Clinical Management of Anxiety

edited by

Johan A. den Boer

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Marcel Dekker, Inc. New York•Basel•Hong Kong

ISBN: 0-8247-9777-9

Marcel Dekker, Inc.
270 Madison Avenue, New York, New York 10016

Current printing (last digit):

10 9 8 7 6 5 4 3 2 1

PRINTED IN THE UNITED STATES OF AMERICA

Medical Psychiatry

Series Editor

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Cornell University Medical College
New York, New York

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Introduction

Anxiety is ubiquitous. Symptomatic anxiety occurs in most patients who are ill, either medically or psychiatrically, and anxiety disorders are common. Despite this, there is little consensus about what physicians and other therapists should do to help these suffering individuals. Should the "merely anxious" receive medication? When should we use which therapy, or therapies, and for which patients? In *Clinical Management of Anxiety* den Boer has succeeded in editing a book that spreads its tent broadly, and includes multiple frameworks: from biology and psychopharmacology on to the psychologies (from Freud to the existentialists, the behaviorists, and the cognitive psychologists). It presents both theory and practice.

One of the special features of this book is that the editor is from The Netherlands. American psychiatrists, who read the *Archives of General Psychiatry, The American Journal of Psychiatry*, and all too many pharmaceutical company throwaways, tend to be psychiatric provincials, unaware of the developments, advances, and viewpoints of those in other countries. While our research may dominate and our theories are important, they do not encompass the whole of psychiatry. Although the biology of the major illnesses is the same everywhere in the world, how we organize what we know and see, as well as what we think we understand, differs from country to country, and from culture to culture. Most of the psychiatrists I have met in China, Egypt, Scandinavia, Great Britain, and elsewhere in Europe, read widely, not only their own national jour-

nals, but also American and, likely, a number of other publications. In 1980, when I visited the provincial psychiatric hospital in Xiang, China, I was told that in addition to Chinese journals, they also read American, British, Scandinavian, German, French, and Russian ones.

Perhaps because of the cosmopolitan history of The Netherlands, this book is more inclusive than most. It presents multiple viewpoints, some unfamiliar to American psychiatrists, Together these enrich our understanding of the anxiety states and of the multitude of treatments that are effective in varying situations with individual patients.

William A. Frosch

Preface

Anxiety is a very complex emotional state in which subjective and cognitive evaluations, as well as behavioral, physiological and neuroendocrine responses, are involved. Considering the complexity of the emotion of anxiety, which can be described in several scientific languages and analyzed on very different levels, it is far from clear which treatment approach should be used with each individual patient. In most patients suffering from anxiety, cognitive, behavioral, and biological factors are intertwined. One way to break this "cycle" is through pharmacotherapy, but there is increasing evidence that additional therapeutic interventions are necessary.

During the last decades, considerable progress has been made not only in neurobiological theories and psychopharmacology, but also in behavioral and cognitive as well as combined approaches to anxiety. Relatively little attention has been given to alternative therapeutic interventions like supportive therapy, family therapy, and hynotherapy.

Clinical Management of Anxiety gives the clinician an updated review of the theoretical foundations of cognitive, behavioral, and neurobiological paradigms of anxiety. In addition, it contains an overview of current therapeutic strategies.

The reader who is less interested in theory and more interested in empirical studies substantiating different therapeutic strategies will be able to skip the more theoretical chapters and still find an overview of current treatment possibilities.

The existential dimension of the subjective experience of anxiety has unfortunately received little attention in most texts. Despite the fact that during the 1950s and '60s many philosophers and psychiatrists made solid contributions to this field, psychiatry as a whole appears to have neglected this line of thinking to a large extent—and unjustly so! Therefore, this book also attempts to shed light on the more subjective and existential aspects of anxiety.

The first two chapters are introductory: Chapter 1 gives a historical overview of different treatment options for anxiety; Chapter 2 reviews current thinking in diagnosis and classification of anxiety disorders.

Chapter 3 gives a critical overview of theories in which the existential significance of the subjective experience of anxiety is described. Chapter 4 is a logical extension of Chapter 3, and describes examples of existential psychotherapy. Chapter 5 provides an overview of the practical aspects of behavioral therapy. Chapter 6 reviews recent experiments of combined psychotherapeutic and pharmacological approaches. Chapters 7 and 8, respectively, focus on the theoretical foundations and empirical studies of cognitive therapy.

Chapter 9 focuses on the significance of modern psychoanalytical theory and Chapter 10 critically reviews the significance of hypnotherapy for the treatment of anxiety.

In Chapters 11 and 12, current neurobiological theory and psychopharmacological approaches are outlined. Chapter 13 is devoted to posttraumatic stress disorder, a disorder in which the intermingling of psychological and biological influences has become a focus of recent attention.

Chapters 14 and 15 give a critical overview of interactional and group psychotherapy. And, finally, Chapters 16 and 17 are devoted to diagnostic aspects and treatment of childhood anxiety disorders.

This book represents the state of the art concerning the theoretical foundations of different therapeutic approaches. In addition, it provides practical guidelines for most of the currently available therapeutic strategies for treating anxiety disorders, which enable the clinician to break the cycle of anxiety.

Johan A. den Boer

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Contents

Introduction (William A. Frosch) *iii*
Preface *v*
Contributors *ix*

1. History of Treatment Options for Anxiety Disorders 1
   German E. Berrios
2. Diagnostic Dilemmas in Anxiety Disorders 23
   Stephen M. Stahl
3. The Subjective Dimension of Anxiety: A Neglected Area in Modern Approaches to Anxiety? 43
   Gerrit Glas
4. Existential and Differential Aspects of Anxiety 63
   A. Kraus
5. Behavioral Treatment Strategies for Panic Disorder, Social Phobia, and Obsessive-Compulsive Disorder 79
   Paul M. G. Emmelkamp and Agnes Scholing
6. Combination Therapy for Anxiety Disorders 109
   Richard van Dyck and Anton J. L. M. van Balkom

7. The Theoretical Basis of Cognitive Therapy 137
Asle Hoffart

8. Practical Applications of Cognitive-Behavioral Therapy in Anxiety Disorders 151
G. Randolph Schrodt, Jr., Jesse H. Wright, and Kevin J. Breen

9. Current Psychoanalytical Views on Anxiety: Consequences for Therapy 179
Frans de Jonghe

10. The Status of Hypnotherapy in the Treatment of Anxiety Disorders 197
Philip Spinhoven, A. J. Willem Van der Does, and Richard van Dyck

11. Neurobiology and the Treatment of Panic Disorder 231
Herman G. M. Westenberg and Johan A. den Boer

12. Psychopharmacological Approaches to the Treatment of Anxiety Disorders: A Critical Review and Practical Guidelines 249
Antoine Pélissolo and Jean-Pierre Lépine

13. Psychobiology and Clinical Management of Posttraumatic Stress Disorder 295
Rolf J. Kleber

14. The Significance of Neuro-Linguistic Programming in the Therapy of Anxiety Disorders 321
Graham Dawes

15. Group Psychotherapy as a Therapeutic Principle in Anxiety Disorders 349
Sherrie L. Smith and Howard D. Kibel

16. Anxiety Problems in Childhood: Diagnostic and Dimensional Aspects 371
Christopher A. Kearney and Karen E. Sims

17. Treatment Strategies in Children with Anxiety Disorders 399
Troy Tranah and William Yule

Index *421*

1

History of Treatment Options for Anxiety Disorders

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In general, historical accounts of psychiatric therapies are difficult to write. The historian faces the danger of ethical judgmentalism in regard to the often cruel nature of some early treatments. There is, however, no reason to believe that the alienists of old were any less intelligent, caring, or ethically motivated than therapists are today. The history of clinical psychiatry has as its main objective the identification of the rules connecting science and ideology with clinical behavior (1). This will also be the guiding idea for this chapter. Since little has been published on the history of anxiety disorders themselves, as much material on such phenomena will be included as to facilitate understanding of the history of their treatment.

THE ORIGINS

The concept of anxiety disorder is a modern one, which, during the late nineteenth century, gradually arose from the mass of clinical phenomena once called the "neuroses" (2–5). Originally, no boundaries existed between what are today called generalized anxiety disorder, panic disorder, and phobia (6). This, of course, does not mean that individual symptoms were not seen in isolation: indeed, some have been known since time immemorial (7), but were reported as part of different social or clinical domains. For example, during the eighteenth century some of these symptoms were considered to be specific diseases;

during the 1890s, these same symptoms were, for the first time, combined into a construct that began to resemble what we now have.

Before the final synthesis took place, such symptoms were found in clinical realms as disparate as cardiovascular, inner ear, gastrointestinal, or neurological medicine. Each symptom was taken at face value and treated as a real physical complaint. Thus, anxiety symptoms were mostly reported in journals of general medicine and their treatment had little to do with psychiatric practice. Indeed, prior to the turn of the century, asylum alienists rarely saw patients thus affected.

Conventionally, the symptoms of anxiety have been divided into two categories. Subjective symptoms (i.e., psychological experiences) include feelings of fear, worry, terror, depersonalization, etc., as well as cognitions such as obsessive thoughts concerning the safety of others, fear of dying, etc. Somatic symptoms (also called anxiety equivalents) putatively involve bodily functions, including abdominal pain, nausea, vertigo, dizziness, palpitations, dry mouth, hot flushes, hyperventilation, breathlessness, headache, restless legs, and other experiences, which are sometimes indistinguishable from complaints caused by physical disease.

According to personality, culture, social class, and other unidentified variables, subjects present symptom combinations and permutations. When repetitive and stable, these become syndromes or diseases. When the subjective symptoms are diffuse and more or less continuous, they are called generalized anxiety disorder; if paroxysmal, panic attacks. The latter are mostly spontaneous, but when triggered by a recognizable stimulus (e.g., going out, spiders, etc.), they are called phobias and are named after the predominant stimulus. The current (fashionable) view that crises of anxiety (panic disorder) constitute a separate disease is also new. In earlier times, such attacks were considered to be part of the anxiety neurosis, neurasthenia, or psychasthenia, and even earlier were thought to be symptoms of cardiovascular (8) or inner ear disorders (9).

An historical account of the origin of the modern concept of anxiety disorder and its allied clinical states must deal with the following questions:

1. Why were such symptoms and signs—often so dissimilar in appearance—brought together under the same banner?
2. Was this the result of clinical observation or of theoretical and social shift?
3. Were these states considered to be exaggerations of normal psychological phenomena, or as morbid forms?
4. How relevant to their inception were late nineteenth-century theories of emotion and the then-developing views on the functions of the ganglionar (autonomic) nervous system?

It goes without saying that the history of anxiety can also be studied from a metaphysical, social, poetic, or religious perspective. This chapter focuses only on its medical aspects.

The Word "Anxiety" and Cognates

The view suggested by Ey (6) that *anxiété* gained its medical meaning at the end of the nineteenth century needs rectification. Eighteenth-century nosologists—including those whose mother tongue was French—had already made use of the Latin term to describe paroxysmal states of restlessness and inquietude. For example, *anxietas* is used by Boissier de Sauvages, Linné, Vogel, and Sagar (10). In addition, panophobia, vertigo, palpitatio, suspirium, and oscitatio (all redolent of anxiety and panic attacks) were used to refer to complaints that Continental nosologists considered as independent physical diseases. It is important to note here that these clinical states were not considered as vesanias (i.e., mental disorders). The Scottish physicians McBride and Cullen were far more economical in their nosological classification, and the nearest Cullen got to describing a somatic symptom of anxiety was in his category of *palpitation melancholica* (10).

Early in the nineteenth century, Landré-Beauvais (11) defined anxiety as "a certain malaise, restlessness, excessive agitation" and used the word *angoisse*; he suggested that such symptoms accompanied acute and chronic diseases. There is little doubt that Landré-Beauvais attempted to conceptualize anxiety as a syndrome with both subjective and somatic components accompanying diverse diseases (see below). In 1858, Littré and Robin defined *angoisse* as "feelings of closeness or pressure on the epigastric region, accompanied by a great difficulty in breathing and excessive sadness; it is the most advanced degree of anxiety" (12) and *anxiété* as a "troubled and agitated state, with feelings of difficulty in breathing and pressure on the precordial region: inquietude, anxiety and anguish are three stages of the same phenomenon" (12).

Lewis has analyzed the way in which the etymology of anxiety, anguish, and anger influenced the clinical conceptualization of the anxiety states (13). To this it must be added that, while the dichotomy anxiety-anguish has little clinical meaning in Anglo Saxon psychiatry (the term *anguish*, in fact, never gained a place in medical terminology), it found a comfortable niche in France, Germany, and Spain where the terms *angoisse, Angst,* and *angustia,* respectively, carry distinct meanings and refer to the paroxysmal and more severe aspects of the disorder. Also playing on the etymology of the term anxiety, Sarbin attempted to demonstrate that the symptom was a metaphor (14,15); unfortunately, historical inaccuracy and loose argument mar his interesting ideas. (For a good discussion of the etymology involved, see Ref. 16.)

Anxiety-Related Behaviors

No matter the name given the states (i.e., the history of the words) or how they were explained (the history of the concepts), behaviors recognizable as anxiety-related are described in the literature of the past (17). Altschule, for example, reminds us that writers such as Arnold, Locke, Battie, Mead, Smith, and Crichton described medical states of inquietude and uneasiness (18). For reasons of space, this chapter will only deal with such behaviors, concepts, or words as they feature in the clinical theater of the nineteenth century and after.

By the early nineteenth century, anxiety symptoms began to be included under other medical categories: for example, Pinel subsumed anxiety symptoms under epilepsy, melancholia, rabies (particularly of the spontaneous variety), and the motility neuroses (19). Georget included some of these complaints in a section of his book on general and sympathetic symptoms (20). Likewise, Griesinger (21) [quoting Guislain (22)] reported that 9% of insanities start with acute fear.

During this period, however, translational difficulties hampered exchanges between the psychiatric communities of Germany, England, and France. For example, where Guislain had written *craintes et frayeurs* (22), Griesinger translated *Shrecken oder Angst* (21) and Robertson and Rutherford "shock or anxiety" (23). The drift in meaning from *frayeur* to *Angst* to "anxiety" reflects well the evolution of this symptom during the middle of the nineteenth century and after. Whereas Guislain was referring only to acute fear, Griesinger introduced *Angst*, a term that, after the publication of Kierkegaard in 1844 (24), acquired a meaning that went well beyond fear. Apart from reflecting Kierkegaard's own psychopathology (25), the term brought into play the new epistemological and religious dimensions that Kierkegaard had attached to "anguish" (26).

Another example is provided by the term "nervousness," used to encompass most of the subjective aspects of the anxiety states. The anonymous reviewer (27) of Bouchut's book on *nérvosisme* (28) complained of its vagueness but accepted that there was no good alternative to the English word "nervousness." It seems clear both from the points made by the reviewer and from Bouchut's quotations that the monograph was *not* only about hysteria or hypochondria (as would have been expected during this period), but also about anxiety and its somatic accompaniments (29).

Anxiety as Cause of Mental Disorder

With his usual clinical acumen, Feuchtersleben wrote that intense anxiety and grief lead us to expect organic affections of the heart and of the larger vessels, fretfulness, dejection, discontent and a disordered digestion (30). The Austrian writer was not discussing, however, diseases as such but the relationship of