Stigma of anxiety

Some 15% of the population suffer from pathological anxiety, making it the most common of all psychiatric conditions (Costa E Silva, 1998). Anxiety disorders are poorly conceptualized, rarely diagnosed and inadequately treated (Hale, 1997). They are taken for granted, yet remain a major source of emotional distress, chronic morbidity and high health-care resource utilization. Greater awareness, earlier recognition and more aggressive treatments would improve the prognosis, and overcome the stigmatization and undervaluation of patients with these disorders (Lloyd et al, 1996).

INTRODUCTION

The World Psychiatric Association has chosen schizophrenia as the target in its fight against stigma and discrimination (Sartorious, 1998). Depression is also seen as a genuine and real condition, worthy of treatment (Rix et al, 1999). Anxiety disorders, on the other hand, have yet to be seen as distinct conditions in their own right, worthy of attention.

Anxiety disorders give the same level of ill health and social distress as depression, and patients with anxiety disorders can suffer as much or more so than patients with chronic schizophrenia. The main difference is that patients with anxiety disorders are aware of their fear and distress, whereas patients with psychotic disorders often have a blunting of their emotions and are less distressed by their condition than patients with anxiety disorders.

THE WORRIED WELL

Most patients with anxiety disorders are never seen by a specialist. Many anxious patients find their way to medical outpatients for investigation of diffuse physical problems.

Patients with anxiety disorders, somatization syndromes or neurosis are seen as an intrusion into the order of conventional medical practice. Their conditions defy easy explanation and are often diffuse and intangible. These patients are often over-investigated just to exclude all possible obscure physical disorders. Doctors will vividly remember those rare patients in whom they delayed making a diagnosis of a serious physical illness, assuming it to be neurotic, but tend to forget the hundreds of patients in whom they failed to make the true diagnosis of a neurotic disorder while excluding physical problems.

The terms 'fat file syndrome' or 'heartsink' patients abound, describing patients who frequently ask for help, but in whom no obvious treatable organic cause can be found. These patients often have a somatization syndrome, expressing their anxieties and distress in physical terms. Another common variant is 'tired all the time', so often a manifestation of minor depression with anxiety, otherwise know as neurasthenia (weak nerves). The most disparaging remark of all is 'worried well', suggesting that there is nothing really wrong with the patients. These conditions are so common that they are taken for granted and almost go unnoticed. It is a case of not seeing the wood for the trees. The common conception is that 'there is nothing wrong, you are just neurotic'. The stigmatization is covert.

THERAPEUTIC OPTIONS

Treatments for schizophrenia and depression are widely acknowledged and include both medication and psychosocial support. Anxiety, on the other hand, does not have a front running treatment such as Prozac to make its mark on the front cover of *Time* magazine, bringing depression and its treatment into the public eye. For the most part the pharmacological treatments of anxiety disorders have been additional indications for the standard antidepressants.

Treatments which appear to be specific for anxiety, namely the benzodiazepines, have generally got a bad press, provoking the almost knee jerk response of the dangers of addiction. Apart from the problems of dependency, the fact that they remain the safest and most effective treatments is seen as insignificant. Buspirone and beta-blockers are of questionable efficacy.

Treatments for anxiety disorders hold little interest for pharmaceutical companies, and hence are rarely marketed. When awareness of anxiety disorders is generated, patients come forward in alarming numbers, almost emerging 'from the woodwork'. This has recently been seen with social phobia and panic disorder, both of which are now being recognized as important conditions in their own right.

GPs who treat anxious patients have limited therapeutic options. Either patients get sent to the practice counsellor for a few sessions of therapy or they resort to using antihistamines, low dose neuroleptics or beta-blockers, all of which have major drawbacks.

COUNSELLING *VS* DRUG TREATMENT

Medication is generally seen as a first-line treatment for schizophrenia and depression. Patients with anxiety disorders, however, are usually referred for counselling in the hope that this will cure them. Indeed the majority of such disorders are self-limiting, and will undergo spontaneous resolution whatever the treatment. A proportion of disorders will be 'nipped in the bud' before the condition escalates. Patients will benefit from simple cognitive

behavioural techniques, but the evidence that counselling does more than placebo is somewhat limited (Drugs and Therapeutic Bulletin, 1993).

Pharmacotherapy is of proven benefit, but is shied away from. Patients do not want medication whatever its nature in the belief that all treatments are addictive. There are few studies which actively compare the efficacy of both treatments. In general psychological therapies are good for controlling the impact of symptoms and biological treatments are good for reducing symptoms. Ideally patients should be offered both concurrently.

DURATION OF TREATMENT

Anxiety disorders are seen as self-limiting disorders that resolve by themselves within a matter of weeks. Thus, long-term treatments are specifically not indicated. The data sheets recommend anxiolytics for short-term use only and long-term use is seen as a sure sign of addiction to be combated at all costs. This is all in the face of evidence supporting the chronic nature of many anxiety disorders (Lloyd et al, 1996).

EARLY DETECTION

Unlike many other psychiatric disorders, patients with anxiety disorders rarely reach a psychiatrist before they have become chronic and relatively impervious to treatment. Early intervention and treatment carries an improved prognosis, but anxious patients rarely see a specialist. Psychiatric specialists are generally skilled in the management of major mental illness (schizophrenia and manic depression). Psychologists, if available, have waiting lists of many months. Neurosis is no longer the province of the hospital psychiatrist. Depressive disorders are seen and treated in general practice, but anxiety disorders are rarely diagnosed as such, especially by the older generation of clinicians who still believe that anxiety is really a subsection of depression.

MEDICAL OUTPATIENTS

A large proportion of neurotic patients are seen in medical and other outpatient departments. These are patients with hypochondriacal complaints and abnormal illness behaviour. They have somatization disorders and the physical manifestations of panic disorder. These patients choose to see their problems in physical terms and are referred for medical consultations and investigation to exclude obscure physical disorders. It is rare for a physician to refer the patient on to a psychiatrist with a special interest in such disorders.

The patients tend to lapse from the service or remain dissatisfied with the lack of appropriate diagnosis and treatment and continue the cycle of inappropriate investigation, high health-care resource utilization and dissatisfaction. My experience of physicians is that they are skilled at detecting abnormal illness behaviour, but despite this they still over investigate and then are unable to institute appropriate treatment.

BENZODIAZEPINE LITIGATION

In 1982 17 000 sufferers tried to sue the manufacturers of Ativan and Valium for alleged harm resulting from benzodiazepine medication. The case failed because most patients had failed to prove that tranquillisers had harmed them. The majority of their illnesses related to their underlying pre-existing (anxiety) disorders unrelated to their use of benzodiazepines.

For a brief moment the forgotten anxious masses had risen up to assert their plight. As the medical profession had not listened to them they took to the law. Unfortunately, this was the wrong way to go about getting help and these unfortunate patients have sunk back into obscurity again. They remain the forgotten legion of patients with chronic anxiety disorders who continue to suffer, who are forgotten and for whom no effective treatment exists. These patients are stigmatized and forgotten and are worthy of a voice and hopefully new therapeutic initiatives.

PROFESSIONAL ATTITUDES

The route to professional advancement in psychiatry is through biological psychiatry. An interest in Alzheimer's disease or schizophrenia, and a knowledge of brain imaging techniques would seem to be the prerequisite for a professional appointment these days. A successful career in private practice involves understanding the complexities of depression and how to deal with that. An interest in anxiety disorders is not seen as a way to promotion, although so many patients actually suffer from them. There are a few specialist posts dealing with anxiety problems and only a limited number of specialist units dealing with such conditions.

Hopefully new and effective treatments will emerge shortly, providing not only an end to the stigmatization of anxiety disorders, but also of benefit to the sufferers. HM

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Costa E Silva JA (1998) The public health impact of anxiety disorders: a WHO perspective. *Acta Psychiatr Scand Suppl* **393**(Suppl 2): 2–5

Drugs and Therapeutic Bulletin (1993) Psychological treatment for anxiety — an alternative to drugs? *Drugs Therapeut Bull* **31:** 73–4

Hale A (1997) Anxiety. *Br Med J* **314:** 1886–9

Lloyd K, Jenkins R, Mann A (1996) Longterm outcome of patients with neurotic illness in general practice. *Br Med J* **313:** 26–8

Rix S, Paykel ES, Lelliott P et al (1999) Impact of a national campaign on GP education: an evaluation of the Defeat Depression campaign. *Br J Gen Pract* **49:** 99–102

Sartorius N (1998) Stigma: what can psychiatrists do about it? *Lancet* **352:** 1058–9

KEY POINTS

- Anxiety disorders are common, but under-diagnosed and under-treated.
- Other psychiatric disorders such as schizophrenia and depression are given much greater attention and anxiety disorders tend to be overlooked.
- Anxiety disorders are so common that they are often seen as 'the norm' rather than an avenue open for examination and treatment.
- Long-term treatment for anxiety disorders is wrongly discouraged.
- The relative merits of pharmacotherapy and psychotherapy need to be explored.