Anxiety Disorders

Operational Definitions

Fear or panic is a basic emotion that involves activation of the “fight-or-flight” response in the sympathetic nervous system.

When this response occurs too often, or inappropriately, it may develop into an anxiety disorder.

Anxiety is a general feeling of apprehension about possible danger.

More oriented to the future and more diffuse than fear.

Composed of cognitive/subjective, physiological, and behavioral components.
Operational Definitions

**Anxiety disorders** have unrealistic, irrational fears or anxieties of disabling intensity as their most obvious manifestation.

The DSM-IV-TR recognizes **seven** primary types of anxiety disorders:

- Phobic disorders of the “specific” type
- Phobic disorders of the “social” type
- Panic disorder with agoraphobia
- Panic disorder without agoraphobia
- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder

General Info

Most common psychiatric problem in U.S. after substance abuse

Lifetime prevalence rates of 31% in general population

There aren’t many differences in rates of anxiety disorders across race and ethnicities; instead the differences are in symptom expression.
**DIAGNOSIS**

Impairment is the most important aspect to differentiate from normal anxiety.

Anxiety is multi-dimensional and divided into:
- Subjective Distress (Self-Report)
- Physiological Response
- Avoidance/Escape Behavior

Clinical interview is very important to diagnosis.

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**DSM-IV-TR ANXIETY DISORDERS**

There are some important similarities among:
- The basic biological causes
- The basic psychological causes
- The effective treatments

For all of these disorders

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**PHOBIC DISORDERS**

A **phobia** is a persistent, disproportionate fear of some specific object or situation that presents little or no actual danger.

- Specific phobia
- Social phobia
- Agoraphobia
Specific Phobia

Acrophobia and claustrophobia are most common in clinical settings.

Most present with Axis I or II disorder; only about 12-30% seek help for their phobia.

The more specific phobias a person has, the more likely they are to have other pathology.

Common Specific Phobias

<table>
<thead>
<tr>
<th>Specific Phobia</th>
<th>Common Phobia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acrophobia</td>
<td>Heights</td>
</tr>
<tr>
<td>Algophobia</td>
<td>Pain</td>
</tr>
<tr>
<td>Astraphobia</td>
<td>Thunderstorms</td>
</tr>
<tr>
<td>Claustrophobia</td>
<td>Enclosed places</td>
</tr>
<tr>
<td>Hydrophobia</td>
<td>Water</td>
</tr>
<tr>
<td>Monophobia</td>
<td>Being alone</td>
</tr>
<tr>
<td>Mysophobia</td>
<td>Contamination</td>
</tr>
<tr>
<td>Nyctophobia</td>
<td>Darkness</td>
</tr>
<tr>
<td>Pyrophobia</td>
<td>Fire</td>
</tr>
<tr>
<td>Zoophobia</td>
<td>Animals or some particular animal</td>
</tr>
</tbody>
</table>

Phobia Subtypes

Animal
Natural Environment
Blood, injection, or injury
Situational

The most common tends to be situational, followed by natural environment.

Overall, women outnumber men 2:1, but this varies across subtypes.
Specific Phobias

Blood-injection-injury phobia occurs in about 3–4% of the population.

16% of women and 7% of men suffer from some form of specific phobia in their life.

The age of onset for different phobias varies widely:

<table>
<thead>
<tr>
<th>Age of Onset</th>
<th>Phobia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animals</td>
<td>4.4 to 10 years</td>
</tr>
<tr>
<td>Thunderstorm</td>
<td>11.9 years</td>
</tr>
<tr>
<td>Blood</td>
<td>5.5 to 8.8 years</td>
</tr>
<tr>
<td>Dental</td>
<td>10.8 years</td>
</tr>
<tr>
<td>Claustrophobia</td>
<td>16.1 to 22.7 years</td>
</tr>
</tbody>
</table>

Comorbidity

Often present with other anxiety disorders.

Rates of co-occurrence range from 50 to 80%.

Approximately 75% of those with the blood injection injury subtype report fainting problems.
Phobias as Learned Behavior

Builds on classical conditioning work and observational learning models

Neutral stimulus + Unconditioned Stimulus = Fear
Dentist + Pain of Dental Work = Fear of Dentist
Dog + Dog Attacking You = Fear of Dogs

Direct exposure is not a requirement, can happen via vicarious conditioning

E.g., you see a person get bit by a snake, then later see a snake and freak out

Individual Differences

Positive experiences can provide a “buffer” against negative experiences
Inescapable vs. escapable situations
Maladaptive cognitions can maintain phobias after they are acquired
INDIVIDUAL DIFFERENCES

Evolutionary preparedness for certain objects and stimuli

Behaviorally inhibited temperaments show more fears

Modest genetic, very strong environmental influence on susceptibility to fear

TREATMENT

Drugs do not work well for this population

Behavior therapies result in 80% improvement with minimal treatment lengths (1.9-9.0 hrs)

Exposure with response prevention is the most commonly used & most effective treatment for specific phobias

SOCIAL PHOBIA

Disabling fears of social situations one may be exposed to the scrutiny and potential negative evaluation of others

Has to recognize the fear as unreasonable and it impairs with functioning

About 12% of the population has this disorder
Social Phobia

- Similar causal factors as simple phobias
- Perceptions of uncontrollability and unpredictability of situations
- Schemas that expect people to be awkward and unacceptable in social situations

Social Phobia Treatments

- Behavior therapy
- Cognitive-behavioral therapy
- Medications

Panic Attacks

- About 15% of the general population report having a panic attack at some point
- Characterized by intense fear or discomfort that develops abruptly and peaks within 10 minutes
- Isn’t a codable disorder; instead you cite it with the disorder it accompanies
Types of Panic Attacks

Unexpected
Not associated with situational trigger

Situationally Bound
Occurs immediately after exposure to (or in anticipation of) a stimulus

Situationally predisposed
More likely to occur upon exposure

Panic Disorder

Panic disorder is characterized by the occurrence of “unexpected” panic attacks that often seem to come “out of the blue”

Usually precipitated by negative life event

Distinguished them from other types of anxiety by their characteristic brevity and intensity

With and without Agoraphobia

Many people with panic disorder also develop an agoraphobic fear of situations in which they might have an attack

Commonly avoided situations include
Crowds Restaurants
Shopping Malls Tunnels
Being home alone Elevator
**PANIC DISORDER**

- Typical age of onset is 19.7 to 32 years ($M = 26.5$ years)
- Lifetime prevalence rates as high as 3.5%
- Panic without agoraphobia is diagnosed twice as often in women as in men; with agoraphobia is diagnosed three times as often in women
- First degree relatives eight times more likely; if age of onset is before 20, it jumps to 20 times more likely

**Comorbidity**
- Major depressive Disorder 10% to 65%
- Social Phobia and GAD 15% to 30%
- Specific Phobia 2% to 20%
- OCD up to 10%

**BIOLOGICAL CAUSAL FACTORS**
- Moderate heritable component, closely linked with phobias
- Broad range of biochemical panic provocation agents, no one mechanism
- Several areas of the brain implicated in panic attacks, the “fear network”
The “fear of fear” model and comprehensive learning theory leads to anticipatory anxiety and agoraphobic avoidance.

Internal body sensations of anxiety/arousal become CSs for higher levels of anxiety. My heart starts beating fast, which makes me afraid that I will have a panic attack, which makes me more anxious and have a panic attack. Leads to anticipatory anxiety and agoraphobic avoidance.

**Psychological Causal Factors**

**Cognitive Theory of Panic**

- Trigger stimulus (internal or external)
- Perceived threat
- Interpretation of sensations as catastrophic
- Apprehension or worry (e.g., about having a panic attack or about any distressing situation)
- Body sensations
- Trigger stimulus (internal or external)

**Panic Treatment**

- Medications
  - Minor tranquilizers (Xanax)
  - Antidepressants (tricyclics & SSRIs)

- Behavioral and CBT treatments
  - Exterceptive & interoceptive exposure
  - Cognitive restructuring
GENERAL ANXIETY DISORDER

Excessive anxiety and worry occurring more days than not for at least 6 months about a number of events

Typically has a gradual onset and unremitting course

Characterized by chronic or excessive worry about a number of events and activities

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PREVALENCE

One month and lifetime prevalence rates are estimated at 5-10%.

Slightly more common in women (about 55-60% that go for treatment are female)

May be over diagnosed in children

Culture greatly impacts how anxiety is experienced (some present with more physical problems)

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COMMON SYMPTOMS

Restlessness
Muscle Tension
Disturbed Sleep
Easily Fatigued
Difficulty Concentrating
Trembling
Shaking
Sweating
Nausea
Exaggerated startle response
COMORBIDITY

Substance-related disorders

Often occurs with other Anxiety Disorders
  - Panic Disorder
  - Social Phobia
  - Specific Phobia

Often occurs with Mood Disorders
  - Major Depressive Disorder
  - Dysthymic Disorder

PSYCHOSOCIAL CAUSAL FACTORS

Psychoanalytic viewpoint says it results from conflict between the id and the ego
  - Untestable hypothesis, no support

Occurs more often in who have had extensive experience with uncontrollable events

A sense of mastery may help to buffer you from being anxious and nervous

PSYCHOSOCIAL CAUSAL FACTORS

People with GAD see worry as a
  - Superstitious avoidance of catastrophe
  - Actual avoidance of catastrophe
  - Avoidance of deeper emotions
  - Coping and preparation
  - Motivating device

Worry is reinforcing, because it suppresses intensity to responses
**Psychosocial Causal Factors**

Worry has some positive aspects, but many more negative consequences
- Increases intrusive imagery
- Increases sense of uncontrollability

Many cognitive biases shown in GAD
- Attentional vigilance towards threats
- Negative view of future
- Interpret ambiguous stimuli as threatening

**Biological Causal Factors**

It is modestly heritable

Neurotransmitters GABA, serotonin, and perhaps norepinephrine all play a role

Corticotrophin-releasing hormone also plays a role

Neurobiological factors implicated in panic disorders and GAD are **not** the same

**Treatment**

Benzodiazepines used with or to replace SSRI’s

Behavioral Techniques
- Systematic desensitization
- Imaginal
- In vivo flooding
- Graduated in vivo exposure
- Participant modeling

At 5 year followup, about 18% were remitted
Even with drugs, about 50% still met GAD criteria
**Obsessive-Compulsive Disorder**

Characterized by intrusive thoughts that are often coupled with repetitive behaviors that are elaborate, time-consuming, and distressful.

Onset during late adolescence to early adulthood, but can be seen as early as age 4

Prior to 18, there is a greater number of obsessions and compulsions and has a greater level of clinical impairment than adult onset

**Common O/C**

- Avoidance
- Excessive alcohol use
- Guilt
- Sleep disturbances
- Relationship and other social problems
- Occupational problems
- Aggressive impulses
- Repeated doubts
- Frequent ‘checking’

**Obsessive-Compulsive Disorder**

Presentation in childhood is about the same as in adulthood

In adults, the disorder is equally common in men and women.

In children, the disorder is more common in boys than girls

Culture may impact the types of rituals performed
OCD Rates

- OCD’s one-year prevalence is 1.6%
- OCD’s lifetime prevalence is 2.5%
- OCD affects both genders equally
- Generally begins in late adolescence, but is fairly common in children

Comorbidity

- In adults, it may be associated with Major Depression, Specific Phobia, General Anxiety Disorder, Eating Disorders, etc.
- In children, it may be associated with learning disorders and disruptive behavior disorders
- Tourette’s and tic seen in 35-50%

OCD Causal Factors

- Behavioral explanation is Mowrer’s two-process theory of avoidance learning
  - Neutral stimuli become associated with frightening thoughts through CC
  - Reducing the (now) obsession by performing a ritual becomes reinforced
- This is the source of ERP treatments
BIOLOGICAL CAUSAL FACTORS

Moderately heritable

Abnormalities in brain function may include
- Structural abnormalities in the caudate nucleus
- High metabolic levels in other parts of the brain

Serotonin is strongly implicated in OCD

TREATING OCD

Exposure with response prevention is the most effective, behavioral treatment

With experienced therapists, as many as 85% show improvements

Much better than any medication

SUMMARY

Anxiety Disorders can result in significant distress in one’s life and can impair work and social life

Typically, behavioral therapies are the most successful types of treatment

It seems that there is a large genetic component, but more research is needed