

## **Chapter 2 : Anxiety Disorders**

Anxiety disorders were first recognised as a discrete group of disorders in 1980 by the American Psychiatric Association (APA 1980). Anxiety disorders include panic disorder, social phobia, post traumatic stress disorder, obsessive compulsive disorder and generalised anxiety disorder.

Many people are surprised when they realise that anxiety disorders represent the largest mental health problem in the general population. While there is now much more publicity about panic attacks and anxiety, anxiety disorders are still hidden within the community. When we begin to develop an anxiety disorder, we feel as if we are the only one in the world experiencing this level of distress. We are not being narcissistic. It is more that we can't believe other people could be feeling this degree of distress and it not be more widely acknowledged in the community.

Anxiety disorders affect people right across the socio-economic spectrum across all age groups. While many people will develop an anxiety disorder between their late teens and mid thirties, children can also develop a disorder and so can people in their forties right through to their eighties.

People often ask me if the increase in the number of people with an anxiety disorder is due to the escalating pressures and demands of life. While this is a factor, the main reason for the increase is that, in the recent past, many people were simply not being diagnosed at all and lived their life suffering from 'nerves'.

### **Causes**

There are various theories as to the cause of anxiety disorders. Physiological research suspects that a chemical imbalance may be involved although researchers are unsure whether a chemical imbalance is the cause or a result of the panic attack (APA 1990). Behaviour theories suggest that anxiety disorders are learned behaviours and recovery means unlearning the previous limiting behaviour (APA 1990). Psychoanalytic theory postulates that anxiety stems from subconscious unresolved conflicts that began during childhood (APA 1990).

This conflicting information about the cause of anxiety disorders makes it difficult for us to come to an informed decision about the most suitable treatment. It is possible that the three schools of thought are each partly correct, and that viewed together they form a whole picture of cause and effect (APA 1990).

### **Panic Attacks**

The experience of panic attacks is central to four of the anxiety disorders, with generalised anxiety disorder the exception. While the disorders were first recognised in 1980, it wasn't until 1994 that a more definitive understanding of panic attacks and anxiety disorders emerged (APA 1994). Prior to this no distinction was made between types of panic attacks and the relevant anxiety disorder. Panic attacks were seen more as a phobic response to particular situations and places, yet for people with panic disorder this was not the case. People were not frightened of situations or places. They were frightened of having panic attack. It didn't matter where they were or what they were doing, it was the fear of actually having an attack that was the problem. In 1994 three separate and distinct types of panic

attacks were identified and their relationship to particular anxiety disorders was defined (APA 1994).

### **Uncued (Spontaneous) Panic Attacks**

The experience of an uncued attack is the central feature of panic disorder. This type of panic attack is not triggered by situations and places. It occurs spontaneously, 'out of the blue', irrespective of what the person may be doing at the time. These attacks can also happen when people are relaxed, reading a book, watching television, when they are going to sleep at night; or they can be woken from sleep with an attack. Attacks can feel completely overwhelming, physically and psychologically, and many people do feel as if they are having a heart attack, or dying or going insane.

What isn't discussed in any detail in the literature on anxiety disorders is the fact that the spontaneous panic attack can have a number of distinguishing symptoms that differ from the other two types of panic attacks. My colleagues and I have found in our own research (Arthur-Jones & Fox 1994) that the symptoms are, in many cases, the reason why people panic. That is, the symptoms come first and people panic in response to them, as opposed to the symptoms being part of the actual panic. I discuss this in detail below.

### **Cued (Specific) Panic Attacks**

Unlike the experience of a spontaneous attack, the cued attack does relate to, and is triggered by, specific situations or places. The cued attack can be one of the components of social anxiety, post-traumatic stress disorder or obsessive compulsive disorder.

### **Situationally Predisposed Panic Attacks**

Some people may be predisposed to having panic attacks in some situations and/or places. The attack is not necessarily always triggered by the particular situation or place---it may happen on some occasions and not on others. People with spontaneous panic attacks may go on to develop this type of attack.

### **Panic Disorder**

Panic disorder is the fear of having a spontaneous panic attack, *fear* being the operative word. It is the *fear* of having a spontaneous panic attack that is the driving force in the development of panic disorder.

Some people may only ever have one panic attack while others may have intermittent attacks throughout their life, in both cases this does not necessarily mean they will go on to develop panic disorder.

Panic disorder is diagnosed after a person has experienced 'at least two' spontaneous panic attacks followed by one month of 'persistent concern' about having another one (APA 1994). It is the 'persistent concern', our fear that not only causes much of our distress but also makes us more vulnerable to having another attack. And many of us do. It is not unusual for people to begin to have two or more panic attacks a day and to experience pervasive anxiety in anticipation of having another one.

Recovery for so many of us has been the loss of the fear of having one of these attacks. Once we can lose our fear we lose the disorder, and lose our ongoing anxiety about having another attack.

## **Social Phobia**

People with social phobia are frightened of making a fool of themselves or embarrassing themselves in some way because they fear being judged in a negative way by other people (APA 1994).

They may fear social occasions or simply talking with other people in day-to-day situations. They may fear eating in front of other people, signing their name or writing in front of others. People can suffer extreme anxiety in these situations, or simply in anticipating them. They may have a panic attack as a result. This panic attack is specific to their fear that they may embarrass, or make a fool of themselves in some way.

## **Post-Traumatic Stress Disorder**

Post-traumatic stress disorder can develop following an event or events in which the person 'experienced, witnessed or was confronted' (APA 1994) with a situation that was life-threatening to themselves and/or other people. This can include victims of violent crime, rape, a serious accident, active war duty or being civilians in war zone, natural disasters such as bushfires, cyclones or earthquakes.

People may have ongoing persistent thoughts about the experience. They may have flashbacks in which they believe they are actually living through the event again, or nightmares in which they relive the experience. Many people will have a cued panic attack in situations or places similar to, or reminiscent of, the actual event.

Panic disorder can be secondary to post-traumatic stress disorder. On occasion people will seek treatment for their panic disorder but will be too frightened or ashamed to speak of the traumatic event or events that precipitated it. And this is especially so in matters relating to childhood abuse. One English study showed that 63.6 percent of young women with panic disorder who were interviewed for the study came from 'difficult childhood backgrounds', which included 'parental indifference, sexual and physical abuse' (Brown & Harris 1993).

## **Obsessive Compulsive Disorder**

Obsessive compulsive disorder means being obsessed by 'persistent ideas, thoughts, impulses, or images that cause marked anxiety or distress' (APA 1994). Unlike generalised anxiety disorder, which is based on 'real life' concerns, the excessive thoughts can be fear of contamination by germs or a fear the person might harm other people, or act in a socially unacceptable way.

Other people may need to have everything arranged in a particular way, or redo certain jobs a number of times. Some people may feel the need to repeat a name or number or phrase constantly. Others may continually check to see if they have locked their house or car, or if they have turned off domestic appliances. Some people may hoard unwanted or useless items. These compulsions can be so severe

that the person becomes totally restricted by them and is unable to lead a normal life.

## **Generalised Anxiety Disorder**

Generalised anxiety disorder is diagnosed when a person experiences 'anxiety and worry' (APA 1994) for at least six months over particular real life events such as marital or financial problems. Most people with his disorder have been worriers all their life and feel powerless to stop the endless cycle of worry.

## **Combinations**

It is not unusual for people to have fears and symptoms from all the disorders. People with panic disorder usually have ongoing anxiety. They may also have aspects of obsessive compulsive disorder, social anxiety and, in some instances, post-traumatic stress disorder.

## **Case Histories**

### **Carolyn**

It had been a long and difficult week. Carolyn was glad she now had some time to herself. She curled up on the lounge with a book she had been wanting to read. As she relaxed she felt the tension ease from her body and she felt herself drifting into sleep. Without warning, she felt a wave of incredible energy surge through her body. As it moved through her, her heart rate doubled, she had difficulty breathing, she felt light headed and dizzy, a wave of nausea swept over her and she began to perspire. She jumped up and ran outside to her husband. 'Help me,' she cried. 'Something is happening to me, I don't know what, but something is very wrong.'

### **Alex**

Alex disliked staff meetings and social get-togethers and did what he could to avoid them. He felt more comfortable just doing his job and avoiding personal interaction with other staff. Now the new owners of the business had arranged a dinner for all staff and their partners and, like it or not, Alex had to go. He had been feeling uncomfortable all day and he knew his anxiety levels were very high. As he and his wife sat down at their table the people next to them began to make conversation. Alex's heart began to race, his breathing became short and shallow, he began to perspire heavily and his hands trembled violently. As he tried to control it, he thought to himself, 'I shouldn't have come. This always happens every time I am in this situation.'

## Jessica

Jessica turned on the ignition of her car. She was feeling very anxious. Is it going to happen today? As she pulled out of her driveway she tried to rationalise with herself for the hundredth time. She wasn't frightened of driving---in fact, she used to enjoy driving before she began to have spontaneous panic attacks. But there was one set of traffic lights where she would sometimes have an attack. There was no pattern to it. Sometimes it happened, sometimes it didn't. Sometimes she would have an attack after she had driven through the traffic lights; on other days there were no attacks at all. Someone had told her she was frightened of that particular intersection, but she thought that was ridiculous. She was frightened of the attacks and their unpredictable nature, it had nothing to do with the intersection.

## Symptoms

**If you haven't been diagnosed as having panic attacks or a panic-related anxiety disorder but think this may be what you are experiencing, speak to a doctor. Don't self diagnose. You need to know exactly what it is you are trying to recover from.**

Many of our symptoms are a direct result of the 'fight and flight' response. This is an automatic response within the body that is activated in times of danger. It assists us either to stay and fight the danger or to run away from it. The problem is, we are not in actual danger. The 'danger' is being created by the way we think and our body responds accordingly.

**The symptoms of anxiety can be quite varied, with any number of symptoms being experienced at the same time. A panic attack is diagnosed when we experience four or more of these symptoms (APA 1994). The most common ones are a rapid or pounding heartbeat, palpitations, 'missed' heartbeats, chest pain, hyperventilation, difficulty in breathing, and an inability to take a deep breath, a feeling breathing will stop altogether, a choking sensation, a tightening of the throat, indigestion, churning or burning in the stomach, dizziness, giddiness, feeling faint, light headed, nausea, pins and needles, diarrhoea, shaking, trembling, dry mouth, excessive perspiration, neck ache, headache, flushed face.**

People with panic disorder can also report left arm pain and jaw pain. Most experience a number of dissociative symptoms such as depersonalisation (the feeling of being detached from the body), derealisation (when nothing appears to be real, or feeling as though looking through a white or grey mist), other visual disturbances including stationary objects appearing to move, tunnel vision, intolerance to sound and intolerance to light (Arthur-Jones & Fox 1994).

Sometimes these symptoms are our constant companion. Not just for a few minutes or hours at a time, sometimes they can be chronic for months or years. To confuse the issue further, people may experience different symptoms and sensations in their anxiety and with each panic attack (Arthur-Jones & Fox 1994).

Many people experience a number of effects as a result of their anxiety disorder. These can include fatigue or overwhelming exhaustion, loss of concentration, loss of appetite, loss of libido and, in some instances, loss of feeling towards family and friends.

## **Dissociation**

Another theory my colleagues and I have been investigating is the role played by dissociation in spontaneous panic attacks. From my research and experience, the ability to dissociate is extremely common in people who experience spontaneous panic attacks. In fact, as they begin to understand their ability to dissociate, they become aware that it is their dissociation that triggers the feeling of panic (Arthur-Jones & Fox 1994).

**Dissociation can also be described as altered or discrete states of consciousness or trance states. Dissociation can be an 'accepted expression of cultural or religious experience in many societies' (APA 1994). A leading expert in altered or discrete states, Dr Charles Tart (1972), comments that many other cultures 'believe that almost every normal adult has the ability to go into a trance state'.**

Individuals in some societies induce trance states not only by meditation but by fasting, sleep deprivation and other forms of physiological stress. For those of us who have the ability to dissociate, major stress can make us more vulnerable to these states. Or stress can be a cause of our not eating properly or of losing sleep, which in turn increases our vulnerability to them.

The ability to dissociate is not harmful in itself, but our lack of understanding of the phenomenon can lead to acute anxiety and panic. Although some people with panic disorder report they are not frightened of these sensations, others are and the fear contributes to the feeling of going insane or loss of control.

## **Dissociation and Spontaneous Panic Attacks**

It has been assumed that dissociation is an effect of a panic attack and that some people use these states as a form of 'escape' from the anxiety or the attack itself. While I have seen this in a few cases, most people are aware it is the dissociation itself that triggers the panic (Arthur-Jones & Fox 1994).

Some people experience depersonalisation or derealisation or other dissociative symptoms first, and panic as a result of these sensations. Others report these sensations together with the feeling like an electric shock, or an intense burning and tingling sensation, moving through the body. Some report a feeling like a wave of unusual energy surging through them (Arthur-Jones & Fox 1994). This wave is usually experienced as beginning in the feet, surging through the body, over the head and back down through the body again (Arthur-Jones & Fox 1994). Or it is

likened to a white hot flame, starting 'just below the breastbone, passing through the chest, up the spine, into the face, down the arms and even down to the groin and to the tips of the toes' (Weekes 1992).

One psychiatrist quotes a description of a panic attack by one of his patients. The attack begins with 'a tingling feeling going up my spine which enters my head and causes a sensation of faintness and nausea. I feel I'm going to lose control or lose consciousness. I thought I was going to die and started to panic...' (Hafner 1986). Notice how his patient separates the attack from the feelings of panic. This is important.

Another psychiatrist describes the attack as being associated to a 'rushing sensation of a hot flash surging through the body'. People may experience a sensation that is 'sometimes associated with a sick of feeling and a sensation of fading out from the world'. This faintness is more like a 'whiteout' than a 'blackout' and the head may literally 'feel light'. The fear of this attack is then followed by the fight and flight response (Sheehan 1983). Again, notice the separation between the precipitating sensations and the fight and flight response.

From my own experience and those of my clients, the rushing sensation, the hot flash, the tingling or the electric shock sensation happen as part of the overall dissociative experience, and we panic in reaction to this.

For those of us who do dissociate, learning to see this separation from the feelings of panic is an important step in recovery and I will return to this point shortly.

People who do dissociate 'may display high hypnotisability and high dissociative capacity' (APA 1994). The dissociative sensations are the effects of an alteration of consciousness which can be similar to the alteration of consciousness when deeply relaxed or meditating or in a hypnotic state.

Many people report they can be fully relaxed when they have an attack and one research study confirmed this. The study looked at EEG activity in people with panic disorder and found, to the researchers' surprise, a 'paradoxical positive correlation between increases in slow wave EEG and increasing anxiety' while the patient was the at rest (Knott 1990).

'Slow wave activity' indicates a very relaxed state. The question is how can we be relaxed and anxious at the same time? The study concluded that 'replication of increases in slow wave activity in further studies would suggest psychobiological disturbances in panic disorder are not merely normal emotions expressed in inappropriate contexts'. (Knott 1990). This study indicates that our overall experience of an attack is more than the spontaneous arousal of the fight and flight response, normally viewed as the reason for a spontaneous panic attack.

## **Nocturnal Panic Attacks**

The theme of Knott's study is also demonstrated in the literature on nocturnal panic attacks. Many of us are woken at night by these attacks. Research suggests the 'sleep' panic attack occurs 'during the transition from stage two to stage three sleep' (Uhde 1994). The research also stipulates that the attack is not a result of dreams or nightmares (Uhde 1994), but happens on the alteration of consciousness.

'Sensory shocks' that accompany the hypnagogic (first) stage of sleep or the transition from dreaming sleep were first noted in 1890. Researchers describe them as 'an upward surge of indescribable nature, an electric sort of feeling ascending from the abdomen to the head sometimes followed by bodily jerks or of a violent explosion and/or a flash of light'. The researchers also note that a sense of alarm, together with a cold sweat, laboured breathing and tachycardia, often follows (Oswald 1962).

And for many of us this sense of 'alarm' can be the 1990s definition of our panic! Our attacks are usually interpreted within the biological model, as the fight and flight response. Within the psychological model it is thought that people have more time to think about their anxiety symptoms when they are relaxed, thereby actuating the fight and flight response. The possibility we may be dissociating first is never considered. As one researcher points out, the transition into the trance states can occur in a split-second (Putman 1989) and it is in that split-second that we can go from feeling relaxed to total panic.

### **Inducing Dissociative States**

Inducing dissociative states when we are vulnerable to them is incredibly easy. The most common way is by staring---at the computer, at the television screen, at a book. We stare while driving---at the traffic lights, the car in front of us, at the road ahead. We stare at people when we are talking to them, we stare ahead when we are out walking, we stare while we are waiting for an elevator. When we are vulnerable we can induce a trance state very quickly and without realising it. Without warning we can fill the sensations of dissociation.

In Eastern traditions, open-eyed meditation is an advanced meditation technique, usually taught only to skilled practitioners (Brunton 1965). Yet many of us unconsciously practice a similar method of 'meditation'. In many cases we induce a dissociative state and panic as a result of the sensations. Our self absorption can be absolute, and this self absorption is similar to other meditation techniques. We need to be aware that our self absorption can be significant enough to also induce dissociative states.

Some people report that fluorescent lighting can also induce a dissociative state (Arthur-Jones & Fox 1994). This is one of the reasons why people can have so much difficulty in shopping centres. The sheer brightness, the glare of the lights can be overwhelming and can induce a dissociative state. Some people can actually see the moment to moment flickering of the lights which can also induce trance states.

### **Fight and Flight Response**

Many of us who experience dissociative sensations know they are not part of the fight and flight response. We have all been in situations where the fight and flight response has been activated---perhaps a near miss with another car while driving, or waiting for surgery, any situation that can produce fear. People with a background of abuse know all too well the feelings of fear and the accompanying symptoms of the fight and flight response. Even if the fight and flight response were activated spontaneously we would be able to recognise it. We would not react with total fear if our experience was simply that of the fight and flight response.

The description of panic disorder is 'the presence of recurrent unexpected panic attacks followed by at least one month of persistent concern about having another panic attack' (APA 1994). Our persistent concern triggers the fight and flight response and adds ferocity to our overall experience. Once the attack subsides, the fight and flight response is continually activated by our fear of having another attack. It is the fight and flight response that creates our anxiety symptoms.

For me and other people, recovery means that we may occasionally experience an attack. In other words, we may dissociate when we are tired or stressed but, instead of reacting with fear and panic, we can now break the dissociated state and allow any physical effects---the 'indescribable surge' ---to happen. When we do this, the attack disappears as quickly as it comes. Recovery is a matter of learning to change our perception of these particular attacks, learning to see them and control them without fear. When we can do this, we are able to think 'So what?' instead of 'What if?' I discuss this further in Chapter 9.