

REGION

A view on the nature of fear, phobias and panic disorder

Editor's note: Wickford resident Robert Sartelli, a fairly regular contributor to our Opinion page over the last year, will begin a series of monthly columns on health and medical issues with this week's paper. Sartelli is a health educator at the University of Rhode Island.

"A man who fears suffering is already suffering from what he fears."

- Michel de Montaigne

The most common simple phobias involve snakes, spiders, insects, rats or mice, and cats or dogs. Other simple phobias include fear of closed spaces (claustrophobia), heights (acrophobia), fears of contamination and the strong aversion to witnessing blood, bone or tissue injury. Simple phobias are more common in women than men. Animal phobias normally begin in childhood whereas blood-injury phobias become evident usually in adolescence or young adulthood. Exposure to the feared object or situation provokes severe anxiety with common symptoms including panicky feelings, shortness of breath, unsteadiness or faintness, sweating and rapid heart palpitations. Impairment is usually minimal if the sufferer can avoid routine contact. At times they are endured with intense anxiety, and the sufferer is fully aware that the fear is unreasonable.

Phobias of closed spaces, roadside driving, bridges, high places and air travel typically begin during the ages of 40 to 50 years. While a snake may be easily avoided in downtown Providence, it is more difficult to eliminate commuting by car or bus, crossing bridges, avoiding heavy traffic, elevators or air travel. Impairment may be considerable if such encounters are part of the occupational and social fabric of the sufferer's everyday life. Social phobias may involve fear of public speaking and/or the fear of social and job-related situations where

the sufferer is vulnerable to scrutiny by others and fears public humiliation or criticism.

Avoidance of such public encounters is the usual strategy employed for coping, and the diagnosis is made only if the avoidance behaviors interfere significantly with normal daily life. People with social phobia are often afraid of talking to others due to their irrational fears of anticipated embarrassment or drawing unwanted attention to themselves. They would like to be less lonely but the heightened anxiety of socializing overpowers their sense of isolation. In time sufferers may develop what is known as avoidant personality disorder, but not true agoraphobia. Agoraphobia in Greek means

"fear of the marketplace" and results from the overwhelming fear of panic attacks. It is defined as a fear of being in situations where help is not available or escape might be difficult or embarrassing.

Panic attacks are fearful episodes of intense anxiety that escalate abruptly and initially appear spontaneously with seemingly no precipitating factors. At first the panic attacks are unexpected, but soon a constellation of situations, cues or triggers may cause a sudden onset of apprehension that can lead to a panic attack. The sufferer is often cognizant that entering a fear-provoking situation, like a crowded street, may prompt feelings of impending doom and increase the chance of a full-blown panic attack.

Symptoms experienced may include choking, trouble breathing, a pounding sensation in the chest, numbness or tingling, hot flashes or cold chills, trembling, nausea or abdominal distress and dizziness. The fear of losing control, going crazy, heart attack or dying may be pronounced. Intense symptoms are often accompanied by a bewildering

sense that the surrounding environment is not real (derealization) or the individual is so disoriented he or she actually may feel detached from his or her self (depersonalization).

Most patients over time will develop agoraphobia and become strongly focused on altering their routines to ensure that another horrifying panic attack will not happen. Some sufferers may worry excessively about their health and visits to the emergency room become ever more frequent. Most sufferers will limit their activities to keep out of harm's way, a task that with the escalation of the illness becomes daunting. Recurrent panic attacks may last just minutes but often happen daily, and this pattern may last for years, typically with periods of waxing and waning of the anxiety symptoms.

If sufferers are at a loss in understanding what is happening to them, it is even more difficult for someone who has no experience of panic attack to fathom the emotional impact of such fear. Many panic sufferers are poor in communicating to others their exact level of emotional discomfort. Most medical terms, like agoraphobia, are somewhat enigmatic in describing what the patient is experiencing or why such anxiety exists. It is the overwhelming fear of what is happening within their bodies during an attack that is the hallmark concern of panic sufferers. Persistent worry or anticipatory anxiety about experiencing another attack is a constant source of consternation. It is the phobic avoidance of such potential threatening cues in the environment that leads to agoraphobic behaviors. Some phobias like that of poisonous snakes do have a rational basis in causing fear. And anxiety when it is proportional to the threat is a survival feature. Irrational, excessive fear is not adaptive and leads to lifestyle restrictions, personal dysfunction and often



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fractures the sufferer's close relationships with family, friends and loved ones.

The management of panic disorder must start with educating the patient that the attacks are not medically in origin. In fact, panic disorder is the most biological-based anxiety disorder. Panic attacks have a familial link, with 2/3 of panic patients having relatives with the same disorder. Such information should alleviate the patient's sense of shame, oddness and failure. Antianxiety drugs are the main treatment in eliminating panic attacks and the goal must be 100 percent elimination of unexpected attacks. Partial elimination is inadequate because patients will still fear the next attack and maintain a defensive vigilance. Patients must be encouraged to participate in all social activities to lessen their phobic behavior. Exposure to panic provoking events will at first dramatically increase the patient's anxiety. The patient must avoid distracting himself from the phobic event, be willing to feel the full extent of the fear and let the fear lessen on its own accord by a process known as habituation. With repeated exposure and perseverance the level of fear and frequency of attacks will diminish. If the patient withdraws, avoids or copes by fleeing the source of apprehension, the cycle of anxiety attack and phobic avoidance will intensify.

President Franklin Delano Roosevelt, in his first inaugural address on March 4, 1933, in trying to raise the spirits of a nation demoralized by the depths of the Great Depression, forewarned us about the pernicious effects of unchecked fear. "So first of all, let me assert my firm belief that the only thing we have to fear is fear itself - nameless, unfigured terror which paralyzes needed efforts to convert retreat into advance."

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