrum.

Anxiety disorders may be complicated by other conditions such as depression or alcohol or other substance abuse. Anxiety problems, or vulnerability to them, often run in families. Both the symptoms of anxiety and depression so often occur together in one person at varying times in their lives and overlap in family histories that clinicians often see them as two sides of the same biologic coin. Even several of the most commonly effective medication and psychotherapy treatments for depression and for anxiety are essentially the same.

Generalized Anxiety Disorder (GAD) is best understood as excessive feelings of worry, nervousness, anxiety, and/or fear that interfere more days than not, causing significant distress or impairment in functioning in social relationships, school or work, and other areas of life. The focus of this anxiety may be unclear or float from one worry to another from time to time, or (most often)

involve several areas of life along with a general uneasiness. This general anxiety may also include panic symptoms or unreasonable fears about important life tasks such as school or relationships. GAD frequently responds to serotonin increasing medications such as the SRI's Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), Luvox (fluvoxamine), Celexa (citalopram), or Lexapro (escitalopram) or the milder and less powerful buspirone or other options. GAD also is often well treated by psychotherapy using techniques of cognitive behavioral therapy and relaxation training.

Panic Disorder consists of recurrent "anxiety attacks" or "hyperventilation" episodes which build up over 5 to 10 minutes and last under an hour but are terrifying, although not inherently dangerous. Panic attacks are often marked by varying numbers of symptoms which may include shortness of breath, skipped heart beats, headache, nausea, tingling or numbness in fingers, toes, or lips, sweating, shaking, dizziness, feeling unreal or not like one's self, fear of dying, etc. It is difficult to overstate the fear or discomfort a panic attack causes. Persons suffering their first panic attack frequently go to emergency rooms or seek quick medical evaluation for what they fear is a dangerous disease or heart attack. Fortunately, many such episodes are actually panic attacks that can usually be treated effectively. Panic recurrence can be lessened or prevented. Benzodiazepines like Ativan (lorazepam), Klonopin (clonazepam), or Xanax (alprazolam) are very effective at interrupting a panic attack at the moment it builds up while SRI's, and several other antidepressants are often very good at preventing them, lessening their intensity, or reducing their frequency. Psychotherapy is aimed at educating about panic disorder, lessening the symptoms, and especially preventing or overcoming the too often associated thinking errors (cognitive distortions) that lead to social avoidance, school refusal, and even agoraphobia (fear of leaving home) that may accompany severe or chronic or untreated panic attacks. Panic attacks may occur as part of other anxiety disorders.

Phobias include Social Phobia, Agoraphobia, and Specific Phobias. **Social Phobia** is a marked and persistent fear of one or more social or performance situations in which the person feels overly exposed or likely to be embarrassed in front of other persons. This typically involves public settings such as malls, restaurants, performing, school, test taking, etc. If compelled to carry on the person feels exquisitely uncomfortable (anxious) and may have or fear a panic attack. In **Agoraphobia** this anxiety is broadened to frequently include multiple settings such that the person feels trapped in their home or other such refuge. **Specific Phobias** typically revolve around or are limited to one of the following: a particular animal type such as dogs, bugs, bees; a type of natural environment such as storms, heights, water; seeing an injury, blood, or needles; certain situations such as airplanes, elevators, or enclosed spaces; or "other" such as fear of choking, costumed characters, or acquiring infections. **School Phobia** or Refusal is not really a specific phobia and it is different from truancy or simply fear of being bullied etc. The anxiety is intense, focused on avoiding anxiety about school but in a broad way. It is often accompanied by stomach, bowel, headache or other vague health complaints and a desire to stay home -- not a desire to go out and play or see friends. School phobia may first show itself at preschool, or kindergarten, or first grade as **Separation Anxiety** marked by trouble leaving the parent(s) or other "safe" setting. The child may be anxious about his or her ability to be OK without the parent or even about the parent's ability to be OK without the child. It is not unusual for separation anxiety or school phobia to show up again at around age 10 to 12 or even later such as starting middle school, high school, college, or a new job. Treatment of **School Phobia** can be an emergency due to its possibly disastrous effect on learning and socialization. School Phobia can be very hard on the youth and family as all parties struggle with how to understand and deal with this troubling condition. Treatment typically is based upon doing everything possible to ensure as much school attendance and participation as possible, as quickly as possible. Psychotherapy for the child and the parents is often advised, along with guidance to the school staff. Medication may include an SRI as a cornerstone of the treatment. Since SRI's may take a few weeks to work well, it can be quite helpful to temporarily add a benzodiazepine to help with anxiety caused sleep disruption and or to make it substantially easier for the child to get out the door from home and into school. As with other anxiety disorders, School Phobia may be one component of a broader vulnerability to anxiety.

Obsessive Compulsive Disorder (OCD) has seen a huge increase in understanding over the last 15 years! Many of these gains have come about as we began to understand its primarily biologic and usually genetic origin and as the first really effective treatments have become available. These have included, mainly, the SRI's Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), Luvox (fluvoxamine), Celexa (citalopram), Lexapro (escitalopram), Anafranil (clomipramine), Effexor (venlafaxine), Cymbalta (duloxetine) and the Cognitive Therapies developed from principles of Exposure and Response (Ritual) Prevention. It is important to remember

that just because something has a primarily biologic basis it still can be effectively treated by certain psychotherapeutic techniques. This fits, for example, with our understanding that purely environmental events such as the death of a loved one can trigger a grief reaction that may become a biologic major depression. **Obsessions** are disturbing or anxiety producing thoughts or images (eg, of illness, violent or sexual events that may or will occur) that are persistent and repetitive which greatly bother the person who experiences them usually as unwanted, distasteful, and foreign. **Compulsions** are repetitive behaviors (eg, hand washing, cleaning, ordering, checking, making symmetrical or balanced or even, etc) or mental acts (eg, counting, praying, repeating things silently, etc) that the person feels driven to do in response to an obsession or according to rules that must be followed rigidly. There is a fair amount of overlap between obsessions and compulsions as well as a considerable range in what individuals experience. There is also at times some overlap between obsessions, compulsions and tics. Tics are semi-involuntary motor (muscle) movements, usually twitch-like, and/or vocal (usually sounds, rarely words) sounds that may occur along with anxiety and/or attention symptoms especially in Tourette's Disorder.

OCD affects about 2% of people and is often associated with other forms of anxiety or depression. It may also be complicated by substance abuse, Attention Deficit Disorder, or tics (see the Medical Memo on Tourette's Syndrome). OCD is caused by faulty processing in the brain, especially the thalamus, basal ganglia, frontal lobe and related connections. OCD is most commonly inherited but may also occur after some brain injuries, tumors, a few strep infections or seizures.

Obsessive Compulsive Disorder can be disabling because of the intensity of the upsetting thoughts or images that can run through the victim's head like a horrifying video and the need to perform odd or illogical rituals that may take minutes to hours, especially when persons become "stuck". Even now, and especially in years past, persons with OCD were certain they were crazy and would be locked up because of their thoughts and rituals if they ever revealed them. OCD often begins as early as childhood. Many people have features of OCD as part of their anxiety or depression symptoms. Certain other patterns may be seen as part of the OCD spectrum of conditions. These may include compulsive patterns of gambling, shopping, sexual behaviors, jealousy, hoarding, eating disorders, some substance abuse, self mutilation, some stealing, and persistent distorted views of one's own body appearance known as **Body Dysmorphic Disorder**. OCD, due to its potentially huge personal, social, and occupational costs, can often be complicated by depression or substance abuse that also may need direct treatment. The risk of suicide can be elevated in this situation especially when panic attacks also occur.

OCD, as is true of almost all psychiatric conditions, can be traced back hundreds or thousands of years. We can also guess at certain evolutionary advantages traits of OCD may have given. Reportedly, in the middle ages the Church recognized that some people were too saintly (too much self denial and asceticism, felt too much responsibility for things beyond their doing, felt too guilty about everything, were way too conscientious) to the point of being psychologically unhealthy. This was labeled "Scrupulosity" and is the extreme opposite of unscrupulous. This was, and is, a form of OCD.

Post Traumatic Stress Disorder (PTSD) first became understood as clinicians treated war veterans, especially after the Vietnam War. "Shell - shocked" veterans from earlier wars are now understood to have had PTSD or **Acute Stress Disorder** (ASD) which is a closely related condition that starts quickly and typically resolves more quickly (less than a month) or evolves into PTSD. Now, we understand that traumas such as being kidnapped, assaulted, abused, molested, being victim of a natural or other disaster, or witnessing a sudden traumatic death or severe injury and similar occurrences may trigger PTSD. We also know that different people may respond in different ways depending on various factors in the situation and the person's own vulnerabilties.

For the diagnosis of PTSD the person must have been exposed to actual or threatened death, serious injury or sexual violence directly to him or herself; or witnessed the dangerous trauma in person as it happened to others; or learned that the violent or accidental trauma occurred to a close family member or close friend; or experienced repeated or extreme exposure to the details such as by being a first responder.

The symptoms described below must continue for over a month. It is called Acute PTSD if symptoms last less than 3 months and is Chronic PTSD if they last over 3 months. Usually symptoms start within days to weeks after the incident(s) but may start as much as 6 months later and are then called delayed onset.

In PTSD, as updated in DSM 5, there are 4 basic symptom clusters. **1)** intrusive re-experiencing the traumatic event in varying ways. This may include recurrent and distressing memories of the event and/or nightmares, flashbacks, and intense emotional distress, or

physical reactivity when exposed to reminders of the trauma or its after-effects. **2)** avoidance such as efforts to avoid places, thoughts, feelings, and other reminders of the trauma. **3)** negative alterations in cognitions (thoughts) and mood associated with the trauma(s) such as inability to recall important details of the event(s), decreased interest in day to day life, feeling detached from others, a lessened range of feelings, pronounced blame of self and/or others, and feeling one's future has been damaged or shortened. **4)** persistent symptoms of altered (hyper)arousal and reactivity such as exaggerated startle reflex, disturbed sleep, poor concentration, irritability, aggressive reckless self destructive behavior, and hyper-vigilance.

PTSD if severe, persistent, or if the trauma is repetitive, especially in a sensitized individual, reflects actual changes in the body and brain chemistry. This can cause inappropriate reactions to otherwise normal events. These brain changes tend to persist but can be lessened or resolved by time and treatment.

PTSD will occur at some time in the life of about 5% of people, with the rate higher in females. More life-threatening, violent, traumas perpetrated intentionally by others, rather than accidents, cause higher rates of PTSD. This is true for both military and civilian trauma. Persons who have pre-existing vulnerabilities and/or who have experienced prior traumas also experience higher rates of PTSD. Most people who experience PTSD will have symptoms resolve with or without treatment in less than a year, although treatment often speeds up recovery and lessens symptoms while helping one to cope and understand the trauma and disorder. However, there are individuals whose symptoms may persist for a few or many years. PTSD may be complicated by accompanying depression, panic attacks, obsessive compulsive disorder, phobias or other disorders. These conditions, substance abuse, and other problems may cause recovery to be more difficult.

Treatment may include psychotherapy, behavior therapy, and/or medication. Therapy techniques especially suited to PTSD include helping the patient process and rethink the event(s) via safe "exposure" techniques, cope with and resolve any loss and grief, lessen the complicating effects of any other conditions like depression or substance abuse, and cognitive (thought changing) techniques including desensitization. **Exposure therapy has repeatedly been shown to be for most cases the most effective treatment.** Hypnosis is sometimes helpful and Eye Movement Desensitization Retraining (EMDR) is often helpful. The medication prazosin often helps the acute symptoms of increased arousal mentioned above, especially nightmares and sleep while antidepressant anti-anxiety medications like the SRI's Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), Luvox (fluvoxamine), Celexa (citalopram), Lexapro (escitalopram), Anafranil (clomipramine), Effexor (venlafaxine), and Cymbalta (duloxetine) are often helpful especially as part of a broader treatment plan including exposure therapy. Even Mild Traumatic Brain Injury leads to and worsens PTSD. Much is being learned from the experiences of our soldiers and support personnel in Iraq, Afghanistan, and throughout the world. Increased attention is being paid to very early interventions into acute effects of trauma on memories including using memory modulators such as beta blockers, NMDA modulators, and specific immediate crisis therapy interventions. Of course, prevention of trauma is the most important intervention.

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