# Introduction to the Anxiety Disorders

## Operational Definitions

- Like love, beauty, truth, wealth, and so many other things, "mental" disorders are a…

**SOCIAL CONSTRUCTION**

- This does *not* rob them of their importance

## Psychiatric Disorders

- A behavioral or psychological syndrome/pattern that occurs in an individual
- Reflects an underlying psychobiological dysfunction
- Consequences are clinically significant distress or disability
- Not an expectable response to common stressors/losses or a culturally sanctioned response to a particular event
- Not primarily a result of social deviance or conflicts with society

Stein et al. (2010)

## Psychiatric Disorders

- Have diagnostic validity and clinical utility
- No definition perfectly specifies precise boundaries for the concept of either “medical disorder” or "mental/psychiatric disorder”
- Diagnostic validators and clinical utility should help differentiate a disorder from diagnostic “nearest neighbors”

Stein et al. (2010)

## What is an Anxiety Disorder?

- Class of psychiatry disorders that purport to share *features of responding*
- Prototypical fear
  - Comprised of escape behaviors, physiological arousal, thoughts of imminent threat
- Prototypical anxiety
  - Comprised of avoidant behaviors, tension, and thoughts of future threat

Craske et al. (2009)

| Fear | Anxious |
|---|---|
| Immediate threat | Future threat |
| Sympathetic arousal | Muscle tension |
| Escape | Avoidance |

## Anxiety vs Fear

- Separate, yet highly correlated
- Social phobia seems to straddle between fear and anxious, but the others are more distinct
- Anxiety-disordered show differences from controls in both experimental and clinical ways
  - Conditioning, attention to fear stimuli, info processing

Craske et al. (2009)

## Anxiety Disorder Characteristics

- Elevated sensitivity to threat
- Preconscious attentional bias toward personally relevant threat stimuli
- Bias to interpret ambiguous information in a threat-relevant manner
- Elevated amygdala responses to specific *and* general threat cues

Craske et al. (2009)

## Culture & Anxiety Disorders

- US and European rates generally converge
- Compared to other national surveys, though
  - Higher 12-month rates of PD, Specific Phobia, and SAD
  - Similar AWOPD, OCD, and GAD rates
- Lowest rates are found in Asia and Africa
  - Replicated by lower rates of disorder among US populations of Asian and African descent

Lewis-Fernandez et al. (2011)

## Culture & Anxiety Disorders

- Several mismatches between cultures and DSM-IV criteria
  - Unexpectedness and 10-minute peak in PD
  - Definition of social anxiety and social reference group in SAD
  - Priority given to psychological symptoms of worry in GAD

Lewis-Fernandez et al. (2011)

## Impact of Anxiety Disorders

- Highest overall prevalence rate among psychiatric disorders
  - 12-month rate of 18.1%; lifetime rate of 28.8%
- 31.5% of total expenditures for mental health, around $46.6 billion
- Huge impact on QoL and functioning

Olatunji et al. (2007)

## Impact of Anxiety Disorders

- Increased marital and financial problems
- Lowered educational attainment
- Higher rates of public assistance
- Role limitations
- Higher rates of divorce and disability

Olatunji et al. (2007)

## QoL in Anxiety Disorders

Effect size estimates for overall quality of life for samples of anxiety disorders compared to control samples

| Diagnosis | No. of samples | *N* | *d* | 95% CI | FSN | $Q_{within}$ |
|---|---|---|---|---|---|---|
| SP | 5 | 496 | 1.60** | 0.68–2.52 | 393 | 130.20** |
| PTSD | 4 | 343 | 1.46** | 1.32–1.60 | 324 | 10.81* |
| GAD | 6 | 248 | 1.35** | 1.04–1.65 | 378 | 15.75* |
| PD | 11 | 846 | 1.28** | 1.04–1.52 | 2186 | 71.78** |
| Anxiety | 1 | 119 | 1.22** | 1.03–1.41 | – [a] | – [a] |
| OCD | 6 | 741 | 1.11** | 0.66–1.57 | 395 | 54.03** |
| All studies | 33 | 2793 | 1.31** | 1.14–1.48 | 17130 | 297.00** |

SP = social phobia. PTSD = post-traumatic stress disorder. GAD = generalized anxiety disorder. PD = panic disorder. Anxiety = any anxiety disorder diagnosis. OCD = obsessive–compulsive disorder. CI = confidence interval. FSN = fail–safe *N*.
*$p<.05$. **$p<.001$.
[a] Could not be computed due to the low number of studies.

- Comparable to other psych disorders
- Overall, mental health and social functioning are the most impaired areas

Olatunji et al. (2007)

## Evidence-Based Practice

- Refers to using best available *scientific* data to guide treatment choices
- Two broad classes of evidence-based treatment: psychotherapy and pharmacology
- Important to know when to *not* treat as well

## To Treat or Not? Consider…

- Severity and persistence of symptoms
- Presence of comorbid mental disorder or physical illness
- Level of disability and impact on functioning
- Concomitant medication
- History of response to previous treatment

Baldwin et al. (2005)

## EBP - Pharmacology

- Anxiety disorders show a strong placebo response, especially at mild-moderate levels
- In milder, recent-onset anxiety disorders consider "watchful waiting" or therapy
- SSRIs are considered the "first line" drug, and are effective across many disorders

Baldwin et al. (2005)

## EBP - Pharmacology

- Benzodiazepines are effective, but should only be used short-term except in treatment-refractory cases
- With all, careful monitoring of side effects and discussion of withdrawal symptoms

Baldwin et al. (2005)

## EBP - Psychotherapy

- Overall, equal initial efficacy for *certain* kinds of therapy to pharmacology, and better long-term outcomes
- Cognitive and behavioral approaches are superior to other therapies for anxiety

## Empirically Supported Treatments

| Disorder and treatments | Overall status | Level of empirical support: Cognition | Physiology | Behavior | Subjective |
|---|---|---|---|---|---|
| *Specific phobia* | | | | | |
| SD | Experimental | Exp | Exp | Exp | Exp |
| OST | Well-established | Exp | Exp | Prob | Well Est |
| *Social phobia* | | | | | |
| BT | Probably efficacious | Exp | Exp | Prob | Prob |
| GCBT | Probably efficacious | Exp | Exp | Exp | Prob |
| *Obsessive–compulsive disorder* | | | | | |
| ICBT | Well-established | Exp | Exp | Exp | Exp |
| GCBT | Experimental | Exp | Exp | Exp | Exp |
| CBT + Med | Probably efficacious | Exp | Exp | Exp | Exp |
| *Posttraumatic stress disorder* | | | | | |
| ICBT | Well-established | Exp | Exp | Prob | Prob |
| GCBT | Experimental | Exp | Exp | Exp | Exp |
| *Childhood anxieties (combined)* | | | | | |
| ICBT | Probably efficacious | Prob | Exp | Prob | Prob |
| GCBT | Well-established | Exp | Exp | Prob | Well Est |
| Family-focused | Probably efficacious | Exp | Exp | Exp | Exp |
| CBT + Med | Probably efficacious | Exp | Exp | Exp | Exp |
| Bibliotherapy | Probably efficacious | Exp | Exp | Prob | Exp |

*Note*: SD = systematic desensitization; CBT = cognitive-behavioral therapy; OST = ones session CBT; BT = behavior therapy; I = individual; G = group; Med = Medication; Exp = experimental empirical status; Prob = probably efficacious empirical status; Well Est = well-established empirical status.

Davis et al. (2011)

## Barriers to Treatment

- Large discrepancy between efficaciousness of EBP treatment and patient access to it
- This is particularly true when it comes to CBT, which is more cost effective and enduring than pharmacological treatments
- CBT has both efficacy and effectiveness data

Gunter & Whitall, (2010)

## What's the Problem?

- Fear of harm from exposure techniques
- Lack of training opportunities
- Non-CBT orientation and resistance
- Clinical-research gap and mistrust of evidence
- Organizational / economic concerns

Gunter & Whitall, (2010), Olatunji et al. (2009)

## The "Evils" of Exposure

- Seen as problematic by many therapists and the pubic, and subsequently not used
- Not only safe and tolerable, but actually has minimal risks associated with usage
- Must be done properly by trained clinicians, though, using clear professional boundaries

Olatunji et al. (2009)

## Obstacles for the Therapist

- I'm making my client *more* upset / anxious
- It's difficult to see people in distress
- Hearing the accounts of trauma can be emotionally draining for some people
- May have to do exposures that *you* are not comfortable with

## Therapy without a Therapist?

- Given poor dissemination and usage of CBT, what are other options?
- Substantial literature showing that persons with anxiety disorders can benefit from technology-assisted treatments
- Improvements are poorer than in full-contact CBT therapy, but better than WLC or TAU

Newman et al. (2010)

## Anxiety Comorbidity

- "Pure" anxiety disorders are an exception, with extremely high comorbidity rates seen
- GAD at 66-83% is the highest, but all the others are over 50%
- Severity tends to increase concurrent with comorbidity

Lack et al. (in press)

## Anxiety Comorbidity

- This has raised concerns about generalization of treatment outcome research
- Overall, research shows that comorbidity does *not* decrease treatment effects from CBT
- Both transdiagnostic and specifically developed treatments have support for treating comorbid anxiety disorders

Lack et al. (in press)

## Primary CBT Techniques

- Three broad categories of tools for anxiety
- Exposure with response prevention
- Cognitive restructuring
- Relaxation methods

## Exposure Techniques

- The common thread in effective anxiety treatments is hierarchy-based exposure tasks
- Controversy over exactly *why* exposure therapy works so well for anxiety
- Does *not* require extensive preparation to be effective and long-lasting

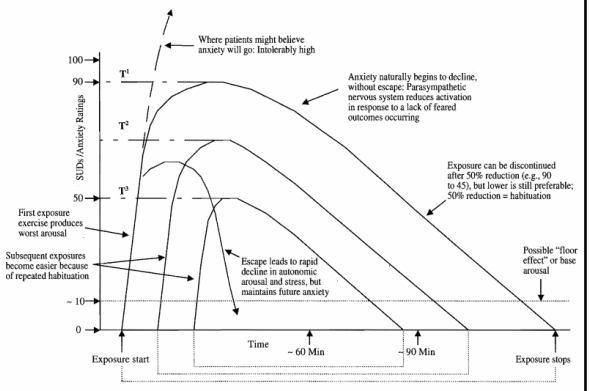
Rosqvist (2005)

## Exposure Techniques

- Begin by constructing a fear hierarchy
  1. Generate specific feared situations
  2. Rate them using Subjective Units of Distress
- Continue by actually doing the exposures, working from lower to higher SUDs situations

## Sample Fear Hierarchy

| *Situation* | *Fear Rating* |
|---|---|
| Driving over the Steel Bridge at rush hour | 100 |
| Driving on the highway at rush hour, at dusk, and in poor weather | 90 |
| Driving on the highway at rush hour, in good weather | 80 |
| Being a passenger on the highway during rush hour | 75 |
| Driving on the highway in the middle of the day, in good weather | 65 |
| Driving on a city street at midday, when it is raining | 65 |
| Driving on a city street at midday, when the sky is clear | 50 |
| Turning onto a city street during traffic hours | 45 |
| Driving in a busy parking lot during business hours | 35 |
| Driving in an empty parking lot during "off" hours | 25 |




## HOMEWORK!

- You are to create your own fear hierarchies for the next class period
- Should include a wide range of fears and/or situations that are distressing
- Use SUDs ratings to distinguish and order the hierarchy

## Exposure Rules

- Ideal exposures are prolonged, repeated, and prevent the use of distraction behaviors
- SUDs decrease of *at least* 50%, with more being better
- *In vivo* are best, imaginal best used to prepare for *in vivo* exposures

## Cognitive Restructuring

- Group of techniques designed to change how a person responds to his or her thoughts
- How one interprets a situation, rather than the situation itself, greatly influences the emotional, behavioral, and physiological response one has
- CR makes these interpretations more adaptive

## Thinking Errors

- Two broad types of errors people make when confronted with a potentially stressful situation:

1. Interpretation errors, where you misread the available information
2. Coping errors, where you misidentify things that protect you from a negative outcome

## The Thought Record

- This is a physical manifestation of the thought challenging process
- Often used early in therapy to help client generalize CR skills outside of therapy
- Should be customized for the age and/or developmental level of the client

Example of an adult thought record

**THOUGHT RECORD**

Trigger: _____

Cognitions (images, thoughts, assumptions, and/or beliefs):_____

_____

Strength of belief in cognitions (on a 1-7 scale): _____

Challenges to cognitions: _____

_____

Types of thinking errors: _____

_____

Alternative viewpoints:
- Worst outcome: _____
- Best outcome: _____
- Most realistic outcome: _____

What effect does this thought have on the way I feel? _____

_____

Rational responses:

Even though I feel that _____ is true,
(thoughts or assumptions)

the reality is that _____.
(answers to challenges and alternative viewpoints)

Example of a child thought record

**THOUGHT RECORD**

What happened that made OCD pop up: _____

_____

What OCD told me or wanted me to ask: _____

_____

How much do you believe OCD? (1 = not at all, 10 = completely) _____

How does this make me feel? _____

What did you tell OCD to fight back? _____

_____

What would be the…..
- Worst outcome?: _____
(if OCD was right)
- Best outcome?: _____
(if OCD was wrong)
- Most likely outcome: _____

**Wrap It Up!**

Even though I feel that _____ is true,
(what OCD says)

the reality is that _____.
(your arguments against OCD)

How do you feel now? _____

How much do you believe OCD now? (1 = not at all, 10 = completely) _____

## Relaxation Techniques

- Progressive muscle relaxation directly targets tension that builds in muscles, and indirectly targets heart and breathing rates
- PMR increases awareness of tension feelings and provides a way to combat that tension
- Diaphragmatic breathing teaches you to breathe as if you were relaxed

## IN CLASS EXERCISE!

- Let's practice some PMR!
- Practice once daily for the remainder of class
- Fill out the log and turn in on Friday