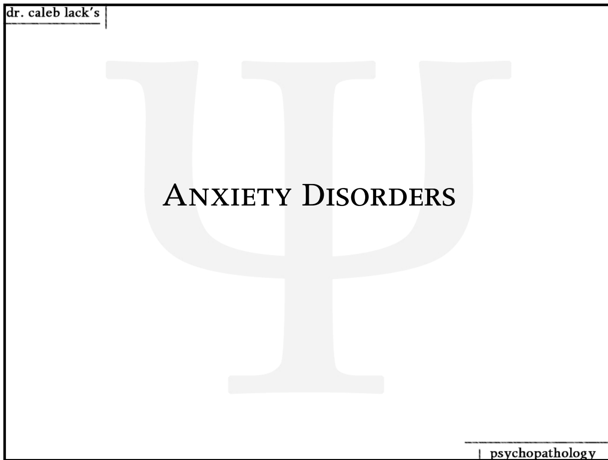

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Operational Definitions

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**

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Operational Definitions

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

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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

DSM-IV-TR 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

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

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

Acrophobia	Heights
Algophobia	Pain
Astraphobia	Thunderstorms
Claustrophobia	Enclosed places
Hydrophobia	Water
Monophobia	Being alone
Mysophobia	Contamination
Nychtophobia	Darkness
Pyrophobia	Fire
Zoophobia	Animals or some particular animal

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

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Age of Onset

Animals - 4.4 to 10 years

Thunderstorm - 11.9 years

Blood - 5.5 to 8.8 years

Dental - 10.8 years

Claustrophobia - 16.1 to 22.7 years

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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

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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

Phobias as Learned Behavior

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

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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

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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

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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

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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

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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
- Shopping Malls
- Being home alone
- Restaurants
- Tunnels
- Elevator

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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

Panic Disorder

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"

Psychological Causal Factors

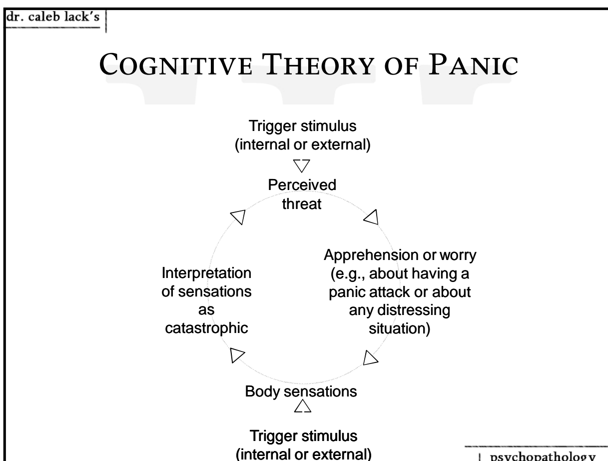
The "fear of fear" model and comprehensive learning theory

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 agroaphobic avoidance

Cognitive Theory of Panic



Panic Treatment

Medications

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

Behavioral and CBT treatments

- Exteroceptive & interoceptive exposure
- Cognitive restructuring

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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

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Comorbidity

Substance-related disorders

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

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

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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

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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

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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 roll
- 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

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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

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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

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