Anxiety Disorders

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Understanding Anxiety

- Physical tension and apprehension
- Negative mood state
- Future oriented
- Enhances physical and intellectual performance
Lang (1969) offered the *Three System Model of Anxiety*

- **Physiological**: Physical changes in body
- **Behavioral**: Actions/Lifestyle
- **Cognitions**: Thoughts and images

![Graph showing the relationship between performance efficiency and anxiety level.](image)
Fear | Anxiety
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Basic emotion | Blend of different emotions
Reaction to current danger | Future-oriented state
Fight or flight response | Arousal - sense of unpredictability

Anxiety Disorders

“Group of mental disturbances with anxiety as a central or core symptom”

- Blanket term
  - several different forms of fear, phobia and nervous conditions
  - prevents pursuing normal routines
Psychological Arousal

- Irritability
- Sensitivity to noise
- Restlessness
- Poor concentration
- Worrying thoughts

Autonomic Arousal

- **Gastro-intestinal**
  - Dry mouth
  - Difficulty in swallowing
  - Frequent or loose motions
- **Respiratory**
  - Constriction in chest
  - Difficulty in inhaling
- **Cardio-vascular**
  - Palpitations
  - Discomfort in chest
- **Muscle Tension**
  - Tremor
  - Headache
- **Hyperventilation**
  - Dizziness
  - Feeling of breathlessness
Anxiety Disorders: Prevalence in the US

- Most common mental illness in the US
- 18.1% of adult US population

What do you think is the prevalence of these disorders in Pakistan?

- WHY?

- Factors.....
Factors positively associated with anxiety and depressive disorders in Pakistan were:
- female sex,
- middle age,
- financial difficulty,
- Arguments with husbands and relational problems with in-laws

Overall prevalence of anxiety and depressive disorders in the community population was 34% (range higher for women than men).

Types Of Anxiety Disorders
Types Of Anxiety Disorders

- Panic Disorder with/without Agoraphobia
- Phobia
- Obsessive Compulsive Disorder (OCD)
- Generalized Anxiety Disorder (GAD)
- Post-traumatic Stress Disorder (PTSD)

I. Panic Attack
- discrete period of intense fear or discomfort, in which four or more of the following symptoms develop abruptly and reach a peak within 10 minutes:
  1. Palpitations
  2. Sweating
  3. Trembling
  4. Sensations of shortness of breath
  5. Feeling of choking
  6. Chest pain
  7. Nausea
  8. Feeling dizzy
- A Panic attack can occur in a variety of anxiety disorders
  - e.g.
    - Panic disorder
    - Social phobia
    - Specific phobia
    - Posttraumatic stress disorder

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Panic Attacks

<table>
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<tr>
<th>Unexpected (Uncued) Panic Attacks</th>
<th>• Onset of panic attack is not associated with a situational trigger (i.e., occurring spontaneously).</th>
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|Situationally bound (Cued) Panic Attacks | • Panic attack almost invariably occurs immediately on exposure to or in anticipation of the situational cue or trigger
|..................................................................................| • (i.e., seeing a snake). |
|Situationally predisposed (possibility of) Panic Attacks | • Occurs on exposure to cue or trigger but are not invariably associated with the cue and do not necessarily occur after the exposure
|..................................................................................| • (e.g., attacks are more likely to occur while driving but there are times when individual drives but does not have a panic attack). |
I. Panic Disorder

- At least two unexpected (uncued) panic attacks are required for the diagnosis of panic disorder
- also have situationally predisposed or situationally bound panic attacks.

Agoraphobia

- Anxiety/avoidance of places
- escape might be difficult/embarrassing
- involve clusters of situations that include
  - Being outside the home alone;
  - being in a crowd or standing in line
**Diagnostic Criteria for Panic Disorder With/ Without Agoraphobia**

- Both (a) and (b)
  - a) Recurrent unexpected Panic Attacks
  - b) At least one of the attacks has been followed by
    - Persistent concern about having additional attacks
    - Worry about the implications of the attack or its consequences
      - (e.g., losing control, having a heart attack, "going crazy")
    - A significant change in behavior related to the attacks
- The presence / absence of agoraphobia

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**Panic Disorder**

- With Agoraphobia: Will include avoidance of special situations/places
- Without Agoraphobia: Will not necessarily include avoidance of special situations/places
Panic Disorder

- Mean age of onset
  - between 25 and 29
- Women are twice more likely to be afflicted

Etiology of Panic Disorders
Panic Disorders: Neurotransmitter Theory

- Poor regulation of serotonin, (GABA) and non-epinephrine in the limbic system

![The Limbic System]

Panic Disorders: Behavioral-Cognitive Model

- People prone to panic attacks tend to
  - (1) pay very close attention to their bodily sensations,
  - (2) misinterpret bodily sensations in a negative way and
  - (3) engage in snowballing catastrophic thinking
II. Phobias

- disrupting, fear-mediated avoidance
- out of proportion to the danger posed by a particular object or situation
Specific Phobia

- **Irrational fear of a specific object/situation**
- **Five major subtypes**
  - Blood-Injection-Injury Phobia
  - Situational Phobia
  - Natural Environment Phobia
  - Animal Phobia
  - Other Type

Specific Phobia (cont)

- Marked and persistent fear
  - excessive or unreasonable and cued
- exposure to the phobic stimulus almost *invariably* provokes an immediate anxiety response
- person recognizes that the fear is excessive or unreasonable.
- phobic situation is avoided or else is endured with intense anxiety or distress
- avoidance of the feared situation *interferes* significantly with the person's normal routine.
Social Phobia

- A marked and persistent fear of
  - one or more social or performance situations
  - where the person is exposed to unfamiliar people or to possible scrutiny by others.
- Exposure to the feared social situation almost invariably provokes anxiety.
- The person recognizes that the fear is excessive.
- The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- The avoidance of the feared social or performance situation interferes significantly with the person’s normal routine.

Etiology of Phobias
Phobic Disorders

- Biological Theory
- Psychoanalytical Theory
- Behavioral Theory
- Cognitive Model

Phobias: Biological theory

- Genetic factors predispose us to develop phobias (Kendler et al., 1992)
Phobias: Psychoanalytical theory

- **Freud**
  - phobias are a defense against the anxiety produced by repressed id impulses.
  - This is displaced from the feared id impulse and moved to an object or situation that has some symbolic connection to it.
  - The phobia is the ego’s way of warding off a confrontation with a real problem, a repressed childhood conflict (conflicts of sexual and aggressive nature).

Phobias: Behavioral Theory

- **Learning to fear**
- **Avoidance Conditioning**
  - Phobic reactions are learned avoidance responses.
  - Via classical conditioning a person can learn to fear a neutral stimulus (the CS) if it is paired with an intrinsically painful or frightening event (the UCS).
- **Modeling**
  - fears may be learned through imitating the reactions of others.
  - emotional responses; may be learned by witnessing a model.
  - The learning of fear by observing others is generally referred to as *vicarious learning*. 
Phobias: Cognitive Model

- Anxiety is related to being more likely to attend to negatives stimuli
- Interpret ambiguous information as threatening
- Belief that negative events are more likely to occur in the future

NEXT CLASS
III. Obsessive Compulsive Disorder

- Obsessions
  - unwanted and intrusive thoughts

- Compulsions
  - repetitive behaviors or mental acts the goal of which is to reduce anxiety

Content of Obsessions

- The more common content areas of obsessions are
  - Contamination
  - Physical violence of self or others, by self or others
  - Death
  - Accidental harm
  - Socially unacceptable behavior
  - Sex
  - Religion (blasphemous or irreligious thoughts)
  - Orderliness
  - Nonsense (meaningless phrases/images/tunes/words)
• Age of onset
  • adolescence or early adulthood
• Modal age of onset is earlier in males than in females;
  • in males 6-15 years
  • in females 20-29 years of age.

Either obsessions or compulsions

- At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.
- The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine.
- The disturbance is not due to the direct physiological effects of a substance or a general medical condition.
Etiology of OCD

OCD: Biological Model

- Interest has focused on two areas of the brain that could be affected by such trauma
  - frontal lobes
    - PET scan studies have shown increased activation in the frontal lobes of OCD patients
      - perhaps a reflection of their over concern with their own thoughts.
  - basal ganglia
    - a system linked to the control of motor behaviour
- Research on neuro-chemical factors has focused on serotonin.
**OCD: Psychoanalytic Theory**

- Anal stage fixation
  - Children experience intense rage and shame that fuel the id-ego battle and set the stage for obsessive compulsive functioning
  - Children are deriving pleasure from bowel movements, parents are trying to delay their anal gratification by toilet-training them

**OCD: Behavioral Model**

- Behavioral accounts of compulsions consider them learned behaviors reinforced by fear reduction (Meyer & Chesser, 1970).
  - For example, compulsive hand washing is viewed as an operant escape-response that reduces an obsessional preoccupation with and fear of contamination by dirt or germs.
  - Similarly, compulsive checking may reduce anxiety about whatever disaster the patient anticipates if the checking ritual is not completed.
**OCD: Cognitive Model**

- The thoughts are **vivid and elicit** great concern.
- Fostered by believing that thinking about a potentially unpleasant event makes it **more likely to occur**
- Trouble **ignoring stimuli** contributing to their difficulties
- People with OCD may **try actively to suppress** these intrusive thoughts
- many attempts at suppression lead to the return of the thought, accompanied by **an increase in negative mood**

**IV. Generalized Anxiety Disorder**

- Anxious **all the time** in almost any type of the situations
  - **6 months** of persistent anxiety
- Onset of GAD is in **mid teens**
- **Stressful life events** appear to play some role in its onset
- Twice as common in **women**
- Excessive anxiety and worry occurring for at least 6 months, about a number of events or activities
- The person finds it difficult to control the worry.
- The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for the past 6 months).
  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
- The focus of the anxiety and worry is not about having a panic attack, being embarrassed in public or being contaminated
- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not due to the direct physiological effects of a substance or a general medical condition
Etiology of GAD

GAD: Biological Model

- GAD may result from some defect in the GABA system so that anxiety is not brought under control.
GAD: Psychoanalytical Model

- an unconscious conflict between the ego and id impulses.
- The impulses, usually sexual or aggressive in nature, are struggling for expression
- the ego cannot allow their expression because it unconsciously fears that punishment will follow.
- Since the source of the anxiety is unconscious, the person experiences apprehension and distress without knowing why.
- The true source of anxiety associated with previously punished id impulses that are striving for expression is ever present.
- In a sense, there is no way to evade anxiety; if the person escapes the id he or she is no longer alive.
- Thus, the person feels anxiety nearly all the time.

GAD: Cognitive Model

- Too few warning signals in life
  - Most people learn to feel safe whenever there is an absence of warning signals
  - People with too few warning signals experience pervasive anxiety
    - They are searching for warning signals in everything
    - Always waiting for the boom to drop, never feeling confident that things are safe
GAD: Humanistic Model

- Carl Rogers
  - Children who do not receive unconditional regard from significant others
  - Become over critical of themselves
  - Develop conditions of worth
    - A set of harsh self standards they feel they must meet in order to be acceptable.
    - Failure to meet standards leads to anxiety

GAD: Existential Model

- Existential views
  - Universal human fear of the limits
  - Responsibilities of one’s existence.
- Existential anxiety arises
  - Facing the finality of death,
  - un-intentionally hurting someone,
  - The prospect that our life has no meaning.
- Failing to confront these issues lead to GA
V. Post Traumatic Stress Disorder

- Re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma
  - Memories and nightmares
  - Difficulties falling asleep,
  - Difficulty concentrating
  - Hyper-vigilance
  - Exaggerated startle response

- Other associated problems may include
  - depression
  - anger
  - guilt
  - substance abuse
  - marital problems
  - sexual dysfunction
  - occupational impairment
PTSD

- Symptoms begin
  - within 3 months after the trauma
- Severity depends on duration and proximity of an individual’s exposure

- **Acute:**
  - if duration of symptoms is less than 3 months
- **Chronic:**
  - if duration of symptoms is 3 months or more

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- Study conducted with Afghan Refugees at Peshawar
  - found nearly 80% of the patients attending psychiatric clinic had a diagnosis of Post Traumatic Stress Disorder
  - about half of them (47.9%) reported family history of mental illness
  - while almost a quarter had a physical disability or long term illness (Naeem et al., 2004).
Etiology of PTSD

PTSD: Biological Model

- Levels of nor-epinephrine were higher in PTSD patients than among controls (Geracioti et al., 2001).
PTSD: Psychodynamic Model

- Memories are so painful that they are either consciously suppressed (by distraction) or repressed