

Life is Full of Ups and Downs

But when the "down" times are long lasting or interfere with your ability to function, you may be suffering from the common, serious illness of depression. Clinical depression affects mood, mind, body, and behavior. Research has shown that in the United States about 19 million people—one in ten adults—experience depression each year, and nearly two-thirds do not get the help they need. Clinical Depression is often unrecognized because it has some similarity to “just feeling down” and thus it is on one end of a continuum that ranges from normal down times to full blown clinical depression. Treatment can alleviate the symptoms in over 80 percent of the cases. Yet, because it often goes unrecognized, depression continues to cause unnecessary suffering.

Depression is a pervasive and impairing illness that affects both women and men, but **women experience depression at approximately twice the rate of men.**

Researchers continue to explore how special issues unique to women; biological, life cycle, and psycho-social may be associated with women's higher rate of depression.

No two people become depressed in exactly the same way. Many people have only some of the symptoms, varying in severity and duration. For some, symptoms occur in time-limited episodes; for others, symptoms can be present for long periods if no treatment is sought. Having some depressive symptoms does not mean a person is clinically depressed. For example, it is not unusual for those who have lost a loved one to feel sad, helpless, and disinterested in regular activities. Only when these symptoms persist for an unusually long time is there reason to suspect that grief has become depressive illness. Similarly, living with the stress of potential layoffs, heavy workloads, or financial or family problems may cause irritability and "the blues." Up to a point, such feelings are simply a part of human experience. But when these feelings increase in duration and intensity and an individual is unable to function as usual, what seemed a

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SYMPTOMS OF DEPRESSION

A thorough diagnostic evaluation is needed if three to five or more of the following symptoms persist for more than 2 weeks, or if they interfere with work or family life. An evaluation involves a complete history and physical checkup. Not everyone with depression experiences each of these symptoms. The severity of the symptoms also varies from person to person.

- Persistent sad, anxious, or "empty" mood
- Loss of interest or pleasure in activities, including sex
- Restlessness, irritability, or excessive crying
- Feelings of guilt, worthlessness, helplessness, hopelessness, pessimism
- Sleeping too much or too little, early-morning awakening
- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue, feeling "slowed down"
- Thoughts of death or suicide, or suicide attempts
- Difficulty concentrating, remembering, or making decisions
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

THE TYPES OF DEPRESSIVE ILLNESS

In **major depression**, sometimes referred to as clinical depression, people have some or all of the symptoms listed for at least 2 weeks but frequently for several months or longer. Episodes of the illness can occur once, twice, or several times in a lifetime.

In **dysthymia**, the same symptoms are present though milder and last at least 2 years. People with dysthymia are frequently lacking in zest and enthusiasm for life, living a joyless and fatigued existence that seems almost a natural outgrowth of their personalities. They also can experience major depressive episodes.

Bipolar disorder, or manic-depression, is not nearly as common as other forms of depressive illness and involves disruptive cycles of depressive symptoms that alternate with mania. During manic episodes, people may become overly active, talkative, euphoric, irritable, spend money irresponsibly, and get involved in sexual misadventures.

Adjustment Disorder with Depressed Mood occurs in response to some specific stressful situation or circumstance and occurs within six months of stressor.

Depressive Disorder Not Otherwise Specified is a depressive episode that fits no other category

CAUSES OF DEPRESSION

Genetic Factors

There is a risk for developing depression when there is a family history of the illness. However, not everybody with a family history develops the illness. In addition, major depression can occur in people who have had no family members with the illness.

Biochemical Factors

Evidence indicates that brain biochemistry is a significant factor in depressive disorders. Depression can be induced or alleviated with certain medications, and some hormones have mood-altering properties.

Environmental and Other Stressors

Significant loss, a difficult relationship, financial problems, or a major change in life pattern have all been cited as contributors to depressive illness. Sometimes the onset of depression is associated with acute or chronic physical illness. In addition, some form of substance abuse disorder occurs in about one-third of people with any type of depressive disorder.

Other Psychological and Social Factors

Persons with certain characteristics—pessimistic thinking, low self-esteem, a sense of having little control over life events, and a tendency to worry excessively—are more likely to develop depression. These attributes may heighten the effect of stressful events or interfere with taking action to cope with them or with getting well. It appears that negative thinking patterns typically develop in childhood or adolescence. Some experts have suggested that the traditional upbringing of girls might foster these traits and may be a factor in women's higher rate of depression.

WOMEN ARE AT GREATER RISK FOR DEPRESSION THAN MEN

Major depression and dysthymia affect twice as many women as men. This two-to-one ratio exists regardless of racial and ethnic background or economic status. The same ratio has been reported in other countries worldwide. Men and women have about the same rate of bipolar disorder, though its course in women typically has more depressive and fewer manic episodes. Also, a greater number of women have the rapid cycling form of bipolar disorder, which may be more resistant to standard treatments.

A variety of factors unique to women's lives are suspected to play a role in developing depression. Research is focused on understanding these, including: reproductive, hormonal, genetic or other biological factors; abuse and oppression; interpersonal factors; and certain psychological and personality characteristics. And yet, the specific causes of depression in women remain unclear; many women exposed to these factors do not develop depression. What is clear is that regardless of the contributing factors, depression is a highly treatable illness.

THE MANY DIMENSIONS OF DEPRESSION IN WOMEN

The Issues of Adolescence

By the age of 15, females are twice as likely to have experienced a major depressive episode as males. This comes at a time in adolescence when roles and expectations change dramatically. The stresses of adolescence include forming an identity, emerging sexuality, separating from parents, and making decisions for the first time, along with other physical, intellectual, and hormonal changes.

Adulthood: Relationships and Work Roles

Stress in general can contribute to depression in persons biologically vulnerable to the illness. Some have theorized that higher incidence of depression in women is not due to greater vulnerability, but to the particular stresses that many women face. These stresses include major responsibilities at home and work, single parenthood, and caring for children and aging parents. How these factors may uniquely affect women is not yet fully understood.

Reproductive Events

Women's reproductive events include the menstrual cycle, pregnancy, the post-pregnancy period, infertility, menopause, and sometimes, the decision not to have children. These events bring fluctuations in mood that for some women include depression. Researchers have confirmed that hormones have an effect on the brain chemistry that controls emotions and mood; a specific biological mechanism explaining hormonal involvement is not known, however.

Specific Cultural Considerations

As for depression in general, the prevalence rate of depression in African American and Hispanic women remains about twice that of men. There is some indication, however, that major depression and dysthymia may be diagnosed less frequently in African American and slightly more frequently in Hispanic than in Caucasian women.

Abuse

Studies show that women molested as children are more likely to have clinical depression at some time in their lives than those with no such history. In addition, several studies show a higher incidence of depression among women who have been raped as adolescents or adults. Since far more women than men were sexually abused as children, these findings are relevant. Women who experience other commonly occurring forms of abuse, such as physical abuse and sexual harassment on the job, also may experience higher rates of depression. Abuse may lead to depression by fostering low self-esteem, a sense of helplessness, self-blame, and social isolation. There may be biological and environmental risk factors for depression resulting from growing up in a dysfunctional family. At present, more research is needed to understand how victimization is connected specifically to depression.

Poverty

Women and children represent seventy-five percent of the U.S. population considered poor. Low economic status brings with it many stresses, including isolation, uncertainty, frequent negative events, and poor access to helpful resources. Sadness and low morale are more common among persons with low incomes and those lacking social supports. But research has not yet established whether depressive illnesses are more prevalent among those facing environmental stressors such as these.

Depression in Later Adulthood

At one time, it was commonly thought that women were particularly vulnerable to depression when their children left home and they were confronted with "empty nest syndrome" and experienced a profound loss of purpose and identity. However, studies show no increase in depressive illness among women at this stage of life.

As with younger age groups, more elderly women than men suffer from depressive illness. Similarly, for all age groups, being unmarried (which includes widowhood) is also a risk factor for depression. Most important, depression should not be dismissed as a normal consequence of the physical, social, and economic problems of later life.

DEPRESSION IS A TREATABLE ILLNESS

Even severe depression can be highly responsive to treatment. Indeed, believing one's condition is "incurable" is often part of the hopelessness that accompanies serious depression. Such individuals should be provided with the information about the effectiveness of modern treatments for depression in a way that acknowledges their likely skepticism about whether treatment will work for them. As with many illnesses, the earlier treatment begins, the more effective and the greater the likelihood of preventing serious recurrences. Of course, treatment will not eliminate life's inevitable stresses and ups and downs. But it can greatly enhance the ability to manage such challenges and lead to greater enjoyment of life. The **first step** in treatment for depression should be a thorough examination to rule out any physical illnesses that may cause depressive symptoms. Since certain medications can cause the same symptoms as depression, the examining physician should be made aware of any medications being used. If a physical cause for the depression is not found, a psychological evaluation should be conducted by the physician or a referral made to a mental health professional.

Types of Treatment for Depression

The most commonly used treatments for depression are antidepressant medication, psychotherapy, or a combination of the two. Which of these is the right treatment for any one individual depends on the nature and severity of the depression and, to some extent, on individual preference. In mild or moderate depression, one or both of these treatments may be useful, while in severe or incapacitating depression, medication is generally recommended as a first step in the treatment. In combined treatment, medication can relieve physical symptoms quickly, while psychotherapy allows the opportunity to learn more effective ways of handling problems.

Medications

There are several types of antidepressant medications used to treat depressive disorders. Each acts on different chemical pathways of the human brain related to moods. Antidepressant medications are not habit-forming. Although some individuals notice improvement in the first couple of weeks, usually antidepressant medications must be taken regularly for at least 4 weeks and, in some cases, as many as 8 weeks, before the full therapeutic effect occurs. To be effective and to prevent a relapse of the depression, medications must be taken for about 6 to 12 months, carefully following the doctor's instructions. Medications must be monitored to ensure the most effective dosage and to minimize side effects. For those who have had several bouts of depression, long-term treatment with medication is the most effective means of preventing recurring episodes. There may be restrictions during pregnancy.

Herbal Therapy

In the past few years, much interest has risen in the use of herbs in the treatment of both depression and anxiety. St. John's wort (*Hypericum perforatum*), an herb is used extensively in the treatment of mild to moderate depression. St. John's wort, an attractive bushy, low-growing plant covered with yellow flowers in summer, has been used for centuries in many folk and herbal remedies. A recent NIH study found that St. John's wort was no more effective in treating major depression than placebo (inactive sugar pill). Another NIH study is under-way looking at St. John's wort for the treatment of minor depression.

The Food and Drug Administration issued a Public Health Advisory on February 10, 2000. It stated that St. John's wort appears to effect an important metabolic pathway that is used by many drugs prescribed to treat conditions such as heart disease, depression, seizures, certain cancers, and rejection of transplants. Therefore, health care providers should alert their patients about these potential drug interactions. Any herbal supplement should be taken only after consultation with the doctor or other health care provider.

Psychotherapy

In mild to moderate cases of depression, psychotherapy is also a treatment option.

- Some **short-term** (10 to 20 week) **therapies** have been very effective in several types of depression.
- **"Talking" therapies** help patients gain insight into and resolve their problems through verbal give-and-take with the therapist.
- **"Behavioral" therapies** help patients learn new behaviors that lead to more satisfaction in life and "unlearn" counter-productive behaviors.
- Research has shown that two short-term psychotherapies, interpersonal and cognitive-behavioral, are helpful for some forms of depression.
- **Interpersonal therapy** works to change interpersonal relationships that cause or exacerbate depression.
- **Cognitive-behavioral therapy** helps change negative styles of thinking and behaving that may contribute to the depression.

Electroconvulsive Therapy

For individuals whose depression is severe or life threatening or for those who cannot take antidepressant medication, electroconvulsive therapy (ECT) may be useful. This is particularly true for those with extreme suicide risk, severe agitation, psychotic thinking, severe weight loss or physical debilitation as a result of physical illness.

Treating Recurrent Depression

Even when treatment is successful, depression may recur. Studies indicate that certain treatment strategies are very useful in this instance. Continuation of antidepressant medication at the same dose that successfully treated the acute episode can often prevent recurrence. Monthly interpersonal psychotherapy can lengthen the time between episodes in patients not taking medication. Psychotherapy is especially important in treating chronic or recurrent depression. The reason for this is that, over time, people get into patterns of thinking and behaving that can serve to increase the risk of reoccurrence or that maintain the depressive symptoms.

THE PATH TO HEALING

Reaping the benefits of treatment begins by recognizing the signs of depression. The next step is to be evaluated by a qualified professional. Although depression can be diagnosed and treated by primary care physicians, often the physician will refer the patient to a psychiatrist, psychologist, clinical social worker, or other mental health professional. Treatment is a partnership between the patient and the health care provider. An informed consumer knows her treatment options and discusses concerns with her provider as they arise.

If there are no positive results after 2 to 3 months of treatment, or if symptoms worsen, discuss another treatment approach with the provider. Getting a second opinion from another health or mental health professional may also be in order. Here are the steps to healing:

- Check your symptoms against the list of symptoms on page 2.
- Talk to a health or mental health professional.
- Choose a treatment professional and a treatment approach with which you feel comfortable.
- Consider yourself a partner in treatment and be an informed consumer.
- If you are not comfortable or satisfied after 2 to 3 months, discuss this with your provider. Different or additional treatment may be recommended.
- If you experience a recurrence, remember what you know about coping with depression and don't shy away from seeking help again. In fact, the sooner a recurrence is treated, the shorter its duration will be.
- Along with professional treatment, there are other things you can do to help yourself get better. Some people find participating in support groups very helpful. It may also help to spend some time with other people and to participate in activities that make you feel better, such as mild exercise or yoga. Don't expect too much from yourself right away. Feeling better takes time.

WHERE TO GET HELP

If unsure where to go for help, ask your family doctor, internist, OB/GYN physician, or health clinic for assistance. You can also check the *Yellow Pages* under "mental health," "health," "social services," "suicide prevention," "crisis intervention services," "hotlines," "hospitals," or "physicians" for phone numbers and addresses. In times of crisis, the emergency room doctor at a hospital may be able to provide temporary help for an emotional problem and will be able to tell you where and how to get further help. Listed below are the types of people and places that will make a referral to, or provide, diagnostic and treatment services.

- Family doctors
- Mental health specialists such as psychiatrists, psychologists, social workers, or mental health counselors
- Health maintenance organizations
- Community mental health centers
- Hospital psychiatry departments and outpatient clinics
- State hospital outpatient clinics
- Family service/social agencies
- Private clinics and facilities
- Employee assistance programs

Anxiety

Anxiety disorders are serious medical illnesses that affect approximately 40 million American adults. These disorders fill people's lives with overwhelming anxiety and fear. Unlike the relatively mild, brief anxiety caused by a stressful event such as a business presentation or a first date, anxiety disorders are chronic, relentless, and can grow progressively worse if not treated.

Effective treatments for anxiety disorders are available, and research is yielding new, improved therapies that can help most people with anxiety disorders lead productive, fulfilling lives. If you think you have an anxiety disorder, you should seek information and treatment. Each anxiety disorder has its own distinct features, but they are all bound together by the common theme of excessive, irrational fear and dread.

Panic Disorder

People with panic disorder have feelings of terror that strike suddenly and repeatedly often with no warning. Many can't predict when an attack will occur, and many develop intense anxiety between episodes, worrying when and where the next one will strike. In fact, the thing that makes panic disorder differ from "having a panic attack" is that a person develops fears about having a panic attack. Some say panic disorder can be described as "fear of fear".

If you are having a panic attack, most likely your heart will pound and you may feel sweaty, weak, faint, or dizzy. Your hands may tingle or feel numb, and you might feel flushed or chilled. You may have nausea, chest pain or smothering sensations, a sense of unreality, or fear of impending doom or loss of control. You may genuinely believe you're having a heart attack or losing your mind, or on the verge of death.

Panic attacks can occur at any time, even during sleep. An attack generally peaks within 10 minutes, but some symptoms may last much longer.

Panic disorder affects about 6 million adult Americans and is **twice as common in women as in men**. It most often begins during late adolescence or early adulthood. Risk of developing panic disorder appears to be inherited. Not everyone who experiences panic attacks will develop panic disorder, for example, many people have one attack but never have another. For those who do have panic disorder, though, it's important to seek treatment. Untreated, the disorder can become very disabling.

Many people with panic disorder visit the hospital emergency room repeatedly or see a number of doctors before they obtain a correct diagnosis. Some people with panic disorder may go for years without learning that they have a real, treatable illness.

Panic disorder is often accompanied by other serious conditions such as depression, drug abuse, or alcoholism and may lead to a pattern of avoidance of places or situations where panic attacks have occurred. For example, if a panic attack strikes while you're riding in an elevator, you may develop a fear of elevators. If you start avoiding them, that could affect your choice of a job or apartment and greatly restrict other parts of your life.

Some people's lives become so restricted that they avoid normal, everyday activities such as grocery shopping or driving. In some cases they become housebound often because of fear about having a panic attack. Or, they may be able to confront a feared situation only if accompanied by a spouse or other trusted person. Basically, these people avoid any situation in which they would feel helpless if a panic attack were to occur. When people's lives become so restricted, as happens in about one-third of people with panic disorder, the condition is called *agoraphobia*. Early treatment of panic disorder can often prevent agoraphobia. Panic disorder is one of the most treatable of the anxiety disorders, responding in most cases to medications or carefully targeted psychotherapy.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder, or OCD, involves anxious thoughts or rituals you feel you can't control. If you have OCD, you may be plagued by persistent, unwelcome thoughts or images, or by the urgent need to engage in certain rituals.

You may be obsessed with germs or dirt, so you wash your hands over and over. You may be filled with doubt and feel the need to check things repeatedly. You may have frequent thoughts of violence, and fear that you will harm people close to you. You may spend long periods touching things or counting; you may be pre-occupied by order or symmetry; you may have persistent thoughts of performing sexual acts that are repugnant to you; or you may be troubled by thoughts that are against your religious beliefs.

The disturbing thoughts or images are called obsessions, and the rituals that are performed to try to prevent or get rid of them are called compulsions. There is no pleasure in carrying out the rituals you are drawn to, only temporary relief from the anxiety that grows when you don't perform them.

A lot of healthy people can identify with some of the symptoms of OCD, such as checking the stove several times before leaving the house. But for people with OCD, such activities consume at least an hour a day, are very distressing, and interfere with daily life.

Most adults with this condition recognize that what they're doing is senseless, but they can't stop it. Some people, though, particularly children with OCD, may not realize that their behavior is out of the ordinary. OCD afflicts about 2.2 million American adults. It strikes men and women in approximately equal numbers and usually first appears in childhood, adolescence, or early adulthood. One-third of adults with OCD report having experienced their first symptoms as children. The course of the disease is variable, symptoms may come and go, they may ease over time, or they can grow progressively worse. Research evidence suggests that OCD might run in families.

Depression or other anxiety disorders may accompany OCD, and some people with OCD also have eating disorders. In addition, people with OCD may avoid situations in which they might have to confront their obsessions, or they may try unsuccessfully to use alcohol or drugs to calm themselves. If OCD grows severe enough, it can keep someone from holding down a job or from carrying out normal responsibilities at home. OCD generally responds well to treatment with medications or carefully targeted psychotherapy.

Post-traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a debilitating condition that can develop following a terrifying event. Often, people with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. PTSD was first brought to public attention by war veterans, but it can result from any number of traumatic incidents. These include violent attacks such as mugging, rape, or torture; being kidnapped or held captive; child abuse; serious accidents such as car or train wrecks; and natural disasters such as floods or earthquakes. The event that triggers PTSD may be something that threatened the person's life or the life of someone close to him or her. Or it could be something witnessed, such as massive death and destruction after a building is bombed or a plane crashes.

Whatever the source of the problem, some people with PTSD repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. They may also experience other sleep problems, feel detached or numb, or be easily startled. They may lose interest in things they used to enjoy and have trouble feeling affectionate. They may feel irritable, more aggressive than before, or even violent. Things that remind them of the trauma may be very distressing, which could lead them to avoid certain places or situations that bring back those memories. Anniversaries of the traumatic event are often very difficult.

PTSD affects about 7.7 million adult Americans. **Women are more likely than men to develop PTSD.** It can occur at any age, including childhood, and there is some evidence that susceptibility to PTSD may run in families. The disorder is often accompanied by depression, substance abuse, or one or more other anxiety disorders. In severe cases, the person may have trouble working or socializing. In general, the symptoms seem to be worse if the event that triggered them was deliberately initiated by a person, such as a rape or kidnapping. Ordinary events can serve as reminders of the trauma and trigger flashbacks or intrusive images. A person having a flashback, which can come in the form of images, sounds, smells, or feelings, may lose touch with reality and believe that the traumatic event is happening all over again.

Not every traumatized person gets full-blown PTSD, or experiences PTSD at all. PTSD is diagnosed only if the symptoms last more than a month. In those who do develop PTSD, symptoms usually begin within 3 months of the trauma, and the course of the illness varies. Some people recover within 6 months, others have symptoms that last much longer. In some cases, the condition may be chronic. Occasionally, the illness doesn't show up until years after the traumatic event. People with PTSD can be helped by medications and carefully targeted psychotherapy.

Social Phobia (Social Anxiety Disorder)

Social phobia, also called social anxiety disorder, involves overwhelming anxiety and excessive self-consciousness in everyday social situations. People with social phobia have a persistent, intense, and chronic fear of being watched and judged by others and being embarrassed or humiliated by their own actions. Their fear may be so severe that it interferes with work or school, and other ordinary activities. While many people with social phobia recognize that their fear of being around people may be excessive or unreasonable, they are unable to overcome it. They often worry for days or weeks in advance of a dreaded situation.

Social phobia can be limited to only one type of situation, such as a fear of speaking in formal or informal situations, or eating, drinking, or writing in front of others or, in its most severe form, may be so broad that a person experiences symptoms almost anytime they are around other people. Social phobia can be very debilitating, it may even keep people from going to work or school on some days. Many people with this illness have a hard time making and keeping friends.

Physical symptoms often accompany the intense anxiety of social phobia and include blushing, profuse sweating, trembling, nausea, and difficulty talking. If you suffer from social phobia, you may be painfully embarrassed by these symptoms and feel as though all eyes are focused on you. You may be afraid of being with people other than your family.

People with social phobia are aware that their feelings are irrational. Even if they manage to confront what they fear, they usually feel very anxious beforehand and are intensely uncomfortable throughout. Afterward, the unpleasant feelings may linger, as they worry about how they may have been judged or what others may have thought or observed about them.

Social phobia affects about 15 million adult Americans. Women and men are equally likely to develop social phobia. The disorder usually begins in childhood or early adolescence, and there is some evidence that genetic factors are involved. Social phobia often co-occurs with other anxiety disorders or depression. Substance abuse or dependence may develop in individuals who attempt to "self-medicate" their social phobia by drinking or using drugs. Social phobia can be treated successfully with carefully targeted psychotherapy or medications.

Specific Phobias

A specific phobia is an intense fear of something that poses little or no actual danger. Some of the more common specific phobias are centered around closed-in places, heights, escalators, tunnels, highway driving, water, flying, dogs, and injuries involving blood. Such phobias aren't just extreme fear; they are irrational fear of a particular thing. You may be able to ski the world's tallest mountains with ease but be unable to go above the 5th floor of an office building. While adults with phobias realize that these fears are irrational, they often find that facing, or even thinking about facing, the feared object or situation brings on a panic attack or severe anxiety.

Specific phobias affect an estimated 19.2 million adult Americans and are **twice as common in women as in men**. The causes of specific phobias are not well understood, though there is some evidence that these phobias may run in families. Specific phobias usually first appear during childhood or adolescence and tend to persist into adulthood.

If the object of the fear is easy to avoid, people with specific phobias may not feel the need to seek treatment. Sometimes, though, they may make important career or personal decisions to avoid a phobic situation, and if this avoidance is carried to extreme lengths, it can be disabling. Specific phobias are highly treatable with carefully targeted psychotherapy.

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is much more than the normal anxiety people experience day to day. It's chronic and fills one's day with exaggerated worry and tension, even though there is little or nothing to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money, family, or work. Sometimes, though, the source of the worry is hard to pinpoint. Simply the thought of getting through the day provokes anxiety.

People with GAD can't seem to shake their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. Their worries are accompanied by physical symptoms, especially fatigue, headaches, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, irritability, sweating, and hot flashes. People with GAD may feel lightheaded or out of breath. They also may feel nauseated or have to go to the bathroom frequently.

Individuals with GAD seem unable to relax, and they may startle more easily than other people. They tend to have difficulty concentrating, too. Often, they have trouble falling or staying asleep. Unlike people with several other anxiety disorders, people with GAD don't characteristically avoid certain situations as a result of their disorder. When impairment associated with GAD is mild, people with the disorder may be able to function in social settings or on the job. If severe, however, GAD can be very debilitating, making it difficult to carry out even the most ordinary daily activities.

GAD affects about 6.8 million adult Americans and about **twice as many women as men**. The disorder comes on gradually and can begin across the life cycle, though the risk is highest between childhood and middle age. It is diagnosed when someone spends at least 6 months worrying excessively about a number of everyday problems. There is evidence that genes play a modest role in GAD. GAD is commonly treated with medications. GAD rarely occurs alone, however; it is usually accompanied by another anxiety disorder, depression, or substance abuse. These other conditions must be treated along with GAD.

Treatment of Anxiety Disorders

Effective treatments for each of the anxiety disorders have been developed through research. In general, two types of treatment are available for an anxiety disorder—medication and specific types of psychotherapy (sometimes called "talk therapy"). Both approaches can be effective for most disorders. The choice of one or the other, or both, depends on the patient's and the doctor's preference, and also on the particular anxiety disorder. For example, only psychotherapy has been found effective for specific phobias. When choosing a therapist, you should find out whether medications will be available if needed.

Before treatment can begin, the doctor must conduct a careful diagnostic evaluation to determine whether your symptoms are due to an anxiety disorder, which anxiety disorder(s) you may have, and what coexisting conditions may be present. Anxiety disorders are not all treated the same, and it is important to determine the specific problem before embarking on a course of treatment. Sometimes alcoholism or some other coexisting condition will have such an impact that it is necessary to treat it at the same time or before treating the anxiety disorder.

If you have been treated previously for an anxiety disorder, be prepared to tell the doctor what treatment you tried. If it was a medication, what was the dosage, was it gradually increased, and how long did you take it? If you had psychotherapy, what kind was it, and how often did you attend sessions? It often happens that people believe they have "failed" at treatment, or that the treatment has failed them, when in fact it was never given an adequate trial.

When you undergo treatment for an anxiety disorder, you and your doctor or therapist will be working together as a team. Together, you will attempt to find the approach that is best for you. If one treatment doesn't work, the odds are good that another one will. And new treatments are continually being developed through research. So don't give up hope.

Medications

Psychiatrists or other physicians can prescribe medications for anxiety disorders. These doctors often work closely with psychologists, social workers, or counselors who provide psychotherapy. Although medications won't cure an anxiety disorder, they can keep the symptoms under control and enable you to lead a normal, fulfilling life.

Antidepressants

A number of medications that were originally approved for treatment of depression have been found to be effective for anxiety disorders. If your doctor prescribes an antidepressant, you will need to take it for several weeks before symptoms start to fade. So it is important not to get discouraged and stop taking these medications before they've had a chance to work.

Anti-Anxiety Medications

High-potency benzodiazepines relieve symptoms quickly and have few side effects, although drowsiness can be a problem. Because people can develop a tolerance to them and would have to continue increasing the dosage to get the same effect benzodiazepines are generally prescribed for short periods of time. One exception is panic disorder, for which they may be used for 6 months to a year. People who have had problems with drug or alcohol abuse are not usually good candidates for these medications because they may become dependent on them. Some people experience withdrawal symptoms when they stop taking benzodiazepines, although reducing the dosage gradually can diminish those symptoms. In certain instances, the symptoms of anxiety can rebound after these medications are stopped. Potential problems with benzodiazepines have led some physicians to shy away from using them, or to use them in inadequate doses, even when they are of potential benefit to the patient. Benzodiazepines include clonazepam, which is used for social phobia and GAD; alprazolam, which is helpful for panic disorder and GAD; and lorazepam, which is also useful for panic disorder. Buspirone, a member of a class of drugs called azipirones, is a newer anti-anxiety medication that is used to treat GAD. Possible side effects include dizziness, headaches, and nausea. Unlike the benzodiazepines, buspirone must be taken consistently for at least two weeks to achieve an anti-anxiety effect.

Other Medications

Beta-blockers, such as propranolol, are often used to treat heart conditions but have also been found to be helpful in certain anxiety disorders, particularly in social phobia. When a feared situation, such as giving an oral presentation, can be predicted in advance, your doctor may prescribe a beta-blocker that can be taken to keep your heart from pounding, your hands from shaking, and other physical symptoms from developing.

Psychotherapy

Psychotherapy involves talking with a trained mental health professional, such as a psychiatrist, psychologist, social worker, or counselor to learn how to deal with problems like anxiety disorders.

Cognitive-Behavioral and Behavioral Therapy (CBT)

Research has shown that CBT, a form of psychotherapy, is effective for several anxiety disorders. It has two components. The **cognitive** component helps people change thinking patterns that keep them from overcoming their fears. For example, a person with panic disorder might be helped to see that his or her panic attacks are not really heart attacks as previously feared; the tendency to put the worst possible interpretation on physical symptoms can be overcome. Similarly, a person with social phobia might be helped to overcome the belief that others are continually watching and harshly judging him or her.

The **behavioral** component of CBT seeks to change people's reactions to anxiety-provoking situations. A key element of this component is exposure, in which people confront the things they fear. An example of a behavioral technique is to teach the patient deep breathing as an aid to relaxation and anxiety management.

A major aim of CBT and behavioral therapy is to reduce anxiety by eliminating beliefs or behaviors that help to maintain the anxiety disorder.

CBT or behavioral therapy generally lasts about 12 weeks. It may be conducted in a group, provided the people in the group have sufficiently similar problems. Group therapy is particularly effective for people with social phobia. There is some evidence that, after treatment is terminated, the beneficial effects of CBT last longer than those of medications for people with panic disorder; the same may be true for OCD, PTSD, and social phobia. Medication may be combined with psychotherapy, and for many people this is the best approach to treatment. As stated earlier, it is important to give any treatment a fair trial. And if one approach doesn't work, the odds are that another one will, so don't give up.

If you have recovered from an anxiety disorder, and at a later date it recurs, don't consider yourself a "treatment failure." Recurrences can be treated effectively, just like an initial episode. In fact, the skills you learned in dealing with the initial episode can be helpful in coping with a setback.

How to Get Help for Anxiety Disorders

If you, or someone you know, has symptoms of anxiety, a visit to your primary care provider is the best place to start. They can help determine whether the symptoms are due to an anxiety disorder, some other medical condition, or both. Frequently, the next step in getting treatment for an anxiety disorder is referral to a mental health professional.

Among the professionals who can help are psychiatrists, psychologists, social workers, and counselors. However, it's best to look for a professional who has *specialized training* in cognitive-behavioral therapy and/or behavioral therapy, as appropriate, and who is open to the use of medications, should they be needed. As stated earlier, psychologists, social workers, and counselors sometimes work closely with a psychiatrist or other physician, who will prescribe medications when they are required. For some people, group therapy is a helpful part of treatment.

It's important that you feel comfortable with the therapy that the mental health professional suggests. If this is not the case, seek help elsewhere. However, if you've been taking medication, it's important not to discontinue it abruptly. Certain drugs have to be tapered off under the supervision of your physician.

Remember, though, that when you find a health care professional that you're satisfied with, the two of you are working together as a team. Together you will be able to develop a plan to treat your anxiety disorder that may involve medications, cognitive-behavioral or other talk therapy, or both, as appropriate.

You may be concerned about paying for treatment for an anxiety disorder. If you belong to a Health Maintenance Organization (HMO) or have some other kind of health insurance, the costs of your treatment may be fully or partially covered. There are also public mental health centers that charge people according to how much they are able to pay. If you are on public assistance, you may be able to get care through your state Medicaid plan.

Strategies To Make Treatment More Effective

Many people with anxiety disorders benefit from joining a self-help group and sharing their problems and achievements with others. Talking with trusted friends or a trusted member of the clergy can also be very helpful, although not a substitute for mental health care. Participating in an Internet chat room may also be of value in sharing concerns and decreasing a sense of isolation, but any advice received should be viewed with caution.

The family is of great importance in the recovery of a person with an anxiety disorder. Ideally, the family should be supportive without helping to perpetuate the person's symptoms. If the family tends to trivialize the disorder or demand improvement without treatment, the affected person will suffer. You may wish to show this information to your family and enlist their help as educated allies in your fight against your anxiety disorder.

Stress management techniques and meditation may help you to calm yourself and enhance the effects of therapy, although there is as yet no scientific evidence to support the value of these "wellness" approaches to recovery from anxiety disorders. There is preliminary evidence that aerobic exercise may be of value, and it is known that caffeine, illicit drugs, and even some over-the-counter cold medications can aggravate the symptoms of an anxiety disorder. Check with your physician or pharmacist before taking any additional medicines.

Source: <http://www.nimh.nih.gov/publicat/anxiety.cfm#anx1>