

# **Living with Anxiety**

**Understanding the role  
and impact of anxiety  
in our lives**

**Mental Health  
Awareness Week 2014**



**mental  
health  
foundation**

**The truth is that anxiety is at once a function of biology and philosophy, body and mind, instinct and reason, personality and culture. Even as anxiety is experienced at a spiritual and psychological level, it is scientifically measurable at the molecular level and the physiological level. It is produced by nature and it is produced by nurture. It's a psychological phenomenon and a sociological phenomenon. In computer terms, it's both a hardware problem (I'm wired badly) and a software problem (I run faulty logic programs that make me think anxious thoughts)".<sup>1</sup>**

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### Acknowledgements

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## Foreword

We all experience anxiety; it is a natural human state and a vital part of our lives. Anxiety helps us to identify and respond to danger in 'fight or flight' mode. It can motivate us to face up to dealing with difficult challenges. The 'right' amount of anxiety can help us perform better and stimulate action and creativity.

But there is another side to anxiety. Persistent anxiety causes real emotional distress and can lead to us becoming unwell and, at worst, developing anxiety disorders such as panic attacks, phobias and obsessional behaviours. Anxiety at this level can have a truly distressing and debilitating impact on our lives and impact on our physical as well as our mental health.

Some commentators have described this as 'The Age of Anxiety'. The Mental Health Foundation's survey, commissioned for this report, backs up this sense of widespread heightened anxiety. Alarming, almost 1 in 5 people revealed that they feel anxious 'nearly all of the time' or 'a lot of the time'. More than half of us have noticed that 'people are more anxious today than they were 5 years ago.' The survey highlights 'finance, money and debt' as the most common source of anxiety, perhaps reflecting the impact of the recession and austerity on public mental health and well-being.

Anxiety is one of the most common mental health problems in the UK and it is increasing. Yet it remains under-reported, under-diagnosed and under-treated. A good ability to cope with anxiety is key to resilience in the face of whatever life throws at us. However, experiencing it too much or too often means we risk becoming overwhelmed, unable to find balance in our lives or to relax and recover. Our ability to find some inner peace has never been more important to our well-being.

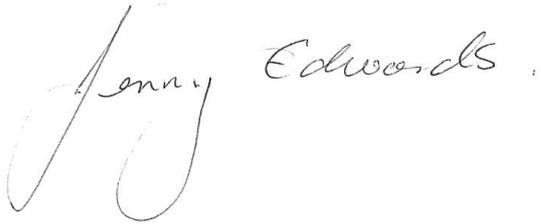
This report is about framing anxiety as an essential aspect of our humanity and part of the natural human emotional response to circumstances in our lives. It is also about challenging the stigma that still gets in the way of our reaching out for help and support when our levels of anxiety become a real problem. As individuals and society we need to understand and engage with anxiety better, recognising when it is helpfully alerting us to pay attention, and ensuring we have coping strategies when its negative impact becomes too great.

We need to recognise when the people around us, our friends, family members and colleagues, are experiencing distressing levels of anxiety or at risk of this because of life events and circumstances. Local public health strategies need to identify the points at which people are most likely to experience high anxiety and to offer a range of help that is simple, quick to access and non-stigmatising. We encourage public health commissioners to check the list of the most common sources of anxiety in this survey and

use them to help identify the best places and partnerships to reach out to those 1 in 5 people who feel anxious nearly all the time or most of the time.

We consider there could be great benefit in public policy becoming “anxiety aware”, adjusting its strategies and styles of interaction with the public in order to prevent and reduce anxiety. If we truly recognised the mounting costs of anxiety distress to people, their children’s futures, to communities and employers, we would act now.

In today’s “Age of Apps” where many people are living dual lives, partly online, then we can develop new and innovative digital approaches to living better with anxiety, particularly to invest in the mental and emotional well-being of our children and young people. We hope that this report will act as a catalyst for a growth in self-help resources to enable us all to manage our response to increasingly anxious thoughts.

A handwritten signature in black ink that reads "Jenny Edwards". The signature is written in a cursive style with a large, stylized initial 'J'.

Jenny Edwards CBE

Chief Executive  
Mental Health Foundation

## Executive summary

Anxiety is a familiar emotion because it is part of everyone's experience. Its natural function is to alert us to potential threats, allowing us to evaluate and respond to them in appropriate ways. This heightened state of readiness can also help people perform better and stimulate creative impulses. Anxiety is often regarded as an artefact of modern societies, one that is increasingly represented in visual arts, music, literature and social media.

For some people anxiety triggers inappropriate or disproportionate responses to perceived threats, leading to persistent and intrusive symptoms associated with anxiety disorders, such as panic, phobias and obsessive behaviours, which often have a debilitating effect on their lives. Anxiety is one of the most prevalent mental health problems in the UK and elsewhere, yet it is still under-reported, under-diagnosed and under-treated. This report explores the intersection between popular perceptions of anxiety, the experience of anxiety in people's everyday lives and the impact of anxiety disorders.

The experience of anxiety often involves interconnected symptoms and disorders. It is estimated that one in four people in the UK will experience a mental health problem each year, while one in six experience a neurotic disorder such as anxiety or depression. Anxiety disorders are also estimated to affect 3.3% of children and young adults in the UK. The prevalence of the most common forms of anxiety are given below.

- While 2.6% of the population experience depression and 4.7% have anxiety problems, as many as 9.7% suffer mixed depression and anxiety, making it the most prevalent mental health problem in the population as a whole.
- About 1.2% of the UK population experience panic disorders, rising to 1.7% for those experiencing it with or without agoraphobia.
- Around 1.9% of British adults experience a phobia of some description, and women are twice as likely to be affected by this problem as men.
- Agoraphobia affects between 1.5% and 3.5% of the general population in its fully developed form; in a less severe form, up to one in eight people experience this.
- Post-Traumatic Stress Disorder (PTSD) affects 2.6% of men and 3.3% of women.
- Obsessive Compulsive Disorders (OCD) affect around 2–3% of the population.
- Generalised Anxiety Disorder affects between 2–5% of the population, yet accounts for as much as 30% of the mental health problems seen by GPs.

Previous survey evidence suggests that:

- Although, on average, women rate their life satisfaction higher than men, their anxiety levels are significantly higher than men.
- People in their middle years (35 to 59) report the highest levels of anxiety compared to other age groups.
- People in the older age groups tend to be happier and less anxious.
- People with a disability are, on average, more anxious than people without a disability.

- Unemployed people report significantly higher anxiety levels than those in employment.
- People in the lowest income groups report significantly higher anxiety levels than those in the higher income groups.
- On average, all ethnic groups report higher levels of anxiety than people who describe themselves as White British.
- Young people aged 16–24 are more likely to report lower levels of anxiety compared with adults generally.
- Women and young adults aged 20–29 are the most likely to seek help for anxiety from their GP.

Our specially commissioned survey of over 2,000 members of the public found that:

- Almost one in five people feel anxious all of the time or a lot of the time.
- Only one in twenty people never feel anxious.
- Women are more likely to feel anxious than men.
- The likelihood of feeling anxious reduces with age.
- Students and people not in employment are more likely to feel anxious all of the time or a lot of the time.
- Financial issues are a cause of anxiety for half of people, but this is less likely to be so for older people.
- Women and older people are more likely to feel anxious about the welfare of loved ones.
- Four in every ten employed people experience anxiety about their work.

- Around a fifth of people who are anxious have a fear of unemployment.
- Younger people are much more likely to feel anxious about personal relationships.
- Older people are more likely to be anxious about growing old, the death of a loved one and their own death.
- The youngest people surveyed (aged 18–24) were twice as likely to be anxious about being alone than the oldest people (aged over 55 years).
- One-fifth of people who have experienced anxiety do nothing to cope with it.
- The most commonly used coping strategies are talking to a friend, going for a walk, and physical exercise.
- Comfort eating is used by a quarter of people to cope with feelings of anxiety, and women and young people are more likely to use this as a way of coping.
- A third of the students in the survey said they cope by ‘hiding themselves away from the world’.
- People who are unemployed are more likely to use coping strategies that are potentially harmful, such as alcohol and cigarettes.
- Fewer than one in ten people have sought help from their GP to deal with anxiety, although those who feel anxious more frequently are much more likely to do this.
- People are believed to be more anxious now than they were five years ago.
- There is a tendency to reject the notion that having anxious feelings is stigmatising.
- People who experience anxiety most frequently tend to agree that it is stigmatising.

- **Just under half of people get more anxious these days than they used to and believe that anxiety has stopped them from doing things in their life.**
- **Most people want to be less anxious in their day-to-day lives.**
- **Women and younger people are more likely to say that anxiety has impacted on their lives.**

Surveys suggest we live in an ‘age of anxiety’ which reflects a shared mood about the defining aspects of modern life: our work, the way we raise children, our attitudes to people who are disadvantaged, the future of public services, the threat of terrorism, and so on. At another level, there is evidence of the hidden impact of more severe forms of anxiety upon the lives of a significant number of people. Our understanding of anxiety disorders has improved in recent years due to research, the development of more sophisticated diagnostics, effective treatments, and the emergence of a genuine voice for people living with anxiety. While these developments are encouraging, our own work suggests that there are still gaps that need to be addressed in the provision of support for people who experience anxiety.

We recommend a stepped care approach be adopted to ensure that support for living with anxiety is provided in the least stigmatising and most inclusive way possible including:

- **Universal approaches to learning to live well with anxiety should be built into school curriculums from primary 1 onwards, including an understanding of the role of anxiety in our lives, and techniques for managing stresses associated with school (such as peer relationships, exams and transitions).**
- **Peer-led approaches should be promoted within universal settings such as employment, schools and universities, in recognition of the importance that young people place on support from peers and the unique level of empathetic understanding that can be provided by those with a common experience.**
- **Access to good quality self-help approaches should be made available across the UK through quality-assured and co-designed digital platforms to ensure they are fit for purpose for those who choose not to use face-to-face services (young people, people in full time employment).**
- **GP training and anxiety-related guidance should be assessed for equalities impact and adapted alongside groups of people who are at highest risk of developing problematic anxiety and least likely to have their needs met by current service provision.**
- **A sample of psychological services should be audited to establish how well current referral processes are working, who is accessing these, and who is falling through the gaps. This audit should include IAPT (Improving Access to Psychological Therapies) in England and Wales and initiatives to improve access in Scotland.**

- **Agencies offering support to people with anxiety should make greater use of peer mentors and advice and information that is explicitly based on the life experiences of people who live with anxiety.**

We also recommend that research be commissioned to better understand:

- **The nature and understanding of anxiety for different groups in society (women, people with long-term conditions, older people, people from black and minority ethnic communities), and whether current approaches and interventions can be found to address specific needs.**
- **The relationship between unemployment, financial distress, and anxiety. The Department of Work and Pensions should develop strategies to prevent people who are not working from becoming marginalised from the workforce. Processes for accessing social welfare for those unable to work due to disability should be assessed for their impact on anxiety levels.**
- **The impact of technological advancements in self-management for anxiety.**

## Introduction

In this report we want to get deeper under the skin of ‘anxiety’, one of our most unwelcomed emotional states, and understand the role that it plays in our lives—for better and for worse. It is not our intent to present the case for eradicating anxiety, for being anxious is an important part of what it means to be human. We are often anxious about those aspects of our lives that we care most about: our health; our ability to clothe and feed ourselves and our family; and our ability to be connected and valued by others. Anxiety helps us to get up in the morning and motivates us to step out of our comfort zone.

However, we often go to great lengths to avoid being anxious, feeling a sense of failure if we don’t keep our worrying thoughts under tight control. There may be times when these thoughts get away from us and begin to feel overwhelming. For some they may become habitual, leading to regular uncomfortable, or even distressing, physical symptoms. Patterns of avoidance may build up, that can have a limiting effect on our lives.

Anxiety can also be exhilarating. Putting ourselves into situations that make us anxious can feel like an ordeal at the time, but getting through to the other side can bring an incredible sense of achievement. Our most important moments in life are usually not achieved without some sleepless nights. Being a new parent, our wedding days, passing exams, and learning to drive bring great rewards, but it is unlikely that these were achieved without some feelings of apprehension.

Anxiety is an emotional state that can work for us as well as against us. It is something we all have in common, but where we often differ is in how we perceive these feelings of arousal and how we respond to them. Our life circumstances, our upbringing and our personalities can all be factors in why one person’s exciting fairground ride will leave another person in abject terror. Feeling anxious isn’t a sign of failure and there are times when it is important to ask for help from those

around us, or from professionals. However, as we come to understand anxiety better, there is much that we can do as individuals to take steps to reduce its hold over us, and to learn to appreciate our full range of emotions without fear that they will overtake us.

## What is anxiety?

Everyone has feelings of anxiety at some point in their life, whether it is about preparing for a job interview, meeting a partner’s family for the first time, or the prospect of parenthood. While we associate anxiety with alterations to our mental state, experienced as worry or apprehension perhaps, and physical symptoms such as raised heart rate and adrenaline, we also understand that it is likely to affect us only temporarily until the source of our anxiety has passed or we have learnt to cope with it. Anxiety is therefore one of a range of emotions that serves the positive function of alerting us to things we might need to worry about: things that are potentially harmful. More importantly, these emotions help us to evaluate potential threats and respond to them in an appropriate way, perhaps by quickening our reflexes or focusing our attention.

Fear, like anxiety, is a familiar emotion precisely because it is part of everyone’s experience and we consider it an essential component of our humanity, yet it is also a psychological, physiological and behavioural state we share with animals when confronted by a threat to our wellbeing or survival. Fear increases the body’s arousal, expectancy, and neurobiological activity, and triggers specific behaviour patterns designed to help us cope with an adverse or unexpected situation. But how do we distinguish anxiety from fear, given that the two are often used interchangeably?

**“If fear is fearful of something particular and determinate, then anxiety is anxious about nothing in particular and is indeterminate. If fear is directed towards some distinct thing in the world, spiders or whatever, then anxiety is anxious about being-in-the-world as such. Anxiety is experienced in the face of something completely indefinite. It is, Heidegger insists, ‘nothing and nowhere’” (Critchley, 2009).**

While fear often has a specific, immediate context which provokes classic ‘fight or flight’ reflexes—the automatic fear response occurs faster than conscious thought, releasing surges of adrenaline which can subside quickly once the perceived or actual threat has passed—anxiety connotes lingering apprehension, a chronic sense of worry, tension or dread, the sources of which may be unclear. It can be a vague, unpleasant emotion experienced in anticipation of some ill-defined misfortune. The committee charged with reviewing the diagnostic criteria for the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)<sup>2</sup> similarly distinguish anxiety as “a future-oriented mood state associated with preparation for possible, upcoming negative events” from fear which “is an alarm response to present or imminent danger (real or perceived)”; but add “importantly, these descriptions represent prototypes of fear and anxiety that lie at different places upon a continuum of responding. Along such a continuum, symptoms of fear vs. anxiety are likely to diverge and converge to varying degrees” (Craske et al., 2009). Another writer, expressing the distinction in less esoteric terms, suggests “the sudden re-arrangement of your guts when an intruder holds a knife to your back (fear), is different from the mild nausea, dizziness and butterflies in your stomach as you’re about to make a difficult phone call (anxiety).”<sup>3</sup>

This report is concerned with the way that different types of anxiety, found at various points on the continuum, are experienced by individuals and how they are represented to the wider public. It explores the everyday manifestations as well as what happens when anxiety becomes more than a temporary experience, and instead is experienced as either a series of debilitating episodes or a constant presence in someone’s

2. Published by the American Psychiatric Association, the DSM offers standard criteria for the classification of mental disorders for use by clinicians, researchers, pharmaceutical companies, policymakers, etc. The latest version, DSM-V, was published in May 2013.

3. From Harriet Lerner, The Dance of Connection blog October 11th 2009.

life. Anxiety disorders such as panic, phobias and obsessive behaviours may be triggered by traumatic memories, irrational hatred of specific objects, proximity to particular situations or physical locations, or a persistent worry that something bad will happen in the future. A defining characteristic of anxiety disorders is that psychological symptoms, such as irritability, difficulties concentrating and depression, become persistent and intrusive. Many people also experience physical symptoms, like heart palpitations, sweating, tensions and pain, heavy and rapid breathing, dizziness, fainting, indigestion, stomach aches, sickness and diarrhoea; in acute cases, people have described how it felt as though they were dying. The lives of those with the most severe forms of anxiety can become completely dominated by their condition, meaning they find it difficult to relax or achieve regular patterns of sleep, becoming stuck in circular patterns of thought that impair their ability to maintain preferred lifestyles, hold down a job or sustain personal relationships.

## Anxiety and modernity

Although it is the most common sign of mental distress in nearly every country in the world, anxiety is often presented as an artefact of modern Western societies; Norman Mailer, for example, suggested that “the natural role of twentieth-century man [sic] is anxiety”. The concept of anxiety per se was first brought to prominence as a philosophical and psychoanalytic concept in the first part of the twentieth century. Freud was a seminal figure in the development of Western thinking about anxiety, which he conceived of as a state of inner tension from which humans are driven to escape. At a most basic level, anxiety is a signal to the ego (the aspect of personality that deals with reality) that something overwhelmingly awful is about to happen and that it needs to employ a defence mechanism in response. Freud saw this as deriving from an infant’s mental helplessness, which is a counterpart of its biological helplessness. Humans learn to cope with anxiety prompted by ‘real’ threats, such as fear of being bitten by a dog, either by avoiding situations likely to contain the threat, or by physically withdrawing from them.

Freud’s typology also included neurotic anxiety arising from an unconscious fear that we will lose control of libidinal impulses, leading to inappropriate behaviour, and moral anxiety, arising from a fear of violating our own moral or societal codes. Moral anxiety, he suggested, manifests itself as guilt or shame. The task of psychoanalysis is therefore to strengthen the ability of the ego to find ways of coping with anxiety such as ‘denial’, ‘rationalisation’, ‘regression’ (to a childhood state) or ‘projection’.

Within the existentialist philosophical tradition, ‘angst’, from the German word for anxiety, is held to be a negative feeling arising from the experience of human freedom and responsibility in a world where faith and traditional social bonds have been undermined. Kierkegaard’s classic example of existential angst is of a person standing on the edge of a high cliff or building;

along with the fear of accidentally falling, the person feels an irrational impulse to deliberately fling themselves over the edge. The emotion the person feels upon realising that he or she has this option is angst. Kierkegaard described the burden of making moral choices as a consequence of free will “the dizziness of freedom”. Existential psychology therefore proceeds from the presumption that anxiety stems from a crisis in the exercise of free will, which might be manifested in anxiety about one’s mortality, the inevitability of loss, or about accepting personal responsibility for one’s thoughts, feelings and actions.

That anxiety “somehow feels new”<sup>4</sup> may be explained partly by the fact that anxiety has been the subject of significant scientific research for less than half a century, while the psychiatric profession first codified diagnostic criteria for all the different disorders as recently as 1980, with the publication of DSM-III. Subsequent advances in diagnostic techniques, coupled with the development of effective pharmacological treatments and psychological therapies, have prompted primary healthcare professionals to more readily identify anxiety in their patients.

Anxiety is now recognised as one of the most prevalent mental health problems in the UK, yet there is good evidence that it is still under-reported, under-diagnosed and under-treated. One reason may be that, unlike many other mental health issues, people whose lives are affected have not yet found a voice that articulates the full range of experiences of anxiety, not just those of people living with anxiety disorders. In recent years, this has begun to change, as writers, bloggers and campaigners have provided us with an insight into “Britain’s silent epidemic”<sup>5</sup> by describing the lived experience of anxiety, the complexities and nuances of the various disorders, the symptoms that are associated with them, and the effect that anxiety has upon their lives. For example, some people living with anxiety describe feelings of shame and embarrassment at their physical symptoms, such as excessive perspiration, which lead them to adopt what

Freudian psychoanalysts would recognise as classical defence mechanisms: “they learn to seal their anxiety off from public view”. According to Daniel Smith, “they learn to cork their anxiety within themselves like acid in a vial. It isn’t pleasant. The human mind isn’t Pyrex, it can corrode. But it works.”<sup>6</sup>

Perhaps more significantly, the testimony of people living with anxiety affords us a more rounded appreciation of the role that it plays in shaping their lives; as Scott Stossel, author of *My Age of Anxiety*, puts it, “anxiety can be a spur to achievement as well as a barrier. Picture a bell curve with extreme anxiety on the far right and extreme lack of anxiety on the far left. If you’re too anxious to the point where it’s physically and mentally debilitating, then your performance suffers. If you’re not anxious enough, if you’re not engaged and slightly activated by anxiety, as it were, then your performance also suffers.”<sup>7</sup>

The voices of people living with the more acute forms of anxiety help us to conceive of anxiety as something more than simply a condition that requires diagnosis and treatment. How individuals engage with their anxiety, how they manage it and represent it to the wider world lifts anxiety beyond the realm of medicine and science and into a broader sociological and cultural context.

4. Rachel Cooke, *The Observer*, Sunday 15th September 2013.

5. *The Observer*, Sunday 15th September 2013.

6. From *Monkey Mind: A Memoir of Anxiety* by Daniel Smith, quoted in *The Observer*, Sunday 15th September 2013.

7. Scott Stossel ‘*My Age of Anxiety*’.

**“For as long as I can remember I have suffered from a deep feeling of anxiety which I have tried to express in my art. Without anxiety and illness I should have been like a ship without a rudder”  
(Edvard Munch).**

The representation of these more acute forms of anxiety within the arts has long been established as a powerful creative force in a way that fear rarely is.<sup>8</sup> From the “dizziness of freedom” has flowed a rich artistic tradition since the beginning of the twentieth century, starting with the close relationship between early modernist artists and psychoanalysis and the rise of art practices within psychiatric hospitals, which in turn had a significant impact on the development of art history. Writers have also recognised anxiety as a “handmaiden to creativity”,<sup>9</sup> either as the motivating spirit acknowledged by Graham Greene, for example, or as the animating theme of novels by Virginia Woolf, Franz Kafka and Haruki Murakami. Most notably, the First World War poets, many with the experience of early psychiatric treatments for trauma, brought the subjective experience of severe anxiety disorders into the public realm. In another sphere, musicians as diverse as Leonard Bernstein, Marvin Gaye and Radiohead have represented anxiety in their work, while *The King’s Speech* demonstrates that a debilitating social anxiety can be the subject matter of a commercially successful film as well as a critically acclaimed one.

In 2009, the Mental Health Foundation published *In The Face of Fear*, which addressed the questions of how fear and anxiety affect our health and society, and what we can do about it. At that time, fear seemed a natural response to the dramatic banking crisis of the previous year and the potential socio-economic consequences that few at the time could predict, except that it was likely to be the deepest recession for a generation. Indeed, research carried out for *In The Face of Fear* found that “people perceive our world as having become more frightening and frightened”. In 2014, five years on, we are exploring whether and how that mood of fear has translated into a more persistent sense of apprehension and, taking a broader perspective, how that fits into our historical understanding of anxiety. We do this by asking: do we live in age of anxiety? In doing so, we want to draw attention to the way that anxiety affects the lives of the people who live with it and consider the contribution of anxiety to our culture.

This report explores the intersection between popular perceptions of anxiety, the experience of anxiety in people’s everyday lives, and the impact of anxiety disorders. In doing so, we have reviewed the research evidence on anxiety disorders, commissioned a survey of public views, and collected people’s stories about their own experiences. The following chapters set out the scale and nature of anxiety in the UK and how it is currently managed, interspersed with case studies describing what it is like to live with anxiety. We hope that the report will contribute to a wider understanding of the role that anxiety plays in our lives and stimulate discussion about the public health implications of learning to live well with anxiety.

8. Later this year, the Anxiety Arts Festival will explore anxiety, its causes, how it affects our lives and how it can act as a motivating force for creativity.

9. Attributed to Aldous Huxley.

## Living with anxiety: Stephanie, journalist, mid-20s

Your greatest strength is also your greatest weakness. I've always had a natural tendency to be on edge, to be extremely aware of my surroundings. I'm alert all of the time and, although a predisposition to being quite observant is great for your career, it isn't always the best for your personal relationships. As a writer, your job is to see the things that other people don't necessarily see. It's because of your ability to notice anything and everything that you are able to draw conclusions, notice trends or comment on various social phenomena.

I had a brilliant upbringing and a really supportive family. But Mum and Dad were in the process of getting divorced when I went off to university, so there I was, worried about putting on weight while I had a lot going on at home. I started to spend more and more time at the gym because exercise was a great stress relief (and the endorphins didn't hurt either). I started to see results in weight loss, which made me want to do a bit more and then a bit more. I guess, because I'm a perfectionist, if I was going to do something, I was going to do it well!

My weight loss was drastic, but it never got to the stage where I was hospitalised. But I was very well aware that my behaviour was not normal; even then I didn't lose that logical side of me. Mum and Dad could see what was happening and did encourage me to see a psychologist. It really really helped. When I got the diagnosis (anorexia nervosa/bulimia nervosa with mild anxiety disorder), it was a shock. I was surprised to find out that I had an anxiety disorder, and it was the eating disorder that was the symptom, not the other way around.

In my sessions with my psychologist, she used CBT<sup>10</sup>. Good old CBT, it works every time! I'm a big champion of it. The best techniques for me are the ones that make me separate my emotions from the thoughts; to realise that what I'm feeling inside isn't necessarily an accurate representation of what the situation is. So, if I'm feeling stressed out of my mind, I take a step back and notice that I'm feeling stressed, then take another step back and notice that I'm having the thought of feeling stressed. That simple dissociation between "I think, therefore I am" really helps.

The heightened anxiety I felt during my parents' divorce lasted for about a year before I got into CBT. Then, within six months I got back to being more like myself. I found that for me, the central issue affecting my anxiety is control; more specifically, the lack of control is what precipitates my anxiety. It definitely flares up when I'm stressed. I used to repress everything to the point where I would become overwhelmed with emotion—I would cut off—but that doesn't ever help because you eventually explode; it has to come out at some stage. Now I allow myself to feel stressed or anxious for a little period because I know that ultimately it will subside. I let it wash over me, but then stop it because I know that the body can only be in a state of stress for so long; it ultimately calms itself down.

I've had a couple of years now of being more mindful and trying to observe myself from a bird's-eye perspective. I know what my limits are now. Having recently moved to London, there were definitely times last year when I fell back into my old patterns of thinking because I was chronically stressed about my job situation and repressed my feelings of loneliness, missing creature comforts, yet wanting to be this strong person. I was too proud to acknowledge that I was having a tough time. I'd never really admit to friends how I was feeling deep down, because that then meant I'd have to admit to myself that I had a problem again. So, I went home and had a couple of booster sessions with my counsellor.

People deal with anxiety in different ways. For some, it's addiction; mine is an eating disorder. Your weight and your food intake is something that will never be out of your control, and that's why you find comfort with it. I know it will never completely go away—it's part of my chemistry—but doing CBT helped me and prevented me from going too far and over-thinking things. It helped me to acknowledge that a thought is simply a thought rather than the truth. Now I can gauge where I am in my overall wellbeing by my drive to watch what I eat or how I exercise. Now, if I have dessert, that's okay. The more that food or weight is in the forefront of my mind, the more I know that I need to change something in my life that is causing me that stress.

10. Cognitive Behavioural Therapy (CBT): is one of a broad range of psychotherapies or 'talking therapies' that aims to change the way that you think and behave.

## Anxiety disorders in the UK

The best estimates suggest that: one in four people in the UK will experience a mental health problem each year; one in six will experience a common mental health problem such as anxiety or depression; and that these figures have steadily increased over the past 20 years. Estimates of the number of people who experience anxiety vary because of the different methods for gathering data and the different criteria used in identifying it. Some surveys rely on self-reporting: people's own assessments of their emotional state. While the results can help us appreciate the general mood of a population and the distribution of anxiety within a population, such surveys lack the consistency of a diagnostic threshold. However, reports based on service data will, by definition, only include those willing and able to seek help for their anxiety and rely on the correct identification by professionals of the presence of a problem. Estimating the prevalence of anxiety problems is further complicated by the fact that, in diagnostic terms, anxiety is the common thread linking a range of disorders, from agoraphobia to obsessive compulsive disorder. Some disorders are linked (for example, agoraphobia and panic disorders), while each displays particular characteristics which themselves impact on people's lives.

## What are the most common anxiety disorders?

The experience of anxiety often involves a bundle of interconnected symptoms and disorders characterised by confusing circularity between the triggers to anxiety and the responses that it invokes. Scott Stossel's "bundle" includes emetophobia, a fear of vomiting (especially in public), which is a condition that according to Anxiety UK is not widely diagnosed even though it is fairly prevalent. This is the aspect of his anxiety that is most debilitating, he says, because it is entwined with agoraphobia caused specifically by a fear of being sick far from home as well as nausea, a commonly experienced physical symptom of many forms of anxiety. While the separate elements to the bundle may not, in themselves, have a decisive impact on his life, the effects of their interaction can be devastating.

This can be seen more clearly in people diagnosed with **co-morbid depression and anxiety**, which often results from a downward spiral in which anxiety leads to low mood which in turn intensifies the anxiety. The most recent national survey of mental health in the UK indicates that while 2.6% of the population experience depression and 4.7% have anxiety problems, as many as 9.7% suffer mixed depression and anxiety, making it the most prevalent mental health problem among the population as a whole (McManus et al., 2009). Previous surveys conducted in 1993 and 2000 showed an increase in the prevalence of mixed anxiety and depressive disorders, but only small changes between 2000 and 2007 (Self et al., 2012).

**Panic** is an exaggeration of the body's normal response to fear, stress or excitement. Panic attacks are a period of intense fear in which symptoms develop abruptly and peak rapidly. Panic attacks have been described as a form of "emotional short-circuiting" (Servian-Schreiber, 2005) whereby the limbic brain suddenly takes over the body's functioning, leading to overwhelming sensations, which might include

a pounding heart, feeling faint, sweating, shaky limbs, nausea, chest pains, breathing discomfort and feelings of losing control. Adrenaline overwhelms the cognitive functions that would normally help the brain assess the real nature of the threat to the body. The effects can be so severe that people experiencing panic attacks believed they were dying. It is estimated that about 1.2% of the UK population experience panic as a separate disorder (Goodwin et al., 2005), rising to 1.7% for those experiencing it with agoraphobia (Skapinakis et al., 2011).

A **phobia** is an intense and irrational fear of a specific object or situation, such that it compels the person experiencing it to go to great lengths to avoid it. Phobias can be about harmful things or situations that present a risk, but they can also be of harmless situations, objects or sometimes animals. Social phobia can include a fear of being judged, scrutinised or humiliated in some way. It can show itself with a fear of doing certain things in front of others, such as public speaking. According to the Office for National Statistics, around 1.9% of British adults experience a phobia of some description, and women are twice as likely as men to be affected by this problem.

Although **agoraphobia** is often associated with a fear of open spaces, the main feature is intense anxiety triggering a panic response in situations where escape is perceived as difficult or potentially embarrassing, or where help may not be readily available; indeed, such crises often occur in confined spaces. People with agoraphobia appear to experience two distinct types of anxiety—panic, and the anticipatory anxiety related to fear of future panic attacks. Agoraphobia can have a dramatic limiting effect upon the lifestyle of people living with the condition, as they seek to avoid situations that make them anxious; for example, only using places where exit routes are known or staying close to exits. In extreme cases, individuals are so fearful they become homebound altogether. Onset of agoraphobia is usually between the ages of 18 and 35 and affects between 1.5% and 3.5% of the general population in its fully

developed form; in a less severe form up to one in eight people, i.e. about 7 million in the UK, may be troubled by some agoraphobic symptoms.

**Post-Traumatic Stress Disorder (PTSD)**, or syndrome, is a psychological reaction to a highly stressful event outside the range of everyday experience, such as military combat, physical violence, or a natural disaster. The symptoms usually include depression, anxiety, flashbacks, recurrent nightmares, and avoidance of situations that might trigger memories of the event. One study of UK armed forces personnel deployed to Afghanistan found that of 1,431 participants, 2.7% were classified as having probable PTSD, while a household survey of UK adults estimated a prevalence of 2.6% in men and 3.3% in women. Whilst a range of studies investigating the health challenges of asylum seekers and refugees have found that PTSD levels can be as much as 10 times higher than the age-matched general population (Fazel et al., 2005). A range of stressors have been identified as impacting adversely on mental health, including those experienced pre-migration, such as torture, traumatic bereavement and imprisonment, but also post-migration factors such as discrimination, detention, destitution and delayed decision making in the asylum process (McColl et al., 2008). One study of women asylum seekers in Scotland and Belgium found that 57% were above the cut-point for PTSD symptomatology (Scottish Refugee Council et al., 2009).

**Obsessive Compulsive Disorder (OCD)** affects around 2–3% of the population and is characterised by unwanted, intrusive, persistent or repetitive thoughts, feelings, ideas, sensations (obsessions), or behaviours that makes the sufferer feel driven to do something (compulsions) to get rid of the obsessive thoughts. This only provides temporary relief and not performing the obsessive rituals can cause great anxiety. A person's level of OCD can be anywhere from mild to severe, but if severe and left untreated, it can destroy a person's capacity to function at work, at school or even to lead a comfortable existence in the home.

**Generalised Anxiety Disorder (GAD)** is the most commonly diagnosed anxiety disorder and usually affects young adults. Women are more likely to be affected than men. While feelings of anxiety are normal, people with GAD find it hard to control them, to such an extent that it impinges upon their daily life. It causes sufferers to feel anxious about a wide range of situations and issues, rather than one specific event. Unlike a phobia, which focuses upon a specific object or situation, generalised anxiety is diffuse and pervades the sufferer's daily life. Although GAD is less intense than a panic attack, its duration and the mental and physical symptoms, such as irritability, poor concentration and the effects of disrupted sleep patterns, mean that people with the disorder often find it difficult to live the life they would prefer to live. GAD affects 2–5% of the population and has increased slightly since 1993 (Self et al., 2012), yet accounts for as much as 30% of the mental health problems in people seen by GPs, which explains why an analysis of people seeking help through primary care suggests a higher prevalence rate of 7.2% (Martin-Merino et al., 2010).

### **Anxiety and health**

The true impact of anxiety can be masked when it is the symptom of other more obvious or treatable physical problems which are likely to be prioritised in any subsequent medical intervention. Anxiety problems are common amongst cardiovascular patients; for example, panic disorder is up to 10 times more prevalent amongst people with chronic obstructive pulmonary disease than in the general population (Livermore et al., 2010, cited by Naylor et al., 2012). People with GAD have been found to be at higher risk of coronary heart disease, while anxiety has also been linked to increased incidence of gastrointestinal problems, arthritis, migraines, allergies, and thyroid disease. People with anxiety disorders are four times as likely as others to develop high blood pressure, and many studies have shown a relationship between anxiety and reduced white blood cell function, a sign of immune system weakness. There is also emerging evidence of a link between stress and Alzheimer's disease. Anxiety is also associated with unhealthy

lifestyle choices such as smoking, drinking too much alcohol, and a poor diet (Mental Health Foundation, 2009).

### **Children and young adults**

Anxiety disorders are estimated to affect 3.3% of children and young adults in the UK (about 290,000) and while we cannot be sure whether children and young adults today are more anxious than previous generations, mental health problems in young people are surprisingly common, disabling and run a chronic course (Cresswell et al., 2010; Hagell et al., 2013). Cohort studies carried out from 1974 show significant increases in emotional problems such as depression and anxiety amongst young people, and in 2004 it was estimated that 4% of children and young people had an emotional disorder (anxiety or depression) (Green et al., 2005). The absence of similar research in the last eight years means that it is difficult to assess the impact of the financial crisis on levels of anxiety amongst young people. Nevertheless, in 2004, children and young people with 'emotional disorders' were found to be living in significantly poorer households compared to other children and were more likely to be educationally disadvantaged (Green et al., 2005). One commentator has concluded that such "mental health problems have important implications for every aspect of young people's lives including their ability to engage with education, make and keep friends, engage in constructive family relationships and make their own way in the world" (Hagell et al., 2013).

The results of a major study revealed that children and adolescents with an autistic spectrum disorder were at particularly high risk of experiencing problematic levels of anxiety. Nearly 40% were estimated to have clinically elevated levels of anxiety or at least one anxiety disorder, with specific phobia most common at nearly 30%, followed by OCD in 17%, social anxiety disorder and agoraphobia in nearly 17% and GAD in 15% (Van Steensel et al., 2011).

## Living with anxiety: Ian, Environmental Trust Manager, mid-30s

I heard a psychologist on the radio say that having anxiety is like sticking your head above a trench every day. Mine is not that severe; it is more like getting ready for a job interview, a feeling that I have to perform more highly than in reality I actually have to. Some days it is worse than others, but it is not often that I'm away from thoughts that distract me from letting go or having a good time; there is always something at the back of my mind saying you've got to sort this or that out.

What we are talking about is GAD. My head says I'm under attack and physically I feel like I'm under attack. I start holding my breath, shallow breathing, my heart starts beating faster, pacing up and down. I get shaking—not like my cup of tea would go everywhere—but more like a buzz, a readiness, as though I'm preparing for something. Maybe I ramble on a bit; that's a product of it. It's energy-sapping although I still manage to find energy.

It's only recently that I've realised there is something that needs to be explored a bit more deeply. I'm currently working with a CBT therapist, talking about the time when I first noticed my anxiety, trying to recognise whether it was a particular incident that triggered it or whether I've had it from a younger age. My gut feeling is that I've always had a tendency to be anxious. My grandmother was anxious and I wonder if there is something genetic there. I was quite shy and reserved at school but it became more pronounced when I went to university. It was less about the stress of moving away from home, although that may have contributed to it, and more uncertainty about me and my place in the world.

While I was at university my GP prescribed anti-depressants, but I wasn't comfortable taking them. I didn't have a diagnosis; I just used to think that I'm not quite hitting the right note, not quite getting satisfaction from what I do, or that I'm flawed in

some way. Having experienced life a bit more, I've noticed patterns of stress for which I sought counselling. I didn't really nail down a diagnosis and acceptance of GAD until about 3 years ago. That led to me to get involved with Anxiety UK and they put me in touch with one of their cognitive behavioural therapists and I'm currently looking at ways to change the way I think and instil new behaviours and habits. It has taken me a while to get to that point.

Anxiety is always there, but it is heightened when there is a transition or anything new, so at a micro-level it could be a social situation I am not entirely comfortable with. So there are different levels of anxiety. When you hear the word anxiety, classically you think of worry and you would be able to see it, but anxiety can be internalised as well. So when I am there with my family at a social event, it might be the most natural, comfortable thing in the world, but in my mind somewhere I've got doubts and worries and anxieties that aren't showing.

My personality is positive by default; however, GAD interrupts my fun and placid temperament and replaces positivity with negative thoughts that I'm not good enough. Sometimes I wonder what part of it is me and what part of it is GAD. I do get a lot of things done, and then I think: is it good that I have GAD? You know what they say: if you want something done, give it to a busy person. Well, that happens to me. But really I could use the energy in much more productive ways. People have said "You need to learn to say no", but part of me on the negative side goes, "If I do say no then what will people think of me?" The other part of me says "I really want to get involved in this; I'm going to do it". And I know, because of the way I am, that if I do agree to do something I'll worry about it. So I agreed to put on the local carnival alongside holding down my full-time job, as well as juggling a social life. I'm naturally an organised person and I do have a passion for my local community, but my worry about doing a bad job and worry about what people will think of me spurred me on to put on a good schedule of events.

I do think that sport is a great medicine. I'd love to do 30 minutes of exercise a day, but the GAD means that I feel I have to do X, Y and Z before I can find time to do some exercise. It's a form of perfectionism which means that you can't start something until you've lessened the anxious feeling about these things that are pressing because the world will blow up if you don't do those. Then you can think about exercising. It's difficult to get a well-rounded routine. I find that taking on responsibilities helps. So I've taken on the responsibility to take this seriously. I used to go out and drink and that didn't help, so now I don't drink, or very rarely.

I haven't ever stopped and that has been one of the problems. Constantly doing things is something I feel is necessary as a way of preventing things going wrong. But that is actually a negative thing because I haven't been able to say, 'hang on I can look at yourself a little bit more, think some more positive thoughts because it has all been a bit of a rush'. Even if GAD gives me fear-fuelled oomph, I'd definitely swap it for peace of mind, clarity, and the yearning to just... be. I'm often left feeling sad, isolated and frustrated at the difficult task of simply enjoying life.

## The state of the nation: anxiety in the UK

To get a picture of the extent and causes of anxiety amongst the general population of Britain in early April 2014, we commissioned a survey of 2,330 adults.<sup>11</sup> The survey complements upon recent large-scale survey evidence about anxiety, which suggests that:

- Although, on average, women rate their life satisfaction higher than men, their anxiety levels are significantly higher than men (Self et al., 2012; the Office for National Statistics (ONS), 2013).
- People in their middle years (35 to 59) report the highest levels of anxiety compared to other age groups (Self et al., 2012; ONS, 2013).
- People in the older age groups tend to be happier and less anxious (Understanding Society, 2013).
- The anxiety levels of people with a disability are higher, on average, than those of people without a disability (ONS, 2013).
- Unemployed people report significantly higher anxiety levels than those in employment (ONS, 2013).
- People in the lowest income groups report significantly higher anxiety levels than those in higher income groups (ONS, 2014).
- On average, all ethnic groups reported higher levels of anxiety than people describing themselves as White British (Hicks, 2013).
- Young people aged 16–24 are more likely to report lower levels of anxiety compared with adults generally (Potter-Collins & Beaumont, 2012; ONS, 2014).
- Women and adults aged 20–29 are most likely to seek help from their GP for anxiety. (Martin-Merino et al., 2010).

For the purposes of the survey, we defined ‘anxious’ as generally feeling worried, nervous, or uneasy. The survey explored how often people feel anxious, the causes of their anxiety, what they do about it, and the impact of anxiety on their lives. The findings presented an opportunity to map the scale of anxiety across a representative sample of the population, and analyse responses by age, gender, social class and employment status.

11. Source: YouGov Plc. April 2014. Total sample size was 2,330 adults. Fieldwork was undertaken between 9th and 10th April 2014. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+).

## How often do people feel anxious?

- Almost one in five people feel anxious nearly all of the time or a lot of the time.
- Only one in twenty people say they never feel anxious.
- Women are more likely to feel anxious than men.
- The likelihood of feeling anxious tends to decline with age.
- Students and people not in employment are more likely than those who are working or retired to feel anxious all of the time or a lot of the time.

When asked to describe how frequently they experience anxiety in their everyday life, our survey found that 19% of people feel anxious either a lot of the time or all of the time. For this group, anxiety is something that almost two-thirds (61%) of them experience on a daily basis and a third (33%) experience it at least once a week. There was a marked difference between the experiences of men and women however, in that almost a quarter of the women surveyed (22%) feel anxious a lot or all of the time, compared to 15% of the men. A further 41% of people in the survey feel anxious some of the time, meaning that six of every ten respondents said they feel anxious at least some of the time. Women were more likely to experience this frequency of anxiety (68%) compared to men (51%). Additionally, 47% of men said they are either rarely or never anxious in their everyday lives, compared to 31% of women.

## In general which ONE, if any, of the following statements do you think BEST describes your experience with anxiety in your everyday life? (n=2,330)

I feel anxious nearly all of the time	4%
I feel anxious a lot of the time	14%
I feel anxious some of the time	41%
I rarely feel anxious	34%
I never feel anxious	5%
Don't know	1%

The frequency of anxious feelings decreased incrementally through the age groups of respondents, while the proportion of those saying they rarely or never feel anxious increased with age, from 25% of 18–24 year olds at the lower end of the scale, to 49% of those aged 55 years or older at the upper end. People not working for other reasons than being unemployed (such as long-term disability) were three times more likely (12%) to experience anxious feelings all of the time than the survey sample as a whole (4%). Students (26%), people who are unemployed (30%), and people not working for other reasons (33%) were more likely to feel anxious a lot of the time or all of the time compared to the survey sample as a whole (19%).

## What causes anxiety?

- **Nearly half of the people who said they feel anxious in their everyday life said that financial issues are a cause of anxiety, but this is less likely to be so for older people (those over 55 years).**
- **Women and older people are more likely to feel anxious about the welfare of loved ones.**
- **Four in every ten people who are currently employed said they experience anxiety about issues to do with their work.**
- **Around one-fifth of people who are anxious have a fear of unemployment.**
- **Younger people are more likely to feel anxious about personal relationships.**
- **Older people are more likely to be anxious about growing old, the death of a loved one, and their own death.**
- **The youngest people surveyed (those aged between 18 and 24) were twice as likely to be anxious about being alone than the oldest people (aged 55 and over).**

We asked people to identify the causes of their anxiety. Almost half of those surveyed (45%) said that financial issues (i.e. money/finance/debt) cause them to feel anxious. The survey highlighted a marked decline in anxiety about finances amongst people aged 55 years and older: nearly one-third (32%) of this age group cited finances as a cause compared to more than half for each of the other age categories. Discounting people who are retired (who are half as likely as others to say financial issues are a cause of their anxiety), this shows that not only are financial issues a significant factor in anxiety for people of working age, but also suggests that people in part-time employment (53%), the unemployed (53%), and people not working for other reasons (55%) are slightly more likely to have anxious feelings about money. The survey findings further suggest that people in social grades C2D&E (49%) may be more likely to feel anxious because of financial issues than people in social grades AB&C1 (42%).

Work issues, such as long hours, were identified by just over a quarter of people (27%) as a cause of anxiety and 17% said that the fear of losing their job or unemployment caused them to feel anxious. Anxiety related to work appears to be consistent across working life and then, as one might expect, diminishes sharply as people approach and enter retirement. Indeed, significantly higher proportions of those in either full- or part-time employment cited work issues (39%) and fear of unemployment (22%) as a cause of anxiety compared to the survey sample as a whole.

## Which, if any, of the following specifically cause you to feel anxious in your everyday life?

(n=2,184)

<b>Money/finance/debt</b>	<b>45%</b>
<b>Welfare of my loved ones/children</b>	<b>36%</b>
<b>Other work issues</b> (e.g. long hours etc.)	<b>27%</b>
<b>Personal relationships</b>	<b>26%</b>
<b>Growing old</b>	<b>25%</b>
<b>Death of a loved one</b>	<b>22%</b>
<b>Fear of losing my job/unemployment</b>	<b>17%</b>
<b>Fear of being alone/isolation</b>	<b>16%</b>
<b>My own death</b>	<b>16%</b>
<b>Fear of crime/personal safety</b>	<b>14%</b>
<b>Other</b>	<b>14%</b>
<b>Don't know/can't recall</b>	<b>6%</b>

Anxiety related to family and relationships featured prominently in the survey. Personal relationships were said to be a cause of anxious feelings for 26% of people who said they feel anxious in everyday life, but significantly more so for people aged 18–24 (44%) and students (46%), and significantly less so for people aged over 55 years (15%). Just over one-third of those surveyed (36%) identified the welfare of a loved one or children as a cause of anxiety, but significantly more women (44%) than men (28%) cited this as a cause, and the likelihood of citing it increased with age so that almost half of people aged over 55 years (47%) said that this was a cause of anxiety.

Age was also a factor in anxiety about growing old, with 36% of those aged 55 years and above saying they were anxious about this, compared to just 15% of 18–24 year olds. Similarly, 29% of the people surveyed from the oldest age group felt anxious about the death of a loved one, compared to 13% from the youngest age group, and twice as many from the oldest age group (19%) were anxious about their own death, compared to the youngest age group (10%).

However, the survey also threw up an interesting anomaly around fear of being alone/isolation. We might hypothesise that this would be a particular source of anxiety for older people, yet young people aged 18–24 (28%) were twice as likely to mention it than people in the 55 years and over age group whose response (14%) was lower than the survey sample as a whole (16%). This may be suggestive of the importance placed on belonging to a peer group by young people. Women (19%) were slightly more likely than men (13%) to mention this as a cause of feeling anxious, while students (27%), people working part-time (23%) and people not working for reasons other than unemployment (23%) were also more likely to have anxious feelings about being alone.

## How do people cope with their anxiety?

- Nearly one-fifth of people who have experienced anxiety do nothing to cope with it.
- The most commonly used coping strategies included talking to a friend, going for a walk, and physical exercise.
- Comfort eating is used by a quarter of people (24%) to cope with feelings of anxiety and women and young people are more likely to use this as a way of coping.
- Almost one-third of students in the survey said they cope by ‘hiding themselves away from the world’.
- People who are unemployed are more likely to use coping strategies that are potentially harmful, such as alcohol and cigarettes, than those who are currently employed.
- Fewer than one in ten people (7%) have sought help from their GP to deal with anxiety, although those who feel anxious more frequently are much more likely to do this.

We asked people who have experienced anxiety in their lives to identify the different ways they cope with it. Just under one in five (19%) do not do, or use, anything to cope with anxiety in their everyday lives. The findings revealed an inverse relationship between the frequency with which people experience anxiety and how active they are in seeking ways to cope with it; so 32% of people who rarely have anxious feelings said that they do nothing to cope with those feelings, while only 6% of people who live with anxiety all the time do nothing about it. The proportion of men not using coping strategies was higher (24%) than for women (16%), and older people (28%) are less prone to using coping strategies than younger people.

## Which, if any, of the following do you do/use to “cope” with your feelings of anxiety in your everyday life? (n=2,184)

Talk to a friend or relative	30%
Go for a walk	30%
Comfort eating	24%
Physical activity/exercise	23%
Hide away from the world	18%
Alcohol	16%
Relaxation/meditation techniques	13%
Cigarettes	10%
Visit my GP	7%
Other	11%
Don't know	2%

The most common coping strategy was talking to a friend or relative, used by 30% of people who feel anxious in their everyday life, although women (38%) were more likely to do this than men (21%), and younger people (42%) were more likely to do so than people in older age groups. This may also be an indication of the central role of peer relationships in the lives of young people.

The survey explored people's use of three active approaches to coping with stress. Almost one-third of all respondents (30%) said they would go for a walk to cope with anxiety, a little under a quarter said they would undertake a physical activity or do some exercise (23%), while fewer (13%) would use relaxation or meditation. While these ways of coping were employed fairly consistently across all groups, the results suggest that people from social grades AB&C1 (27%) may be more likely to undertake physical activities to deal with anxiety than people from social grades C2D&E (19%).

The survey also included four potentially harmful coping strategies. Of these, comfort eating, was employed by 24% of those surveyed and women (29%) were more likely to cope in this way than men (18%). People in the younger age groups were much more likely to use comfort eating

than people in the older age groups. A similar pattern across age and gender emerged in relation to hiding away from the world, which was cited by 18% of respondents. Students were more likely than other groups to hide themselves away; 31% of students in the survey said they use this as a coping strategy. The pattern of usage for alcohol (just over one in six people) and cigarettes (one in ten people) was not significantly different across age groups or between men and women.

The findings suggest that unemployment may be a factor in determining the types of strategies that people use to cope with anxious feelings. Unemployed people were more likely than other groups to use potentially harmful strategies: about a quarter (23%) said they would hide away from the world, use alcohol (27%) and use cigarettes (23%). In contrast, people who are retired are much less likely than any of the other groups to use any of these potentially harmful coping strategies to cope with their anxiety.

Visiting a GP to deal with anxiety was an option taken up by just 7% of respondents who had reported anxious feeling at some point in their lives, a proportion that was consistent across gender and age groups. Yet those experiencing anxiety most frequently were over five times more likely to visit their GP than the survey sample as a whole, while those experiencing anxiety a lot of the time were more than twice as likely to visit their GP.

Despite this apparently low rate of self-referral usage to GP services, 27% of those surveyed agreed that a problem with anxiety is something they would see a GP about. Agreement amongst women was higher (31%) than amongst men (23%), and more than half (56%) of those experiencing anxiety nearly all of the time agreed that anxiety is something they would visit their GP about.

## Perceptions of anxiety

- **People are believed to be more anxious now than they were 5 years ago.**
- **There is a tendency to reject the notion that having anxious feelings is stigmatising.**
- **People who experience anxiety most frequently tend to agree that it is stigmatising.**

The survey found strong agreement with the proposition that people are more anxious now than they were five years ago; as one might expect, agreement is strongest amongst people who experience anxiety most frequently (72%).

People were also asked to indicate the extent of their agreement with statements addressing aspects of stigma that may be attached to anxiety. Just over a quarter of respondents (26%) felt that feeling anxious is a sign of not being able to cope, but almost twice as many (50%) disagreed with this sentiment. Slightly more people (29%) agreed that they would be embarrassed to tell someone they have anxieties, but again just under half (46%) indicated that they would not be embarrassed. There was an even stronger rejection of the notion that feeling anxious is something to be ashamed of; just 10% of people agreed with this sentiment, while nearly three-quarters (74%) of them disagreed. However, people experiencing anxious feelings most frequently were much more likely to agree with these stigmatising views of anxiety, while, conversely, respondents who had never experienced anxious feelings were much more likely to disagree with the proposition that they would be embarrassed to tell someone they have anxieties (57%).

## The impact of anxiety

- **Just under half of people get anxious more often these days than they used to and believe that anxiety has stopped them from doing things in their life.**
- **Most people want to be less anxious in their day-to-day lives.**
- **Women and younger people are more likely say that anxiety has impacted on their lives in these ways.**

We asked three questions of those people who had experienced feelings of anxiety about the impact it has upon their lives. More people agreed (47%) than disagreed (31%) that they get more anxious these days than they used to and there were similar levels of agreement that feelings of anxiety had stopped them from doing things in their lives. There was a more clearly defined tendency for people to agree (57%) than disagree (14%) when asked if they would like to be less anxious in their day-to-day lives. In each of these domains, the tendency for agreement was larger for women compared to men and for people in the younger age groups compared to the older age groups. People experiencing anxiety on a frequent basis were also more likely to agree than disagree with these statements.

## The state of the nation

Our survey provides an important insight into the impact that anxiety has upon people's everyday lives. The findings suggest that feelings of anxiety are experienced widely and form part of a familiar emotional landscape for people taking part in the survey. The survey highlights those areas of people's lives most likely to generate feelings of anxiety; stresses and worries about families and personal relationships are a major cause of anxiety, while financial issues and work-related matters feature prominently in people's concerns. Overall, people believe that society is more anxious than it was five years ago and many of those who have experienced anxiety in their own lives say that they are more anxious than they used to be. However, the message from people taking part in our survey is that anxiety is not something to be ashamed of or embarrassed about, or that anxious feelings should be interpreted as a sign that someone is unable to cope. This perhaps tells us something about the level of awareness about anxiety that now exists amongst the general public and their potential receptiveness to initiatives to address the problems posed by anxiety.

An important message to emerge from the survey is that people find a variety of ways of coping with feelings of anxiety that fall short of seeking professional help. Although we made no attempt to gauge the effectiveness of these strategies, the preferences expressed for simple human interaction and physical activity may suggest that people deal with feelings of anxiety in ways that have proved helpful with other emotional crises. The survey also maps a less positive tendency for some people to use potentially harmful coping strategies, notably comfort eating or social withdrawal.

The survey identifies discrete groups within the populations for whom anxiety may be persistent and at times debilitating, or for whom anxiety has a disproportionate impact. It suggests that there is a small but significant group of people for whom anxious feelings are a constant presence that may provoke a heightened sense of stigma, yet they are also more active than most in seeking ways to cope with them and are more likely to call upon primary care services for help. This group will include people who have a recognised anxiety disorder, whether diagnosed or not, as well as those at risk of experiencing acute episodes of anxiety.

The survey suggests that gender, age and employment status may be factors in shaping the experience of anxiety in the UK. It reconfirms that anxiety has a disproportionate effect upon the lives of women compared to men in terms of the frequency of anxious feelings, the source of their anxiety and their preferences for coping with it. Women are also more likely to report that their anxiety has had a negative impact upon their lives by, for example, stopping them doing things. Similarly, younger people are more likely to be affected by anxiety than people from older groups, while people in the oldest age group (55 years and over), and especially retired people, are markedly less likely to be affected. Finally, the survey does suggest that people who are not employed are more likely to experience anxiety more frequently than those in work, are more likely to be anxious about financial matters, and be more likely to cope in ways that are potentially harmful.

## Living with anxiety: Jane, Volunteer, early 50s

I was probably considered a shy child, but I didn't have any major problems in childhood. I had one or two good friends although I wasn't really comfortable in big groups and I did panic if I was ever invited to parties or if there was a big group thing in class. My anxiety has always been social anxiety, so it has prevented me from doing a lot of things. It really came to a head in my teenage years—that traditional transition stage when I was doing exams. That was when it really started to kick in and I couldn't go to school, I couldn't sit my exams, so I left and I got a job through a relative. But I struggled with the work so I had to leave. I tried college and had to leave that too.

I felt very ashamed and very embarrassed about having anxiety and it was something I tried desperately to cover up. Of course the more I tried to cover it up, the more anxious I became. I thought there was a real stigma around anxiety at the time; I didn't realise that young people of my age had similar experiences and feelings. I thought it was just something that affected adults. My father suffered with anxiety and it was something he was ashamed of. He tried to cover it up and wouldn't talk about it. So I picked up on that as being something to be embarrassed about.

My GP diagnosed anxiety—it wasn't social anxiety then, it was just anxiety—and he gave me valium; I was about 17 at the time. I was also referred to a psychologist at the local hospital, but I really didn't understand what the psychologist or psychiatrist was telling me; it was very unpleasant. The tablets worked while I was taking them, but once I stopped taking them, all the symptoms came back and I still had all the very negative frightening thoughts—it didn't help those. I had a lot of physical symptoms, blushing and sweating which people would comment on, so I became more and more withdrawn. Eventually, I stopped going out, so I lost friends, had no social life, no relationships and became quite housebound. My anxiety has meant that I haven't been able to work

for a long time and even looking for a job is really really difficult for me. I wanted to do something because I'm on benefits and I wanted to give something back, also to feel better in myself, to boost my own self-esteem.

I am a member of Anxiety UK and I've been working as a volunteer on their helpline for about 4 years now. I decided to do some volunteering to help me practise my coping skills. I was always terrified of doing it and then somebody gave me a push and said "You've got to make an effort now". I had a major panic attack the first day I was here, but one of the staff took me outside and had a chat with me; they said, "It's OK, it's understandable, we've seen this before, it's not only you that this has happened to". Just hearing that—that it happens to other people as well—made all the difference. Everybody here has experience of anxiety or, if they haven't, they have a special interest in it, so I don't have to hide it. That was the biggest thing: not having to hide it. I could have anxiety attacks with all the symptoms and nobody would make any comments about it. The people here have encouraged me and given me support, and that has really helped me build my self-esteem and confidence.

The biggest change has been coming here because it's such a supportive environment. Peer support is the main thing that helps me cope, but I've also done an online CBT course. I've seen some therapists, but it may be part of my anxiety, I just feel uncomfortable with therapists being in the room; I feel trapped. I think it's my social anxiety. So I've not been able to concentrate on what they are saying because I've been focused on my anxiety and wanting to leave. Doing it online there were no distractions and I really seemed to take that in. I've used those CBT techniques and breathing control. There is some excellent self-help online. So it's been a combination of things.

Because it has been there for such a long time, anxiety has taken root. Maybe I have an anxious nature, so it is always going to be a part of my life. But now I understand it a lot better, I know I am not the only one who has it—that helps a lot—and it doesn't worry me as much because I have some coping techniques and know what I can do to reduce my anxiety.

Working here I can give people hope because when they ring up they often think that anxiety is going to ruin their lives and they are never going to get better. I tell them, from my many years' experience, "You can learn to manage it, it doesn't have to control you, you can still get on with your life. If you nip it in the bud when it starts, you have a better chance of it not getting really bad. Don't be frightened of it and don't bottle it up; share it with someone you feel comfortable with". I also contribute to a course at a local university, helping to train therapists of the future. The fact that I can use my anxiety in a positive way like this is a massive thing for me because for so many years I felt ashamed and embarrassed about it. So to be able to talk about it openly and for my experience to be embraced—they really want to hear it—that's been tremendous for me. And in general, I think it makes you a more caring person, I really do.

## Managing anxiety

“A person cannot just simply decide not to be anxious anymore” (Anxiety Care UK).

Although anxiety can be a debilitating condition, it is not an illness and therefore is no more susceptible to being ‘cured’ than other emotional states that serve important functions as part of the human survival kit. Our survey illustrates how people experiencing anxiety in their everyday lives often find the personal resources to cope through simple remedies such as talking things through or doing a physical activity, although the finding that people from social grades C2D&E are less likely to engage in a physical activity may suggest an inequality in access to such resources. This gives pause for thought when considering emerging evidence on the benefits of this form of coping strategy on wellbeing more generally (Mental Health Foundation, 2013) and in managing stress levels specifically (Gerber and Puhse, 2009).

These self-help strategies are less likely to work for more acute disorders even though most are highly treatable and full recovery is an achievable goal. Medicines can ameliorate the worst symptoms and aid the recovery process, but are less useful in helping people to manage the threat of relapse in the longer term. Lingering symptoms, vulnerability to ‘normal’ anxiety, and stress-related intensification of symptoms and anxiety contribute to a continuous risk of relapse, but these are factors that are directly addressed by psychological therapies which have been shown to improve the long-term outcomes for people who seek this type of help.

In 2010 it was estimated that there were 8.2 million diagnosed cases of anxiety disorder in the UK (Fineberg et al., 2013) yet only about one-third to half of sufferers receive treatment (McCrone et al., 2008). One of the problems of tackling anxiety disorders in the UK is the fact that despite the incidence of anxiety symptoms rising between 1998 and 2008, the incidence of GP recorded anxiety diagnoses fell over the same

period (Walters et al., 2012). A number of reasons for this apparent under-recording have been suggested, including an increased preference by GPs for recording the symptoms of anxiety rather than specific diagnoses. Others have suggested a preference for broad diagnostic labels, such as ‘anxiety states’, which may reflect a lack of training, a belief that the distinctions in anxiety states are not meaningful in primary care practice, or reluctance to use formal diagnoses which may be perceived as stigmatising for patients (Walters et al., 2012).

Others have pointed to structural problems in the pathways that exist between primary and specialist services following implementation of the National Service Framework for Mental Health (Cohen, 2008). This introduced the Improving Access to Psychological Therapies (IAPT) programme, which is designed to provide services for those suffering from anxiety and depression disorders; during the year 2012–13, more than three-quarters of a million people in England were referred to IAPT services nationally. Yet there is evidence that only half of the people referred to IAPT services go on to receive treatment, while for those that remain, about half show significant improvements or recover (Richards and Borglin, 2011). Somewhere along the line a great many people who experience anxiety are either not getting the treatment they require or are choosing not to complete the course of therapy.

At the same time, the treatment of co-morbid health and anxiety problems in acute patients appears to be seriously under-developed. For example, while 42% of patients with cardiovascular disease are currently provided with rehabilitation, only 16% of these programmes have a psychological component, despite 31% of these patients experiencing significant anxiety problems (Naylor et al., 2012). New collaborative approaches involving a number of health professionals working together with a patient are likely to help and have been associated with significant improvements in depression and anxiety outcomes compared with usual care (Archer et al., 2012).

Several different treatments are available to ease the psychological and physical symptoms of anxiety, including psychological therapies and medication, as well as a range of guided self-help strategies and exercise on prescription. The National Institute for Health and Care Excellence (NICE) recommends a 'stepped care' approach to treatment, starting with interventions that are the least intrusive of those likely to be effective (NICE, 2012). However, the evidence about the most effective ways of treating anxiety is mixed and we know little about the treatment preferences of those seeking help with anxiety. This is worth further exploration, as one American review found evidence for enhanced outcomes for those receiving the treatment of their choosing and a marked preference for psychotherapeutic support over other forms of treatment (McHugh et al., 2013).

### Keeping active

Studies on participation in leisure activities have shown improvements in self and life satisfaction, which helps in reducing depression and anxiety and enhances a person's sense of wellbeing (Haworth, 2010), while the evidence about the effectiveness of exercise alone is mixed. According to Sport England, participation in physical activity and sport has been shown to be effective in reducing depression, anxiety, psychological distress and emotional disturbance. Low to moderate physical exercise can reduce anxiety and have both short and long-term beneficial effects on psychological health. Taking part in sport and spectating can have a positive impact on the wellbeing and happiness of young people (ONS, 2014). A major limitation in the evidence base is that while numerous studies and meta-analyses show that exercise is associated with reduced anxiety in clinical settings, not enough research has been done to map the effect of exercise on anxiety in real life (Anderson and Shivakumar, 2013). A recent systematic review of relevant Randomised Controlled Trials (RCTs) concluded that exercise is effective in conjunction with other treatments (Jayakody et al., 2014), confirming the conclusions of the Mental

Health Foundation (2013) that exercise can be particularly effective in reducing the symptoms of clinical anxiety when combined with CBT, although a review of 7 RCTs found no effect for interventions comprising aerobic exercise only (Bartley et al., 2013).

**Media link:** [Gretchen Reynolds 'How Exercise Can Calm Anxiety'](#) (New York Times).

### Cognitive Behavioural Therapy

When someone is distressed or anxious, the way they see and evaluate themselves can become negative. Cognitive behavioural therapy (CBT) helps people to understand the link between negative thoughts and mood and how altering their behaviour can enable them to manage anxiety and feel in control. It is the most effective non-pharmacological treatment for reducing the symptoms of almost all mental health problems, but especially anxiety and depression (Stuhlmiller and Tolchard, 2009; Olatunji et al., 2010), for people with anxieties about their health (Tyrer et al., 2013), and leads to more general improvements in the quality of life of people experiencing anxiety (Hoffman et al., 2014). CBT has also been shown to be effective with children and young people, although it is not yet clear whether it is more effective than other treatments for these younger age groups (James et al., 2013).

One feature of CBT is that it is a short-term therapy and, it is claimed, can be delivered effectively by primary care therapists either face-to-face or as part of a self-help programme (Høifødt et al., 2011). There is evidence that CBT delivered in primary care settings has a moderate effect on reducing symptoms of anxiety (Seekles et al., 2013). NICE therefore recommends CBT for anxiety and panic disorders, and the availability of it has expanded rapidly in England under the government-funded Improving Access to Psychological Therapies (IAPT) programme. The Scottish Mental Health Strategy (2012–15) has also committed to improving and monitoring access to psychological therapies with an

important focus on older people, where there remains an equity issue across the UK despite an emerging evidence base of effectiveness in treating anxiety and depression in later life (McMurchie et al., 2013).

**Media link:** Jane Feinmann 'Coping with anxiety – on the cheap' (the Daily Telegraph).

### **Mindfulness**

Mindfulness is a variation of CBT in that it focuses on changing the relationship between the anxious person and his or her thoughts, rather than changing the thoughts themselves. Using meditation and similar techniques, it can help people break out of the 'automatic pilot mode' that leads to negative ways of thinking and responding. Instead, it is about helping people to experience the world in the 'here and now'. It does this by addressing the bodily symptoms experienced when someone is anxious, but rather than avoiding or withdrawing from these feelings, he or she remains present and fully experiences them and in this way is able to observe their reactions in a different way. One guide to mindfulness provides a useful analogy:<sup>12</sup>

Reviews of studies into Mindfulness Behavioural Therapy (MBT) have found the approach has a strong positive effect upon mood and symptoms of people with anxiety disorders (Hoffman et al., 2010; Vollestad et al., 2012).

**Media link:** Julie Myerson 'How mindfulness based cognitive behaviour therapy changed my life' (the Guardian).

**“It may be helpful to think of this approach in terms of a radio. That is, imagine that the negative thoughts that drift into your mind are coming from a loud radio that is tuned to a station where the thoughts are very negative and seem to be shouting at you.**

**The skill in mindfulness is not so much about trying to turn the radio off, but changing the way you listen to the radio. In this way the volume of the radio station can be reduced, and therefore seem less disruptive and distressing.”**

## Guided self-help

Guided self-help has become an increasingly popular way of offering treatment because of its low cost, adaptability to different forms of digital and social media and its acceptability to people who might otherwise not receive treatment (Andrews et al., 2010) either for reasons connected with their anxiety or because of time pressure from commitments such as caring. Most guided self-help is based on cognitive behavioural approaches and aims to help the person experiencing anxiety achieve a level of recovery whereby they are able to understand the nature of their anxiety and what is happening physiologically to them. They are then helped to develop the necessary skills to tolerate and cope with it, by challenging unhelpful thinking, evaluating their bodily symptoms realistically and managing graded self-exposure to the source of their anxiety.

Computerised CBT can be supported by reminders from a non-clinical technician or practice nurse, or guided by a clinician via telephone, email, live links such as Skype, or posts on a private forum. Many areas of the country also have self-help groups that offer peer support. Andrews et al. (2010) point out that a major advantage of this form of CBT is the level of treatment fidelity that can be achieved. Similarly, an evaluation of an online mindfulness course has shown promising results in terms of the acceptability of the means of delivering help to people who might otherwise not receive treatments and its ability to decrease the anxiety experienced by course participants (Krusche et al., 2013).

There is good evidence that guided self-help is effective for:

- **Certain types of disorder, such as social phobia and panic disorder (Van't Hof et al., 2009; Lewis et al., 2012; Mayo-Wilson and Montgomery, 2013).**
- **Reducing the symptoms of some anxiety-related conditions and improving quality of life outcomes (Haug et al., 2013; Stubbings et al., 2013).**
- **Children with anxiety disorders (Creswell et al., 2010).**
- **People who are motivated (Newman et al., 2011).**
- **Those who have lower level anxiety problems (Newman et al., 2011).**
- **People who are not able or are not willing to use other services for people with anxiety disorders (Mayo-Wilson and Montgomery, 2013).**

There are doubts as to the long-term effectiveness of these approaches compared to face-to-face approaches (Coull and Morris, 2011; Haug et al., 2013) and there is a lack of evidence of their usefulness with older people or people with more severe conditions (Newman et al., 2011). Nevertheless, there are good reasons to believe that where face-to-face CBT treatment is not available or where individuals would choose not to use such a service for reasons of control, stigma or convenience, then it makes sense to make self-help treatment widely available.

The range and diversity of self-help approaches and methods of engagement means that individuals have the ability to select those that work best for their specific needs. As we engage in more complex ways with technology then it seems probable that we will see more innovation develop in this field of support. More research is

needed, but a recent co-production project funded by NHS Greater Glasgow and Clyde et al. found that young people valued digital approaches to self-help and peer support and recommended increased development of digital assets aimed specifically at and co-designed by young people (NHS Greater Glasgow and Clyde et al., 2013).

For the past three years, The Mental Health Foundation has worked with the Paul Hamlyn Foundation, Comic Relief and Nominet Trust to deliver the Innovation Labs programme,<sup>13</sup> working with technology companies, mental health organisations and young people to co-design and deliver seven tools to support young people address mental health concerns. Throughout the process, the value of technology to young people has been demonstrated, as has their ability to manage risk and challenge in online spaces.

We have also seen the development of scaled technology-based tools for people to self-manage mental ill health, including anxiety. A range of products exist, with many health authorities in the UK having engaged the services of companies like Big White Wall<sup>14</sup> to provide a validated, well controlled online community for self-management and self-exploration online. In Scotland, a different approach is being developed with the Scottish Government, NHS 24 and New Media Scotland collaborating on the development of Project Ginsberg. Ginsberg will provide a route for people who use technology to gain insight into their lives, using a range of apps and tools to better self-manage distress. Ginsberg will provide an online platform that will provide a selection of digital products, including access to diagnostic, treatment and monitoring tools that people can access independently of face-to-face services.

Such developments recognise the new ways that people want to access support, but also the importance of providing a safe and quality assured space to do so. At the same time it is critical that digital spaces for mental health don't merely replicate online what is available offline. A nuanced understanding of the way different audiences use technology is needed to best leverage opportunities. Equally, digital services need to be an opt in for those who are keen to use them, and not an opportunity to remove or 'reframe' existing services by forcing people online when they aren't comfortable with that modality. In time this may create cost-savings, but this should be a collateral benefit and not a driver of digital innovation in mental health.

## Peer support

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful” (Mead, 2003). The benefits of peer support have been evidenced in a number of studies in relation to supporting individuals to self-manage their mental health problems and for those whose mental health is most at risk, such as isolated older people, people with dementia and young carers. Identified key benefits of peer support are the ability for the peer mentor to provide support based on empathetic understanding and from a position of having previous experience of developing coping skills for the particular set of problems encountered. Most of the research regarding people experiencing mental health problems has not been specific to anxiety. However, there are indications from work in relation to young people during transitions and people adapting to life with long-term conditions that peer support can provide a helpful approach in learning to cope with the anxiety that uncertainty brings.

UK Governments are recognising the benefits of peer support and over recent years there has been a move to embed peer support approaches within specialist mental health services as an additional layer of support. The advancements in digital technology may see further innovations in relation to peer support available online and is an area worthy of fuller investigation in relation to anxiety.

For fuller consideration of the role of peer support, see the Mental Health Foundation’s [Need 2 Know Peer Support Briefing](#) available to download from the [Mental Health Foundation website](#).

## Medication

Among patients diagnosed with anxiety, approximately two-thirds are treated with medication, anti-depressants accounting for almost 80% of prescriptions made out to this group (Martin-Merino et al., 2010). Pharmacological interventions have been found to be effective at improving quality of life by reducing the symptoms of anxiety for some patients (Hofmann et al., 2013), although not for a significant number (Ravindran and Stein, 2010). Medication is generally not as effective for older adults as it is for younger adults (Wetherall et al., 2013).

NICE suggests that for particular kinds of anxiety, such as panic, social phobia and obsessions, GPs should prescribe anti-depressants, especially certain SSRIs (selective serotonin reuptake inhibitors). SSRIs appear effective in treating social phobia over the short term and the long term (Stein et al., 2004), while augmentative medications appear to be useful in the treatment of GAD, which is a more chronic condition (Chessick et al., 2006). Due to high rates of treatment resistance, there is interest in new pharmacological treatment options such as second-generation antipsychotics (Depping et al., 2010). Additionally, beta-blockers and tranquilisers are sometimes prescribed in the short term to treat the physical symptoms without reducing the psychological symptoms of anxiety.

**“The storm has died away, and still we are restless, uneasy, as if the storm were about to break. Almost all the affairs of men remain in a terrible uncertainty. We think of what has disappeared, and we are almost destroyed by what has been destroyed; we do not know what will be born, and we fear the future, not without reason... Doubt and disorder are in us and with us. There is no thinking man, however shrewd or learned he may be, who can hope to dominate this anxiety, to escape from this impression of darkness”  
(Paul Valery, *Crisis of the Mind*, 1919).**

## **A new ‘Age of Anxiety’?**

The term ‘age of anxiety’ has been applied to several periods in modern history and is taken to mean a period of time marked by uncertainty about how we make sense of life. It is often used to refer to the period spanning the two world wars. Previous generations, particularly in the West, had believed that the trajectory of human society was inexorably upwards, fuelled by the civilising influences of faith, education and science in the service of industry and commerce. The First World War dealt a shattering blow to those old certainties and the long period of economic and political turmoil that followed is often characterised as a time of despair and darkness. It was also marked by a flowering of the visual arts, the emergence of the social sciences as a discipline, and the development of psychiatric medicine.

Are we living in similar times? The shock of the recent economic crisis may have prompted fear and anxiety in the short term, but some longer term research suggests that the prevalence of anxiety disorders is largely impervious to the vicissitudes of the economy, suggesting instead that social trends such as divorce and crime may have greater explanatory validity (Twenge, 2000). While the notion of anxiety disorders undoubtedly relates to the individual human condition, is it possible to speak more generally of anxiety as a sociological phenomenon, a mood or emotion that permeates a community of people? Can an understanding of the state of the nation’s mood give us an insight into the effects of wider economic and social forces?

In 2010, the Government introduced a new measure of wellbeing to broaden the indicators of economic development in the UK. It is intended that these indicators be used to inform the public about the nation’s wellbeing and “lead to government policy that is more focussed not just on the bottom line but on all those things that make life worthwhile” (Number10, 2010; Hicks, 2011). One of the measures used in the first of these wellbeing surveys relates to anxiety,

because being anxious “is widely used as an indicator of poor mental wellbeing, a widely used generic measure of health status” (Dolan et al., 2011). This is important for the ‘bottom line’ because anxiety disorders are estimated to cost the UK economy £10.1bn annually<sup>15</sup> in direct medical costs as well as indirect costs such as lost productivity due to absence from work or early retirement (Fineberg et al., 2013). For example, during 2011, around 27.4 million working days were lost due to minor illnesses such as coughs, colds and flu, while as many as 13.3 million working days were lost due to stress, depression and anxiety. Moreover, the group of people diagnosed with anxiety and depression has one of the lowest rates of employment (27.2%) of groups with a disability defined under the Disability Discrimination Act. People suffering anxiety are heavier users of primary care services than other users of those services (Martin-Merino et al., 2010) and the presence of an anxiety disorder significantly increases the costs of providing care to people with long-term conditions (Naylor et al., 2012).

Our survey showed that worries about money and jobs are significant components of feelings of anxiety and that employment status directly effects how people assess their own anxiety; working conditions, job satisfaction and job security are known factors in people’s assessment of their own anxiety levels (Bryan, 2012; Oguz et al., 2013). The Office for National Statistics (ONS), which is charged with collecting data to inform the wellbeing indicator, has detected subtle changes between 2011–12 and 2012–13: a small decrease in people rating their lives as unsatisfactory corresponding with a small decrease in the same sample reporting high levels of anxiety.<sup>16</sup> Yet the significant decrease in levels of anxiety amongst people in employment was not shared by people of working age who were unemployed (ONS, 2013). This may reflect a shift in mood as the worst of the recession passes, albeit short of outright optimism about the future.

The ‘age of anxiety’ narrative is attractive because it appeals to our sense of zeitgeist, a desire to find a shared mood about the defining aspects of modern life; our work, the way we raise children, our attitudes to people who are disadvantaged, the future of public services, the threat of terrorism and so on. But there is a danger that in concentrating too much on the cultural significance of anxiety, we miss the continuing hidden impact of anxiety upon the lives of a great many people. For those living with the chronic forms of anxiety, it is more than a social index that rises and falls over time. Even within the last decade we have achieved a much better appreciation of this, even though we still lack definitive answers about the causes of anxiety disorders. We know more about the complexity of anxiety disorders, their symptomologies, manifestations and the multiplicity of factors that may be at play when someone experiences anxiety. Our understanding has been enhanced by a number of developments.

Firstly, a recognition by the medical and scientific communities that anxiety is worthy of attention. The collective clinical gaze has fallen upon particular aspects of anxiety: developing diagnostic consistency, the epidemiology of the various conditions that fall within the diagnostic criteria, causation and treatment. New technologies have helped, so genetics is now at the stage of suggesting heredity as a possible factor in anxiety.

Secondly, the available options for managing anxiety are now more sophisticated and nuanced and we have a more robust evidence base for assessing the effectiveness of treatments, therapeutic interventions and coping strategies. In particular, the utility of psychological approaches, especially CBT, in managing anxiety either through a therapeutic relationship or as part of a self-help programme has been established and there is still great scope for expanding the availability of these.

15. At 2010 prices.

16. Both findings statistically significant at the 0.05 level.

Thirdly, the public profile of anxiety has been raised as part of a wider public debate about mental health and what we, as a society, need to do about it. There are a number of strands to this from campaigning and awareness-raising by organisations such as Anxiety UK, to greater interest from the news media and the emergence of a distinctive voice for people who experience anxiety through books and social media. These have helped tackle perceptions of stigma that have been associated with anxiety in the past.

While these developments are encouraging, our own work suggests that there are still gaps that need to be addressed in the provision of support for people who experience anxiety. We know, for example, that people approaching primary care services do not always get the responses they need, including accurate diagnosis and referral to appropriate specialists, and too many people fail to complete courses of treatment when they do.

## Recommendations

We therefore make recommendations regarding approaches to helping people with anxiety and the research that is required to further our understanding of the experience of living with anxiety.

A stepped care approach should be adopted to ensure that support to live with anxiety is provided in the least stigmatising and most inclusive way possible, including:

- **Universal approaches to learning to live well with anxiety should be built into school curriculums from primary 1 onwards, including an understanding of the role of anxiety in our lives and techniques for managing stresses associated with school (such as peer relationships, exams and transitions).**
- **Peer-led approaches should be promoted within universal settings such as employment, schools and universities, in recognition of the importance that young people place on support from peers and the unique level of empathetic understanding that can be provided by those with a common experience.**
- **Access to good quality self-help approaches should be made available across the UK through quality assured and co-designed digital platforms to ensure they are fit for purpose for those who choose not to use face-to-face services (young people, people in full time employment).**
- **GP training and anxiety-related guidance should be assessed for equalities impact and adapted alongside groups of people who are at highest risk of developing problematic anxiety and least likely to have their needs met by current service provision.**

- **A sample of psychological services should be audited to establish how well referral processes are working, who is accessing these, and who is falling through the gaps. This audit should include IAPT in England and Wales and initiatives to improve access in Scotland.**
- **Agencies offering support to people with anxiety should make greater use of peer mentors and advice and information that is explicitly based on the life experiences of people who live with anxiety.**

Research should be commissioned to better understand:

- **The nature and understanding of anxiety for different groups in society (women, people with long-term conditions, older people, people from black and minority ethnic communities), and whether current approaches and interventions can be found to address specific needs.**
- **The relationship between unemployment, financial distress, and anxiety. The Department of Work and Pensions should develop strategies to prevent people who are not working from becoming marginalised from the workforce. Processes for accessing social welfare for those unable to work due to disability should be assessed for their impact on anxiety levels.**
- **The impact of technological advancements in self-management for anxiety.**

Perhaps the most important conclusion to be drawn from this report is the importance of framing anxiety as an essential aspect of our humanity. All of us could trace a mental bell curve like the one described by Scott Stossell to plot the positive and negative uses to which we put our stock of anxiety, both the creative impulses and the destructive ones. The findings of our survey

show how anxiety stems as much from concern for family, friends and relationships as it does from the demand of the outside world. Most people instinctively seek solace and comfort in human interaction when confronted with anxious thoughts and feelings, and we know that these are the most effective ways of dealing with them. But anxiety can cause us to withdraw from society and look for solutions in ways that may harm us.

We can glimpse in all of this the vital function that anxiety plays in alerting us to threats to the things that we hold most dear, as well as the material things (jobs, money, possessions) that we need to sustain a modern existence. The testimony of people living with anxiety demonstrates how they cope and manage anxiety so that it remains a vital component of who they are without coming to define them. There remains a significant amount of work to be done across society to equip ourselves and bring our children up to live with anxiety, not only focusing our attention on the point where it becomes an identified problem, but ensuring that we are able to get the most out of life. Living to our full potential not limited by the fear of anxiety.

## Useful resources and information

### Books about the lived experience of anxiety

Scott Stossel (2014)

[My Age of Anxiety: Fear, Hope, Dread, and the Search for Peace of Mind](#) published by Heinemann.

Daniel Smith (2013)

[Monkey Mind: A Memoir of Anxiety](#) published by Simon & Schuster.

### Blogs about living with anxiety

Claire Eastham's Blog [weallmadhere](#).

The [time to change](#) blog about anxiety.

The [Anxiety No More](#) website and a blog by its founder Paul David.

### Self-help guides

Northumberland Tyne and Wear NHS Foundation Trust has a self-help guide that has been commended by the BMA and has been well reviewed by people accessing it online. For more information and to download a copy, click [here](#).

The NICE Guide to self-help resources for generalised anxiety disorder is available to download [here](#).

### Radio and television programmes and films

BBC Radio 4 [Woman's Hour](#) Programme.

### Psychological therapies

[Directory of IAPT services](#).

[The Counselling Directory](#) has a number of articles about anxiety.

An online mindfulness course is available at [Be Mindful Online](#).

Mental Health Foundation How to overcome fear and anxiety.

A video about anxiety from the [NHS Choices website](#).

[Anxiety Care UK website](#).

Tips on physical activity from the [MIND website](#).

## National organisations offering help, advice and information

### Anxiety UK

08444 775 774

[anxietyuk.org.uk](http://anxietyuk.org.uk)

### Anxiety Care

[anxietycare.org.uk](http://anxietycare.org.uk)

### British Association for Behavioural and Cognitive Psychotherapies (BABCP)

01617054304

[babcp.com](http://babcp.com)

Can provide a list of qualified therapists.

### British Association for Counselling and Psychotherapy (BACP)

01455 883300

[bacp.co.uk](http://bacp.co.uk)

Information about counselling and therapy. See the [itsgoodtotalk](http://itsgoodtotalk.com) website for details of local practitioners.

### The British Psychological Society

01162549568

[bps.org.uk](http://bps.org.uk)

Produces a directory of chartered psychologists.

### Mindfulness Based Cognitive Therapy

[mbct.co.uk](http://mbct.co.uk)

Information about the therapy, classes in Mindfulness and training.

### NICE (National Institute for Health and Care Excellence)

[nice.org.uk](http://nice.org.uk)

Information and guidelines on recommended treatments for different disorders.

### No Panic

Helpline 08001388889

[nopanic.org.uk](http://nopanic.org.uk)

Provides a helpline, step-by-step programmes, and support for those with anxiety disorders.

### Samaritans 24-hour helpline

08457909090

email: [jo@samaritans.org](mailto:jo@samaritans.org)

[samaritans.org](http://samaritans.org)

Emotional support for anyone feeling down, experiencing distress or struggling to cope.

### UK Council for Psychotherapy (UKCP)

02070149955

[psychotherapy.org.uk](http://psychotherapy.org.uk)

Has a voluntary register of qualified psychotherapists.

[The Young Minds website](http://The Young Minds website) has information for parents concerned about a child's anxiety, including a helpline (0808 802 5544) Monday to Friday 9.30am-4pm.

YouthNet runs [The Site](http://The Site) which offers young adults help with a range of problems, including anxiety.

## References

- Anderson, E. and Shivakumar, G. (2013) Effects of Exercise and Physical Activity on Anxiety, *Frontiers, Psychiatry* 4, 27.
- Anderson, E. and Shivakumar, G. (2013) Effects of Exercise and Physical Activity on Anxiety, *Frontiers, Psychiatry* 4, 27.
- Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C. and Coventry, P. (2012) Collaborative care for depression and anxiety problems *Cochrane Database of Systematic Reviews* 2012, Issue 10.
- Bartley, C., Hay, M. and Bloch, M. (2013) Meta-analysis: aerobic exercise for the treatment of anxiety disorders *Progress, Neuro-Psychopharmacology & Biological Psychiatry* 45, 34–9.
- Bryan, L. (2012) Job Related Stress, Working Time and Work Schedules in Understanding Society: Findings 2012 downloaded from the Understanding Society website on 20th March 2014.
- Clark, D. (2011) Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience, *International Review of Psychiatry* 23, 375–84.
- Cohen, A. (2008) The primary care management of anxiety and depression: a GP's perspective, *Advances, Psychiatric Treatment* 14, 98–105.
- Coull, G. and Morris, P. (2011) The clinical effectiveness of CBT-based guided self-help interventions for anxiety and depressive disorders: a systematic review *Psychological Medicine* 41 (11), 2239–52.
- Craske, M., Rauch, S., Ursano, R., Prenoveau, J., Pine, D. and Zinbarg, R. (2009) What Is An Anxiety Disorder? *Depression & Anxiety* 26, 1066–85.
- Creswell, C., Hentges, F., Parkinson, M., Sheffield, P., Willetts, L. and Cooper, P. (2010) Feasibility of guided cognitive behaviour therapy (CBT) self-help for childhood anxiety disorders in primary care, *Mental Health, Family Medicine* 7 (1), 49–57.
- Critchley, S. (2009) Being and Time, part 5: Anxiety, *The Guardian*, Monday 6th July.
- Cuijpers, P., Donker, T., van Straten, A. et al. (2010) Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies, *Psychological Medicine* 40, 1943–57.
- Depping, A., Komossa, K., Kissling, W. and Leucht (2010) Second-generation antipsychotics for anxiety disorders, *Cochrane Database of Systematic Reviews* 2010, Issue 12.
- Dolan, P., Layard, R., Metcalfe, R. (2011) *Measuring Subjective Well-being for Public Policy*, London: Office for National Statistics.
- Driessen, E., Cuijpers, P., Hollon, S.D. et al. (2010) Does pretreatment severity moderate the efficacy of psychological treatment of adult outpatient depression? A meta-analysis, *Journal of Consulting and Clinical Psychology* 78, 668–80.
- Fazel, M., Wheeler, J. and Danesh, J. (2005) Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review, *Lancet* 365, 1309–14.
- Fineberg, N., Haddad, P., Carpenter, L., Gannon, B., Sharpe, R., Young, A., Joyce, E., Rowe, J., Wellsted, D., Nutt, D. and Sahakian, B. (2013) The Size, Burden and Cost of Disorders of the Brain in the UK, *Journal of Psychopharmacology* 27(9), 761–70.
- Gerber, M. and Puhse, U. (2009) Do exercise and fitness protect against stress-induced health complaints? A review of the literature, *Scandinavian Journal of Public Health*, 37(8), p. 801–19.
- Goyal, M., Singh, S., Sibinga, E., Gould, N., Rowland-Seymour, A., Sharma, R., Berger, Z., Sleicher, D., Maron, D., Shihab, H., Ranasinghe, P., Linn, S., Saha, S., Bass, E. and Haythornthwaite, J. (2014) Meditation Programs for Psychological Stress and Well-being: A Systematic Review and Meta-analysis, *JAMA Internal Medicine* (accessed online 14/1/14).
- Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2005) *Mental health of children and young people in Great Britain, 2004: summary report*, London: Office for National Statistics.
- Goodwin, R., Faravelli, C., Rosi, S., Cosci, F., Truglia, E., de Graaf, R. and Wittchen, H. (2005) The epidemiology of panic disorder and agoraphobia in Europe *European, Neuropsychopharmacology* 15, 435–43.
- Hagell, A., Coleman, J. and Brooks, F. (2013) *Key Data on Adolescence 2013*, London: Association for Young People's Health.
- Haug, T., Nordgreen, T., Öst, L. and Havik, O. (2013) Self-help treatment of anxiety disorders: a meta-analysis and meta-regression of effects and potential moderators, *Clinical Psychology Review* 32 (5), 425–45.
- The Health & Social Care Information Centre (2009) *Adult Psychiatric Morbidity in England: results of a household survey*.

- Hicks, S. (2011)  
Spotlight on: subjective wellbeing, London: Office for National Statistics.
- Hicks, S. (2013)  
Differences in well-being by ethnicity, London: Office for National Statistics.
- Hofmann, S., Sawyer, A., Witt, A. and Oh, D. (2010)  
The Effect of Mindfulness-Based Therapy on Anxiety and Depression: A Meta-Analytic Review, *J Consult Clin Psychol.* 78 (2), 169–183.
- Hofmann, S., Wu, J., Boettcher, H. and Sturm, J. (2013)  
Effect of pharmacotherapy for anxiety disorders on quality of life: a meta-analysis, *Quality Of Life Research: An International Journal Of Quality Of Life Aspects Of Treatment, Care And Rehabilitation* Nov 16.
- Hofmann, S., Wu, J. and Boettcher, H. (2014)  
Effect of Cognitive-Behavioral Therapy for Anxiety Disorders on Quality of Life: A Meta-Analysis, *J Consult Clin Psychol.* 2014 Jan 20. [Epub ahead of print].
- Højfød, R., Strøm, C., Kolstrup, N., Eisemann, M. and Waterloo, K. (2011)  
Effectiveness of cognitive behavioural therapy in primary health care: a review, *Family Practice* 28 (5), 489–504.
- Howarth, J. (2010)  
Life, Work, Leisure and Enjoyment: the role of social institutions, Working Paper presented during the ESRC/Manchester Metropolitan University Well-being Seminar Series.
- James, A., James, G., Cowdrey, F., Soler, A. and Choke, A. (2013)  
Cognitive behavioural therapy for anxiety disorders in children and adolescents, *The Cochrane Database of Systematic Reviews* Jun 03; Vol. 6.
- Jayakody, K., Gunadasa, S. and Hosker, C. (2014)  
Exercise for anxiety disorders: systematic review *British Journal Of Sports Medicine* 48 (3), 187–96.
- Krusche, A., Chylarova, E. and Williams, J. (2013)  
Mindfulness online: an evaluation of the feasibility of a web-based mindfulness course for stress, anxiety and depression, *BMJ Open* 3: e003498 Downloaded from [bmjopen.bmj.com](http://bmjopen.bmj.com) 1st March 2014.
- Lewis, C., Pearce, J. and Bisson, J. (2012)  
Efficacy, cost-effectiveness and acceptability of self-help interventions for anxiety disorders: systematic review, *The British Journal of Psychiatry: The Journal Of Mental Science* 200 (1), 15–21.
- McColl, H., McKenzie, K. and Bhui, K. (2008)  
Mental Healthcare of asylum seekers and refugees, *Advances in Psychiatric Treatment* (14) 452–9.
- McCrone, P., Dhanasiri, S., Patel, A., Knapp, M. and Lawton-Smith, S. (2008)  
Paying The Price: the cost of mental health care in England to 2026, London: King's Fund.
- McHugh, R., Whitton, S., Peckham, A., Welge, J. and Otto, M. (2013)  
Patient preference for psychological vs pharmacologic treatment of psychiatric disorders: a meta-analytic review, *The Journal Of Clinical Psychiatry* 74 (6), 595–602.
- McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (2009)  
Adult psychiatric morbidity in England, 2007: Results of a household survey, Leeds: The NHS Information Centre for health and social care.
- McMurchie, W., Macleod, F., Power, K., Laidlaw, K. and Prentice, N. (2013)  
Computerised cognitive behavioural therapy for depression and anxiety with older people: a pilot study to examine patient acceptability and treatment outcome, *International Journal of Geriatric Psychiatry* [online]. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/gps.3935/pdf>.
- Martín-Merino, E., Ruigómez, A., Wallander, M.A., Johansson, S., García-Rodríguez, L.A. (2010)  
Prevalence, incidence, morbidity and treatment patterns in a cohort of patients diagnosed with anxiety in UK primary care, *Family Practice* 27 (1), 9–16.
- Mayo-Wilson, E. and Montgomery, P. (2013)  
Media-delivered cognitive behavioural therapy and behavioural therapy (self-help) for anxiety disorders in adults, *The Cochrane Database Of Systematic Reviews* 9.
- Mental Health Foundation (2009)  
In the face of fear. How fear and anxiety affect our health and society, and what we can do about it, London: Mental Health Foundation.
- Mental Health Foundation (2013)  
Let's Get Physical: the impact of physical activity on wellbeing, London: Mental Health Foundation.
- NHS Greater Glasgow & Clyde, Young Scot, Snook & Mental Health Foundation (2013)  
Project 99: Exploring internet based approaches to support young mental health in Greater Glasgow & Clyde [online]. Available at: <http://www.wegot99.com/wp-content/uploads/2013/12/final-report-draft-v11-interactive.pdf>.
- National Institute for Clinical Excellence (2011)  
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care (NICE clinical guideline 113), London: NICE.

- National Institute for Clinical Excellence (2012) Depression: Evidence Update April 2012. A summary of selected new evidence relevant to NICE clinical guideline 90 'The treatment and management of depression in adults' (2009), London: NICE.
- Naylor, C., Parsonage, M., McDaid, D., Knapp, M. and Fossey, M. (2012) Long-term conditions and mental health: The cost of co-morbidities, London: The Kings Fund and Centre for Mental Health, downloaded from The Kings Fund 14th January 2014.
- Newman, M., Szkodny, L., Llera, S. and Przeworski, A. (2011) A review of technology-assisted self-help and minimal contact therapies for anxiety and depression: is human contact necessary for therapeutic efficacy? *Clinical Psychology Review* 31 (1), 89–103.
- Oathes, D., Squillante, D., Ray, W. and Nitschke, J. (2010) The Impact of Worry on Attention to Threat *PLoS ONE* 5(10): e13411 downloaded 14th January 2014.
- Office for National Statistics (2011) People with Disabilities in the Labour Market, 2011, downloaded from the ONS website 14th January 2014.
- Office for National Statistics (2012) Sickness Absence in the Labour Market, April 2012, downloaded from the ONS website 14th January 2014.
- Office for National Statistics (2013) Personal Well-being in the UK, 2012/13 ONS Statistical Bulletin, 30th July.
- Office for National Statistics (2014) Measuring National Well-being – Young People's Well-being, 2014, downloaded from the ONS website 20th March 2014.
- Oguz, S., Merad, S. and Snape, D. (2013) Measuring National Well-being – What matters most to Personal Well-being? London: Office for National Statistics.
- Olatunji, B., Cisler, J. and Deacon, B. (2010) Efficacy of Cognitive Behavioral Therapy for Anxiety Disorders: A Review of Meta-Analytic Findings, *Psychiatric Clinics of North America* 33 (2010), 557–77.
- Potter-Collins, A., Beaumont, J. (2012) Measuring National Well-being - Measuring Young People's Well-being, 2012, London: Office for National Statistics.
- Ravindran, L. and Stein, M. (2010) The pharmacologic treatment of anxiety disorders: a review of progress, *The Journal Of Clinical Psychiatry* 71 (7), 839–54.
- Richards, A. and Borglin, G. (2011) Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study, *Journal of Affective Disorders* 133, 51–60.
- Scottish Refugee Council, Fedasil, Belgian Red Cross, Gender, Violence and Health Centre, London School of Hygiene & Tropical Medicine (2009) Asylum-Seeking Women, Violence & Health: Results from a Pilot Study in Scotland and Belgium, London: London School of Hygiene & Tropical Medicine (LSHTM) and Scottish Refugee Council (SRC).
- Seddon, C. (2012) Measuring National Well-being – Personal Finance, downloaded from the ONS website 20th March 2014.
- Seekles, W., van Straten, A., Beekman, A. et al. (2011) Stepped care treatment for depression and anxiety in primary care: a randomized controlled trial, *Trials* 12, 171.
- Seekles, W., Cuijpers, P., Kok, R., Beekman, A., van Marwijk, H. and van Straten, A. (2013) Psychological treatment of anxiety in primary care: a meta-analysis, *Psychological Medicine*, 43 (2), 351–61.
- Self, A., Thomas, J. and Randall, C. (2012) Measuring National Well-being: Life in the UK, 2012 London: Office for National Statistics.
- Servian-Schreiber, D. (2005) Healing Without Freud or Prozac: natural approaches to curing stress, anxiety and depression, London: Rodale International.
- Singleton, N., Bumpstead, R., O'Brien, M., Lee, A., Meltzer, H. (2001) Psychiatric morbidity among adults living in private households, 2000, London: The Stationery Office.
- Skapinakis, P., Lewis, G., Davies, S., Brugha, T., Prince, M. and Singleton, N. (2011) Panic disorder and sub-threshold panic in the UK general population: epidemiology, comorbidity and functional limitation, *European Psychiatry* 26 (6), 354–62.
- Stein, D., Ipser, J. and van Balkom, A. (2004) Pharmacotherapy for social anxiety disorder, *Cochrane Database of Systematic Reviews* 2004, 4.
- Stubbings, D., Rees, C., Roberts, L., and Kane, R. (2013) Comparing in-person to videoconference-based cognitive behavioral therapy for mood and anxiety disorders: randomized controlled trial, *Journal of Medical Internet Research* 15 (11), e258.
- Stuhlmiller, C. and Tolchard, B. (2009) Computer-assisted CBT for depression & anxiety: increasing accessibility to evidence-based mental health treatment, *Journal of Psychosocial Nursing and Mental Health Services* 47 (7), 32–9.
- Tyrer, P., Cooper, S., Salkovskis, P., Tyrer, H., Crawford, M., Byford, S., Dupont, S., Finnis, S., Green, J., McLaren, E., Murphy, D., Reid, S., Smith, G., Wang, D., Warwick, H., Petkova, H. and Barrett, B. (2013) Clinical and cost-effectiveness of cognitive behaviour therapy for health anxiety in medical patients: a multicentre randomised controlled trial, *The Lancet*, Early Online Publication, 18 October 2013.

Twenge, J. (2000)

The Age of Anxiety? Birth Cohort Change in Anxiety and Neuroticism, 1952-1993, *Journal of Personality and Social Psychology* 79 (6), 1007–21.

Understanding Society (2013)

Beyond GDP: Using Understanding Society and the British Household Panel Survey to develop a picture of well-being downloaded from the Understanding Society website on 20th March 2014.

Van Steensel, F., Bögels, S. and Perrin, S. (2011)

Anxiety Disorders in Children and Adolescents with Autistic Apectrum Disorders: A Meta-Analysis [online]. Available at the Autism Now website.

Van't Hof, E., Cuijpers, P. and Stein, D. (2009)

Self-help and Internet-guided interventions in depression and anxiety disorders: a systematic review of meta-analyses, *CNS Spectrums* 14 (2 Suppl 3), 34–40.

Vøllestad, J., Nielsen, M., Nielsen, G. (2012)

Mindfulness- and acceptance-based interventions for anxiety disorders: a systematic review and meta-analysis, *British Journal of Clinical Psychology* 51 (3), 239–60.

Walters, K., Rait, G., Griffin, M., Buszewicz, M. and Nazareth, I. (2012)

Recent Trends in the Incidence of Anxiety Diagnoses and Symptoms in Primary Care, *PLoS ONE* 7(8) e41670 downloaded 14th January 2014.

Wetherell, J., Petkus, A., Thorp, S., Stein, M., Chavira, D., Campbell-Sills, L., Craske, M., Sherbourne, C., Bystritsky, A., Sullivan, G. and Roy-Byrne, P. (2013)

Age differences in treatment response to a collaborative care intervention for anxiety disorders, *The British Journal Of Psychiatry: The Journal of Mental Science* 203 (1), 65–72.



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