Anxiety Disorders: Diagnosing & Conceptualizing

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Anxiety Disorders

- Feeling of uneasiness
- Brings people into med docs and then psychotherapists
- Definite form of human suffering

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Anxiety Disorders

- Remember that your assumptions of pathology affect
  - how you view what is pathological
  - in this case, what is pathological anxiety
  - How do you think it should be dealt with?
    - Altered
    - Reduced
    - Removed
    - Accepted

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Anxiety Disorders

- Anxiety has been discussed by all theorists
  - Freud, Adler, Horney, Rogers, Skinner, etc.
- Some question whether anxiety is different from other disorders
  - e.g., depression
- Anxiety appears to be part of almost all of the disorders at some level
  - Overlap problem

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Anxiety

- Your task
  - memorize criteria
  - conceptualize the disorder
- My task: teach you the ins and outs of the disorder
  - Clarify the DSM when there are questions
  - Help learn how it "really looks" in clinical practice"
  - Try to help with overlap
  - Not to go over all the criteria, per se (may do some of this)

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Anxiety Specified

- **Anxiety** is defined as uneasiness stemming from the anticipation of danger
  - distinguished from *fear* - a reaction to a specific threat from the real, physical world
- For a person to be diagnosed as having anxiety:
  - the anxiety must be out of proportion to the perceived threat
  - the anxiety is recognized by the individual seeking treatment to be excessive or unreasonable

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Anxiety

- Three components of anxiety
  1. **Physical** component
     - increased heart rate, queasiness/ upset stomach (due to stopping of digestion), rapid breathing
  2. **Cognitive** Component
     - thoughts are described as "fast", "irrational"
  3. **Behavioral** component
     - see a lot of avoidance behavior
     - e.g.: people avoid studying because of anxiety
     - other things people do include self-medicating with alcohol and drugs

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Anxiety

- Anxiety is an evolutionary useful feeling
  - part of the flight or fight response
  - useful to have a response of energizing to get out of a situation
  - sometimes this gets in our way - not so adaptive
- Encourage you to think about anxiety as being on a continuum of health
  - Likely that some avoidance is just fine
  - When become less effective – may be problematic (pragmatism)

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Anxiety

- **Escape or Avoidance learning**
  - Mowrer's 2 Factor theory of learning
  - classical conditioning of the stimuli with anxiety occurs
  - operant learning - avoidance learning -- anxiety goes away
    - this is negative reinforcement - remove a stimulus and behavior is increased

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Contextualizing Anxiety

- Are there some cultural groups where this may be more or less acceptable
- Is it more likely to affect men or women in some situations as opposed to others
- What is going on in the person's life
  - May be causing other family/relationship probs
  - May be facilitated by family/relationship probs
- How does the person understand the anxiety
  - Is it tolerable…ever?

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Case conceptualization with anxiety

- From your theoretical position
- Need to
  - Identify source of pathology (Where does this come from?)
    - Intrapersonal?
    - Interpersonal?
    - Developmental?
    - Learned?
    - Cognitive?
    - Underlying pathology that is symbolically represented?

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Case conceptualization with anxiety

- Identify mechanism of change by theory
  - examine relevance of theory to this client
    - look for problem with client
  - identify steps of behavioral change
  - apply to client and identify behaviors
  - relate these behavior to each other given theory
  - attempt to alter behavior
  - ASSESS for changes in behaviors

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The Paul question and anxiety

- *"What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" (Paul, 1969, p. 44)*
- What are these anxiety behaviors, for this person, in these circumstances (culture, family, gender, etc.)?
- How do I bring about change with these behaviors for this person?

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Types of Anxiety disorders

- Panic Disorder with Agoraphobia
- Panic Disorder without Agoraphobia
- Agoraphobia without hx of Panic
- Simple (or Specific) Phobia
- Social Phobia
- Obsessive Compulsive Disorder
- Acute Stress Disorder
- Post Traumatic Stress Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder due to Medical Condition
- Substance-Induced Anxiety Disorder
- Anxiety Disorder NOS

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Panic Disorder

- profound episodes of terror
- last from a few minutes to an hour (or more)
- symptoms:
  - can't breathe, smothering, heart palpitations, trembling, shaking, dizziness (feeling faint), heart racing, feel loss of control, feel like you're going to die; may feel like a heart attack
- appear to come out nowhere to the person, there is no identifiable cause to the attack to the person

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Panic

- May have recurrent episodes
- OR have one or more followed by at least one month of persistent fear of having another attack, worry about implications, change in behavior
- relatively common in college students

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Panic

- two types of panic disorder
  - with agoraphobia - afraid to go out of the house
    - **agoraphobia** - fear of being in public places from which escape might be difficult or help not available in case of incapacitation
  - without agoraphobia

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Panic

- Panic with Agoraphobia
- Why would this occur?
  - person may have had panic attacks and may be restricting where they will go
  - there is a gradual closing in
    - only leave the house with "safe person" or never leave at all

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Panic Differentials

- you must rule-out certain physiological abnormalities which symptomalogically look a lot like panic disorder
  - R/O - hyperthyroidism
    - may mimic panic attacks feeling
  - R/O - cardiac problems
    - heart valve problem due to congenital abnormality - leads to panic symptoms in some people
      - mitral valve prolapse
      - arrhythmias
      - superventricular tachycardia -

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Panic Differentials

- R/O – seizure disorders
- R/O - Amphetamine intoxication
  - you must rule out a chemical cause
- R/O other substances
  - Caffeine, cocaine

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Panic

- Agoraphobia without History of Panic Disorder
  - usually person has had *limited symptom panic attacks*
  - not enough to be diagnosed as having panic disorder

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Panic Treatment

- Pharmacological
  - SSRIs
  - Benzodiazapines
    - Fast acting, for acute attacks

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Panic Treatment

- Psychological
  - Relaxation
  - Cognitive
  - Exposure
  - Education
    - Great deal of variance accounted for initially by explaining that person is not going to die
    - Need longer term exposure, too

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Panic Treatment

- Psychological and Pharmacological equally effective
  - If applied separately
- Psychological and Pharmacological combinations
  - Worse outcome than separate (w/ BZD)
  - Why would this occur?

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Post Traumatic Stress Disorder (PTSD)

- group of symptoms occurring after experience of an event considered outside the range of normal human experience -- extremely traumatic
  - e.g., wars, earthquakes/natural disasters, concentration camps
  - rape and sexual abuse
- R/O Adjustment Disorder with Anxious Mood

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PTSD

- **Symptoms/Behaviors**
  - Following experience of trauma
    - Re-experience
    - Avoidance/Numbing
    - Increased arousal

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PTSD

- Persistent **re-experiencing** of the traumatic event
  - dreaming, nightmares, flashbacks, constant memories
  - stimuli or situations will bring memories back

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PTSD

- **Avoidance** of stimuli associated with trauma
  - may avoid situations that bring up feelings
  - may not be able to avoid some of these situations,
    - person learn how not to feel anything anymore
    - numbing
    - this is a temporarily adaptive response
  - can cut self off from feeling or off from thoughts
    - may have "amnesia" of event
  - engage in physical or emotional avoidance

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PTSD

- **Increased arousal**
  - sleep problems
  - irritable
  - hypervigilance
    - incredibly sensitive to things going on around them
    - can be viewed as an adaptive response
  - exaggerated startle response
  - difficulty concentrating

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PTSD

- symptoms may begin right after trauma for some people
- Durations
  - Less than 3 months: acute
  - More than 3 months: chronic
- for others it may take longer
  - with delayed onset - after six months
- often see problems with drug or alcohol abuse -- self medication

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Acute Stress Disorder

- brief PTSD symptoms (2 days to 1 month)
- R/O Adjustment Disorder

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Treatments for PTSD

- Pharmacological
  - Treat depressive symptoms
  - Treat anxiety
  - Not generally effective by itself
- Psychological
  - Cognitive processing
  - Exposure therapies
  - Acceptance based strategies

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PTSD Treatment:

- Stress Inoculation Training
- Prolonged Exposure
- Cognitive Processing Therapy

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Stress Inoculation Training (SIT)

- giving client a sense of mastery over fears by teaching variety of coping skills
- flexible approach and can be used in individual or group settings.
  - Phase I: Educational
    - helps client understand the origin and nature of fear and anxiety
    - make sense of the trauma and its aftermaths.
    - social learning theory explanation
      - three channels.
      - the physical or autonomic channel
      - the behavioral or motoric channel
      - the cognitive channel.

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Stress Inoculation Training (SIT)

- Phase II: Training of coping skills.
  - At least two of the coping skills for each of the three channels are taught.
  - Daily log is maintained regarding each target fear.
  - Muscle relaxation and breathing control are the skills most often taught for coping with fear.
  - Other skills being Covert Modeling, Role-Playing, Thought Stopping, and Guided Imagery.

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Prolonged Exposure

- PTSD results from inadequate processing of the trauma stimuli, responses, and the meaning associated with them.
- Tx requires activation of the fear memory and incorporation of new information incompatible with the current fear structure, so that new memories are formed.
- Memory is activated through exposure techniques.

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Prolonged Exposure

- Recall assault in detail and memory is processed until it is no longer intensely painful
- *In vivo* exposure to feared (but objectively safe) stimuli.
  - Hierarchy of feared stimuli is generated
  - Scene is relived in imagination, and described aloud in present tense
  - Descriptions are repeated several times each session (60 min) and tape recorded
- More effective than SIT at 31/2 months follow-up.

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Cognitive Processing Therapy:

- To treat the specific Sx of PTSD in victims of sexual assault
- 12-session structured therapy program based on Information Processing Model of PTSD
- combines main ingredient of exposure-based therapies with the cognitive restructuring
  - Cognitive component: challenges specific cognitions disrupted as a result of assault

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Cognitive Processing Therapy

- Exposure-based therapy:
  - activate memory by either information about the stimuli, responses, or meaning
- Systematic Desensitization to the traumatic memory in safe environment
  - new information must be provided that is incompatible with the current fear structure in order for a new memory to be formed

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Specific (aka Simple) Phobias

- fears related to specific kind of situations or objects
- generally this fear is considered irrational by self and others
- the fear is way out of perspective, or proportion, to the real danger
- **simple phobia** - refers to persistent fear of one or two objects
  - common simple phobias - animals (snakes, dogs, spiders), heights (acrophobia), blood, closed spaces (claustrophobia)

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Social phobia

- type of specific phobia
- fear related to being in social situations where you might be evaluated by others
  - public speaking falls here
- Generalized type
  - Most social situations
- R/O? – AvPD
  - How is this different?
  - Can be co-morbid

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Social phobia

- There is a definite behavioral component of avoidance
  - avoid feared stimulus
  - avoidance, then, is reinforced
- the diagnosis can only be given if the avoidant behavior interferes with the person's normal routine, usual activities, or relationships with others, or if there is marked distress about having the fear

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Explanation of phobias

- not good at finding biological explanation
- popular explanations include psychoanalytic and behavioral
  - a. **psychoanalytic** - phobias are some kind of displaced anxiety
    - some id impulse is so threatening that the ego displaces anxiety onto something else

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Explanation of phobias

- b. **behavioral** theories –
  - Mowrer's 2 factor learning theory
    - Classically condition to feared stimulus, then
    - avoidance is negatively reinforced (as operant)

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Phobia treatments

- exposure treatment - most important factor in the treatment of phobias
  - systematic desensitization - develop hierarchy around the feared situation
    - rank stages from lowest levels of anxiety to highest
    - teach relaxation techniques
    - have the client relax while they imagine the frightening situations
    - gradually desensitize to feared stimulus
    - this is imaginary

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Phobia treatments

- flooding - real life
  - put person into situation and don't let them escape
  - person is flooded with anxiety, gradually extinguish the fear
  - present CS without the UCS so that CR decreases
- both flooding and systematic desensitization have been shown to be effective
  - the key point in exposure is that you don't let the client escape during their anxiety or they will be negatively reinforced

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Obsessive Compulsive disorder

- characterized by obsessions and compulsions
  - **obsessions** which are persistent thoughts, impulses, or ideas
    - person recognizes this in her or his mind, but they can't control the thoughts
    - not same as delusions, by definition
    - e.g., images of unacceptable sexual behaviors, thoughts of dying, belief that they are somehow contaminated

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OCD

- **Compulsions** are behaviors that are repetitive and intentional or rituals
  - performed in response to obsession in to relieve the anxiety
    - e.g., checking behaviors, hand washing (give example of door closing and breathing) there is a magical quality to controlling the obsessive thoughts
  - "compulsive gambling", "compulsive eating" are not compulsions
    - these are "pleasurable" to people while engaging in them

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Theories of OCD

- Behavioral theory
  - Two factor learning theory
  - classically conditioned
  - maintained by avoidance behavior (operant)
- Biological explanation
  - involves the neurotransmitter serotonin
  - postulated that there is a problem with serotonin
  - this has lead to the use of antidepressants for the treatment of OCD

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Treatment of OCD

- Behavioral Treatment
  - most common treatment
  - *in vivo treatment*
  - **Exposure with response prevention**
    - must prevent the avoidance behavior or you will only increase the cycle
  - Psychoanalytic criticisms: symptom substitution
    - Evidence?

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Generalized Anxiety Disorder (GAD)

- Characterized by chronic, unrealistic and excessive anxiety about 2 or more areas of functioning
  - key is chronic, excessive
  - 2 or more areas
  - for **6** months
- These are the worriers
- High utilizers of primary care and psychologists

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GAD

- see motor tension, hyperactive nervous system (sweating, dry mouth), concentration problems, hypervigilance, sleeping problems
- GAD is one of the most common diagnosis in outpatient treatment settings
- to be diagnosed with GAD it must interfere with normal functioning
- also see drug and alcohol abuse to control the anxiety

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Treatments for GAD

- Pharmacological
  - Treat anxiety with benzodiazapines and buspar
  - Not effective by itself
- Psychological
  - Cognitive therapies
  - Behavioral therapies (relaxation, behavioral rehearsal)
  - Acceptance based strategies

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Other types of Anxiety Disorders

- Need to be able to rule these out
- Anxiety Disorder due to Medical Condition
  - Look at problems described in panic
- Substance-Induced Anxiety Disorder
  - Need to make sure not treating a biological problem with psychological intervention
- Anxiety Disorder NOS
  - Just doesn't seem to fit in the other areas
  - OK to use, but be sure not in another category
  - NOS - called the trashcan for disorders

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DISSOCIATIVE DISORDERS

- Group of disorders based on the phenomenon of dissociation - separation of part of the person's consciousness or identity from the central identity
- Conceptualized as being on a continuum from day dreaming to highway hypnosis to pathological dissociation
- Common with extreme anxiety

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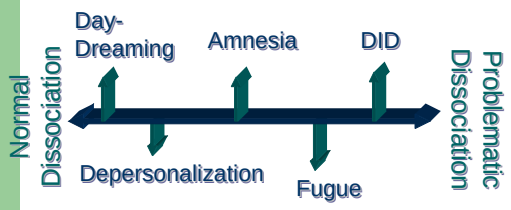
Continuum of Dissociative States



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Types of Dissociative Disorders

- 1. Dissociative (psychogenic) amnesia
- 2. Dissociative (psychogenic) fugue
- 3. Depersonalization Disorder
- 4. Dissociative Identity Disorder (formerly MPD)

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Theories about dissociation

- psychodynamic - extreme repression
- behavioral - coping mechanism that is an avoidance move
  - DID may be reverting to behavior repertoires that had reinforcing properties for the individual

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Adaptive features

- escape from reality that is too overwhelming to deal with, "go off into their own world"
  - these occur on a continuum from none to severe
- Think about when things get extremely anxiety provoking

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Dissociative Identity Disorder (formerly *MPD*)

- Rule Out the following
  - schizophrenia -- this is an important distinction to make
  - bipolar disorder -- scattered thoughts of mania
  - depression (with psychotic features)
  - borderline personality disorder

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Fugue and Amnesia

- Travel or memory loss
- R/O?

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Depersonalization Disorder

- sense that you are detached from your body and mind
- don't feel like your self
- like observing self, outside of self
- sense of lack of reality

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Depersonalization Disorder

- accompanied by derealization - whole world seems unreal
  - loss of sense of reality
  - not "just spacing out" - this is very distressing to the person involved
- relatively common among the Dissociative dis and Anxiety dis

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