CHAPTER 5

ANXIETY DISORDERS

What Are Anxiety Disorders?

Individuals with anxiety disorders experience excessive anxiety, fear or worry, causing them to either avoid situations that might precipitate the anxiety or develop compulsive rituals that lessen the anxiety.

While everyone feels anxious in response to specific events, individuals with an anxiety disorder have excessive and unrealistic feelings that interfere with their lives in their relationships, school and work performance, social activities and recreation.

Symptoms
Anxiety Disorders
• Intense and prolonged feelings of fear and distress that occur out of proportion to the actual threat or danger • The feelings of fear and distress interfere with normal daily functioning

Types of Anxiety Disorders[1]

Generalized Anxiety Disorder (GAD)

Excessive anxiety and worry about a number of events or activities occurring for more days than not over a period of at least six months with associated symptoms, such as fatigue and poor concentration.

Specific Phobia

Marked and persistent fear of clearly discernible objects or situations, such as flying, heights and animals.

Post-traumatic Stress Disorder (PTSD)

Flashbacks, persistent frightening thoughts and memories, anger or irritability in response to a terrifying experience in which physical harm occurred or was threatened, such as rape, child abuse, war or natural disaster.

Social Phobia, also known as Social Anxiety Disorder

Extreme fear or avoidance associated with social or performance situations, such as conversations, parties, meetings, public speaking and other situations in which a person may be embarrassed, humiliated or observed.

Obsessive-Compulsive Disorder (OCD)

Obsessions: Persistent thoughts, ideas, impulses or images that are perceived as intrusive and inappropriate and that cause marked anxiety or distress. Individuals with obsessions usually attempt to ignore or suppress such thoughts or impulses or to counteract them by other thoughts or actions (compulsions).

Compulsions: Repetitive behaviours (such as hand-washing, ordering or checking) or mental acts (such as praying, counting or repeating words) that occur in response to an obsession or in a ritualistic way.

Panic Disorder

Presence of recurrent, unexpected panic attacks, followed by at least one month of persistent concern about having additional attacks, worry about the implication of the attack or its consequences, or a significant change in behaviour related to the attacks.

The essential feature of the panic attack is a discrete period of intense fear or discomfort that is accompanied by at least four of thirteen physical symptoms such as:

- Palpitations, increased heart rate or pounding heart;
- Sweating;
- Trembling or shaking;
- Sensations of shortness of breath or smothering;
- Feeling of choking;
- Chest pain or discomfort;
- Nausea or abdominal distress;
- Dizziness, unsteadiness, light-headedness or fainting;
- De-realization or de-personalization;
- Fear of losing control or going crazy;
- Fear of dying;
- Paresthesias; and
- Chills or hot flashes.

Agoraphobia

Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of an unexpected or contextually cued panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train or automobile.

How Common Are Anxiety Disorders?

As a group, anxiety disorders represent the most common of all mental illnesses. Population-based surveys provide various estimates of how common anxiety disorders are in the population. One Ontario study[2] estimated that 12% of adults between 15 and 64 years of age—9% of men and 16% of women—had experienced an anxiety disorder during the 12 months prior to the survey. The US National Comorbidity Survey (2001–2003) estimated that 18.1% of adults 18 years of age and over had an anxiety disorder in the 12 months preceding the survey.

According to Statistics Canada's 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2), 4.7% of Canadians 15 years of age and over reported symptoms that met the criteria for one of the following anxiety disorders in the previous 12 months: 1.6% panic disorder; 0.7% agoraphobia; and 3.0% social anxiety disorder. Over 1 in 10 adults (11.5%) reported symptoms that met the criteria for having had one of these anxiety disorders during their lifetime: 3.7% panic disorder; 1.5% agoraphobia; and 8.1% social anxiety disorder.

Earlier Canadian studies[3,4,5] estimated the prevalence of various anxiety disorders during a one-year period among individuals between the ages of 15 and 64 years:

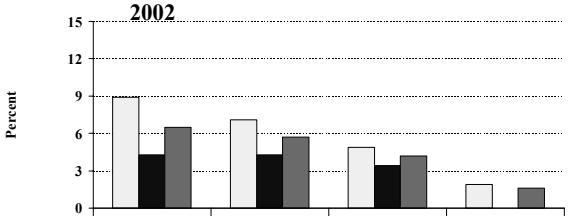
- 1.1% had generalized anxiety disorder;
- 6.2%–8.0% had specific phobia;
- 6.7% had social phobia;
- 1.8% had obsessive compulsive disorder and
- 0.7% had panic disorder.

Impact of Anxiety Disorders

Who Is Affected by Anxiety Disorders?

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), a greater proportion of women than men under the age of 65 year had symptoms that met the criteria for one of the measured anxiety disorders during the previous 12 months. (Figure 5-1) The greatest difference was among young adults (15–24 years), where young women were twice as likely as young men to have an anxiety disorder (8.9% compared to 4.3%). The gap narrowed with age because the proportion of women with an anxiety disorder decreased with age. Seniors had lower 12-month and lifetime prevalence of anxiety disorder than all younger age groups. (Figure 5-2) Approximately 1 in 8 adults in Canada aged 15–24, 25–44 and 45–64 years reported symptoms that met the criteria for having had one of the selected anxiety disorders during their lifetime.

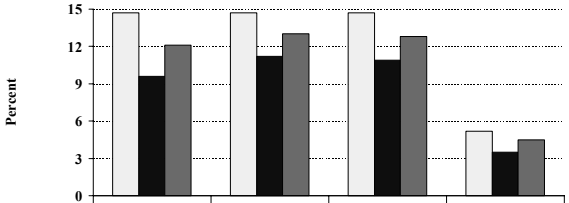
Figure 5-1 Proportion of population that met the criteria for one of the selected anxiety disorders in the previous 12-months, by age and sex, Canada, 2002



	15-24 years	25-44 years	45-64 years	65+ years
Women	8.9	7.1	4.9	1.9
Men	4.3	4.3	3.4	**
Both	6.5	5.7	4.2	1.6

** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 5-2 Proportion of population that met the criteria for one of the selected anxiety disorders during lifetime, by age and sex, Canada, 2002



	15-24 years	25-44 years	45-64 years	65+ years
Women	14.7	14.7	14.7	5.2
Men	9.6	11.2	10.9	3.5
Both	12.1	13.0	12.8	4.5

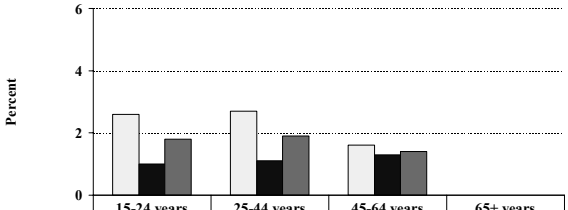
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Women in the 15–24 and 25–44 year age groups were more likely than men to be identified as having **panic disorder** in the previous 12 months. (Figure 5-3) In the 45–64 year age group, the proportions among men and women were similar. Although the 12-month prevalence of panic disorder was lower in the 45–64 year-old age group, the lifetime prevalence was higher in this age group than in all other age groups. (Figure 5-4).

A greater proportion of young women than young men (15–24 years) reported symptoms that met the criteria for having had **social phobia** during the previous 12 months. (Figure 5-5) The proportion among women decreased with age. Nearly 1 in 10 Canadians under the age of 65 years met the criteria for having had social phobia at some time in their lives. (Figure 5-6) Lifetime prevalence decreased dramatically over age 65 years.

Women were twice as likely as men to report symptoms that met the criteria for **agoraphobia:** 1.0% versus 0.4%. The sample size was too small to assess the prevalence by age.

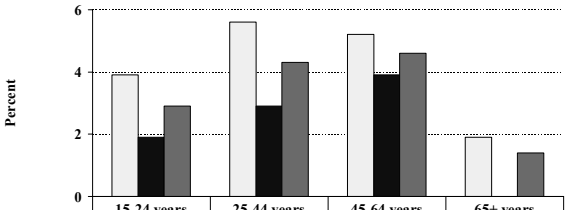
Figure 5-3 Proportion of population that met the criteria for panic disorder during the previous 12 months, by age and sex, Canada, 2002



	15-24 years	25-44 years	45-64 years	65+ years
Women	2.6	2.7	1.6	**
Men	1.0	1.1	1.3	**
Both	1.8	1.9	1.4	**

** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

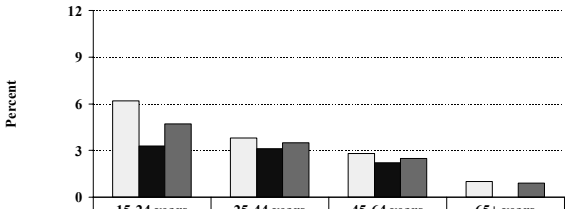
Figure 5-4 Proportion of population that met the criteria for panic disorder during lifetime, by age and sex, Canada, 2002



	15-24 years	25-44 years	45-64 years	65+ years
Women	3.9	5.6	5.2	1.9
Men	1.9	2.9	3.9	**
Both	2.9	4.3	4.6	1.4

** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

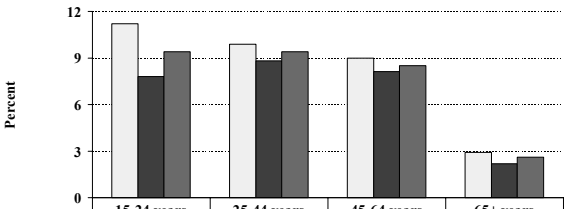
Figure 5-5 Proportion of population that met the criteria for social phobia during the previous 12 months, by age and sex, Canada, 2002



	15-24 years	25-44 years	45-64 years	65+ years
Women	6.2	3.8	2.8	1.0
Men	3.3	3.1	2.2	**
Both	4.7	3.5	2.5	0.9

** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 5-6 Proportion of population that met the criteria for social phobia during lifetime, by age and sex, Canada, 2002



	15-24 years	25-44 years	45-64 years	65+ years
Women	11.2	9.9	9.0	2.9
Men	7.8	8.8	8.1	2.2
Both	9.4	9.4	8.5	2.6

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

How Do Anxiety Disorders Affect People?

Symptoms of anxiety disorders often develop during adolescence or early adulthood.[6] People with anxiety disorders avoid situations that precipitate their symptoms. This avoidance can seriously restrict education, work, recreation and social activities.[7]

Individuals severely affected by one anxiety disorder are also more likely to have either another type of anxiety disorder, major depression or dysthymic disorder, problematic substance use, or a personality disorder.[8] This compounds the impact of the anxiety disorder and presents challenges for effective treatment.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), most of the individuals who reported symptoms that met the criteria for social phobia or panic disorder in the previous 12 months reported that it interfered with their lives: 75.6% of those with panic disorder and 82.6% with social phobia. These individuals reported that their conditions affected their home, school, work and social life. (Figure 5-7) Two-thirds (66.3%) of those with social phobia reported that it interfered with their social life. Approximately 1 in 2 of those with panic disorder stated that it interfered with home, work and social life.

Economic Impact

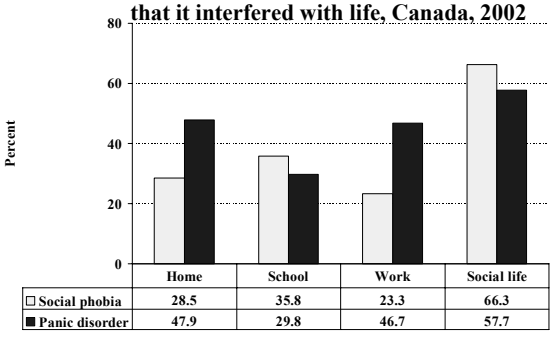
Because they are so common, anxiety disorders have a major economic impact.[9] They contribute to lost productivity due to both time away from work and unemployment. Other associated costs include claims on disability insurance.

Heavy use of the emergency department and primary care system in reaction to physical symptoms also contributes to significant health care costs.

Stigma Associated with Anxiety Disorders

Because anxiety disorders are the extension of what most people perceive as normal worry and concern, those who experience them may fear that others will label their worry and fear as excessive and weakness. As a result, they may keep their symptoms to themselves and try to deal with them alone.

Figure 5-7 Proportion of population aged 15+ years that met criteria for social phobia or panic disorder in previous 12 months who stated that it interfered with life, Canada, 2002



	Home	School	Work	Social life
□ Social phobia	28.5	35.8	23.3	66.3
■ Panic disorder	47.9	29.8	46.7	57.7

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Causes of Anxiety Disorders

Anxiety disorders develop from a complex interplay of genetic, biological, cognitive, developmental and other factors, such as personal, socio-economic and workplace stress. A variety of theories has been proposed to explain how these factors contribute to the development of anxiety disorders.[10]

The first is experiential: people may learn their fear from an initial experience, such as an embarrassing situation, physical or sexual abuse, or the witnessing of a violent act. Similar subsequent experiences serve to reinforce the fear.

A second theory relates to cognition or thinking, in that people believe or predict that the result of a specific situation will be embarrassing or harmful. This may occur, for example, if parents are over-protective and continually warn against potential problems.

A third theory focuses on a biological basis. Research suggests that the amygdala, a structure deep within the brain, serves as a communication hub that signals the presence of a threat and triggers a fear response or anxiety. It also stores emotional memories, and may play a role in the development of anxiety disorders. The children of adults with anxiety disorders are at much greater risk of an anxiety disorder than the general population, suggesting that genetics may play a role as well.[11] Numerous studies have also confirmed that neurotransmitters in the brain, such as serotonin, norepinephrine, as well as hormonal factors influence the onset and course of anxiety disorders.

Recovery from Anxiety Disorders

Early recognition and appropriate management are imperative to the enhancement of the quality of life of individuals with anxiety disorders. Proper recognition and management also help to prevent common secondary disorders, such as depression and problematic substance use.

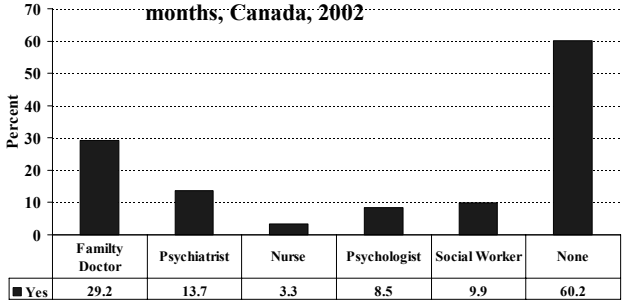
Several factors, such as stigma, lack of knowledge or personal financial resources, or lack of available health professionals, may discourage people from seeking help for anxiety disorders. In addition, family physicians may not always recognize the pattern in an individual's symptoms that would lead to a correct diagnosis. Too often, symptoms are not taken seriously and an individual with an anxiety disorder is labelled as being emotionally unstable. Education of both the public and family physicians would help to solve this problem.

A recent review of anxiety disorders research suggests that effective treatments include drug therapy (usually with anti-depressants or anti-anxiety drugs) and cognitive-behavioural therapy, which helps people turn their anxious thoughts into more rational and less anxiety-producing ideas and encourages them to confront feared situations and eliminate various safety behaviours.[12,13] Support groups for individuals and families can also help develop the tools for minimizing and coping with the symptoms.

Anxiety disorders can be well managed in the primary care setting. Creating access to experts in cognitive-behaviour therapy through a shared-care model can help family physicians provide optimal care for the individuals under their care.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), 3 of 5 individuals with one of the selected anxiety disorders reported that they did not consult a health professional about their condition. (Figure 5-8) The most commonly consulted professional was the family doctor, followed by a psychiatrist, social worker or psychiatrist.

Figure 5-8 Consultation with a professional by adults aged 15+ years who met the criteria for a selected anxiety disorder in the previous 12 months, Canada, 2002



	Family Doctor	Psychiatrist	Nurse	Psychologist	Social Worker	None
Yes	29.2	13.7	3.3	8.5	9.9	60.2

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Endnotes

1 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th edition. Washington, DC: American Psychiatric Association; 1994.

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6 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DMS-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62:593–602.

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8 Brown TA, Campbell LA, Lehman CL, Grisham JR, Mancill RB. Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. Journal of Abnormal Psychology. 2001;110:4:585–99.

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