

Chapter 5 — Anxiety Disorders

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Handout 2: Anxiety

What distinguishes fear from anxiety?

- Fear is a state of immediate alarm in response to a serious, known threat to one's well-being
- Anxiety is a state of alarm in response to a vague sense of threat or danger
- Both have the same physiological features: increase in respiration, perspiration, muscle tension, etc.

Handout 3: Anxiety

- Is the fear/anxiety response useful/adaptive?
 - Yes, when the “fight or flight” response is protective
 - However, when it is triggered by “inappropriate” situations, or when it is too severe or long-lasting, this response can be disabling
 - Can lead to the development of anxiety disorders

Handout 4: Anxiety Disorders

- Most common mental disorders in the U.S.
 - In any given year, 18% of the adult population in the U.S. experience one or another of the six DSM-IV anxiety disorders
 - Close to 29% develop one of the disorders at some point in their lives
 - Only ~20% of these individuals seek treatment
- Most individuals with one anxiety disorder suffer from a second disorder, as well
- Anxiety disorders cost \$42 billion each year in health care, lost wages, and lost productivity

Handout 9: GAD: The Sociocultural Perspective

- According to this theory, GAD is most likely to develop in people faced with social conditions that truly are dangerous

- Research supports this theory (example: Three Mile Island in 1979)
 - One of the most powerful forms of societal stress is poverty
 - Why? Run-down communities, higher crime rates, fewer educational and job opportunities, and greater risk for health problems
- As would be predicted by the model, there are higher rates of GAD in lower SES groups

Handout 11: GAD: The Sociocultural Perspective

- Although poverty and other social pressures may create a climate for GAD, other factors are clearly at work
 - How do we know this?
 - Most people living in dangerous environments do not develop GAD
 - Other models attempt to explain why some people develop the disorder and others do not...

Handout 16: GAD: The Psychodynamic Perspective

- Psychodynamic therapies
 - Overall, controlled research has not consistently shown that psychodynamic approaches are helpful in treating cases of GAD
 - Short-term dynamic therapy may be beneficial in some cases

Handout 17: GAD: The Humanistic Perspective

- Theorists propose that GAD, like other psychological disorders, arises when people stop looking at themselves honestly and acceptingly
- This view is best illustrated by Carl Rogers's explanation:
 - Lack of "unconditional positive regard" in childhood leads to "conditions of worth," (harsh self-standards)
 - These threatening self-judgments break through and cause anxiety, setting the stage for GAD to develop

Handout 18: GAD: The Humanistic Perspective

- Therapy based on this model is "client-centered" and focuses on creating an accepting environment where clients can "experience" themselves
 - Although case reports have been positive, controlled studies have only sometimes found client-centered therapy to be more effective than placebo or no therapy

- Only limited support has been found for Rogers's explanation of causal factors

Handout 20: GAD: The Cognitive Perspective

- Theory: GAD is caused by maladaptive assumptions
 - Albert Ellis identified basic irrational assumptions:
 - It is necessary for humans to be loved by everyone
 - It is catastrophic when things are not as one wants them to be
 - If something is fearful, a person should be terribly concerned and dwell on the possibility that it will occur
 - One should be competent in all domains to be a worthwhile person
- When these assumptions are applied to everyday life, GAD may develop

Handout 21: GAD: The Cognitive Perspective

- Aaron Beck is another cognitive theorist
 - Those with GAD hold unrealistic silent assumptions that imply imminent danger:
 - Any strange situation is dangerous
 - A situation/person is unsafe until proven safe
- Research supports the presence of these types of assumptions in GAD, particularly about dangerousness

Handout 22: GAD: The Cognitive Perspective

- What kinds of people are likely to have exaggerated expectations of danger?
 - Those whose lives have been filled with unpredictable negative events
 - To avoid being “blindsided,” they try to predict events; they look everywhere for danger (and therefore see danger everywhere)
 - Theory still under investigation

Handout 23: GAD: The Cognitive Perspective

- Second-Generation Cognitive Explanations
 - In recent years, two promising explanations have emerged:
 - Metacognitive theory
 - Developed by Wells; holds that the most problematic assumptions in GAD are the individual's beliefs about worrying itself
 - Avoidance theory
 - Developed by Borkovec; holds that worrying serves a “positive” function for those with GAD by reducing unusually high levels of bodily arousal
 - Both theories have received considerable research support

Handout 24: GAD: The Cognitive Perspective

- Two kinds of cognitive therapy:
 - Changing maladaptive assumptions
 - Based on the work of Ellis and Beck
 - Helping clients understand the special role that worrying plays, and changing their views about it

Handout 28: GAD: The Biological Perspective

- Theory holds that GAD is caused by biological factors
 - Supported by family pedigree studies
 - Blood relatives more likely to have GAD (~15%) than general population (~6%)
 - The closer the relative, the greater the likelihood
 - Issue of shared environment

Handout 29: GAD: The Biological Perspective

- GABA inactivity
 - 1950s—Benzodiazepines (Valium, Xanax) found to reduce anxiety
 - Why?
 - Neurons have specific receptors (lock and key)
 - Benzodiazepine receptors ordinarily receive gamma-aminobutyric acid (GABA, a common NT in the brain)
 - GABA is an inhibitory messenger; when received, it causes a neuron to stop firing

Handout 30: GAD: The Biological Perspective

- In the normal fear reaction:
 - Key neurons fire more rapidly, creating a general state of excitability experienced as fear or anxiety
 - A feedback system is triggered; brain and body activities work to reduce excitability
 - Some neurons release GABA to inhibit neuron firing, thereby reducing experience of fear or anxiety
 - Problems with the feedback system are believed to cause GAD
 - Possible reasons: GABA too low, too few receptors, ineffective receptors

Handout 31: GAD: The Biological Perspective

- Promising (but problematic) explanation

- Other NTs also bind to GABA receptors
- Research conducted on lab animals raises question: is “fear” really fear?
- Issue of causal relationships
 - Do physiological events CAUSE anxiety? How can we know? What are alternative explanations?

Handout 36: Phobias

- We all have some fears at some points in our lives; this is a normal and common experience
 - How do phobias differ from these “normal” experiences?
 - More intense fear
 - Greater desire to avoid the feared object or situation
 - Distress that interferes with functioning

Handout 41: Social Phobias

- Severe, persistent, and unreasonable fears of social or performance situations in which embarrassment may occur
 - May be narrow—talking, performing, eating, or writing in public
 - May be broad—general fear of functioning inadequately in front of others
 - In both cases, people rate themselves as performing less adequately than they actually did

Handout 44: What Causes Phobias?

- All models offer explanations, but evidence tends to support the behavioral explanations:
 - Phobias develop through conditioning
 - Once fears are acquired, they are continued because feared objects are avoided
 - Behaviorists propose a classical conditioning model...

Handout 46: What Causes Phobias?

- Other behavioral explanations
 - Phobias develop through modeling
 - Observation and imitation
 - Phobias are maintained through avoidance
 - Phobias may develop into GAD when a person acquires a large number of phobias

- Process of stimulus generalization: responses to one stimulus are also elicited by similar stimuli

Handout 50: What Causes Phobias?

- A behavioral-evolutionary explanation
 - Theorists argue that there is a species-specific biological predisposition to develop certain fears
 - Called “preparedness”: humans are more “prepared” to develop phobias around certain objects or situations
 - Model explains why some phobias (snakes, heights) are more common than others (grass, meat)
 - Unknown if these predispositions are due to evolutionary or environmental factors

Handout 51: How Are Phobias Treated?

- Surveys reveal that ~19% of those with specific phobia and 25% of those with social phobia currently are in treatment
- Each model offers treatment approaches
 - Behavioral techniques (exposure treatments) are most widely used, especially for specific phobias
 - Shown to be highly effective
 - Fare better in head-to-head comparisons than other approaches
 - Include desensitization, flooding, and modeling

Handout 52: Treatments for Specific Phobias

- Systematic desensitization
 - Technique developed by Joseph Wolpe
 - Teach relaxation skills
 - Create fear hierarchy
 - Sufferers learn to relax while facing feared objects
 - Since relaxation is incompatible with fear, the relaxation response is thought to substitute for the fear response
 - Several types:
 - *In vivo* desensitization (live)
 - Covert desensitization (imaginal)

Handout 53: Treatments for Specific Phobias

- Other behavioral treatments:
 - Flooding

- Forced nongradual exposure
- Modeling
 - Therapist confronts the feared object while the fearful person observes
- Clinical research supports each of these treatments
 - The key to success is ACTUAL contact with the feared object or situation

Handout 54: Treatments for Social Phobias

- Treatments only recently successful
 - Two components must be addressed:
 - Overwhelming social fear
 - Address behaviorally with exposure
 - Lack of social skills
 - Social skills and assertiveness trainings have proved helpful

Handout 55: Treatments for Social Phobias

- Unlike specific phobias, social phobias respond well to medication (particularly antidepression drugs)
- Several types of psychotherapy have proved at least as effective as medication
 - People treated with psychotherapy are less likely to relapse than people treated with drugs alone
 - One psychological approach is exposure therapy, either in an individual or group setting
 - Cognitive therapies also have been widely used

Handout 56: Treatments for Social Phobias

- Another treatment option is social skills training, a combination of several behavioral techniques to help people improve their social functioning
 - Therapist provides feedback and reinforcement
- No single treatment approach is consistently helpful or superior to the others
 - Results from using a combination of approaches seem to be most encouraging

Handout 57: Panic Disorder

- Panic, an extreme anxiety reaction, can result when a real threat suddenly emerges
- The experience of “panic attacks,” however, is different

- Panic attacks are periodic, short bouts of panic that occur suddenly, reach a peak, and pass
- Sufferers often fear they will die, go crazy, or lose control
- Attacks happen in the absence of a real threat

Handout 59: Panic Disorder

- Anyone can experience a panic attack, but some people have panic attacks repeatedly, unexpectedly, and without apparent reason
 - Diagnosis: panic disorder
 - Sufferers also experience dysfunctional changes in thinking and behavior as a result of the attacks
 - Example: sufferer worries persistently about having an attack; plans behavior around possibility of future attack

Handout 61: Panic Disorder

- Often (but not always) accompanied by agoraphobia
 - From the Greek “fear of the marketplace”
 - Afraid to leave home and travel to locations from which escape might be difficult or help unavailable
 - Intensity may fluctuate
 - There has only recently been a recognition of the link between agoraphobia and panic attacks (or panic-like symptoms)

Handout 63: Panic Disorder: The Biological Perspective

- In the 1960s, it was recognized that people with panic disorder were not helped by benzodiazepines, but were helped by antidepressants
 - Researchers worked backward from their understanding of antidepressant drugs

Handout 64: Panic Disorder: The Biological Perspective

- What biological factors contribute to panic disorder?
 - NT at work is norepinephrine
 - Irregular in people with panic attacks
 - Research suggests that panic reactions are related to changes in norepinephrine activity in the locus ceruleus
 - Although norepinephrine is clearly linked to panic disorder, what goes wrong isn't exactly understood
 - May be excessive activity, deficient activity, or some other defect

- Other NTs and brain circuits seem to be involved

Handout 65: Panic Disorder: The Biological Perspective

- It is also unclear why some people have such abnormalities in norepinephrine activity
 - **Inherited biological predisposition** is one possible reason
 - If so, prevalence should be (and is) greater among close relatives
 - Among monozygotic (MZ, or identical) twins = **24%**
 - Among dizygotic (DZ, or fraternal) DZ twins = **11%**
 - Issue is still open to debate

Handout 66: Panic Disorder: The Biological Perspective

- Drug therapies
 - Antidepressants are effective at preventing or reducing panic attacks
 - Function at norepinephrine receptors in the panic brain circuit
 - Bring at least some improvement to 80% of patients with panic disorder
 - ~50% recover markedly or fully
 - Require **maintenance** of drug therapy; otherwise relapse rates are high
 - Some benzodiazepines (especially Xanax [alprazolam]) have also proved helpful

Handout 67: Panic Disorder: The Biological Perspective

- Drug therapies
 - Both antidepressants and benzodiazepines are also helpful in treating panic disorder with agoraphobia
 - Break the cycle of **attack**, **anticipation**, and **fear**
- It is important to note that when drug therapy is stopped, **symptoms may return**
 - Combination treatment (medications + behavioral exposure therapy) may be more effective than either treatment alone

Handout 69: Panic Disorder: The Cognitive Perspective

- Misinterpreting bodily sensations
 - Panic-prone people may be overly sensitive to certain **bodily sensations** and may misinterpret them as signs of a medical catastrophe; this leads to panic
 - Why might some people be prone to such misinterpretations?
 - Experience more frequent or intense bodily sensations
 - Poor coping skills

- Lack of social support
- Unpredictable childhoods
- Overly protective parents

Handout 72: Panic Disorder: The Cognitive Perspective

- Cognitive therapy
 - May also use “biological challenge” procedures to induce panic sensations
 - Induce physical sensations which cause feelings of panic:
 - Jump up and down
 - Run up a flight of steps
 - Practice coping strategies and making more accurate interpretations

Handout 73: Panic Disorder: The Cognitive Perspective

- Cognitive therapy is often helpful in panic disorder
 - 85% of treated patients are panic-free for two years compared with 13% of control subjects
 - Only sometimes helpful for panic disorder with agoraphobia
 - At least as helpful as antidepressants
- Combination therapy may be most effective
 - Still under investigation

Handout 74: Obsessive-Compulsive Disorder

- Made up of two components:
 - Obsessions
 - Persistent thoughts, ideas, impulses, or images that seem to invade a person’s consciousness
 - Compulsions
 - Repeated and rigid behaviors or mental acts that people feel they must perform to prevent or reduce anxiety

Handout 75: Obsessive-Compulsive Disorder

- Classified as an anxiety disorder because obsessions cause anxiety while compulsions are aimed at preventing or reducing anxiety
 - Anxiety rises if obsessions or compulsions are avoided
- ~2% of U.S. population has OCD in a given year; between 2% and 3% over a lifetime

- Ratio of women to men is 1:1
- It is estimated that more than 40% of those with OCD seek treatment

Handout 79: What Are the Features of Obsessions and Compulsions?

- Compulsions
 - “Voluntary” behaviors or mental acts
 - Feel mandatory/unstoppable
 - Person may recognize that behaviors are irrational
 - Believe, though, that catastrophe will occur without if they don’t perform the compulsive acts
 - Performing behaviors reduces anxiety
 - ONLY FOR A SHORT TIME!
 - Behaviors often develop into rituals

Handout 85: OCD: The Psychodynamic Perspective

- The battle between the id and the ego
 - Three ego defenses mechanisms are common:
 - Isolation: disown disturbing thoughts
 - Undoing: perform acts to “cancel out” thoughts
 - Reaction formation: take on lifestyle in contrast to unacceptable impulses
 - Freud believed that OCD was related to the anal stage of development
 - Period of intense conflict between id and ego
 - Not all psychodynamic theorists agree

Handout 88: OCD: The Behavioral Perspective

- Learning by chance
 - People happen upon compulsions randomly:
 - In a fearful situation, they happen to perform a particular act (washing hands)
 - When the threat lifts, they associate the improvement with the random act
 - After repeated associations, they believe the compulsion is changing the situation
 - Bringing luck, warding away evil, etc.
 - The act becomes a key method to avoiding or reducing anxiety

Handout 90: OCD: The Behavioral Perspective

- Behavioral therapy

- **Exposure and response prevention (ERP)**
 - Clients are repeatedly exposed to anxiety-provoking stimuli and prevented from responding with compulsions
 - Therapists often model the behavior while the client watches
 - **Homework** is an important component
 - Treatment is offered in individual and group settings
 - Treatment provides significant, long-lasting improvements for most patients
 - However, as many as 25% fail to improve at all and the approach is of limited help to those with obsessions but no compulsions

Handout 92: OCD: The Cognitive Perspective

- Overreacting to unwanted thoughts
 - To avoid such negative outcomes, they attempt to **neutralize** their thoughts with actions (or other thoughts)
 - Neutralizing thoughts/actions may include:
 - Seeking reassurance
 - Thinking “good” thoughts
 - Washing
 - Checking

Handout 98: OCD: The Biological Perspective

- Two additional lines of research:
 - Role of NT **serotonin**
 - Evidence that serotonin-based antidepressants reduce OCD symptoms
 - **Brain abnormalities**
 - OCD linked to orbital region of frontal cortex and caudate nuclei
 - Frontal cortex and caudate nuclei compose brain circuit that converts sensory information into thoughts and actions
 - Either area may be too active, letting through troublesome thoughts and actions