ANXIETY

A MULTIDISCIPLINARY REVIEW

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ANXIETY: A MULTIDISCIPLINARY REVIEW

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Dedicated to the tolerant tribe

Ann, illustrious illustrator
Clare, výborná učitelka
Freya, the human face of public health
Jonathan, man of many powers, and
Suki, organiser of manuscripts

PREFACE

Anxiety is a conundrum and our ignorance about its origins, generation, significance and purpose is profound. We certainly know much more about its manifestations but without this other information our interpretation of these could be badly flawed. Texts on anxiety often attempt to paper over these cracks and present a comprehensive picture of the subject, and although these are often internally consistent, they inevitably contain a great deal of speculation.

This is a personal account of anxiety in its many forms, encountered mainly in a pathological degree during thirty years of psychiatric practice. As such, it is bound to be idiosyncratic and somewhat deviates significantly from more conventional views, particularly with regard to classification. I have tried to be frank and honest about these differences, explaining the reasons for my concerns, and making it clear where my own views deviate significantly from the majority opinion.

Although there are sometimes specific reasons for these deviations, the fundamental one which crystallises my concern over existing views of anxiety is that the emotion has been excessively compartmentalised and its separate elements are too often studied in isolation. We need to be reminded that anxiety is one of the most prominent features of the psychiatric landscape. It is like an old and well recognised tree, that is visible from all perspectives, and whose roots penetrate deep into other conditions and cannot be considered in isolation. My personal view, and I am prepared to admit it may be a mistaken one, is that our present knowledge is so limited that we should continue to regard anxiety as a diffuse emotion that is rarely seen in pure form and that much of its significance in clinical practice and normal function lies in its interactions

with other emotions and behaviour. The facts of anxiety are relatively straightforward; it is their content that confuses.

Despite these differences of opinion from those of others, the format of this book is a fairly standard one. The book is divided into two main sections, a general one in which the main features of anxiety are described, how it is measured and what physiological changes accompany it, and how it is interpreted in dynamic terms; and a second clinical section which describes the ways in which pathological anxiety is classified, how it is treated, and what are its usual outcomes. In a last chapter, I try to bring together the somewhat disparate elements of the preceding discussion to focus on the main core of pathological anxiety and how it relates to the other elements of the mood. There are many omissions, amongst which the most prominent may be the absence of significant discussion about the neuropharamacology of the subject, which I find bewildering in its speed of development and changes of emphasis, but which I am sure has contributed greatly to our understanding.

I have tried to write in relatively simple language but it is impossible to avoid discussing this subject in any depth without introducing the reader to a host of new words that now surround the subject. I have tried to give an appropriate explanation for each of these but appreciate that I may not be successful in clarifying all of them and apologise in advance; I do not understand them all fully either. Because I have indulged in a personal account I realise that many aspects of the subject may be under-represented and some other may be ignored altogether. What I hope will become apparent is that anxiety is both a healthy emotion and a major concern for a very large number of people and, for the latter, our efforts to reduce the suffering associated with it remain woefully inadequate. The book therefore attempts to illuminate our ignorance rather than offer easy solutions; it is in no way a self-help primer.

I should like to thank Jenny d'Souza, Jackie Reynolds and Sarah Dodd for secretarial help, and my many colleagues for giving me at least partial support for my aberrant views on this subject, among whom Nick Seivewright, Siobhan Murphy, Robert Kendell, Paul Pilkonis, Patricia

Casey, Brian Ferguson and Michael Stone are prominent. They have helped me to find a way of understanding the conundrum which I suspect is like the exhortation of the Irish priest, "the steep and narrow path between right and wrong", but at least has sustained me on my clinical and research travels.

Peter Tyrer January, 1998

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CONTENTS

Chapter 1

WHAT IS ANXIETY?

What is anxiety? Let me count some of the ways in which it has been expressed to me over the past thirty years, mainly by people who have suffered greatly from it:

"it is like being about to die and never being able to leave that moment"
"being chased by dragons"
"worrying about every second of the future and always getting it wrong",
"it makes my body all a-jangle"
"indescribable awfulness"
"like an elastic band just about to break"
"like I've been injected with gun powder"
"not knowing who or what I am, just a feeling"
"like being at the end of the world and then the world never ends".

However, there is another sense in which anxiety is used in everyday life and this is not nearly so disturbing. People are anxious to get things done, to make sure things go well, to be on time for a big occasion and while awaiting a major event, whether it brings joy or sadness. It is when one comes across anxiety in this context that it becomes clear that anxiety is not something to be abhorred or stamped out; a world without anxiety would be a grey and boring place that would lead to frustration and torpor.

Anxiety therefore seems to cover a range of experiences, a large deal of which is normal and experienced by all at sometime in their lives, and some of which is pleasurable. At the more pathological extreme, anxiety becomes unpleasant, distressing and, in its most extreme form,

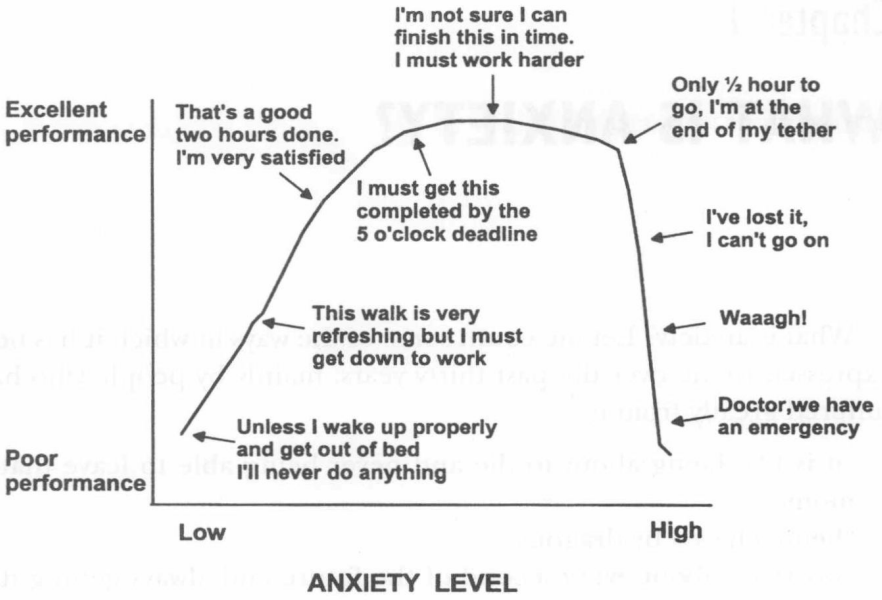

Fig. 1.1 The Yerkes-Dodson law of the relationship between anxiety and performance illustrated by an example.

one of the most intolerable experiences to which our minds and bodies are exposed. This range is best encapsulated by a research finding demonstrated by American psychologists 90 years ago. Yerkes and Dodson (1908) noted that anxiety had an unusual relationship to performance and this is best represented by an inverted U (Fig. 1.1).

The lowest level of anxiety is absolute calm, or more accurately described as deep sleep or, at an even more inactive state, coma. In such a state there is no response to most stimuli and only the most intense of experiences will arouse the individual. However, coma is generally an abnormal state and does not necessarily represent the total absence of anxiety. At somewhat higher levels the person is drowsy, often drifting in and out of sleep, and is functioning at a very low level. In Fig. 1.1, this person is at the bottom end of the U-shaped curve on the left. As awareness improves, performance and function also improve. The level of anxiety rises as basic drives need to be satisfied such as hunger, thirst,

physical and sexual activities. In fact, at these levels anxiety is also a drive and is extremely important for the protection of the species.

As demands increase, anxiety does also, and is rewarded by an improvement in performance. Eventually, however, a plateau of activity is reached in which performance cannot improve anymore. In these circumstances the individual feels tense and anxious and under pressure but is able to cope with this without improving any further in performance. Once anxiety levels increase beyond this point, performance disintegrates rapidly. Concentration deteriorates, the ability to perform co-ordinated physical and mental activities is lost, and the person ceases to have any control over the task in hand. At its most extreme state the person returns to the primitive levels of activity found in the lowest levels of anxiety and (rarely) may need admission to an institution for care. The captions on each part of the figure indicate the subjective responses of an individual passing along this spectrum of "the rise and fall of the anxious man".

It is difficult to decide where anxiety is first noted on this spectrum. It is certainly not present early in the U-shaped curve and probably is only noted when each increment of demand no longer leads to an equal increment of performance and instead levels off towards the plateau. It is also uncertain from the above descriptions what the essential elements of anxiety are. Is it a feeling or a mood, a brain state, a syndrome of specific symptoms, particularly bodily ones, or a catastrophic interpretation of events? It is first necessary to define our terms.

THE ETYMOLOGY OF ANXIETY

Aubrey Lewis (1967), in a celebrated paper that demonstrates his breadth of scholarship, described the problems that can arise from different interpretations of the word "anxiety" and also showed that its etymological derivation covers all the elements of anxiety described above. The root of anxiety is the indogermanic word "Angh" which appears in Greek and Latin in a variety of words describing the feeling of constriction or throttling but also encompassing longer-lasting distress and discomfort. What is curious is that what is generally accepted as

one of the richest languages in the world, English, has largely stuck to one word, anxiety, to describe both the acute and long-term forms of this feeling. This has led to considerable confusion as anxiety now has at least four separate meanings:

- a state of agitation and tension
- troubled in mind
- solicitous desire to effect some purpose (a use that will not be discussed elsewhere in this book as it is irrelevant to its subject)
- uneasiness about a coming event.

Table 1.1 The Words for the Two Forms of Anxiety in Different Languages

Language	Acute Anxiety (attacks) (associated with fear and bodily perturbations)	Chronic Anxiety (unpleasure, subjective discomfort, mental tension)
French	angoisse	anxiété
German	Angst	Erregungszustände
Italian	angoscia	ansieta
Spanish	angustia	ansiedad
Swedish	ångest	anxietas

Another word, anguish, used formerly to describe anxiety, has now been lost from the nomenclature as it has been transferred to the territory of depression, where it is associated with grief and despair. However, in other languages the distinction has been retained and there are usually two words for anxiety: one devoted to a long-term state which is equivalent to "troubled in mind" above, and another describing the acute episodes of anxiety in which there are bodily accompaniments such as tightness in the chest and difficulty in breathing, palpitations, sweating and tremor. Some of these words are shown in Table 1.1. Unfortunately, because of the all-pervading influence of English as a developing universal language, the separate meanings of these two words are in danger of being lost.

Table 1.2 Six Main Characteristics of Anxiety as a Morbid State (adapted from Lewis, 1967)

Descriptions of anxiety	Element	Best descriptive word (language)
Emotional state closely related to fear	Mood	Angst (German)
Unpleasant emotion	Anhedonia	Unlust (German)
Directed towards the future	Expectation	Furcht (German)
Absence of threat, or exaggeration of minor threat, despite intensity of emotion	Maladaptiveness	none available
Subjective bodily symptoms	Somatic anxiety	angoisse (French)
Objective bodily symptoms	Observed anxiety	none available

Lewis concluded from his review that there were six elements involved in anxiety and these, with some adaptation and abbreviation, are shown in Table 1.2. Anxiety is clearly a state of mood or emotion of which an excess is unpleasant; it is concerned with uncertainty and is directed towards the future rather than the past (and thereby differs importantly from depression). In its pathological form it represents an over-reaction to a threat which is perceived as greater than it really is. It is also associated with bodily accompaniments which are both experienced subjectively by the sufferer and can be observed, with varying degrees of accuracy, by other people.

One word which was conspicuously absent in Lewis' review was "panic". This may surprise any reader who is aware of contemporary writings on anxiety. Although the concept of panic is well described in early writings on anxiety, most notably by Hecker (1893) and Sigmund Freud (1895) in their description of anxiety attacks (Angstzustand), it was regarded as an integral part of anxiety neurosis (Angstneurose). Following the work of Donald Klein in the 1960s (described in more detail in Chapter 5), the concept of panic as a separate component of anxiety has become so

well developed that it is now regarded as a completely different disorder. It is tempting to conclude from examination of the terminology of anxiety that if the two essential components of pathological anxiety (acute attacks and chronic inquietude) had been retained in English as well as in other languages, then the notion of panic as a separate condition would never have arisen.

Another word intimately associated with anxiety is fear. Fear is a special type of anxiety specifically associated with an object or setting; it is usually situational anxiety. Fear differs from most other forms of anxiety in that it is related to an external threat, whereas much of the rest of anxiety is either linked to an internal threat (the ferment and torment of one's own psyche) or is unfocussed. Persistent fears of situations naturally leads to avoidance of such situations, and the combination of fear and avoidance creates phobic anxiety, usually abbreviated to phobia.

Stress is another word commonly linked to anxiety. It is the most confusing word of all those used to describe anxiety. In Paris in the 1980s most of the benzodiazepine tranquillising drugs prescribed for the population were for "le stress" (Boyer, personal communication), yet the average patient with anxious symptoms blames stress for their cause; private clinics give special treatments for "stress anxiety"; and explanations for curious behaviour often argue that the individual concerned "had been stressed" at the time. Stress is therefore, apparently simultaneously, both a cause of stress and its consequence, a qualifying adjective and a passive verb. "What explanation have you for this sorry course of actions?", asked the judge. "Stress", my lord, says the anxiety-ridden prisoner, "I was stressed by the stress of it and I suffer from stress". When "distress" is introduced into this vocabulary, it can be exchanged with "stress" almost willy-nilly and this confuses the vocabulary further. Let us confine stress to its technical psychiatric use in the rest of this book, a word which is short for "stressor", an event or act that creates anxiety.

TYPES OF ANXIOUS REACTIONS

Already we have a set of terms which describe different forms of anxiety and we can now set them into context. It is first necessary to separate

normal from pathological anxiety. This can be done quite easily from the Yerkes-Dodson curve in Fig. 1.1. When anxiety is promoting performance, it is essentially normal (the first limb of the U), and when it leads to a catastrophic loss of performance, it is clearly pathological (the second limb of the U). In between (the plateau phase), it is not quite clear when the anxiety becomes pathological. Before performance deteriorates, the sufferer may have a range of psychological and bodily symptoms — nervous and muscular tension, distractibility, palpitations, difficulty in breathing, tremor, headache — and when these become unpleasantly pervasive, the anxiety is clearly pathological.

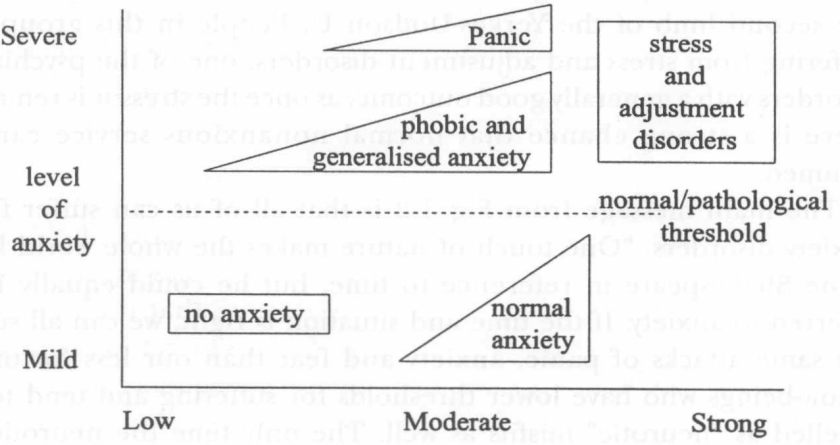

Fig. 1.2 Relationship between stress and anxiety disorder.

In Fig. 1.2 the different forms of anxiety that form the main subject of this book are shown in relationship to the intensity of stimulus (or level of stressor). At low levels of stimulus, most people do not have any symptoms of anxiety but a minority will experience pathological anxiety in various forms. The most severe of these is panic, sudden and unpredictable attacks of anxiety that are all the more distressing because they are so unexpected. Generalised and phobic anxiety (or unfocused and situational anxiety) are less severe, but it is still unpleasant and can

also occur against a background of little stimulus. However, they are more common when the level of stress rises and this explains the triangular expansion in Fig. 1.2 with these disorders.

At somewhat more severe levels of stimulus, normal anxiety is experienced by most people. The psychological and bodily symptoms described above are present to some degree but are usually tolerated quite well as the source of anxiety is clear. In most instances, it is predictable when the stimulus will end, or what can be done to bring it to an end, and this helps to make the symptoms more tolerable. At more severe levels of stimulus, this ability to cope is suddenly lost and the formerly phlegmatic "normal" individual suddenly crosses the threshold to pathological anxiety and shows the disintegration of the second limb of the Yerkes-Dodson U. People in this group are suffering from stress and adjustment disorders, one of the psychiatric disorders with a generally good outcome, as once the stressor is removed there is a strong chance that normal nonanxious service can be resumed.

The main message from Fig. 1.2 is that all of us can suffer from anxiety disorders. "One touch of nature makes the whole world kin", wrote Shakespeare in reference to time, but he could equally have referred to anxiety. If the time and situation is right, we can all suffer the same attacks of panic, anxiety and fear than our less fortunate fellow-beings who have lower thresholds for suffering and tend to be labelled as "neurotic" misfits as well. The only time the neurotically anxious have the edge is when the level of stress is so great that all "normal" people go to pieces. For example, when a cluster of German bombs landed on St Thomas's Hospital in London in 1941, the psychiatric unit for neurotic patients was in the middle of the conflagration that followed. Amidst the scenes of panic that followed, it was observed that the most fearless of the rescuers of the patients in the main hospital were some of the most anxious psychiatric patients (Sargant, personal communication). When asked to explain this apparently unexpected ability to cope in the face of such obvious danger, one replied, "We feel like this (very anxious) almost all the time but don't know the cause. When the bombs landed we knew what the cause