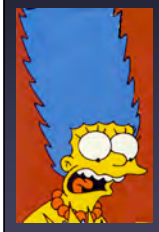
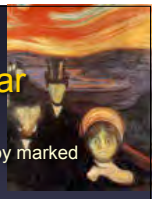
# Abnormal Psychology

PSYCH 40111



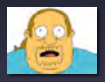
# Anxiety Disorders

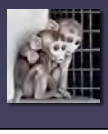
## Nature of Anxiety and Fear



- Anxiety
  - Future-oriented mood state characterized by marked negative affect
  - Somatic symptoms of tension
  - Apprehension about future danger or misfortune
- Fear
  - Present-oriented mood state, marked negative affect
  - Immediate fight or flight response to danger or threat
  - Strong avoidance/escapist tendencies
  - Involves abrupt activation of the sympathetic nervous system
- Anxiety and Fear are Normal Emotional States

## The Nature of Fear/Panic



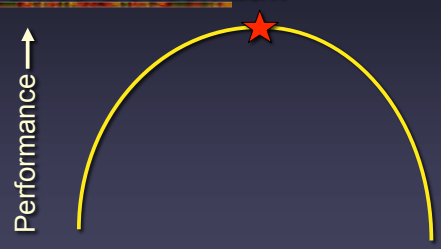


Also - a basic emotional response

IMMEDIATE “Alarm” response activated in the context of threat

Leads to Action Tendency - escape/avoidance

## Yerkes-Dodson Law




## From Normal to Disordered Anxiety and Fear

- Characteristics of Anxiety Disorders
  - Psychological disorders – Pervasive and persistent symptoms of anxiety and fear
  - Involve excessive avoidance and escapist tendencies
  - Symptoms and avoidance causes clinically significant distress and impairment

## Phobias

- A *phobia* is a fear-mediated avoidance that is out of proportion to the object or situation
  - Phobias involve intense distress
  - Phobias are disruptive
  - Person recognizes that the fear is groundless

**Table 5-4 DSM-IV Checklist**

SPECIFIC PHOBIA

1. Marked and persistent fear of a specific object or situation that is excessive or unreasonable, lasting at least six months.
2. Immediate anxiety usually produced by exposure to the object.
3. Recognition that the fear is excessive or unreasonable.
4. Avoidance of the feared situation.
5. Significant distress or impairment.

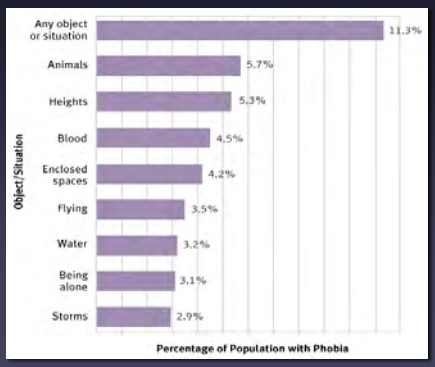
Based on APA, 2000, 1994.

## Specific Phobias: An Overview

- Facts and Statistics
  - About 11% of the general population meet diagnostic criteria for specific phobia
    - 7% men, 16% women (lifetime prevalence)
  - Females are again over-represented
  - Phobias run a chronic course, with onset beginning between 15 and 20 years of age

## Specific Phobias: Associated Features and Treatment

- Associated Features and Subtypes of Specific Phobia
  - Situational phobia – Public transportation or enclosed places (e.g., planes)
  - Natural environment phobia – Events occurring in nature (e.g., heights, storms)
  - Animal phobia – Animals and insects
  - Other phobias – Do not fit into the other categories (e.g., fear of choking, vomiting)
  - *Blood-injury-injection phobia – Vasovagal response to blood, injury, or injection*




## Specific Phobias: Perspectives

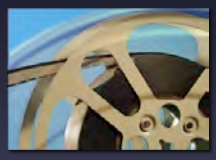
- Psychoanalytic theory: Phobias result when unconscious anxiety is displaced onto a neutral object
- Cognitive theory: Thought processes result in high levels of anxiety
- Behavioral theories: focus on learning as the etiological basis of phobias
  - Phobias are learned avoidance responses
  - Phobias may be acquired through modeling

## Anxiety Disorders: The Behavioral Perspective

- Avoidance learning
  - Stage 1
    - Neutral stimulus is paired with aversive stimulus
  - Stage 2
    - Negative reinforcement

## Behavioral Treatment

- Systematic desensitization
  - "hierarchy of fears"
- Exposure
  - confrontation with the feared stimulus
- Modeling
  - Watching others handle object or engage situation
- Flooding
  - person is confronted with the feared stimulus for prolonged periods of time



## Specific Phobias: Biological Factors

- Prepared learning of fears and phobias through evolution
- Genetic and temperamental causal factors

## Drug Treatments for Specific Phobias

- Biological approach uses drugs to eliminate anxiety symptoms
  - Anxiolytic drugs such as the benzodiazepines (Valium)
  - MAO (Monoamine Oxidase) inhibitors such as phenelzine (Nardil) reduce the degradation of norepinephrine and serotonin
    - MAO inhibitors can have adverse side effects
  - Selective serotonin reuptake inhibitors (SSRI's) (fluoxetine) increase brain serotonin and help reduce anxiety symptoms when approaching feared stimuli

Fear of Speaking in Public

Fear of Interacting with Others

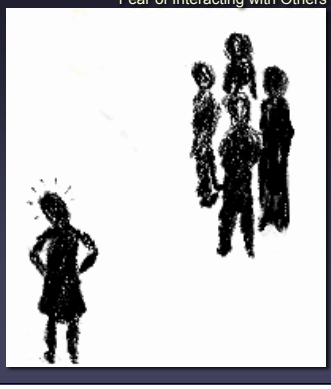


**Table 5-5 DSM-IV Checklist**

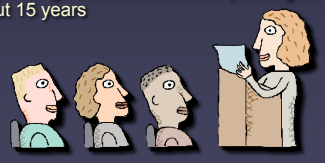
**SOCIAL PHOBIA**

1. Marked and persistent fear of social or performance situations involving exposure to unfamiliar people or possible scrutiny by others, lasting at least six months. Concern about humiliating or embarrassing oneself.
2. Anxiety usually produced by exposure to the social situation.
3. Recognition that the fear is excessive or unreasonable.
4. Avoidance of feared situations.
5. Significant distress or impairment.

Based on APA, 2000, 1994.

## Social Anxiety Disorder (Social Phobia)

- Facts and Statistics
  - About 13% of the general population meet lifetime criteria for social phobia
  - Females are slightly more represented than males
  - Onset is usually during adolescence with a peak age of onset at about 15 years

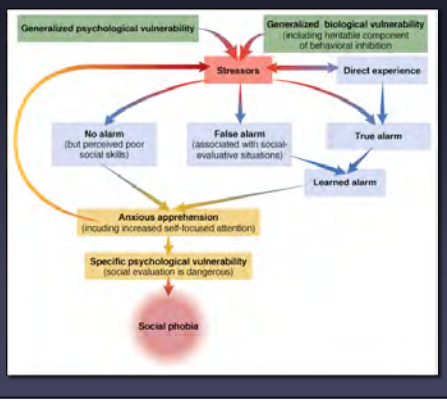


## Social Anxiety Disorder: Perspectives

- Behavioral Perspective
  - Direct conditioning, reinforcement, observational learning
  - Social skills deficits
- Cognitive Perspective
  - Cognitive distortions involving overestimation of negative evaluation
- Biological Perspective
  - Social fears and phobias in an evolutionary context
  - Genetic and temperamental factors
  - Biological vulnerability

## Social Anxiety Disorder: Treatment

- Psychological Treatment of Social Phobia
  - Cognitive-behavioral treatment – Exposure, rehearsal, role-play in a group setting
  - Cognitive-behavior therapies are highly effective
- Medication Treatment of Social Phobia
  - Beta blockers are ineffective
  - Tricyclic antidepressants and monoamine oxidase inhibitors reduce social anxiety
  - SSRIs like Paxil is FDA approved for treatment of social anxiety disorder
  - Relapse rates are high following medication discontinuation




## The Phenomenology of Panic Attacks

- Panic Is Analogous to Fear as an Alarm Response
- What Is a Panic Attack?
  - Abrupt experience of intense fear or discomfort
  - Accompanied by several physical symptoms
    - breathlessness, chest pain

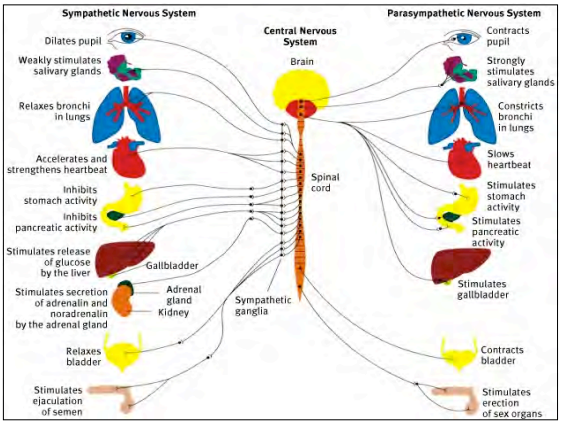



**Table 6-1 DSM-IV Checklist**

**PANIC ATTACK**

A discrete period of intense fear in which at least four of the following symptoms develop suddenly and reach a peak within 10 minutes:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- A feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Derealization or depersonalization
- Fear of losing control or going crazy
- Fear of dying
- Numbness or tingling sensations
- Chills or hot flashes

Based on APA, 2000, 1994.

## Panic Attacks

### DSM-IV Subtypes of Panic Attacks

- Situationally bound (cued) panic
  - Expected and bound to some situations
- Unexpected (uncued) panic
  - Unexpected "out of the blue" without warning
- Situationally predisposed panic
  - May or may not occur in some situations

**Table 6-2 DSM-IV Checklist**

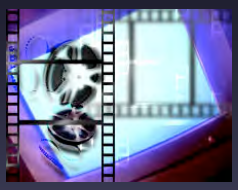
**PANIC DISORDER WITHOUT AGORAPHOBIA**

1. Recurrent unexpected panic attacks.
2. A month or more of one of the following after at least one of the attacks.
   (a) Persistent concern about having additional attacks.
   (b) Worry about the implications or consequences of the attack.
   (c) Significant change in behavior related to the attacks.

**PANIC DISORDER WITH AGORAPHOBIA**

1. Symptoms of panic disorder.
2. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help might not be available if paniclike symptoms were to occur.
3. Situations either avoided, endured with marked distress, or manageable only with the presence of a companion.

Based on APA, 2000, 1994.



## Panic Disorder with and without Agoraphobia

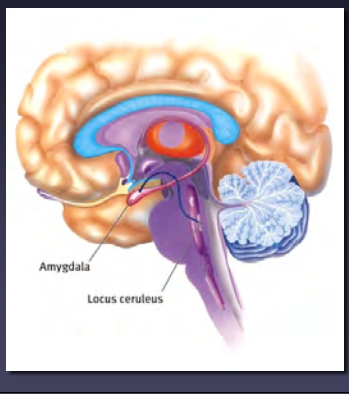
- Facts and Statistics
  - 3.5% of the general population meet diagnostic criteria for panic disorder
  - Two thirds with panic disorder are female
  - Onset is often acute, beginning between 25 and 29 years of age
  - Nocturnal panic attacks – 60% experience panic during deep non-REM sleep

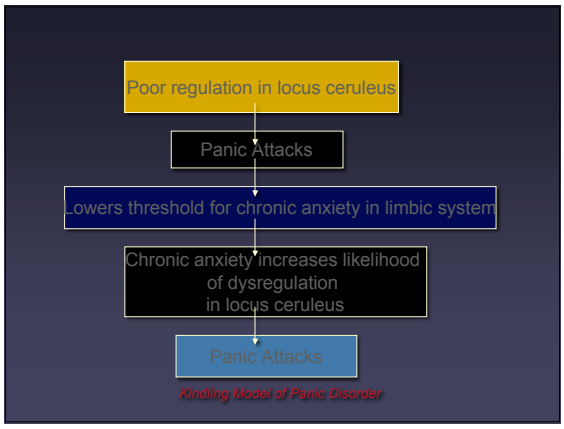
## Panic Disorder: Cognitive Perspective

- Anxiety sensitivity: The Fear-of-fear hypothesis of panic disorder suggests that some people have an overly aroused nervous system and a tendency to be upset by the sensations generated by their nervous system
  - Eventually, worry about a panic attack makes a future attack more likely (vicious circle)
  - Safety behaviors engender persistence of panic
- Cognitive biases and the maintenance of panic
- Perceived control and safety

## Panic Disorder: Biological Perspective

- Heredity Component
- Norepinephrine/5-HT activity involved
- Panic can be induced experimentally using Hyperventilation/Lactate infusion
- Panic attack may result from an exaggerated central response to arousal in the respiratory center of the brainstem (Locus Ceruleus)






## Panic Disorder: Associated Features and Treatment

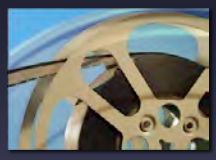
- Psychological Treatment of Panic Disorder
  - includes a combination of relaxation training, cognitive interventions and exposure to the internal cues that elicit panic
  - Cognitive-behavior therapies are highly effective
- Medication Treatment of Panic Disorder
  - Target serotonergic, noradrenergic, and benzodiazepine GABA systems
  - SSRIs (e.g., Prozac and Paxil) are currently the preferred drugs
  - Relapse rates are high following medication discontinuation

## Drug Treatment

- Antidepressant drugs
  - MAO inhibitors)
  - Tricyclics
  - Selective Serotonin Reuptake Inhibitors (SSRIs)

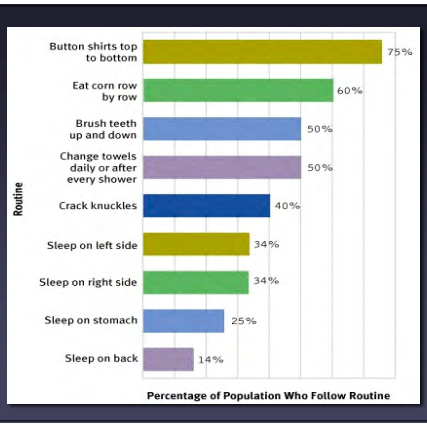
## Panic Disorder: Combined Model and Treatment

- Combined treatments do well in the short term
- Best long-term outcome is with cognitive-behavior therapy alone
- However, best to view panic disorder as involving both biological and cognitive vulnerabilities that interact



## Obsessive-Compulsive Disorder (OCD): An Overview

- Overview and Defining Features
  - Obsessions – Intrusive and nonsensical thoughts, images, or urges that one tries to resist or eliminate
  - Compulsions – Thoughts or actions to suppress the thoughts and provide relief




## Obsessions and Compulsions

- Common Compulsions:
  - Pursuing cleanliness
  - Avoiding particular objects (e.g. cracks in a sidewalk)
  - Performing repetitive, magical, protective practices
  - Checking (e.g. "is the gas off?")
  - Performing a particular act (e.g. chewing slowly)
- Most persons with OCD present with cleaning and washing or checking rituals
- Most persons with OCD display multiple obsessions/compulsions

**Table 6-4 DSM-IV Checklist**

**OBSESSIVE-COMPULSIVE DISORDER**

1. Recurrent obsessions or compulsions.
2. Past or present recognition that the obsessions or compulsions are excessive or unreasonable.
3. Significant distress or impairment, or disruption by symptoms for more than one hour a day.

Based on APA, 2000, 1994.

## OCD: Associated Features

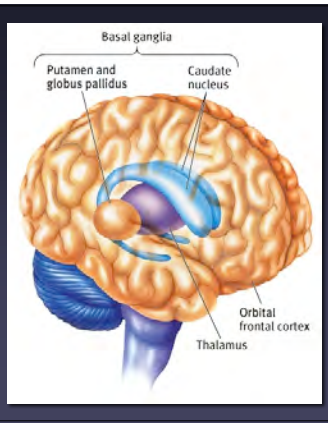
- Facts and Statistics
  - About 2.6% of the general population meet criteria for OCD in their lifetime
  - OCD roughly equivalent in men and women as adults; higher prevalence in boys
  - OCD tends to be chronic
  - Onset is typically in early adolescence or young adulthood

## OCD: Psychological Perspectives

- The psychoanalytic view is that OCD reflects arrest of personality development at the anal stage
- Behavioral accounts of OCD point to learned behaviors reinforced by the belief that some thoughts are dangerous/unacceptable and need to be reduced
- Cognitive approaches look at the role of memory and how attempts to suppress obsessive thoughts contribute to the condition
  - Thought-action fusion – Tendency to view the thought as similar to the action

## OCD: Biological Perspective

- Genetic influences
- The role of serotonin
- Abnormalities in brain function (frontal lobes and basal ganglia)




## OCD: Treatment

- Psychological Treatment of OCD
  - Psychoanalytic procedures not shown to be effective
  - Cognitive-behavioral therapy is most effective with OCD
  - Exposure and response prevention-involves exposing the OCD client to situations that elicit a compulsion and then restraining the client from performing the compulsion
  - Combining medication with CBT does not work as well as CBT alone

## OCD: Treatment

- Medication Treatment of OCD
  - Biological treatment involves drugs that increase brain serotonin activity (Prozac)
  - Clomipramine and other SSRIs seem to benefit up to 60% of patients
  - Psychosurgery (cingulotomy) is used in extreme cases
  - Relapse is common with medication discontinuation

## What is Stress?

- Stress
- Stressors
  - Frustrations
  - Conflicts
  - Pressures
- Eustress (positive stress)
- Distress (negative stress)
- Coping strategies

## Adjustment Disorder: Reactions to Common Life Stressors

- Stress from unemployment
- Stress from bereavement
- Stress from divorce or separation

## Traumatic Stressors

- Disasters
  - Tornadoes, floods, earthquakes, fires
- Abuse
  - Physical, emotional, sexual
- Combat and War-Related Traumas
  - Combat fatigue syndrome, “Shell Shock”
- Common Traumatic Events
  - Car accidents, sudden deaths of loved ones

## Severe Threats to Personal Safety and Security

- Forced migration to a strange land
- The trauma of being held hostage
- Psychological trauma among victims of torture
- Victim of terrorist act

**Table 6-5 DSM-IV Checklist**

POSTTRAUMATIC STRESS DISORDER

1. A history of having experienced, witnessed, or confronted event(s) involving death, serious injury, or threat to the physical integrity of self or others. Reaction of intense fear, helplessness, or horror produced by event.
2. Event persistently reexperienced in at least one of the following ways:
   (a) Recurrent distressing recollections.
   (b) Recurrent distressing dreams, illusions, flashbacks, or a sense of reliving the experience.
   (c) Distress caused by reminders of event.
   (d) Physical arousal produced by reminders of event.
3. Persistent avoidance of reminders of the event and a subjective sense of numbing, detachment, or emotional unresponsiveness.
4. At least two marked symptoms of increased arousal:
   (a) Difficulty sleeping.
   (b) Irritability.
   (c) Poor concentration.
   (d) Hypervigilance.
   (e) Exaggerated startle response.
5. Significant distress or impairment, with symptoms lasting at least one month.

Based on APA, 2000, 1994.

## PTSD: Associated Features

Subtypes and Associated Features of PTSD

- Acute PTSD – May be diagnosed 1-3 months post trauma
- Chronic PTSD – Diagnosed after 3 months post trauma
- Delayed onset PTSD – Onset of symptoms 6 months or more post trauma
- Acute stress disorder – Diagnosis of PTSD immediately post-trauma

## Posttraumatic Stress Disorder (PTSD): An Overview

- Facts and Statistics
  - About 7.8% of the general population meet criteria for PTSD
  - Combat (predominantly men) and sexual assault (predominantly women) are the most common traumas
  - Children also experience PTSD

**TABLE 6.1** Factors Affecting the Likelihood of Posttraumatic Stress Disorder

| Features of the Trauma | Features of the Person | Features of the Posttrauma Environment |
|---|---|---|
| Intensity of exposure to trauma | Pretrauma psychological adjustment | Availability and quality of social support |
| Duration of exposure to trauma | Family history of psychopathology | Additional major stressors |
| Extent of threat posed by trauma | Cognitive and coping styles | |
| Nature of trauma: caused by humans or natural disaster | Feelings of guilt | |

## PTSD: Perspectives

- Learning Theory
  - Traumatic stressor (UCS) gets associated with neutral stimuli (CS)
- Cognitive/Psychodynamic Theory
  - Avoidance/Inability to integrate event leads to PTSD (emotion processing)
- Biological Theory
  - Norepinephrine
  - Amygdala-Locus Coeruleus circuit
  - Hypothalamic-Pituitary Axis, CRF, and Cortisol

## PTSD: Treatment

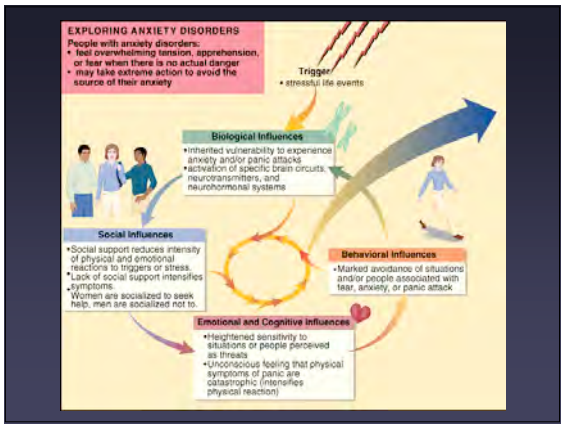
- Psychological Treatment of PTSD
  - Cognitive-behavioral treatment involves graduated or abrupt imaginal exposure
  - Increase positive coping skills and social support
  - Cognitive-behavior therapies are highly effective
- Psychopharmacological Treatment of PTSD
  - SSRIs

## PTSD: Controversies in Treatment

- Debriefing
- Crisis intervention therapy
- Resiliency: The abuse of PTSD and other stress diagnoses

## Toward an Integrated Model

- Diathesis-Stress
  - Consistent with diathesis-stress model
  - Inherit vulnerabilities for anxiety and panic, not anxiety disorders
  - Biological vulnerability interacts with psychological, experiential, and social variables to produce an anxiety disorder



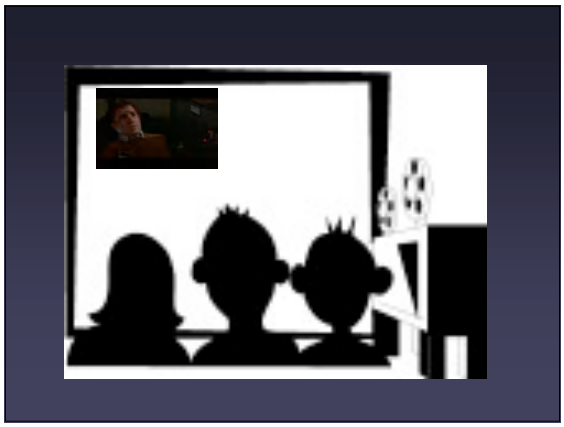



**Table 5-1 DSM-IV Checklist**

**GENERALIZED ANXIETY DISORDER**

1. Excessive or ongoing anxiety and worry, for at least six months, about numerous events or activities.
2. Difficulty controlling the worry.
3. At least three of the following symptoms: restlessness • easy fatigue • irritability • muscle tension • sleep disturbance.
4. Significant distress or impairment.

Based on APA, 2000, 1994.

## Generalized Anxiety Disorder

- Facts and Statistics
  - 4% of the general population meet diagnostic criteria for GAD
  - Females outnumber males approximately 2:1
  - Onset is often insidious, beginning in early adulthood
  - Tendency to be anxious runs in families

## GAD: Psychoanalytic/Existential Viewpoints

- Psychoanalytic View
  - Generalized anxiety results from unconscious conflicts between ego and id impulses
  - Types of Anxiety
    - Realistic, Neurotic, Moral
  - Interpersonal/Attachment theory of GAD
- Existential View
  - Existential versus Neurotic Anxiety
  - Need for acceptance of anxiety

## GAD: Cognitive-Behavioral Viewpoint

- Behavioral Perspective
  - Classical, Operant conditioning/Modeling
- Cognitive Perspective
  - Attention, memory and judgment biases towards threat
- Cognitive-Behavior Therapy
  - Relaxation training
  - Cognitive Restructuring

## Worry in GAD

- Worry is the primary feature of GAD
- What we know about the function of worry:
  - More thoughts than images
  - Reduces physiological arousal
- Fail to process emotional component of thoughts and images
- Theory: People suffering from GAD worry to lessen their physical and emotional discomfort in the short term

## Worry and Emotion

- Question:
- Why use worry to avoid negative emotions?

## A New Model For Understanding GAD

Possible Answers:

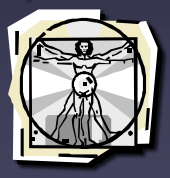
- GAD patients experience their emotions intensely and get overwhelmed by their emotional experience
- GAD patients lack the necessary and essential skills for the management and regulation of their emotional life
- GAD patients overuse worry as a strategy for managing their emotions

## Emotion Dysregulation in GAD
### Implications for Treatment

- Increase ability to identify, differentiate, and describe emotions
- Decrease use of worry and other emotional avoidance strategies
- Increase acceptance of emotional experience
- Increase ability to utilize affective information to aid in identifying needs, making decisions, guiding thinking, and motivating behavior
- Increase understanding of how one's emotions affect interpersonal relationships and are affected by them

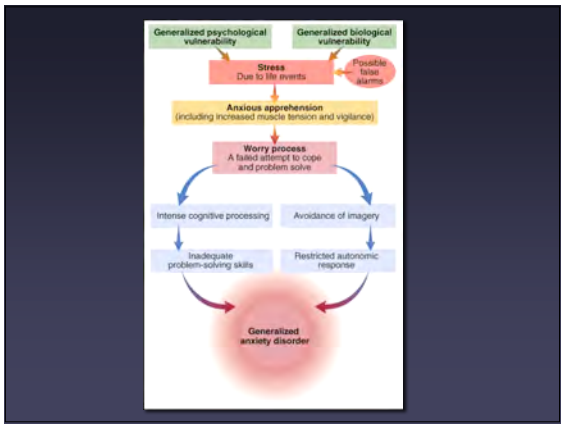
## Generalized Anxiety Disorder: Biological Factors

- Genetic factors
- Dysregulation in cortical (i.e., frontal) and subcortical (i.e., amygdala) structures
- A functional deficiency of GABA



## GAD: Drug Treatment

- Benzodiazepines
  - Valium (diazepam)
  - Xanax (alprazolam)
  - Ativan (lorazepam)
  - Tranxene (chlorazepate)
- Azaspirones
  - BuSpar (buspirone)
- Selective Serotonin Reuptake Inhibitors
  - Paxil (paroxetine)
  - Effexor (venlafaxine)


Generalized psychological vulnerability
Generalized biological vulnerability
Stress
Due to life events
Possible false alarms
Anxious apprehension
(including increased muscle tension and vigilance)
Worry process
A failed attempt to cope and problem solve
Intense cognitive processing
Avoidance of imagery
Inadequate problem-solving skills
Restricted autonomic response
Generalized anxiety disorder