# Anxiety Disorders

Related to impaired or highly distressing experiences of anxiety.

Anxiety can be experienced:

- Physiologically (e.g., heart pounding, sweating)
- Emotionally (e.g., fear)

And can result in:

- Behavioral changes (e.g. avoidance of anxiety-producing stimuli)
- Cognitive rumination (e.g., worry)
- Hypervigilence (persistent awareness of fear-inducing stimuli)
- Heightened autonomic arousal (e.g., insomnia, muscle tensions)

# Separation Anxiety Disorder (1/2)

A. Developmentally inappropriate and excessive anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry that an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
7. Repeated nightmares involving the theme of separation.
8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

# Separation Anxiety Disorder (2/2)

B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.

C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in Autism Spectrum Disorder; delusions or hallucinations concerning separation in Psychotic Disorders; refusal to go outside without a trusted companion in Agoraphobia; worries about ill health or other harm befalling significant others in Generalized Anxiety Disorder; or concerns about having an illness in Illness Anxiety Disorder.

# Selective Mutism

A. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.

B. The disturbance interferes with educational or occupational achievement or with social communication.

C. The duration of the disturbance is at least 1 month (not limited to the first month of school).

D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

E. The disturbance is not better explained by a Communication Disorder (e.g., Childhood-Onset Fluency Disorder) and does not occur exclusively during the course of Autism Spectrum Disorder, Schizophrenia, or another Psychotic Disorder.

# Panic Attack

This is a syndrome – NOT A DISORDER

An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

1. palpitations, pounding heart, or accelerated heart rate
2. sweating
3. trembling or shaking
4. sensations of shortness of breath or smothering
5. feelings of choking
6. chest pain or discomfort
7. nausea or abdominal distress
8. feeling dizzy, unsteady, lightheaded, or faint
9. chills or heat sensations (e.g., hot flashes)
10. parathesias (numbness or tingling sensations)
11. derealization or depersonalization
12. fear of losing control or “going crazy”
13. fear of dying

# Panic Disorder (1/2)

A. Recurrent unexpected Panic Attacks.

B. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy")
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations)

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

# Panic Disorder (2/2)

D. The disturbance is not better explained by another mental disorder, (e.g., the panic attacks do not occur only in response to feared social situations, as in Social Anxiety Disorder; in response to circumscribed phobic objects or situations, as in Specific Phobia; in response to obsessions, as in Obsessive-Compulsive Disorder; in response to reminders of traumatic events, as in Posttraumatic Stress Disorder; or in response to separation from attachment figures, as in Separation Anxiety Disorder.

# Panic Disorder – Prevalence, etc.

Prevalence

- Lifetime 4-5%
- Annual 2-3%

Incidence

- 10-30% of Neurology patients; 60% of Cardiology patients

Panic Disorder 2xF : M

Onset

- Adolescence to mid-30s, mean age 20-24

Posttreatment – about 70% continue to experience symptoms

# Agoraphobia (1/3)

A. Marked fear or anxiety about two (or more) of the following five situations:
   1. Using public transportation
   2. Being in open spaces
   3. Being in enclosed places
   4. Standing in line or being in a crowd
   5. Being outside of the home alone

B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence),

C. The agoraphobic situations almost always provoke fear or anxiety.

# Agoraphobia (2/3)

D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational (or academic) or other important areas of functioning.

H. If another medical condition (e.g., IBD, Parkinson's Disease) is present, the fear, anxiety, or avoidance is clearly excessive.

# Agoraphobia (3/3)

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder – for example, the symptoms are not confined to Specific Phobia, Situational Type; do not involve only social situations (as in Social Anxiety Disorder); and are not related exclusively to obsessions (as in Obsessive-Compulsive Disorder), perceived defects or flaws in physical appearance (as in Body Dysmorphic Disorder), reminders of traumatic events (as in Posttraumatic Stress Disorder), or fear of separation (as in Separation Anxiety Disorder).

# Agoraphobia – Prevalence, etc.

Prevalence

- Lifetime 3.5-5%
- Annual 1.5-1.8%

Gender: 2xF : M

Onset

- Late adolescence to early 20s and mid-life (possibly bimodal onset)

# Specific Phobia (1/3)

A. Marked fear or anxiety about a specific object or situation (e.g. flying, heights, animals, receiving an injection, seeing blood)

Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging

B. The phobic object or situation almost always provokes immediate fear or anxiety.

C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.

D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.

E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

# Specific Phobia (2/3)

F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational (or academic) or other important areas of functioning.

G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in Agoraphobia); objects or situations related to obsessions (as in Obsessive-Compulsive Disorder), reminders of traumatic events (as in Posttraumatic Stress Disorder), separation from home or attachment figures (as in Separation Anxiety Disorder), or social situations (as in Social Anxiety Disorder).

# Specific Phobia – Specfiers (3/3)

Animal (e.g., dogs, spiders, insects, etc.)

onset often in childhood

Natural Environment (e.g., heights, storms, water)

onset often in childhood

Blood-Injection-Injury

highly familial and related to vasovagal response (fainting)

Situational (e.g., airplanes, elevators, enclosed places)

bimodal onset - in childhood and in mid-20s

Other (e.g, phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)

# Specific Phobia

Fear may be related to harm from the object (i.e., being bitten by dog, plane crashing)

May also be related to losing control when encountering the feared stimulus (i.e., becoming dizzy when driving, having a panic attack)

May also be related to fear of embarrassment by doing something when in the feared situation (i.e., fainting at sight of blood, or in elevator)

# Specific Phobia – Prevalence, etc.

Prevalence

- Lifetime 7.2-11.3%
- Annual 7-9%

In the National Comorbidity Study using community responses (N=8089), 49.5% reported strong fears to various stimuli (Kessler et al., 1994)

- 23% met criteria for Specific Phobia
- 16% of all women, 7% of all men surveyed
- 22% Animals (most common among women, 70-90% women)
- 20% Heights (most common among men, 30-45% men)
- Least prevalent were storms and water (both 9%)
- 76% indicated phobia to more than one stimulus

In clinical settings, most present with Situational Type

50-80% Comorbidity with other disorder, most commonly Panic Disorder

Only 12-30% of individuals with Specific Phobia seek treatment

# Specific Phobia – Etiology

Evolutionary Theory

- Fear response is natural and adaptive as God intended
    - many animals are dangerous (insects, snakes)
    - as are walking/being in high places
    - some indicators of injury may reflect contagion (e.g., lepers)

# Specific Phobia – Etiology

Psychodynamic Theories

- Anxiety stemming from dynamic conflicts (id vs. superego) get displaced onto a stimulus that is both feared and avoidable

- Feared objects are symbolic representations of true fears

  (e.g., fear of spiders reflects an individual's fear of their own sexual appetite)

  (e.g., fear of injections has to do with fears of (sexual) penetration)

# Specific Phobia – Etiology

Behavioral Theories

- Classical conditioning

  occurs when a stimulus becomes associated with a negative experience (e.g., seeing a dog, hearing a loud noise that induces startle response, “Little Albert”)

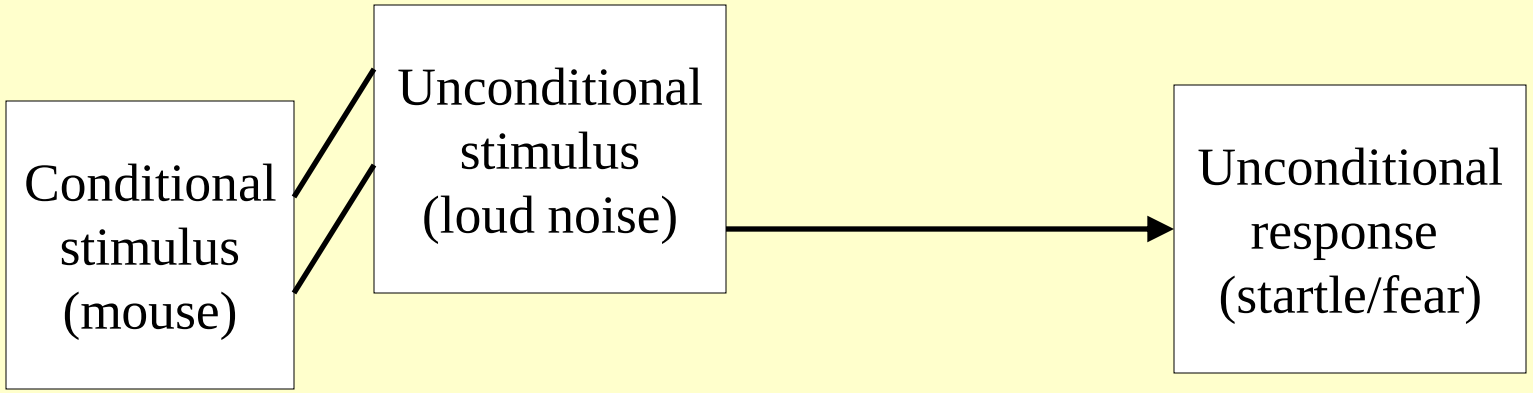
- Vicarious conditioning

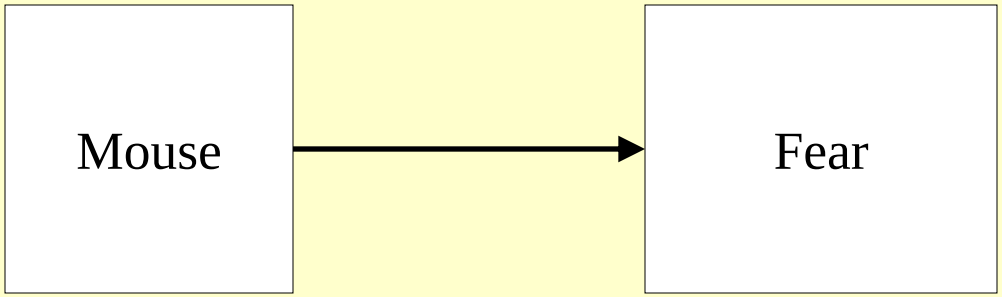
  occurs through watching another person either by watching someone become distressed (e.g., in presence of an animal) or through watching another’s experience (e.g., seeing people fall from building – 9/11)

- Particularly in the case when unexplained panic attacks become associated with either the environment or whatever stimuli happen to be present at the time

- Maintained by cognitive biases, selective attention to negative aspects or experiences (i.e., recalling only the times when elevators were shaky or stuck or something awful happened in them and not remembering all the times when riding an elevator was without event)

# Specific Phobia – Etiology



# Specific Phobia – Etiology

Cognitive Theories

- Maladaptive automatic thoughts
  - about how negative an experience is (e.g., It will be awful, I'll lose control, I won't be able to survive)
  - about control (e.g., I'll be stuck and I'll just have to live through it and hope that I don't get hurt, I won't be able to get out of the situation)
  - about lack of ability/mastery (e.g., I'll never be able to travel overseas, I'll always be an idiot at the doctor's office, It will never get better)
- Selective attention
  - instead of focusing on a variety of aspects of the situation, including one's goals, one's experience of anxiety, one's plan of problem-solving, one focuses on negative aspects of the situation that maintain fear (e.g., focusing attention on the dog and thoughts of whether or not it will bite you)

# Social Anxiety Disorder (1/3)

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

   Note: In children, the anxiety must occur in peer settings, not just during interactions with adults

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

   Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

# Social Anxiety Disorder (2/3)

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational (or academic) or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

# Social Anxiety Disorder (3/3)

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as Panic Disorder, Body Dysmorphic Disorder, or Autism Spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

**Performance only**: if the fear is restricted to speaking or performing in public.

# Social Anxiety Disorder – Prevalence, etc.

1-year prevalence in US is 7% compared to 0.5-2.0% in Europe.

Lifetime prevalence is 13.3% (females 15.5%; males 11.1%)
(Kessler et al., 1994)

In clinical settings, more men present for treatment than women

Mean age of onset is in mid-adolescence (based on retrospective reports, Turner et al., 1992)

Early onset (prior to age 11) is associated with poorer prognosis (Ballenger et al., 1998)

In Epidemiological Catchment Area study (Schneier et al., 1992)

59% had comorbid Simple Phobia
45% had comorbid Agoraphobia
17% had comorbid Major Depressive Disorder
19% had comorbid Alcohol Abuse
13% had comorbid other Substance Abuse

# Social Anxiety Disorder – Etiology

Psychodynamic Theories

- Negative interactions with parents are internalized (others are painful, harmful, shaming, hostile, critical, rejecting)
- Self is internalized as helpless and dependent (on parents for fear of abandonment) and inferior

- Also, parents may view “others” as threatening and children internalize this from parents

  (similar to vicarious learning in cognitive and behavioral theories)

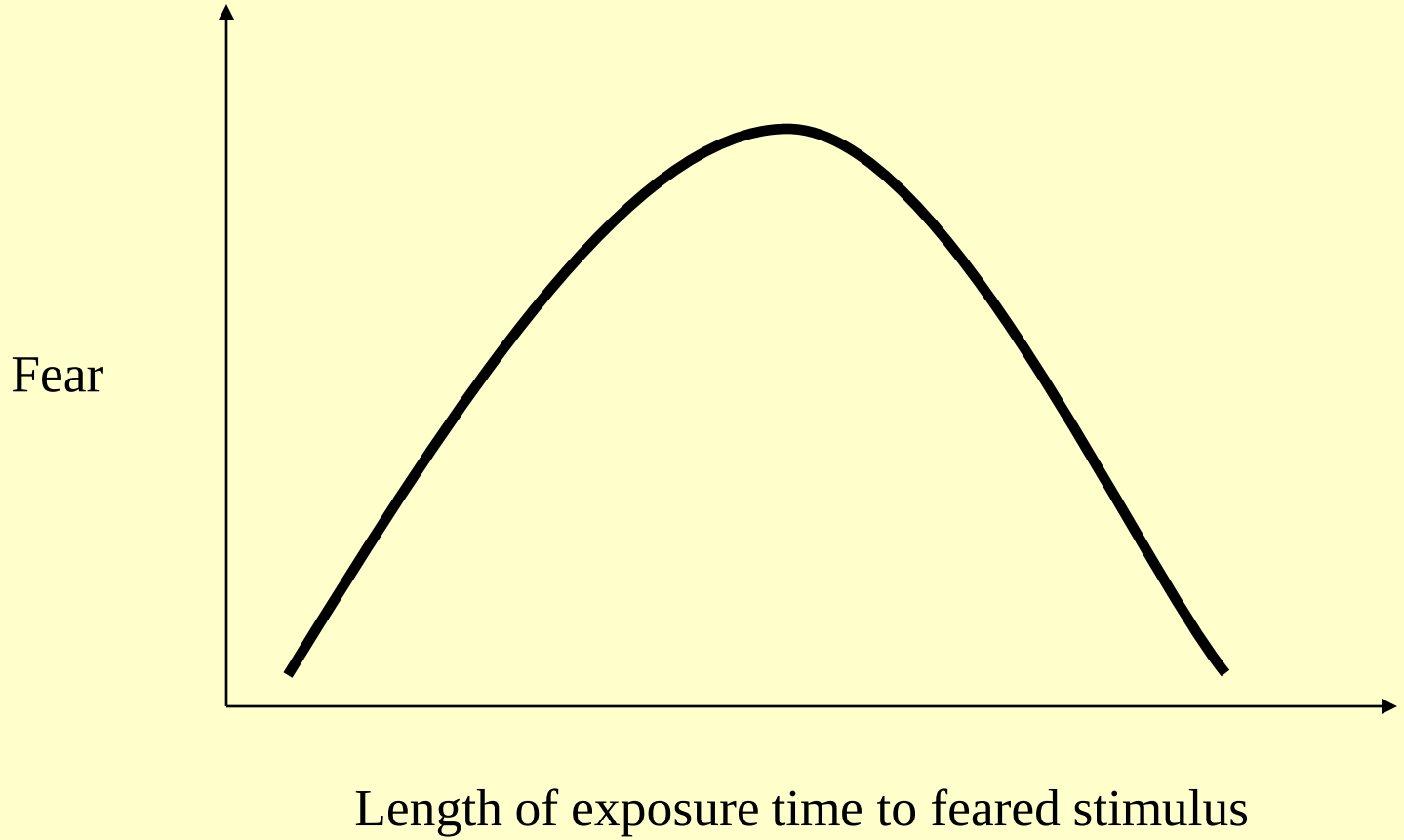
# Social Anxiety Disorder – Etiology

Biological Theories

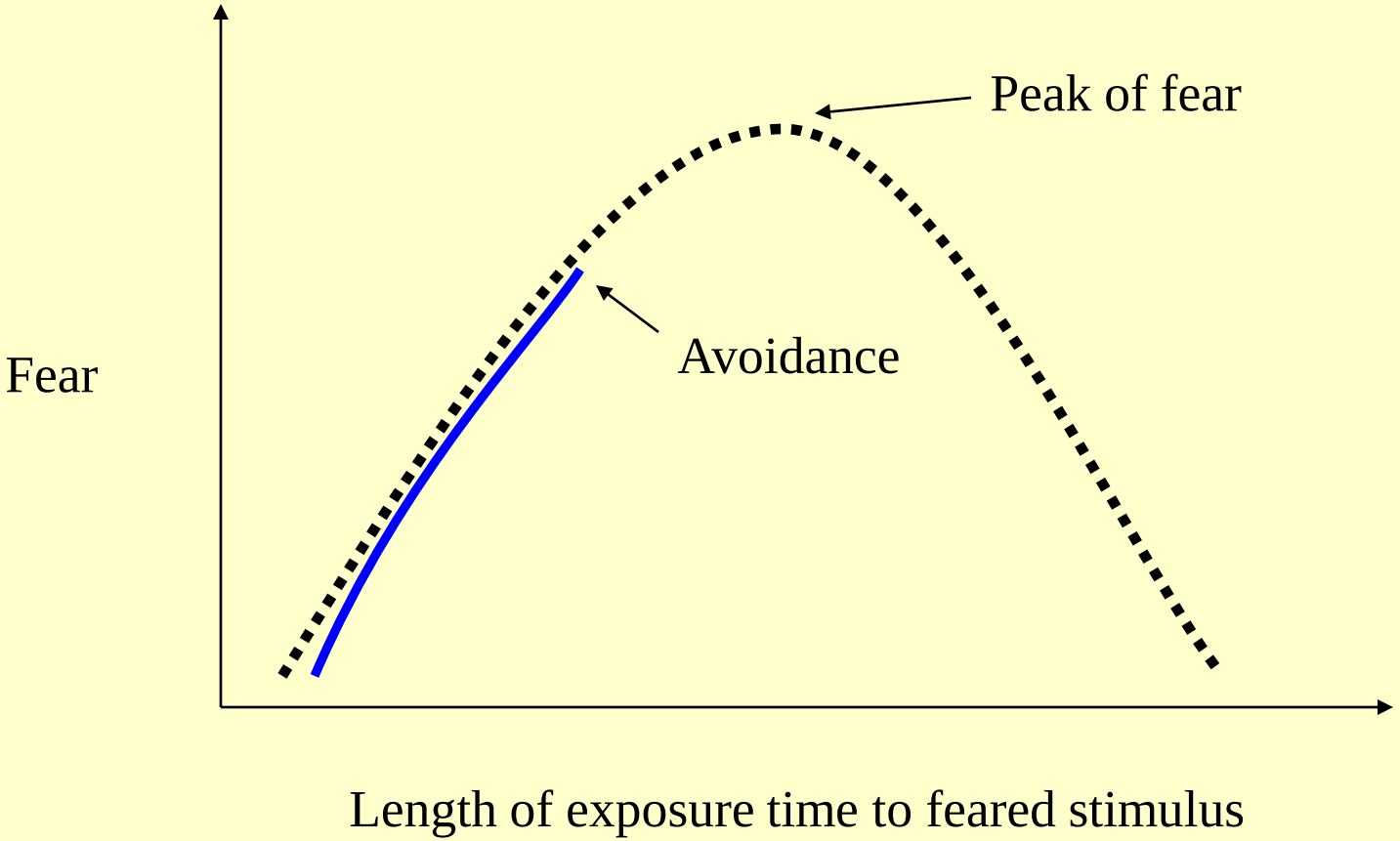
Kagan (1997), in studying infants, has found that some infants have what he calls “highly reactive” temperament (easily overstimulated, longer time to soothe, regarded to have a more sensitive sensory system (lower sensory threshold)) and that these infants are more likely to develop anxiety-spectrum disorders (though not all)

In a study of monozygotic vs. dizygotic twins, Kendler et al. (1992) found concordance rates for social phobia were 24.4% for MZ vs. 15.3 for DZ.

# OCD/Anxiety Disorders – Etiology (Foa & Kozak, 1986)



# OCD/Anxiety Disorders – Etiology (Foa & Kozak, 1986)



# OCD/Anxiety Disorders – Etiology (Foa & Kozak, 1986)

Theorized that individuals have a Fear Structure

In order for habituation to occur, exposure to feared stimulus must access the peak point of fear (arousal initially increases and then decreases)

When avoidance of feared stimuli occur, arousal never peaks and thus, habituation does not occur

The avoidance of the feared stimulus (or the decrease in arousal from obsessions and compulsions) reinforces future avoidance (or future occurrence of obsessions and compulsions) because it removes the aversive stimulus

# Anxiety Disorders – Treatment

Behavioral Therapy

- Exposure to the feared stimulus
  - can be graded
  - also known as Systematic Desensitization
  - for example: Specific Phobia – Animal Type (snakes)

1. seeing a picture of a snake sleeping on grass
2. seeing a picture of a snake with its tongue out, looking at you
3. watching a video clip of a snake slithering away from you
4. watching a video clip of a snake slithering towards you
5. watching a video clip of a snake with its mouth open
6. being in a room next door to a room with a live snake in a cage in it (can't see snake)
7. being at the doorway of a room with a live snake in a cage in it
8. being in the same room as a live snake in a cage

…and so on

# Anxiety Disorders – Treatment

Behavioral Therapy

- Relaxation Training

activates the Parasympathetic branch of the Autonomous Nervous System

Sympathetic branch releases adrenaline – heart pumps more blood, blood pressure goes up, flight or fight response

Parasympathetic branch releases chemicals that counter the effects of adrenaline – decreases heart rate, blood pressure

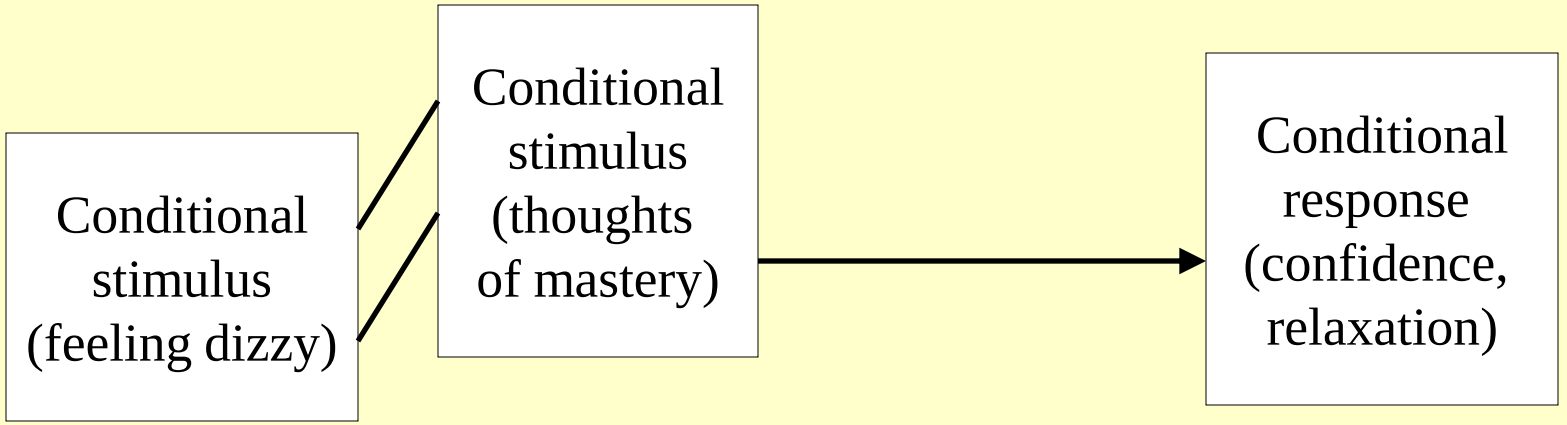
can be used to increase desensitization

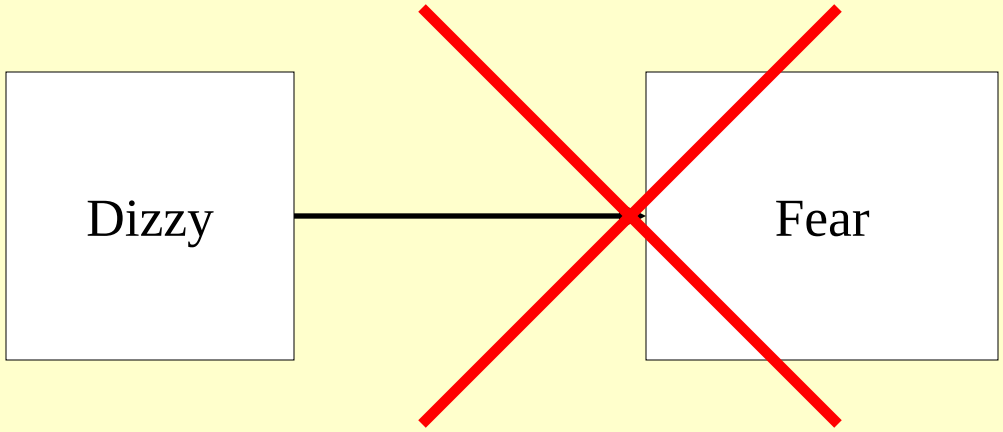
# Anxiety Disorders – Treatment

Cognitive Therapy

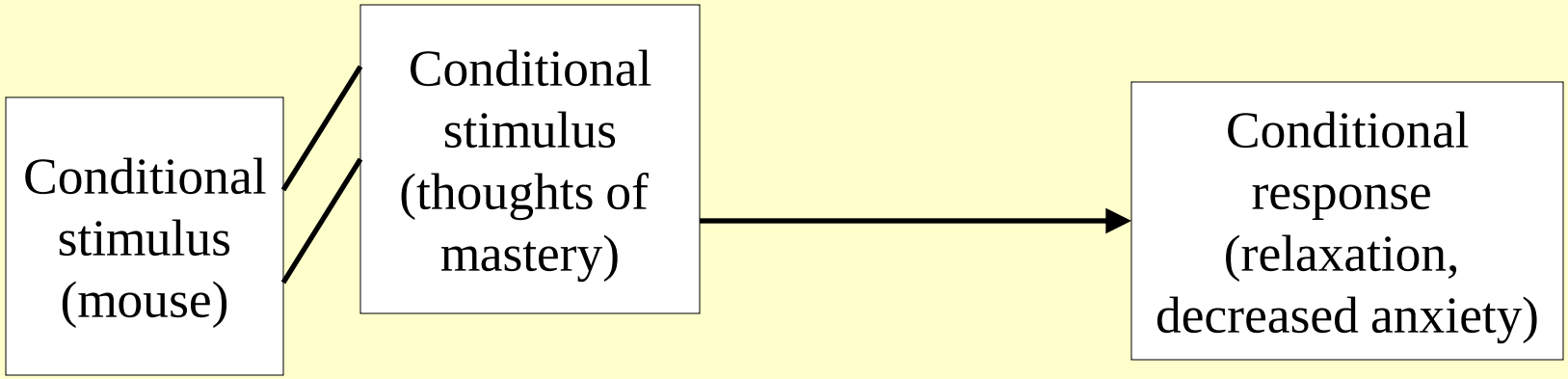
- Cognitive Restructuring (replacing maladaptive automatic thoughts)
  - helping patients see the positive aspects of an experience (e.g., It will be an opportunity to overcome my fear)
  - helping patients perceive control (e.g., I have a choice about exposing myself to the thing I'm afraid of, I can continue to avoid or I can practice being stronger)
  - helping patients see their own gains, their ability/mastery (e.g., I can do this, I've already come this far)
- Selective attention
  - instead of focusing on the negative aspects of the situation, focusing on positives or on goals of mastery (e.g., focusing attention on one's experience of fear or anxiety and rehearsing adaptive and positive responses such as telling yourself that you're much bigger than the dog and that you are brave enough to walk by it) instead of focusing attention on thoughts of whether or not the dog will bite you

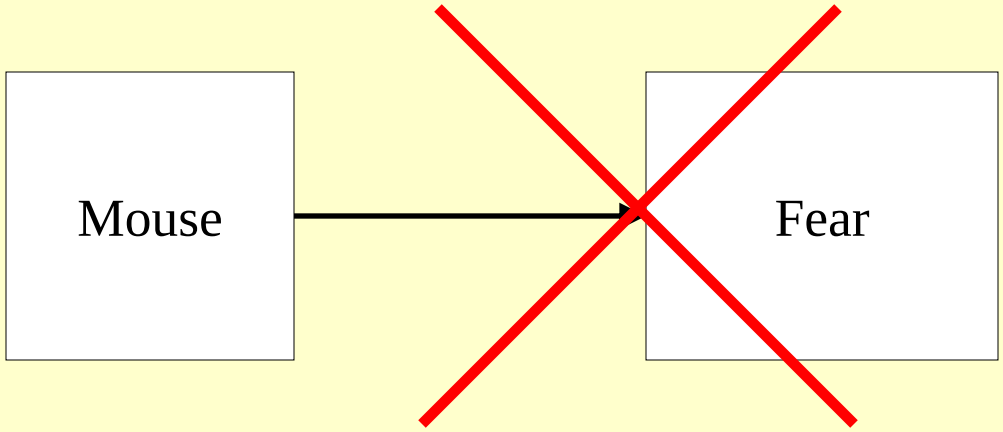
# Panic Disorder – Treatment



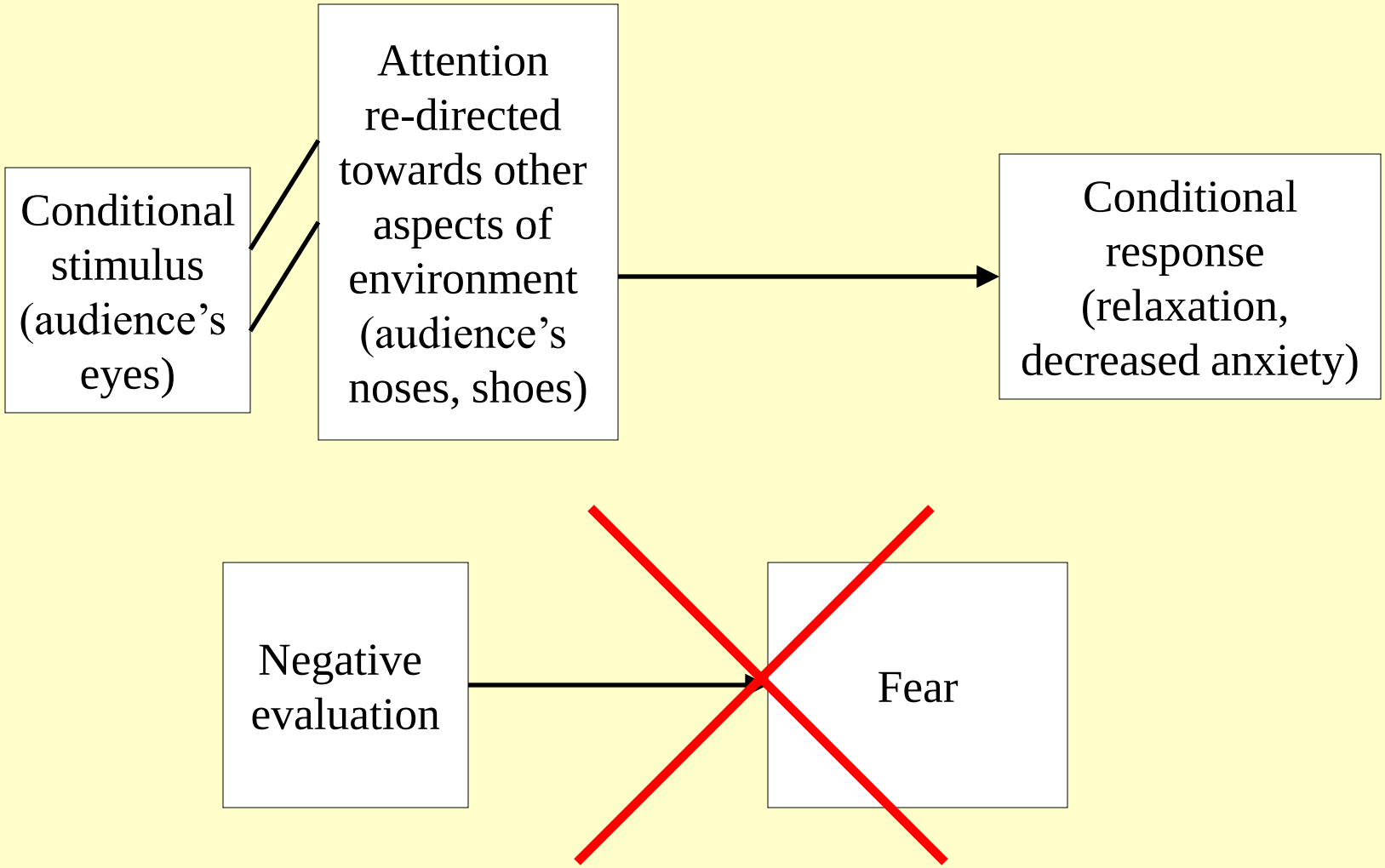



# Specific Phobia – Treatment



# Social Anxiety Disorder – Treatment



# Generalized Anxiety Disorder (1/2)

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

**Note:** Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

# Generalized Anxiety Disorder (2/2)

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).