CHAPTER SIX

Anxiety Disorders

CHAPTER OUTLINE

• Symptoms
• Diagnosis
• Frequency
• Causes
• Treatment
OVERVIEW OF ANXIETY DISORDERS

- Anxiety Disorders are the most common type of abnormal behavior.
- They share similarities with mood disorders:
  - Both are defined in terms of negative emotional responses.
  - Close relationship between symptoms of anxiety and depression.
  - Stressful life events seem to play a role in the onset of both depression and anxiety.

SYMPTOMS

- People with anxiety disorders share a preoccupation with, or persistent avoidance of, thoughts or situations that provoke fear or anxiety.

- The diagnosis of anxiety disorders depends on several types of symptoms.

SYMPTOMS: THE NATURE OF ANXIETY VS FEAR

<table>
<thead>
<tr>
<th>ANXIETY</th>
<th>FEAR</th>
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<tbody>
<tr>
<td>Associated with the anticipation of future problems</td>
<td>Experienced in the face of real, immediate danger</td>
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<tr>
<td>Involves more general or diffuse emotional reactions</td>
<td>Usually builds quickly in intensity</td>
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<tr>
<td>The emotional experience is out of proportion to the threat</td>
<td>Helps behavioral responses to threats</td>
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SYMPTOMS

• **Excessive Worry**
  – Cognitive activity associated with anxiety
  – A relatively uncontrollable sequence of negative, emotional thoughts that are concerned with possible future threats or danger.
  – Worriers are preoccupied with “self-talk”

• **Normal vs. Pathological Worry**
  – Distinctions hinges on quantity and quality of worrisome thoughts.

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SYMPTOMS

• **Panic Attack**
  – Sudden, overwhelming experience of terror or fright
  – Emotional response more focused than diffuse
  – More intense than anxiety
  – Has a sudden onset

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Why is a panic attack sometimes called a “false alarm”?

• Some think of panic as a normal fear response that is triggered at an inappropriate time.
Panic Attacks (continued)

- Described in terms of the situations in which they occur
  - **Cued**: expected or occurring only in the presence of a particular stimulus
  - **Unexpected**: appear without warning or expectation, as if “out of the blue”

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Phobias

- Defined as persistent, irrational, narrowly defined fears that are associated with a specific object or situation
- Avoidance is an important component of the definition.
- Reactions are irrational and unreasonable.

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Typical types of phobias

- Involve fear of specific object or situation
  - **Acrophobia**: fear of heights
  - **Claustrophobia**: fear of enclosed spaces
  - **Zoophobia**: fear of small animals
  - **Hemophobia**: fear of blood
  - **Aerophobia**: fear of flying on an airplane
  - **Agoraphobia**: fear of being in places where escape may be difficult
## SYMPTOMS

<table>
<thead>
<tr>
<th>OBSESSIONS</th>
<th>COMPULSIONS</th>
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| • Unwanted, anxiety-provoking thoughts  
• Thoughts may seem silly or crazy  
• Rarely act upon thoughts or impulses | • Compulsions cannot be resisted without distress  
• Reduce anxiety, but do not produce pleasure  
• Two most common forms: cleaning and checking |

## DIAGNOSIS

### Brief Historical Perspective
- Anxiety and abnormal fears did not play a prominent role in psychiatric classification systems during the second half of the nineteenth century.
- Freud and his followers were responsible for some of the first extensive clinical descriptions of pathological anxiety states.

### Contemporary Classification
- The DSM-IV-TR approach to classifying disorders is based primarily on descriptive features, rather than etiological hypotheses.
- Recognizes several specific subtypes:
  - Panic disorder
  - Three type of phobic disorders
  - Obsessive-compulsive disorder
  - Generalized anxiety disorder
  - Posttraumatic stress disorder
  - Acute stress disorder
**Specific Phobia**
- A "marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation."
- Exposure to phobic stimulus must be followed by an immediate fear response.
- The person must appreciate the fact that the fear is excessive or unreasonable.

**Social Phobia**
- Nearly identical to specific phobia but includes additional element of performance
- Afraid of or avoids social situations
  - Situations fall under two broad headings:
    - Performance Anxiety
    - Interpersonal interaction
- Fear of humiliation or embarrassment

**Agoraphobia**
- Most complex and incapacitating phobic disorder
- Fear of the marketplace
- Usually described as fear of public places
- Typical situations
  - Crowded streets and shops
  - Traveling on public transportation
• Contemporary Diagnostic Systems (DSM-IV-TR) (continued)

– Generalized Anxiety Disorder (GAD)
  • Excessive anxiety and worry
  • Trouble controlling the worries
  • Worries lead to significant distress
  • Worry must occur more days than not for a period of at least 6 months
  • Worries must be about different events or activities

– Panic Disorder
  • Recurrent, unexpected panic attacks
  • At least one of the attacks must be followed by a period of 1 month or more with persistent concerns about having additional attacks.
  • Divided into two subtypes, depending on the presence of absence of agoraphobia

– Obsessive-Compulsive Disorder
  • Most people who meet criteria exhibit both
  • Recognition that the obsessions or compulsions are excessive or unreasonable
  • Attempts to ignore, suppress, or neutralize the unwanted thoughts or impulses
Course and Outcome
- Anxiety disorders are often chronic conditions, some people do not recover.
- The frequency and intensity of panic attacks tend to decrease during middle age.
- Agoraphobic avoidance typically remains stable.
- OCD follows a pattern of improvement mixed with some persistent symptoms.

Prevalence
- Anxiety disorders are more common than any other form of mental disorder (Kessler et al., 2005).
- Specific phobias are most common.
- Social phobia is almost as common.
- Panic disorder and GAD affect approximately 3% of the population.
- OCD and agoraphobia without panic affect 1% of the population.
FREQUENCY

• Comorbidity
  – The symptoms of various anxiety disorders overlap considerably.
  – 50% of people who met criteria for one anxiety disorder also met criteria for at least one of form of anxiety or mood disorder (Brown & Barlow, 1992).

Do people who meet the criteria for both depression and anxiety suffer from two distinct syndromes?

• Approximately 60% of people diagnosed with major depression also qualify for a secondary diagnosis of some type of anxiety disorder.

FREQUENCY

• Gender Differences
  – Relapse rates: higher for women than men
  – Specific phobia: women are three times more likely than men
  – Panic disorder, agoraphobia (without panic disorder): women about twice as likely as men
  – Social phobia: more common among women
  – OCD: no significant gender differences (Torres et al., 2006)
FREQUENCY

• Anxiety Across the Life Span
  – Rates for anxiety disorder have been found to be lower when people over the age of 60 are compared to younger adults (Kessler et al., 2005).
  – Anxiety may increase as people move into their 70s and 80s.
  – The only type of anxiety disorder that begins in late life is agoraphobia.

FREQUENCY

• Cross Cultural Comparisons
  – People in Western societies often experience anxiety in relation to their work performance, whereas other societies may be more concerned about family issues or religious experiences.
  – Few epidemiological studies have attempted to collect cross-cultural data using standardized criteria.

CAUSES

• Adaptive and Maladaptive Fears
  – Evolutionary perspective often focused on evolutionary significance of anxiety and fear
    • Emotional responses are adaptive
      – Mobilize responses that help the person survive in the face of both immediate danger and long-range threats
Is there a unique causal pathway for each type of anxiety disorder?

- Unlikely, particularly in light of extensive overlap among the various subtypes.

CAUSES

- Social Factors
  - Causal patterns are complex.
  - Stressful life events, particularly involving danger and interpersonal conflict, can trigger the onset of certain kinds of anxiety disorders and depression.

Why do some negative life events lead to depression while others lead to anxiety?

- The nature of the event may be an important factor in determining the type of mental disorder that appears (McLaughlin & Hatsenbuehler, 2009; Updegraff & Taylor, 2000).
- For anxiety, an event(s) involving danger is more likely to have occurred.
- For depression, an event(s) involving severe loss (lack of hope) is more likely to
CAUSES

• Childhood Adversity
  – This concept includes experiences such as maternal prenatal stress, multiple maternal partner changes, parental indifference (neglect), and physical abuse.
  – Children who are exposed to higher levels of anxiety are more likely to develop anxiety disorders later in their lives (Moffitt et al., 2007; Phillips et al., 2005).

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Causes

• Attachment Relationships and Separation Anxiety
  – According to the attachment theory, anxiety is an innate response to separation, or the threat of separation, from the caretaker.
  – Several studies have found that people with anxiety disorders are more likely to have had attachment problems as children (Cassidy & Mohr, 2001; Dozies et al., 2008; Lewinsohn et al., 2008).

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CAUSES

• Psychological Factors
  – Learning Processes
  – Specific fears might be learned through classical conditioning.
    • The process by which fears are learned suggests that the process is guided by a module, or specialized circuit (Ohman & Mineka, 2001).
CAUSES

Psychological Factors (continued)

Human beings seem to be prepared to develop intense, persistent fears only to a select set of objects or situations.

Preparedness Model

Research results appear to suggest that conditioned responses to fear-relevant stimuli (e.g., spiders, snakes) are more resistant to extinction than those to fear-irrelevant stimuli (e.g., flowers).

Psychological Factors (continued)

Cognitive Factors

Perceptions, memory, and attention all influence reaction to events.

Play a crucial role in the development and maintenance of various types of anxiety disorders

Four aspects:
  - Perception of controllability
  - Catastrophic misinterpretation
  - Attentional biases
  - Thought suppression

Psychological Factors (continued)

Perception of control

People who feel that they are able to control events in their environments are less likely to show symptoms of anxiety than people who believe they are helpless.

Feelings of lack of control contribute to the onset of panic attacks among patients with panic disorder.
Causes

• Psychological Factors (continued)
  – Catastrophic Misinterpretation
  • Panic attacks can be precipitated by
    internal stimuli, such as bodily sensations,
    thoughts, or images.
  • People may misinterpret bodily sensations
    as a catastrophic event.
  • A person’s automatic, negative thoughts
    may also lead to behaviors that are
    expected to increase safety, when they are,
    in fact, counterproductive.

• Psychological Factors (continued)
  – Attention to Threat and Biased Information
    Processing
  • People prone to excessive worrying and
    panic are unusually sensitive to cues that
    signal the existence of future threats.
  • The recognition of danger cues triggers
    maladaptive, self-perpetuation cycle of
    cognitive processes that quickly spin out of
    control.
Is it useful to struggle actively against unwanted thoughts?

- Recent evidence suggest that trying to rid one’s mind of a distressing or unwanted thought can have the unintended effect of making the thought more intrusive.

GENETIC FACTORS

- Sheds light on the relationship between anxiety and depression
- Twin studies
- Virginia Adult Twin Study
- Anxiety appears to be modestly heritable between 20%-30%

CAUSES

- Biological Causes (continued)
  - Neurobiology (Pathway One)
    - Thalamus ➔ Amygdala ➔ Fight or Flight (behavioral responses coordinated through projections from the hypothalamus) ➔ Endocrine glands ➔ Autonomic Nervous System
CAUSES

- Biological Factors (Continued)
  - Neurobiology (Pathway Two)
    Thalamus → Visual Cortex → Amygdala
    (triggers an organized response to threat)

FIGURE 6-3
Two Pathways in the Brain That Detect Danger and Trigger Fear Responses

TREATMENT

- Anxiety disorders are one the areas of psychopathology in which clinical psychologists and psychiatrists are best prepared to improve the level of the client's functioning.
TREATMENT

• Psychological Interventions
  – Psychoanalytic psychotherapy
   • The emphasis in this type of treatment is on fostering insight regarding the unconscious motives that presumably lie at the heart of the patient’s symptoms.

TREATMENT

• Psychological Interventions (continued)
  – Systematic Desensitization
   • Initially developed for the purpose of treating anxiety disorders, especially phobias
   • The crucial feature of the treatment involves systematic maintained exposure to the feared stimuli (McNally, 2007; Rachman, 2002)
   • Progressive relaxation
   • A hierarchy of feared stimuli

TREATMENT

• Psychological Interventions (continued)
  – Situational Exposure: used to treat agoraphobic avoidance (Hahlweg et al., 2001)
   – The procedure involves the person repeatedly confronting the situations that have been previously avoided.
  – Interoceptive Exposure: aimed at reducing the person’s fear of internal, bodily sensations frequently associated with panic
TREATMENT

• Psychological Interventions (continued)
  – Relaxation Skills Training
    • Involves teaching the client to alternately tense and relax specific muscle groups while breathing slowly and deeply
    • This procedure is described to clients as an active coping skill.

TREATMENT

• Psychological Interventions (continued)
  – Breathing Retraining
    • Involves education about the physiological effects of hyperventilation and practice in slow breathing
    • The client learns to control breathing through repeated practice using muscles of the diaphragm, rather than the chest.

TREATMENT

• Psychological Interventions (continued)
  – Cognitive Therapy
    • Identify cognitions that are relevant to their problems
    • Recognize the relation between these thoughts and maladaptive emotional responses
    • Examine evidence that supports or contradicts these beliefs
    • Teach clients more useful ways of interpreting events (Schuyler, 1991)
TREATMENT

• Psychological Interventions (continued)
  – Cognitive Therapy
    • Helps clients to:
      – Review how they think about situations in their lives
      – Decatastrophize (What if the worst case scenario happened?)
    • Sessions are followed by extensive practice and homework assignments.

TREATMENT

• Biological Interventions
  – Antianxiety Medications
    • Most frequently used minor tranquilizers are from the class of drugs known as benzodiazepines
      – Benzodiazepines include Diazepam (Valium) and Alprazolam (Xanax)
    • These drugs reduce many symptoms of anxiety, especially vigilance and subjective somatic sensations.
    • They have less effect on worry and rumination.

TREATMENT

• Biological Interventions (continued)
  – Antianxiety Medications: Benzodiazepines
    • Shown to be effective in the treatment of GAD and social phobias
    • Not typically beneficial for patients with specific phobias or OCD
    • Many patients with panic disorder and agoraphobia relapse if they discontinue taking medication (Marks et al., 1993).
• Biological Interventions (continued)
  – Benzodiazepines
  • Side Effects
    – Sedation accompanied by mild psychomotor and cognitive impairments
    – Problems in attention and memory, especially among elderly
    – Potential for addiction – the most serious effect of benzodiazepines

• Biological Interventions (continued)
  – Antidepressant Medications
  • Selective Serotonin Reuptake Inhibitors (SSRIs) have become the preferred form of medication for treating all forms of anxiety
    – Include:
      » Fluxosetine (Prozac)
      » Fluvoamine (Luvox)
      » Sertaline (Zoloft)
      » Parosetine (Paxil)

• Biological Interventions (continued)
  – Antidepressant Medications: SSRIs
    • They are at least as effective as other, more traditional forms of antidepressants in reducing symptoms of various anxiety disorders (Anderson, 2006; Roy-Byrne & Cowley, 2002).
    • They have fewer unpleasant side effects and are safer to use.
    • Withdrawal reactions are less prominent.
    • Considered to be the first-line medication for treating panic disorder, social phobias, and OCD
TREATMENT

• Biological Interventions (continued)
  – Antidepressant Medications: Tricylic, Imipramine or Trofanil
  – Used less frequently than the SSRIs because they produce several unpleasant side effects:
    – Weight gain
    – Dry mouth
    – Overstimulation
    – Sensations such as feeling jittery, nervous, lightheaded

Treatment

• Biological Interventions (continued)
  – Antidepressant Medications: Tricylic
    – Clomipramine (Anafranil) has been used extensively in treating OCD.
    – Improvement is seen in 50% of patients receiving clomipramine but relapse is common if medication is discontinued.

Do psychological treatments have any advantages over medication for treatment of anxiety?

• In actual practice, anxiety disorders are often treated with a combination of psychological and biological procedures.
• The selection of specific treatment components depends on the specific group of presenting symptoms.