ANXIETY DISORDERS

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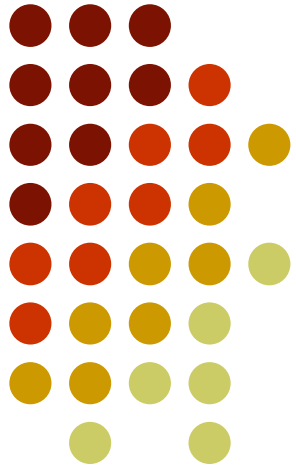
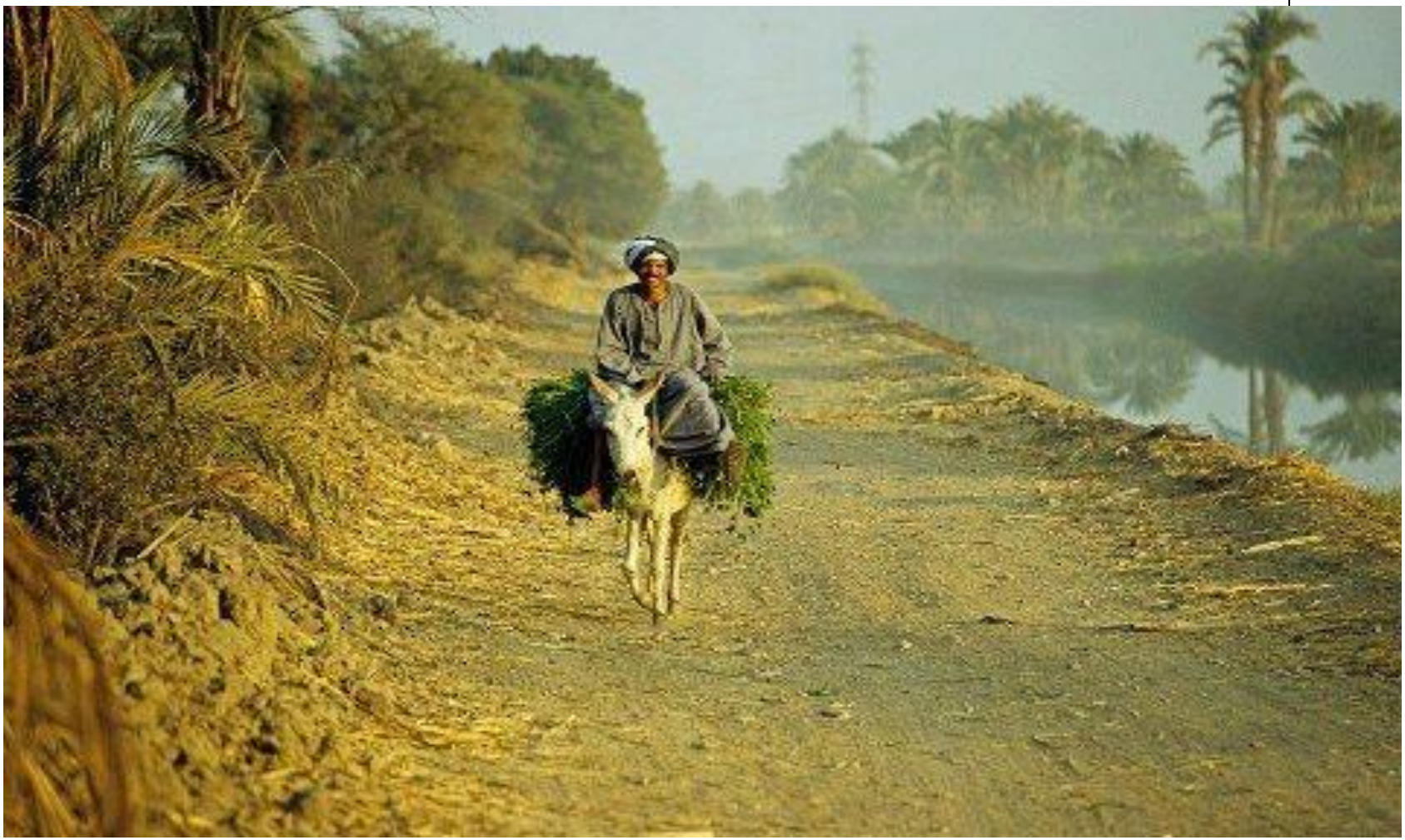
ANXIETY DISORDERS

- Anxiety vs. Anxiety Disorder
- Biological pathways
- Major anxiety disorders: development & treatment
- Post Traumatic Stress Disorder



When does anxiety become a disorder?



When does anxiety become a disorder?

- Anxiety is a normal human response to objects, situations or events that are threatening
- Anxiety is different from fear due to its cognitive component (i.e. fear of the future)
- Anxiety can be helpful and adaptive (e.g. anxiety about giving lectures!)
- Anxiety becomes a disorder when out of proportion or when it significantly interferes with life.

Anxiety disorders

ANXIETY DISORDERS

- Anxiety—Vague,
  subjective non specific feeling.
  *uneasiness, apprehension
  *tension,feeling of dread or impending doom
- Causes- result of threat to one's Biologic, Physiologic and Social Integrity- external influences

Levels of Anxiety

- Hildegard Peplau “Interpersonal Relations in Nursing 1952” identified Four stages of anxiety on a continuum
- Mild
- Moderate
- Severe
- Panic

Behavioral & Physiologic changes in Mild Anxiety

- Perceptual field widens
- Î awareness & motivation
- Î problem solving & learning
- Irritable
- Restlessness
- “butterflies in stomach”
- Î sleep disturbance
- More sensitive to noise

Behavioral & Physiologic changes Moderate Anxiety

- Immediate task oriented
- Attentive to immediate task
- Difficulty w/concentration,but can be redirected

- V/S normal – increased
- Frequent urination
- Dry mouth/muscle tension
- Î rate of speech
- diaphoretic

Behavioral & Physiologic changes in Severe Anxiety

- Narrowed perceptual field-one detail
- Difficulty completing task or solving problems
- Cannot learn effectively
- Feelings of dread/doom
- Crying
- Ritualistic behaviors ie. Rocking
- Headache/nausea&vomiting
- Vertigo
- Pale
- Tachycardia
- C/o chest pain
- Rigid stance

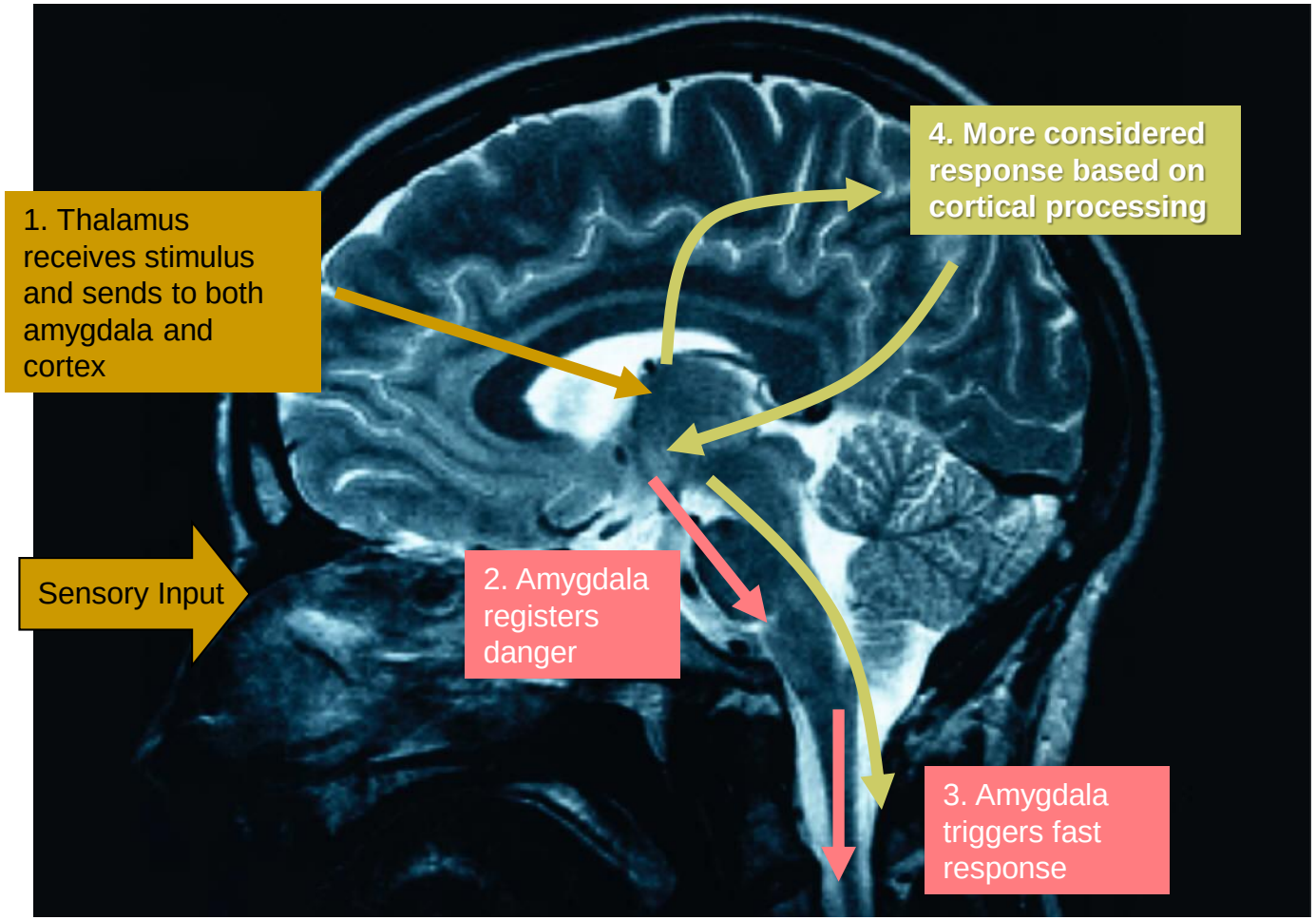
Behavioral & Physiologic changes in Panic level anxiety

- Unable to process environmental stimuli
- Distorted perceptions
- Can only focus on self
- Risk for self harm
- Unable to communicate
- Irrational thoughts/behaviors
- Possible delusions/hallucinations

- Can run away from scene or
- Can be immobilized & mute
- Dilated pupils
- Î B/P, P, R
- Flight,fight or freeze reaction

Anxiety disorders…

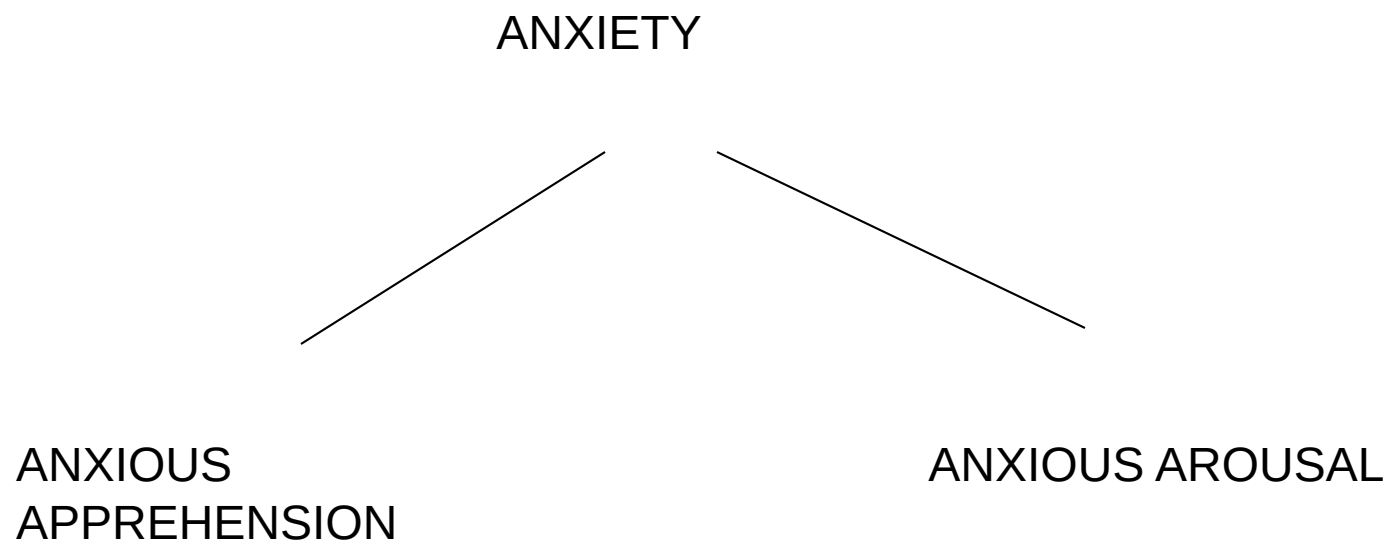
- Highly treatable yet also resistant to extinction
- Often begins early in life
- Reported more by women than men
- Reported more in Western countries
- Often comorbid both with other anxiety diagnoses and with other disorder groups (e.g. Mood disorders, psychoses)



• Parts of the brain involved in fear response = thalamus, amygdala, hypothalamus, which then instruct the endocrine glands and autonomic nerv.sys.

• Evolved fear module (pink) versus considered response (green) = “fight or flight” versus “feel the fear and do it anyway (or do it differently)”!

A new model of anxiety



Anxiety: a new model

- Anxious apprehension
- characterized by concern for the future and verbal rumination about negative expectancies or fears
- often accompanied by muscle tension, restlessness and fatigue
- Important variable in GAD

- Anxious arousal

-characterized by a set of somatic symptoms including shortness of breath, pounding heart, dizziness, sweating and feelings of choking

-important variable in panic attacks

Specific Phobias

- Selective, persistent and out of proportion
- Includes cognition that leads to behavioural response, whether or not the threat is present
- May be genetically, neurologically or experientially based
- Maintained through the processes of classical and operant conditioning.

Social Phobia

- A more pervasive, highly cognitive type of phobia
- Distinguishing feature is the fear of doing something *in front of others*
- May be situation or context (e.g. performance versus interaction anxiety) specific
- Fear of one's own behaviour causing negative attention from others

Therapeutic Treatment of Phobia

- Mainly behavioural or cognitive behavioural techniques are used
  - Systematic Desensitisation (with or without relaxation training)
  - Flooding (with or without relaxation training)
  - Modelling
  - Cognitive restructuring, skills training, gradual exposure

  [Relaxation not recommended for blood phobia where fainting is a risk]
- Hypnosis
- Medication (mainly social phobia)
  - MOAIs
  - SSRIs

Panic Attack

Is a discrete episode of intense fear usually lasting less than 20 minutes, characterized by at least four of the following :

- Rapid or irregular pulse
- Shortness of breath
- chest pain, sweating
- Feeling detached from oneself
- Feeling detached from one's surroundings
- Faintness
- Trembling
- Choking, Fear of dying
- Fear of losing control, "going crazy"

CONT. *Panic Attack*

Pounding, racing heart

~~Sweating~~

Trembling or shaking

Shortness of breath

Shortness of breath

Fear of dying

Panic Disorder

- Two major types: with or without agoraphobia
- Consists of a pattern of *recurring* panic attacks
- Emotional, physical, cognitive and behavioural components
- Main fear is of losing control (consequence = dying, going crazy, embarrassment, not being able to get help)
- The *fear* of having a panic attack becomes a problem of itself, possibly leading to agoraphobia (fear of open spaces, crowds etc. Any place where escape or finding help is difficult or embarrassing) or other phobias

Treatment of Panic Disorder

- Debate about the extent to which Panic Disorder is biological versus psychological (most likely both)
- Genetic and medication studies support biological view
- Cognitive strategies - reality testing, psycho education, cognitive restructuring, graded exposure - all may add to effectiveness of treatment supporting psychological argument

Obsessive Compulsive Disorder

- Classified as anxiety disorder, but with unique presentation
- Characterised by obsessions *and* compulsions (in most cases)
- Compulsions may be physical or mental
- Types of presentation: contamination fear; doubt/checking; magic thinking; symmetry; hoarding
- Severity = frequency + capacity to resist + interference with normal functioning

Aetiology of OCD

- Psychoanalytical theories: attempt to suppress instinctual drives – sexual and aggressive – arising from the anal stage
- Biological theories: Brain injury/trauma/acute disease and/or neurochemical (serotonin); Genetic factors
- Behavioural and Cognitive theories: conditioning; modelling; memory deficits

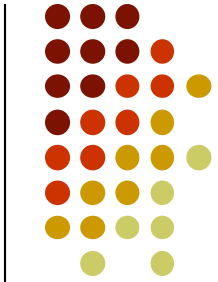
Treatment of OCD

- Medical: particularly high doses of SSRIs
- Psychoanalysis
- Cognitive-behavioural therapy
  - Exposure and response prevention
  - Thought-stopping not generally effective alone

Generalised Anxiety Disorder

- Characterised by persistent and global worry: worry about “everything”, “worry about worry”
- Distinguished from normal worry by severity, interference, irrationality
- Common problem but little is known
- Resistant to change
- A product of Western society?

Treatment of GAD



- Medication (SSRIs used more for GAD than other anxiety disorders)
- Psychoanalysis: GAD is caused by conflict between the ego and id impulses. The ego fears punishment but id cannot be extinguished = constant anxiety and conflict (has not been displaced as with phobia)
- Behavioural Techniques: difficult to implement due to global nature of GAD. May choose themes or priorities
- Cognitive Therapy: apparently most useful but still shows limited success
- Others: Rational Emotive Therapy, Existential Therapy, Gestalt Therapy, Narrative Therapy

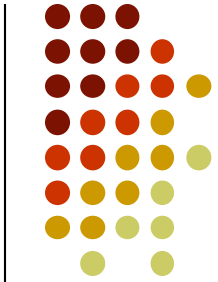
Post Traumatic Stress Disorder

- Is it an anxiety disorder?
- Main diagnostic criteria:
  - Witness or experience of an event that (a) involved actual or threatened death or injury, *and*
  - Feelings of intense fear, horror, or helplessness
  - Person must relive the event in some way (e.g. dreams, “flashbacks”, internal distress, physiological reactions)
  - Avoidance (subconscious and/or conscious)
  - Hyperarousal or mood instability
  - Usually persisting for at least three months

PTSD contd…

- Inclusion in DSM-III due to awareness of symptoms in Vietnam veterans
- Control and helplessness often key factors
- Severity most determined by perceived threat
- Unexpectedness?
- Typified by delayed onset and lack of insight
- Past experience may increase vulnerability (e.g. past trauma, psychological issues, personality)
- No good data to suggest some more likely to develop than others, although prognoses may differ

Types and Aetiology



- Acute versus Chronic (< 3 mths vs. > 3 mths)
- May be caused by personal encounters, war, natural event/disaster, extreme events [outside normal human experience]
- May develop slowly or rapidly, acutely or after a long time
- Can be difficult to recognise or diagnose

Therapeutic Treatment of PTSD

- Medication (treats the symptoms, but minimally effective)
- Exposure Therapy
- Critical Incident Stress Debriefing
- Supportive psychotherapy
- Eye Movement Desensitisation and Reprogramming (EMDR)
  - Rapid saccadic eye movements coupled with exposure and positive thought
  - Huge movement but has attracted much criticism due to its secrecy and lack of controlled studies

Complex PTSD
(Judith Herman: “Trauma & Recovery” 1992)

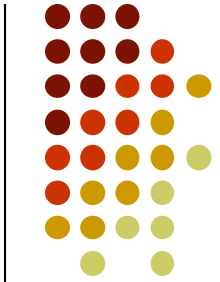
- Argument for a new PTSD classification
- Current criteria and understanding do not ‘fit’ with those in situations of chronic, ongoing abuse or subjugation
- Controversial: history of PTSD and lack of recognition of abuse
- Symptoms are entrenched, prognosis tends to be poorer
- Often present as other ‘disorders’ (e.g. personality, mood, dissociative, other anxiety)

Complex PTSD contd.

A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war concentration-camp survivors and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

1. Alterations in affect regulation, including

- persistent dysphoria (a state of anxiety, dissatisfaction, restlessness or fidgeting)
- chronic suicidal preoccupation
- self-injury
- explosive or extremely inhibited anger (may alternate)
- compulsive or extremely inhibited sexuality (may alternate)



2. Alterations in consciousness, including

- amnesia or hyperamnesia for traumatic events
- transient dissociative episodes
- depersonalization/derealization (depersonalization - an alteration in the perception or experience of the self so that the usual sense of one's own reality is temporarily lost or changed; derealization - an alteration in the perception of one's surroundings so that a sense of the reality of the external world is lost)
- reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation

3. **Alterations in self-perception**, including

- sense of helplessness or paralysis of initiative
- shame, guilt, and self-blame
- sense of defilement or stigma
- sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

4. **Alterations in perception of perpetrator**, including

- preoccupations with relationship with perpetrator (includes preoccupation with revenge)
- unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
- idealization or paradoxical gratitude
- sense of special or supernatural relationship
- acceptance of belief system or rationalizations of perpetrator

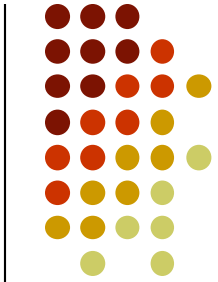
5. Alterations in relations with others, including

- isolation and withdrawal
- disruption in intimate relationships
- repeated search for rescuer (may alternate with isolation and withdrawal)
- persistent distrust
- repeated failures of self-protection

6. Alterations in systems of meaning

- loss of sustaining faith
- sense of hopelessness and despair

Treatment of Complex PTSD



- Ongoing concern of how best to deal therapeutically with this type of presentation
- Very difficult cases to work with: complexity, severity, disturbance to sense of self
- Long term treatment probably best, although may be delivered in short courses
- Difficult to study outcomes based on current research methodology

PTSD Issues

- The same disorder?
- Danger of both minimising and maximising with diagnosis of Complex PTSD
- Political and legal consequences of diagnostic category
- Social consequences