PSYCH 239

ANXIETY DISORDERS

Learning Objectives

- Be able to describe the major classes of anxiety disorders and discuss those factors which differentiate them.
- Recognize the key DSM-5/TR diagnostic criteria for panic attacks, panic disorder, and GAD.
- Describe the essential features of phobias, PTSD, ASD, and OCD
- Discuss the main theoretical perspectives and treatment approaches for each of the above.

ANXIETY

- Anxiety is a general state of apprehension or foreboding.
  - Adaptive when it prompts us to seek medical attention, to study for an upcoming test or avoid a dangerous situation.
  - Maladaptive when the level of anxiety is out of proportion to the level of threat or when it occurs out of the blue, not in response to environmental changes.
- Common: Most people experience it in varying degrees.

Anxiety Disorders – Major Types

- Panic Disorder
  - With Agoraphobia
  - Without Agoraphobia
- Agoraphobia without hx of panic disorder
- Specific Phobia
- Social Phobia
- Generalized Anxiety Disorder
- Obsessive-Compulsive Disorder (OCD)
- Postraumatic Stress Disorder (PTSD)
- Acute Stress Disorder

- Most are more common in females than males.

Two others are listed in DSM-5-TR

- Anxiety Disorder due to a General Medical Condition
- Substance-Induced Anxiety Disorder

- (There is also an Anxiety Disorder NOS category)

DSM-5/TR Criteria – Panic Attack

- The building block of *Panic Disorder* (defined next)
- DSM-5/TR: A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

1) palpitations, pounding heart, or accelerated heart rate
2) sweating
3) trembling or shaking
4) sensations of shortness of breath or smothering
5) feeling of choking
6) chest pain or discomfort

cont…

DSM-5/TR Criteria – Panic Attack (cont)

- 7) nausea or abdominal distress
- 8) feeling dizzy, unsteady, lightheaded, or faint
- 9) *derealization* (feelings of unreality) or *depersonalization* (being detached from oneself)
- 10) fear of losing control or going crazy
- 11) fear of dying
- 12) *paresthesias* (numbness or tingling sensations)
- 13) chills or hot flushes

- *Situationally Bound* vs *Situationally Predisposed*

DSM-5/TR Criteria – Panic Disorder

- (1) recurrent unexpected *Panic Attacks* and
- (2) at least one of the attacks has been followed by one month (or more) of one (or more) of the following:
  - (a) persistent concern about having additional attacks
  - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
  - (c) a significant change in behavior related to the attacks

DSM-5/TR Criteria – Panic Disorder

- B) The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
- C) The Panic Attacks are not better accounted for by another mental disorder

- 1 – 5% prevalence (lifetime)

- Anxiety sensitivity

Agoraphobia

- *Agoraphobia* (fear of the market place) accompanies panic attacks in a large minority of cases (30 – 50%; other writers report up to 75%).
  - When it does, it is usually fear of having another panic attack that is most impairing.
  - Makes treatment less likely unless patient gets strong support to attend, or psychologist makes house calls.
- Even without agoraphobia, panic disordered patients are often reluctant to discuss their episodes for fear of triggering another attack.
  - (Almost like victims of violence who refuse to report to police.)

Generalized Anxiety Disorder (GAD)

- An anxiety disorder characterized by general feelings of dread, foreboding, and heightened states of sympathetic arousal.
  - –Not linked to any one particular fear or trigger
  - –Formerly referred to as *free-floating anxiety*
    - •Freudian term

DSM-5/TR Criteria – GAD

- A. At least 6 months of "excessive anxiety and worry" about a variety of events and situations. Generally, "excessive" can be interpreted as more than would be expected for a particular situation or event.
  - Most people become anxious over certain things, but the intensity of the anxiety typically corresponds to the situation.

DSM-5/TR Criteria – GAD (cont)

- B. There is significant difficulty in controlling the anxiety and worry. If someone has a very difficult struggle to regain control, relax, or cope with the anxiety and worry, then this requirement is met.
  - Telling them not to worry is unlikely to be enough.

DSM-5/TR Criteria – GAD (cont)

- C. The presence for most days over the previous six months of 3 or more (only 1 for children) of the following symptoms:
  - 1. Feeling wound-up, tense, or restless
    2. Easily becoming fatigued or worn-out
    3. Concentration problems
    4. Irritability
    5. Significant tension in muscles
    6. Difficulty with sleep

- Note: The usual criteria regarding level of impairment and the disorder not being better accounted for by another medical or psychological condition are also in DSM-5/TR, but will be omitted from this point on for brevity.

Phobic Disorders

- Specific phobia
  - Claustrophobia
- Social Phobia
- Agoraphobia

Specific Phobias

Five diagnostic subtypes of specific phobias.

Most phobias fall into five subtypes, including
(a) animal type,
(b) natural environment type,
(c) blood-injection-injury type,
(d) situational type, and
(e) other types (e.g., phobias of choking or contracting an illness).

Specific Phobias

- There is a strong relationship between age (developmental stage) and the type of phobia one is most likely to develop
  - Young children: animals
  - Teenagers: social
  - Adults: agora- or claustrophobia

ANXIETY DISORDERS

Physical Features include jumpiness, jitters, increased perspiration and heart rate, shortness of breath, dizziness, nausea

Behavioural Features include the need to escape or avoid a situation, agitation, clinginess, need for reassurance

Cognitive Features include excessive and prolonged worrying, overly aware of bodily sensations, jumbled thoughts, nagging thoughts

DSM-5/TR Criteria – Specific Phobia

1. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g. flying, heights, animals, receiving an injection, seeing blood)
2. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally pre disposed panic attack. **Note**: in children, the anxiety may be expressed by crying, tantrums, freezing or clinging.
3. The person recognizes that the fear is excessive and unreasonable. **Note**: in children this feature may be absent.

DSM-5/TR Criteria – Specific Phobia (cont)

4. The phobic situation is avoided or is endured with intense anxiety or distress.
5. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with a person's routine, occupational (or academic) functioning, or social activities or relationships or there is a marked distress about having the phobia.
6. In individuals under the age of 18 years the duration is at least 6 months.

Obsessive-Compulsive Disorder

Obsession: An intrusive, unwanted, and recurrent thought, image, or urge that seems beyond a person's ability to control**.**

Compulsion: A repetitive behaviour or mental act that a person feels compelled or driven to perform.

ANXIETY DISORDERS

TABLE 3.7

Examples of Obsessive Thoughts and Compulsive Behaviours

Obsessive Thought Patterns	Compulsive Behaviour Patterns
Thinking that one's hands remain dirty despite repeated washing	Constantly washing one's hands to keep them clean and germ free
Difficulty shaking the thought that a loved one has been hurt or killed	Constantly checking with loved ones to be sure they are alive and well
Repeatedly thinking that one has left the door to the house unlocked; worrying constantly that the gas jets in the house were not turned off	Rechecking that doors are locked or gas jets are switched off before leaving home
Constant concerns with contamination (e.g., fear of dirt, germs, or illness)	Excessive cleaning (e.g., ritualized housecleaning)
Obsessive need for symmetry or exactness	Checking, ordering, and arranging rituals; counting; repeating routine activities (e.g., going in/out of a doorway)
Unacceptable sexual or religious thoughts (e.g., sacrilegious images of Christ)	Mental rituals (e.g., silent recitation of nonsense words to vanquish a horrific image)

ANXIETY DISORDERS

- **All of these must be distinguished from Adjustment Disorders**
  - Maladaptive reactions to an identified stressor or stressors that occur shortly following exposure to the stressor(s) and result in impaired functioning or signs of emotional distress that exceed what would normally be expected in the situation.
  - The reaction may be resolved if the stressor is removed or the individual learns to adapt to it successfully.

Acute & Posttraumatic Stress Disorder

Acute Stress Disorder (ASD): A traumatic stress reaction occurring in the days and weeks following exposure to a traumatic event.

Acute & Posttraumatic Stress Disorder (PTSD)

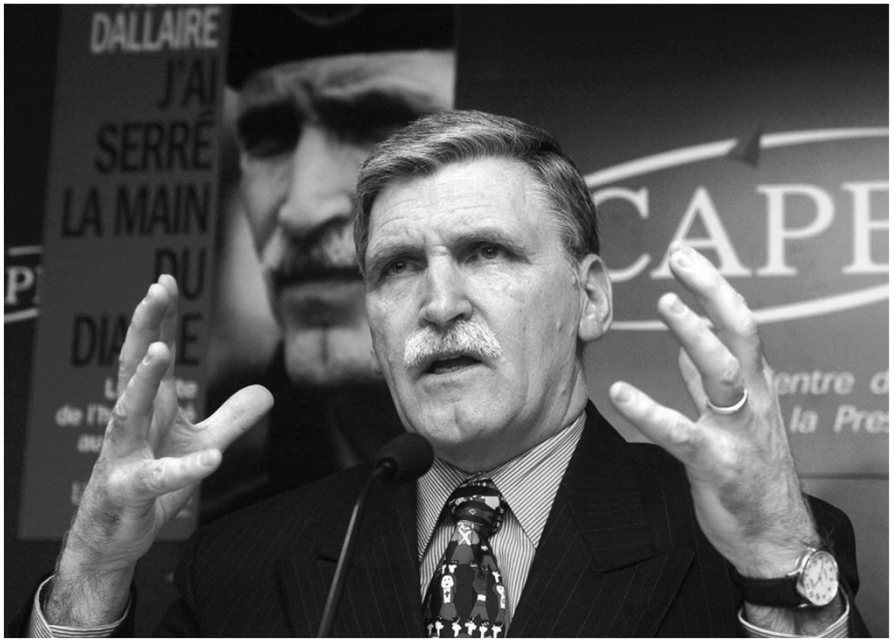
– A prolonged reaction to a traumatic event that threatened death or serious injury to one's own or another's physical safety.

Acute & Posttraumatic Stress Disorder

Features of Traumatic Stress Reactions

- Extreme anxiety or *dissociation* (feelings of detachment from one's self or one's environment)
- Intrusive memories & flashbacks (chronic re-experiencing, extremely vivid, may feel like they're back in the situation)
- Heightened arousal or vigilance
- Difficulty concentrating

ANXIETY DISORDERS



Romeo Dallaire.

Dallaire, the former head of the doomed United Nations peacekeeping mission in Rwanda, was discharged from the military for PTSD a few years after the 1994 mission, in which his force tried in vain to stop the slaughter of 800 000 to 1 million Tutsis and moderate Hutus. He attempted suicide several times before learning to cope thanks to medication and therapy.

THEORETICAL PERSPECTIVES

Psychodynamic Perspective

•Anxiety is warning sign that some unconscious conflict is approaching consciousness

- *Projection*: anxiety is brought about by the perception that some external threat is posed by someone or something else.
  - Anxiety likely to be more specific in focus
- *Displacement*: anxiety more likely to be generalized.

THEORETICAL PERSPECTIVES

Learning Perspective

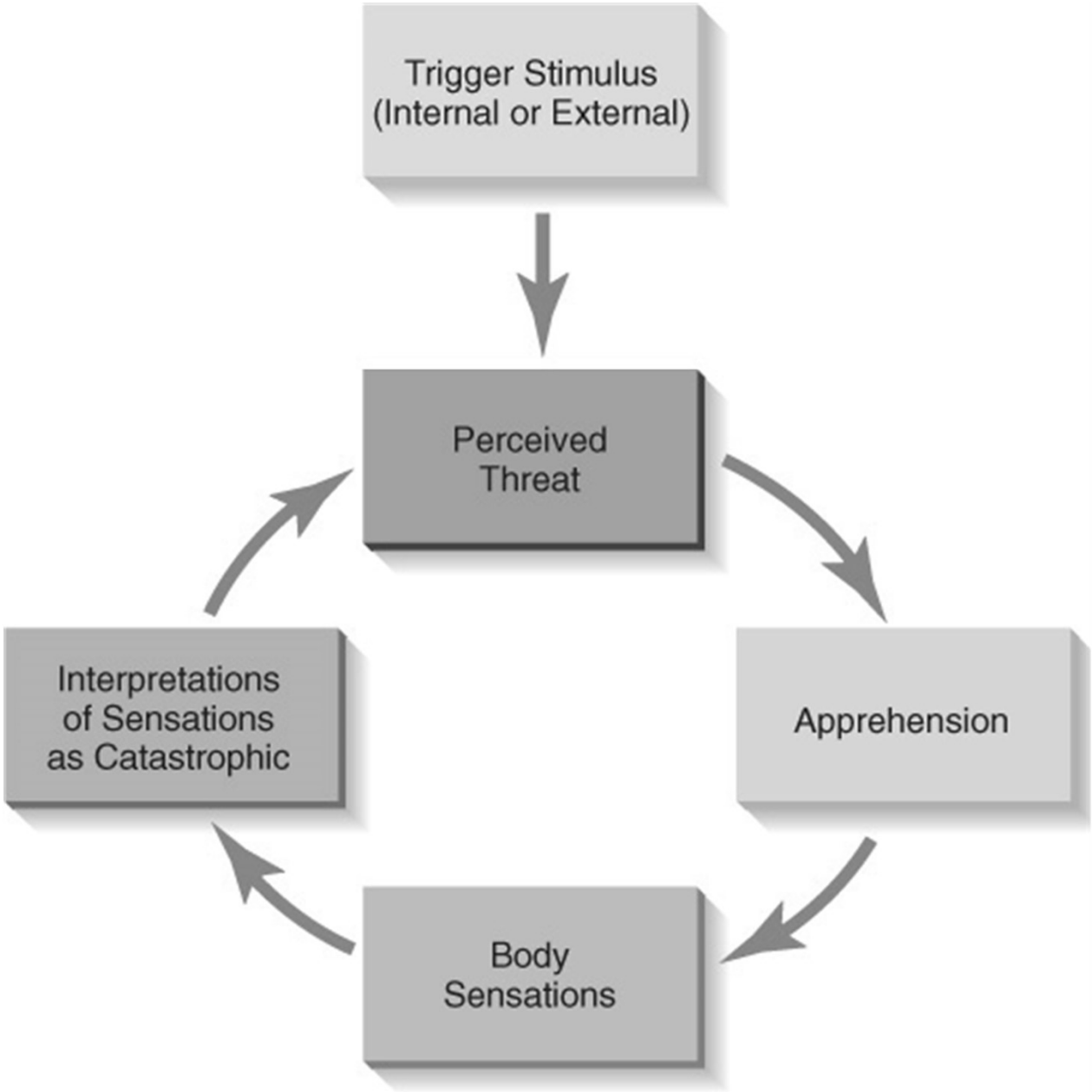
- *Two-factor model*: O. Hobart Mowrer eg.,
  - Φ_1: Man is on street (CS) barely escapes being run down (US) → Fear reaction (UR)
    - Subsequently experiences fear upon walking roadside (CR)
  - Φ_2: Road (Sd): Walks away (R) → Fear reduction (Rf)
    - Subsequently finds he can minimize anxiety/fear symptoms by avoiding roadways
- *Prepared conditioning*
  - The reason we seem to develop phobias to some things more readily than others – a diathesis
- *Superstition*: OCD

THEORETICAL PERSPECTIVES

Cognitive Perspective

- Self-defeating or irrational beliefs
- Oversensitivity to threat
- Anxiety sensitivity
- Misattributions for panic attacks

THEORETICAL PERSPECTIVES



THEORETICAL PERSPECTIVES

Biological Perspective

- Genetic Factors
  - Higher concordance rates MZ twins
  - Neuroticism

THEORETICAL PERSPECTIVES

Biological Perspective

- Neurotransmitters
  - Gamma-aminobutyric acid (GABA)
    - – Inhibitory
  - Benzodiazepines
- Biological Aspects of Panic Disorder
  - Hyperventilation – Can bring about panic-like symptoms
- Biological Aspects of Obsessive-compulsive Disorder

TYING IT TOGETHER

- Not all people who experience traumatic events develop related phobias or anxiety reactions.

- Some people may inherit a genetic predisposition (diathesis) that makes them respond with greater negative arousal or makes them more likely to panic in response to changes in bodily sensations.

- Whether anxiety gets out of control may depend on another vulnerability factor, anxiety sensitivity.

TYING IT TOGETHER

Social-Environmental Factors
Threatening or Traumatic Events
Observing Fear Responses in Others
Challenging Demands in New Situations
Cultural Factors Leading to Socialization in Passive or Dependent Roles
Lack of Social Support

Biological Factors
Genetic Predisposition
Disturbances in Neurotransmitter Activity or Suffocation Alarm System
Abnormalities in Brain Circuits Involved in Signalling Danger or Inhibiting Repetitive Behaviours

Behavioural Factors
Conditioning Experiences
Lack of Extinction Opportunities

Emotional and Cognitive Factors
Unresolved Psychological Conflicts (Freudian or psychodynamic)
Cognitive Factors (anxiety sensitivity, self-defeating or irrational thinking, catastrophic misinterpretations of bodily cues, oversensitivity to threats, low self-efficacy)

TREATMENT

Psychodynamic Approaches

- Free association and psychoanalysis to resolve the deeper conflict.
- Phobic objects are symbolic of those conflicts.

Humanistic Approaches

- Unconditional positive regard allows integration of inauthentic social presentation with authentic self.

Biological Approaches

- Antidepressants

  SSRIs / SNRIs - Less likely to have enduring benefit than CBT

Cognitive Approaches

- Irrational beliefs, bolstering self-efficacy, individual meaning, regular “worry periods” (Borkevic, 1985)

TREATMENT

Learning-Based Approaches

- Best approaches combine exposure with response prevention
  - Systematic Desensitization
    - Fear-Stimulus Hierarchy
    - Gradual Exposure
  - Behavioural Treatment of Social Phobia
  - Behavioural Treatment of Agoraphobia
  - Behavioural Treatment of Obsessive-compulsive disorder
  - Cognitive-Behavioural Treatment of Generalized Anxiety
  - Cognitive-Behavioural Treatment of Panic Disorder

TREATMENT

Virtual reality research.

For Combat vets with PTSD

The system contains eye-tracking software to study a person's response when exposed to a virtual combat environment

• It's important to realize that treatment for anxiety disorders often improves the condition significantly, but doesn't necessarily eliminate it completely.

Class Exercise (Time Permitting)

- A fear hierarchy as used in systematic desensitization typically contains anywhere from 10 to 20 steps, or items (some as many as 100).
- Create a fear hierarchy for a flying phobia. The last step should be entering the aircraft and being able to endure a short (say two-hour) flight with minimal discomfort.