Excerpt (Chapter 1) from
The Natural Medicine Guide to Anxiety
by Stephanie Marohn

1 What Is Anxiety and Who Suffers from It?

Every year in the United States, more than 19 million people are suffering from an anxiety disorder. Of these, 6.3 million have a specific phobia such as fear of flying, 5.3 million are afflicted with social anxiety disorder (also known as social phobia), 5.2 million have posttraumatic stress disorder (PTSD), 4 million have generalized anxiety disorder (GAD), 3.3 million have obsessive-compulsive disorder (OCD), and 2.4 million suffer from panic disorder.[11]

While these numbers make anxiety disorders the most common mental illness in the United States today, that unfortunately does not translate into widespread understanding of the disorder. On average, people with anxiety disorders see ten doctors before they finally get a diagnosis,[12] and less than a third of those afflicted receive "appropriate treatment."[13] Since the latter phrase conventionally refers to psychiatric medication with or without attendant psychotherapy, that means that even those who seek help are likely getting, at best, management of their symptoms.

While public awareness of depression as an illness has increased, due in part to the media flurry surrounding Prozac making depression a household word, anxiety is still regarded by many as a psychological failing and a less serious condition than depression. In actuality, the conventional medicine view of anxiety disorders is akin to that of depression; that is, they are biologically based brain disorders that have potentially grave consequences for the individual and for society.

An anxiety disorder is far beyond the nervousness or anxiousness we all feel at various times in our lives. While the different types of disorders have their own symptomatology, one prevailing characteristic is shared by all: irrational and excessive fear and dread.[14] This fear and dread can interfere with every aspect of a person's life. At its most severe, it railroads career, social life, and intimate relationships. It can also lead to psychiatric hospitalization. In fact, people with anxiety disorders are six times more likely to undergo such hospitalization than people who do not have anxiety disorders.[15] They are also at greater risk of suicide. Further, anxiety disorders worsen over time if untreated.

Not only are anxiety disorders the most common among mental illnesses, they also carry the highest price tag at $42 billion a year, which is nearly one-third of the total costs for all mental illness.[16] While treatment itself tends to be less expensive than for schizophrenia, for example, the estimated cost in lost productivity from the millions of people suffering from an anxiety disorder comprises about 75 percent of the total costs.[17]

It is clear from these facts that anxiety disorders and the growing epidemic of anxiety in the Western world need to be regarded as a serious problem with serious consequences. At the same time, in the face of these gloomy statistics, it is important to realize that management of symptoms is not the best we can hope for. As you will learn in this book, treating the underlying causes of anxiety poses the opportunity to reverse this epidemic.

The Nature of Anxiety

Anxiety occurs along a spectrum from mild to severe. There is the low-grade anxiety of worry and uneasiness about an event or condition of your life. There is the chronic anxiety of always worrying over something. Then there is the emergency response type of anxiety, which normally occurs in response to a perceived threat. The body's normal reaction to a threat is the fight-or-flight response—the emergency mobilization in which the heartbeat and breathing become rapid, the blood pressure rises, and there is a rush of adrenaline—all of which prepare the individual to act quickly. This response is what happens during an anxiety (panic) attack, but there is no actual threat.

Panic attacks may or may not be linked to fearful stimuli, such as taking a plane trip when one suffers from fear of flying. They can strike out of the blue, even during sleep. A panic attack is such a terrifying experience that people can come to "fear the fear," a phenomenon known as anticipatory anxiety. They may begin to curtail their activities to avoid situations that they think might bring on an attack.

A panic attack on its own does not constitute an anxiety disorder, but is part of the symptomatology of such disorders. To meet the official definition of a panic attack, according to the *DSM-IV,* the American Psychiatric Association's diagnostic bible for psychiatric disorders, at least four of the symptoms below must develop quickly and peak within ten minutes in the context of intense fear or discomfort:[18]

- heart palpitations, increased heart rate, or pounding heart
- sweating
- chills or hot flushes
- trembling or shaking
- numbness or tingling
- feeling short of breath or as though one were smothering
- choking feeling
- chest pain or discomfort
- nausea or abdominal distress
- dizziness, lightheadedness, unsteadiness, or faintness
- feeling of unreality or being detached from oneself
- fear of losing control or going crazy
- fear of dying

An anxiety disorder can be likened to allergies in that the response is abnormal in relation to the circumstances. In the case of an allergic reaction, the body mobilizes against a substance that is harmless to most people. In the case of an anxiety disorder, the body mobilizes for no apparent reason or against something that is not objectively threatening.

Types of Anxiety Disorders

In the psychiatric profession, the main diagnostic subcategories of anxiety disorders are panic disorder, specific phobia, social anxiety disorder, generalized anxiety disorder, obsessive-compulsive disorder, and posttraumatic stress disorder. A holistic approach does not use such diagnoses to determine the appropriate treatment course, focusing instead on the particular manifestations and underlying imbalances in the individual patient. Many people receive these labels, however, so it's helpful to know to what they refer.

In regard to the reputed higher prevalence of most of these disorders among women as compared to men, the ratios may not be accurate. Among other factors, women's greater willingness to seek help and the societal onus on men not to admit "weakness" may be skewing the numbers. In addition, men are more apt to mask their anxiety with alcohol and drugs.[19]

Panic Disorder

The *DSM-IV* categorizes panic disorder as two types: with and without agoraphobia. For a diagnosis of either type, the person must have recurrent, unexpected panic attacks, meaning that they seem to come "out of the blue," with at least one month of subsequent worry about having another attack, worry over the consequences, or significant change in behavior connected to the attacks.[20]

Agoraphobia, which translates from the Greek *agora* (marketplace) and *phobos* (fear) as fear of open spaces, is more accurately fear of a place where an attack might occur and from which the person cannot escape, get help, or avoid embarrassment. Typical situations that can raise agoraphobic fears are being away from the home on one's own, in a crowd, standing in a line, on a bridge, or in a car, bus, or train. About a third of the people who have panic disorder suffer from agoraphobia.[21]

Depression, other anxiety disorders, substance abuse, and hypochondriasis (abnormal anxiety about one's health, often with the belief that one has a serious disease, despite lack of medical evidence) are common in panic disorder. Twice as many women as men receive a diagnosis of panic disorder without agoraphobia, and three times as many the agoraphobic type. Onset is usually between late adolescence and the mid-thirties.[22]

In Their Own Words

"To someone who has not experienced an anxiety disorder, the terror, discomfort, and irrationality associated with these conditions will seem incomprehensible. Having lived through it myself, I can say that there are few experiences in life more terrifying or baffling."[23]

—Jerilyn Ross, president of the Anxiety Disorders Association of America

Specific Phobia

Formerly known as simple phobia, this form of anxiety is related to identifiable things or situations. Since exposure to the thing or situation generally brings on a panic attack, the person tends to practice avoidance even though they know that the fear is "excessive and unreasonable." The fear may be so great that the person engages in elaborate measures to avoid the phobic stimulus. For a psychiatric diagnosis of this type of anxiety disorder, the person must exhibit distress at having the phobia, and the avoidance, dread, or phobic reaction must significantly interfere with some aspect of the person's life, whether it be career, daily routine, social life, or intimate relationships.[24]

The *DSM-IV* categorizes specific phobias as of the animal type (fear of cats, for example), natural environment type (includes fear of heights, storms, and water), blood-injection-injury type, situational type (such as fear of flying, taking an elevator, or being in an enclosed place), and other type (includes fear of choking or contracting an illness). People who suffer from a specific phobia often suffer from more than one.[25]

Other anxiety disorders, mood disorders, and substance abuse are common among those with specific phobias. Overall, twice as many women as men are diagnosed with specific phobias. Onset typically occurs in childhood or early adolescence.[26]

Social Anxiety Disorder

Also known as social phobia, this form of anxiety is characterized by fear of social or performance situations involving unfamiliar people or the potential for public scrutiny. Those with social phobia fear being watched and judged by others, behaving in an embarrassing way, or being humiliated by having an evident panic attack. The most commonly reported fear in this disorder is introduction to a stranger.[27] In addition to intense anxiety in this or other problem

social situations, the person may blush, break out in a sweat, feel nauseous, tremble, and have trouble talking.

In Their Own Words

"[I] tried having a couple of drinks before a social situation, thinking that perhaps the alcohol would help. I was very fortunate in that it did not help because if it had, I might have pursued that as a solution."[28]

—CEO of a large corporation, who suffered from social anxiety disorder

As with the specific phobia, exposure typically brings on an attack, and the person knows that the fear is excessive and unreasonable but practices avoidance anyway. Psychiatric diagnosis requires that the person be distressed at having the phobia or that the avoidance, dread, or phobic reaction significantly interfere with career, daily routine, social life, or intimate relationships.[29]

Other anxiety disorders, mood disorders, substance abuse, and bulimia are conditions that may be paired with social anxiety disorder. The use of alcohol and sedatives such as barbiturates to relieve anxiety is particularly paired with social phobia.[30] The age of onset is generally in midadolescence. Research shows that social anxiety disorder affects both men and women equally, although some study samples reveal that more men than women are afflicted.[31]

Generalized Anxiety Disorder (GAD)

For a diagnosis of GAD, one must suffer from excessive and difficult-to-control anxiety and worry over multiple subjects more days than not for a period of at least six months. In addition, at least three of the following symptoms attend the anxiety and worry, with some present during the entire six-month period cited:[32]

- restlessness, edginess, or a keyed-up feeling
- irritability
- concentration problems or moments of the mind going blank
- easily becoming fatigued
- muscle tension
- sleep problems

Again, distress over one's condition or interference with one's functioning is an additional criterion for diagnosis. It is unusual for a person to suffer from GAD alone; it is most often paired with another anxiety disorder, depression, or substance abuse.[33] Stress-related conditions such as headaches and irritable bowel syndrome are also common among people who suffer from generalized anxiety disorder. The age of onset in more than 50 percent of people with GAD dates from childhood or adolescence; onset after the age of 20 can also occur. Two out of three of those afflicted with GAD are women.[34]

Obsessive-Compulsive Disorder (OCD)

Obsessions are persistent ideas, thoughts, images, or impulses that the person has difficulty ignoring or controlling and which cause distress. Compulsions are repetitive behaviors (such as hand-washing and checking locks) or mental acts (such as counting) aimed at reducing distress or anxiety, often that caused by obsessions. Obsessive-compulsive disorder consists of obsessions or compulsions that take up more than an hour per day, produce obvious distress, or significantly interfere with functioning. As with other anxiety disorders, the person is aware that the obsessions and compulsions are excessive or unreasonable.

An example of compulsive behavior is trichotillomania, which is the uncontrollable urge to pull out one's hair. An estimated eight million people in the United States suffer from this disorder.[35]

OCD may coexist with other anxiety disorders, depression, eating disorders, Tourette's disorder, and some personality disorders. OCD occurs equally among adult men and women, but in children, it occurs more frequently in boys than girls. For males, the age of onset is most frequently between 6 and 15 years old, while for females it is between 20 and 29 years old.[36]

In Their Own Words

"Getting dressed in the morning was tough because I had a routine, and if I didn't follow the routine, I'd get anxious and would have to get dressed again."[37]

—an OCD sufferer

Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder involves the reexperiencing of a highly traumatic event, avoidance of associated stimuli, numbing of responsiveness, and increased arousal symptoms such as insomnia, irritability or angry outbursts, hypervigilance, concentration problems, and an exaggerated startle response. Diagnosis requires that the syndrome be present for longer than one month and cause marked distress or significant interference with one's functioning in life.

People who have undergone rape, been in combat, or been the target of incarceration or genocide based on ethnicity or politics have the highest incidence of PTSD among those exposed to traumatic events. Research has found that from one-third to more than 50 percent of these people develop PTSD.[38]

Any age is subject to PTSD. The symptoms may first occur within three months of the trauma or as long as years later. People with PTSD are more likely to suffer from depression, bipolar disorder, substance abuse, and other anxiety disorders (panic disorder, agoraphobia, social phobia, specific phobias, GAD, and OCD).[39]

Anxiety, Comorbidity, and Suicide

Anxiety can be a corollary of other medical conditions (see chapter 2), and there is a comorbidity factor. Comorbidity means that two or more disorders exist together. According to the National Institute of Mental Health (NIMH), about 70 percent of people with an anxiety disorder have another psychiatric problem as well.[40] They are very likely to suffer from depression. For example, more than half of people with panic disorder or OCD also have depression.[41]

One study found that nearly 25 percent of subjects who suffered from seasonal affective disorder (SAD), the "winter blues," also had seasonal panic attacks that disappeared along with the depression with the advent of the longer hours of daylight in the spring.[42] Depression and anxiety coexist so often that the *DSM-IV* included the possibility of a new diagnostic category, called "mixed anxiety-depressive disorder." The overlapping quality of the two disorders is reflected in the fact that many of the underlying causes of anxiety discussed in chapter 2 also produce depression.

As noted throughout the sections on the various types of anxiety disorders, people tend to suffer from more than one kind. Many people with panic disorder, for example, also have phobias. Substance abuse and eating disorders are common comorbid conditions in anxiety as well.

One study revealed that two-thirds of 102 alcoholic admissions to an alcohol treatment facility suffered from phobic symptoms, with one-third having agoraphobia or a social phobia.

Other research demonstrated that in the majority of alcoholic phobics their phobias predated their alcohol dependence.[43]

While many people are aware of the danger of suicide among people with depression, the danger of suicide amongst anxiety sufferers is less widely known. In fact, one study found that the psychiatric patients most apt to commit suicide were those whose ailment was a combination of depression and anxiety.[44]

Research has demonstrated a lifetime rate of suicide attempts of 19.8 percent in people with panic disorders, compared to a rate of 6 percent among those with other mental illnesses, and 0.8 percent in people who don't have a psychiatric disorder. Among people whose panic attacks are below the severity required for a diagnosis of panic disorder, the rate is still high at 12.1 percent.[45] Another study of people with panic disorder found that 42 percent attempted suicide at least once.[46]

The combination of an anxiety disorder with depression or substance abuse puts one at greater risk of suicide. One study found that the incidence of suicide attempts among people with panic disorder was higher if they also suffered from depression and/or substance abuse. Of those with panic disorder combined with major depressive episodes and substance abuse, 72.2 percent attempted suicide; 50 percent of those with panic disorder and either depression or substance abuse did so; 46.2 percent of those with panic disorder and substance abuse; and 17.1 percent of those with panic disorder and neither depression nor substance abuse.[47]

If you or a loved one has an anxiety disorder, it is important to be aware of the warning signs of suicide, so you can act to prevent this tragedy from happening if the signs begin to manifest. A family history of suicide or a previous suicide attempt places one at increased risk of suicide. In addition, the warning signs of suicide are:[48]

- feelings of hopelessness, worthlessness, anguish, or desperation
- withdrawal from people and activities
- preoccupation with death or morbid subjects
- sudden mood improvement or increased activity after a period of depression
- increase in risk-taking behaviors
- buying a gun
- putting affairs in order
- thinking, talking, or writing about a plan for committing suicide

If you think that you or someone you know is in danger of attempting suicide, call your doctor or a suicide hotline or get help from another qualified source. Know that there is help and, though it may be difficult to ask for it, a life may depend upon it.

The History of Anxiety

Anxiety disorders have likely plagued humankind throughout time. References to anxiety as a medical condition date back to Greece in the fourth century B.C., with the writings of Hippocrates, the "father of medicine," who prescribed herbs for "nervous unrest."[49] The ancient Greeks also coined the word "agoraphobia" to designate the condition in which otherwise normal people were afraid to leave their houses.[50] In the Bible, we find reference to "abnormal fearfulness."[51]

The names by which anxiety disorders have been known over the centuries include nervous illnesses, nerves, hysteria (in women; hypochondria was considered the equivalent in men), "the vapors," nervous unrest, nervousness, neurasthenia, and anxiety neurosis. Shell shock was an early name for PTSD resulting from war experiences.

In the late 1800s and early 1900s, the German physician Emil Kraepelin studied and documented mental illnesses, providing the foundation for modern psychiatry. Its focus on

diagnosis and classification comes from Dr. Kraepelin.[52] The belief that psychological factors were the cause of anxiety arose from the work of Sigmund Freud, however, who in the late 1800s described what he termed "anxiety neurosis." This belief gained cachet in the American medical establishment in the early part of the twentieth century and held sway until the advent of the pharmaceutical age in the latter part of the century.

The various treatments for anxiety conditions through the ages have included herbal medicines, cold-water immersion, hydropathy (heat therapy), bloodletting, the "rest cure," and "nervous clinics." The first manufactured sedative was chloral hydrate, which came into use in 1832.[53] The barbiturate Veronal, introduced in 1904, quickly took hold as the "drug of choice" in private clinics treating nervous conditions.[54] Librium (chlordiazepoxide) was the first antianxiety drug and the first benzodiazepine (a class of tranquilizer) used in psychiatric treatment.[55]

From these pharmaceutical beginnings came a virtual drug explosion, which continues today with the search for new and better anxiolytics (antianxiety drugs) and antidepressants. Psychotherapy was not neglected entirely in this boom. Cognitive therapy, behavioral therapy, and cognitive-behavioral therapy (CBT) were used to good effect with anxiety disorders. The cognitive approach seeks to change the thinking patterns that contribute to anxiety, while the behavioral approach does the same with patterns of behavior and uses behavioral methods such as exposure therapy to desensitize the individual to the objects or situations that bring on fear. Today, it is widely accepted, due to much research evidence, that these forms of "talk" therapy are particularly beneficial in the treatment of anxiety disorders. They are often used concurrently with medications.

Despite the use of psychiatric drugs and other treatments to address symptoms of anxiety disorder, it wasn't until 1980 that the American Psychiatric Association officially recognized anxiety disorders as a diagnostic category.

The Pharmaceutical Approach to Anxiety

The increasing emphasis on drugs gradually transformed the psychiatric field, shifting the focus of the causality of mental illness from psychological to biochemical and turning the profession into a pharmaceutical industry. While there are quite a few drugs that have long been prescribed for the various anxiety disorders, it wasn't until the 1990s that drugs became the universal panacea for anxiety (and also depression).

In addition to antianxiety drugs, antidepressants are often prescribed for anxiety disorders. In 2000, the Food and Drug Administration (FDA) gave approval for the antidepressant Paxil (paroxetine) to be used specifically in treating social anxiety disorder, the first drug approved for that condition.[56]

In 2001, it approved Paxil for posttraumatic stress disorder. In 2003, the FDA approved the use of Prozac (fluoxetine) for treating children with depression or obsessive-compulsive disorder.[57]

The idea that psychological factors can contribute to anxiety has not been wholly dismissed, but the emphasis in the conventional approach to anxiety, and indeed all psychiatric conditions, is now on medication. There are a number of reasons for this, among which are the pharmaceutical lobby, the shift to a model of biological causality, and the economic strictures of managed care.

The current conventional medical view is that anxiety is a brain disorder caused by an imbalance or dysfunction in neurotransmitters, the brain's chemical messengers that enable communication between cells. Neurotransmitters are the targets of antianxiety drugs (such as Xanax) and antidepressant drugs (such as Prozac), which attempt to manipulate brain chemistry.

Researchers postulate that the problem may center in certain areas of the brain, notably the limbic system. The limbic system of the brain acts as a filter or a kind of switchboard for sensory information and is associated with emotion and behavior. Disturbances in the limbic system can affect mood and, it is thought, contribute to anxiety.

The main components of the limbic system are the amygdala, the hippocampus (a ridge of gray matter, or nerve tissue, in the brain that is involved in memory), and interconnections with the hypothalamus (a supervisory center in the brain that regulates body temperature, blood pressure, metabolism of fats and carbohydrates, blood-sugar level, and emotional expression, among other functions).

The amygdala, an almond-shaped mass of gray matter located deep within the brain, is thought to play a role in arousal, including that of fear. Researchers hypothesize that in anxiety disorders the amygdala is in a hypersensitive state or there is another problem with its circuitry, but this has not been proven and the cause for such dysfunction is unknown.[58] The basal ganglia, a set of four masses of gray matter surrounding the deeper limbic system, which are involved in integrating thoughts, feelings, and movement, may be implicated in anxiety, panic attacks, and especially OCD.[59]

Neither the area of the brain involved nor the role of neurotransmitters in producing anxiety states has been proven, but research suggests that the main neurotransmitters implicated are serotonin, epinephrine/norepinephrine, and GABA (gamma-aminobutyric acid). Part of the "proof" of their involvement comes from the antianxiety effects of making more of these neurotransmitters available in the brain or manipulating their activity, as antianxiety and depressant drugs do. Prozac, for example, acts on serotonin, and Xanax is thought to mimic the action of GABA.

Serotonin is distributed throughout the brain, where it is "the single largest brain system known."[60]

Serotonin, norepinephrine, and dopamine, another neurotransmitter, are monoamines (they are derived from amino acids) and known colloquially as the "feel good" neurotransmitters, meaning that it is their presence and function that allow us to be in a good mood. In addition to influencing mood, serotonin is involved in sensory perception and the regulation of sleep and pain, to name but a few of its numerous activities. Among the symptoms of serotonin deficiency are anxiety, worry, obsessions, compulsions, panic, phobias, insomnia, depression, and suicidal thoughts.[61]

Epinephrine (also known as adrenaline) and norepinephrine (noradrenaline) are hormones produced by the adrenal glands. Norepinephrine is similar to epinephrine and is the form of adrenaline found in the brain.[62] They are involved in the stress response and the physiology of fear and anxiety; an excess has been evidenced in some anxiety disorders.[63]

The amino acid neurotransmitter GABA has a large presence in the brain, being extant in 30 to 50 percent of brain synapses.[64] It operates to stop excess nerve stimulation, thereby exerting a calming effect on the brain. By occupying receptor sites, GABA actually inhibits the transmission of anxiety-related neural messages.[65] Symptoms of deficiency include a stressed and burned-out state, an inability to relax, and tense muscles.[66]

As noted above, neurotransmitters are the targets of psychiatric drugs used in the treatment of mental illness. In the case of anxiety disorders, the drugs typically prescribed are benzodiazepines (tranquilizers), which mimic the action of GABA, and antidepressants, which target the "feel good" neurotransmitters.[67]

The class of drugs known as high-potency benzodiazepines are "new and improved" tranquilizers, such as Valium and Xanax. "When they first came out in the 1960s, benzodiazepines were promoted as relatively safe and free of the well-known addiction problems associated with barbiturates," state psychiatrist Peter R. Breggin, M.D., and David

Cohen, Ph.D., authors of *Your Drug May Be Your Problem.* "Nothing could be further from the truth."[68]

In actuality, they are quite addictive and have a range of side effects, which include drowsiness; impairment of coordination, memory, and concentration; and even amnesia.

Tranquilizers work by suppressing brain function. The implications of this are sobering, especially given the dearth of research into the effects of these drugs on the mind over time. "[T]he long-term use of any such drug, especially in high doses, should be viewed as posing a risk of irreversible mental dysfunction,"[69] warn Drs. Breggin and Cohen.

Aside from the dependency issue, the withdrawal reaction from benzodiazepines can involve a return of anxiety symptoms, more severe than they were originally. With a short-acting benzodiazepine such as Xanax, this "rebound effect" can happen daily, say Drs. Breggin and Cohen. "The individual can end up cycling between withdrawal and intoxication from dose to dose throughout the day."[70]

In addition to the negative effects, benzodiazepines do not work to reduce anxiety in one-third of the people who take them.[71] The reason is unknown, so there is no way to tell beforehand if the drug is going to work for you.

Antidepressant drugs are thought to help reduce panic and anxiety as well as depression. For this reason, they are often prescribed for anxiety disorders, even when depression is not an apparent component. There are three classes of antidepressants used in anxiety disorders: SSRIs, tricyclics, and MAOIs.

The SSRIs (selective serotonin re-uptake inhibitors) are typically prescribed for panic disorder, social anxiety disorder, OCD, and PTSD. Prozac and Paxil are in this category. SSRIs block the natural reabsorption of serotonin by brain cells, which boosts the level of available serotonin. SSRIs are relatively new arrivals on the antidepressant scene; Prozac was introduced on the market in 1987.

Earlier categories of antidepressant drugs are tricyclics and monoamine oxidase inhibitors (MAOIs). Tricyclics inhibit serotonin re-uptake, but block norepinephrine re-uptake as well, thus they are less selective than SSRIs. Drugs in this category include clomipramine (Anafranil), which is prescribed for OCD, and imipramine (Tofranil), used for panic disorder and GAD. MAOIs act by inhibiting a certain MAO enzyme that breaks down monoamines; the outcome is more available neurotransmitters.[72] Phenelzine (Nardil) is prescribed for panic disorder and social anxiety disorder. Tranylcypromine (Parnate) is another MAOI that is used for anxiety disorders.[73]

Contrary to popular belief, the newer, more expensive antidepressants—Prozac, Zoloft, and Paxil—are no more effective than the older antidepressant drugs, according to a report issued by researchers for the U.S. Agency for Health Care Policy and Research and the U.S. Department of Health and Human Services. Not only that, but research has not established that any drug produces better results than psychotherapy, the report reveals.[74]

The reverse is true when it comes to the performance of antidepressants in cases of anxiety disorder. One NIMH-funded study of 300 people who suffered from panic attacks compared cognitive-behavioral therapy (CBT), antidepressant drugs or placebo pills, and a combination of the two. CBT produced results equal to the drugs over the 12-week trial period, and the combination of drugs and therapy was no better than CBT alone. A six-month follow-up revealed that when the subjects who had received the drugs alone went off the medication at the end of the trial, their symptoms rapidly returned, and by the end of the six months, their condition was no better than those who had been on placebos. The people who had received CBT, however, did not lose the benefits produced by the therapy.[75]

Like benzodiazepines, antidepressants come with a range of side effects, from uncomfortable to untenable, although not everyone who takes the drugs is afflicted. Flattened or

dulled feelings and sexual dysfunction are common effects of taking SSRIs. With Prozac, adverse effects include nausea, headaches, insomnia, drowsiness, diarrhea, dry mouth, loss of appetite, sweating, tremors, and rash. Worst of all for anxiety sufferers, Prozac can actually induce anxiety and nervousness.[76]

Research results published in the *International Journal of Psychopharmacology* reported that 15 percent of people taking Prozac experience this effect.[77] A condition called akathisia (drug-induced agitation) is associated with Prozac-like drugs. In this, panicky agitation, described as like "being tortured from the inside out," prompts pacing, restlessness, and even suicidal urges.[78]

Further, while many people are on antidepressants for years, there has been little research on the long-term effects of taking SSRIs. It is known, however, that they can produce neurological disorders, and permanent brain damage is a danger.[79]

Perhaps the most important argument against the use of antianxiety, antidepressant, and other pharmaceuticals as treatment for anxiety disorders is that they are not a treatment. They do nothing to address the deeper causes of anxiety. If the neurotransmitters are indeed out of balance, what caused that to happen? And if that cause is not corrected in treatment, isn't it likely that the neurotransmitters will become imbalanced again after the individual stops taking the drug presumed to compensate for the imbalance? What other factors are involved in this particular person's anxiety disorder? Chapter 2 explores the many causes, triggers, and contributing factors in anxiety, which can serve as a starting point for answering these questions.

Notes

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