The Psychopathology of Everyday Life

Lecture 4 – Anxiety II

Separation Anxiety

- More common in younger people, often seen in children
- Need to separate what is developmentally appropriate to what is not e.g. younger children being attached to their parents – 'developmentally appropriate'
- According to the DSM-5, it should be developmentally inappropriate and excessive fear or anxiety concerning separation from attachment figure.
    - 3 of following: excessive distress when anticipating or experiencing separation from home or attachment figures; about losing major detachment figures; about possible harm to attachment figure
    - Reluctance or refusal to go out, away from home to school or work because of separation fear
    - Reluctance about being alone without major attachment figure
    - Refusal to sleep away from home
    - Repeated nightmares
    - Repeated complains about physical symptoms
- Acute or insidious onset -often develops following a life stressor. (loss of relative or pet, illness, parental divorce).
- Comorbid separation anxiety is as high as 73% in young people with panic attacks
- Wide variation between cultures – some avoid separation and choose to keep children with parents for longer
- Gender differences – girls tend to have it more than boys

Consequences of Separation Anxiety

- Limited independent activities away from home
- May not participate in school camps sleep overs with friends
- May have difficulty with appropriate separation as they mature.

Epidemiology of Anxiety Disorders in the 21st Century

- Before the development of DSM-V separation anxiety disorder could only be diagnosed in children or adolescents. Therefore, adult separation anxiety disorder did not appear in the older epidemiological studies.
- According to a newer survey, the lifetime prevalence rate for adolescents aged 13 to 17 was 7.7%, while it was 6.6% in adults aged 18 to 64.3

Link Between Childhood Separation Anxiety and Panic Attacks

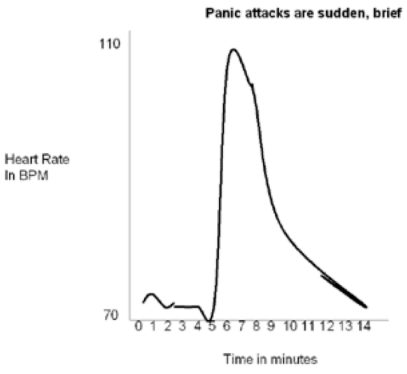
- Strong genetic link between childhood SAD and adult onset PA.
- Both disorders are associated with heightened sensitivity to inhaled CO(2) and can be influenced by childhood parental – but there are other factors that may predispose someone to have adult onset

Anxiety and Panic

	Males (%)	Females (%)	Persons (%)
Panic disorder	2.3	2.9	2.6
Agoraphobia	2.1	3.5	2.8
Social phobia	3.8	5.7	4.7
Generalized anxiety disorder	2.0	3.5	2.7
Posttraumatic stress disorder	4.6	8.3	6.4
Obsessive-compulsive disorder	1.6	2.2	1.9
Any anxiety disorder	**10.8**	**17.9**	**14.4**

What is Panic?

- an abrupt experience of intense fear or acute discomfort, accompanied by physical symptoms that include:,
    - palpitations,
    - chest pain or tightening,
    - shortness of breath, and sometimes dizziness, i.e, feeling faint
- Some somatic symptoms include:
    - Increased heart rate
    - Shortness of breath
    - Chest pain
    - Choking sensation
    - Trembling
    - Sweating
    - Nausea
    - Dizziness
    - Numbness
    - Hot flashes/chills
    - Depersonalization



- Cognitive Symptoms include:
  - Fear of dying
  - Fear of losing control *onset of symptoms is quite abrupt

Suffering from a Panic Attack can Lead to:

a) Worrying about having another attack (Panic attacks + fears about having future attacks = **Panic Disorder**

b) Avoid situations where they experienced an attack (Safety Behaviours) leading to avoiding leaving home **(Agoraphobia)**

Biology of Panic

Fear → adrenaline release + activation of sympathetic nervous system → increased HR + hyperventilation + increased muscle tension → lightheadedness, decreased CO_2 in lungs, tingling/numbness

Some Facts about Panic Attacks

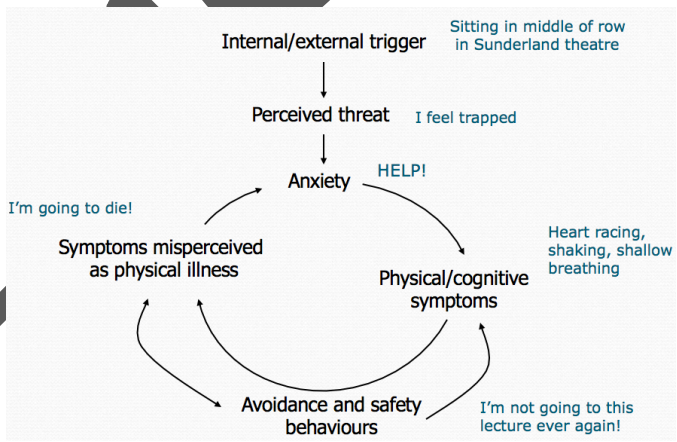
- No matter how bad it feels, panic attacks cannot actually harm the person or make them go mad.
- Panic attacks do not last forever. They always pass after a while.
- The persons thinking will affect how bad the panic is and how long it lasts.
- If the person runs away from a panic attack (for relief), it will make it harder in longer term and their life will become more and more restricted –escape and avoidance prolongs recovery
- During a panic, the client is encouraged to remember that they will not die, go mad or lose control. And to try to let the panic attack wash over them, without fighting it - just waiting for it to subside by itself.

Risk Factors for Panic

- Genetics
- An abnormally sensitive fear network
- Major life stressors
- A history of sexual or physical abuse

Other Contributors

- Use of CNS stimulants – i.e. caffeine, amphetamines, cocaine
- Withdrawal from CNS depressants - i.e. alcohol, barbiturates
- Medical conditions- i.e. hyperthyroidism, arrhythmias



Cognitive Model

- Panic Attacks result from 'catastrophic misinterpretation' of bodily or mental events;
- Events misinterpreted as signs of impending disaster- i.e. a heart attack or going crazy;
- A vicious cycle of events is triggered- associated with rising levels of anxiety and panic.

Sub-Types of Panic Attacks

- Situationally-bound/cued;
- Unexpected/uncued;
- Situationally predisposed

Panic Disorder and Prevalence

- ~40% of young people have had at least one spontaneous PA- most will not have repeated attacks and do not meet criteria for PD
- Australian data- 12-month prevalence: 1.1% meet DSM-IV criteria
- Peak age at onset of spontaneous panic: 15 - 25 years (many life stressors during these years e.g. education, relationships, responsibility)
- Onset after age 40- suggests depression or a possible somatic cause;
- 70% of sufferers are women- related to cultural factors?
- Course is usually chronic but it waxes and wanes.

Impacts of Panic Disorder

- Highly comorbid- up to 80% of individuals with PD have another mental illness
- Associated with decrease in quality of life and impairment in several domains- particularly employment

Culturally Bound Syndromes Related to Panic Disorder

- *Koro (probably of Malaysian origin):* individual has an overpowering belief that his or her genitals (e.g., penis or female nipples) are retracting and will disappear, despite the lack of any true longstanding changes to the genitals. This diagnosis is included in the Chinese Classification of Mental Disorders (CCMD-2)
- *Shen-k'uei (Taiwan), shenkui (China):* Marked anxiety or panic with accompanying somatic complaints (eg. dizziness, insomnia, frequent dreams) for which no physical cause can be demonstrated. Attributed to excessive semen loss from frequent intercourse, masturbation etc.
- *Dhat (India):* Severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish coloration of urine and feelings of weakness and exhaustion.

Anxiety Versus Fear:

Anxiety

- anxious apprehension and worry that is a more general reaction that is out of proportion to threats in environment
- future oriented
- can be adaptive if not excessive

Fear

- Experienced when a person is faced with real and immediate danger.
- Present-oriented
- Can be adaptive

What is Specific Phobia (DSM-5)

- Irrational fear of a specific object or situation;
- *Markedly* interferes with individual's ability to function;
- Individual recognises fear is excessive or unreasonable;
- Exposure to phobic stimulus results in anxiety response;
- Phobic situation is avoided or endured with intense anxiety/distress;
- Typically lasting 6 months or more.

Specific Phobia – Diagnostic Criteria

- Significant anxiety is provoked by exposure to (or anticipation of) a specific feared object or situation;
- Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a panic attack;
- Individual recognises the fear is excessive and unreasonable;
- The phobic situation is avoided or else endured with intense anxiety;
- The avoidance or distress significantly interferes with the person's normal routine, functioning or social activities or there is marked distress about having a phobia.

Specific Phobia: DSM Subtypes

- Environments – heights, water, storms
- Situations- aero planes, elevators, enclosed places;
- Animal- spider, cat
- Blood, injections, injuries
- Other- vomiting, choking, illnesses, people in costumes (e.g. clowns)
- *Refer to lecture slides for more types of phobia

Developmental Aspects:

- 75% of individuals with a specific phobia will have more than 1 fearful situation of object
- Prevalence for specific phobia in US 7-9%
- Higher in European countries (approximately 6%)compared to Asian, African and Latin American; 2-4%
- 5% of children
- 16% of 13-17 year olds

Specific Phobias

- Specific fears: very prevalent i.e. snakes ~25% population (Barlow & Durand, 2005);
- Prevalence of specific phobias: ~ 9% (Kessler et al., 2005);
- Male: female- 1:4;
- Only most severe seek treatment

Specific Phobias – Aetiology

- Psychodynamic theory
- Stems from Freud's case study of Little Hans ("Analysis of a Phobia in a Five-year-old Boy" 1909);
- Castration anxiety and Oedipus complex;
- Freud theorized that phobias were actually displaced fears or conflicts

Conditioning theory of fear acquisition

- Watson & Little Albert - Individual learns to associate a threatening stimulus with a non-threatening stimulus so that the latter by itself can trigger anxiety
- Fear is then maintained by avoidance- individual does not get the chance for 'reality testing' and new learning

Problem:

- Many phobias have no obvious environmental cause- direct or indirect. "She has always been fearful of cats"
- Why are some phobias more common than others, even though few encounters with the feared object (i.e. snakes)

Social learning

- Fear may be learnt via observation of trauma in others;
- Fear may be learnt by hearing of experiences of others;
- Fear may be modeled or 'instructed'

Evolutionary perspective

- Ohman and Mineka (2001)- organisms which learned to fear environmental threats faster
- had a survival and reproductive advantage.

Social Anxiety Disorder – DSM-V

- Marked fear about 1 or more social situations
- Individual fears that they will act in a way or show anxiety symptoms that will be negatively evaluated
- Social situations almost always provoke fear or anxiety
- Social situations are avoided or endured with intense fear or anxiety.
- Fear out of proportion
- Lasting 6 months or more
- Clinical distress
- Not due to substance etc.
- Not better explained by other mental disorder

If other condition (e.g. burns, obesity) fear/avoidance unrelated or excessive

Social Anxiety Disorder

- Shyness- 20-48% of college students (Heiser et al., 2003);
- Social phobia- 7-13% of individuals in Western societies across lifetime (Furmark, 2002);
- Prevalence of social phobia among shy persons (18%) is significantly higher than among non-shy persons (3%) (Heiser et al., 2003)

Emotion Regulation and the Transdiagnoistic Role of Repetitive Negative Thinking in Adolescents with Social Anxiety and Depression

- Adolescents (N = 1065)
- Completed measures assessing emotion regulation and symptoms of social anxiety and depression.
- Reported decreased emotional awareness, dysregulated emotion expression, and reduced use of emotion management strategies.
- better fit than model where worry and rumination predictors of symptomatology.

Findings implicate

- Emotion regulation deficits in the developmental
- psychopathology of youth anxiety and mood disorders

Social Anxiety – Risk Factors

- Individual factors
- Genetics- specific or general heritability of emotional disorders?
- Cognitive factors- negative appraisal of social interactions- stem from adverse social interaction?
- Social skills deficits- "chicken or egg"?
- Temperament- shyness

Agoraphobia

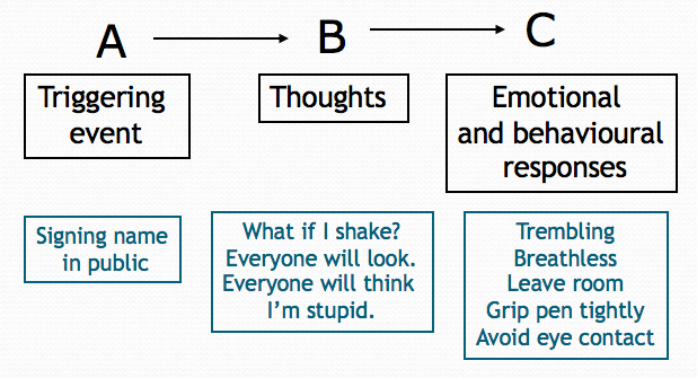
- A pathological fear of being in public places, often resulting in the sufferer becoming housebound
- Marked fear or anxiety of 2 or more of: using public transport, being in open spaces, being in enclosed places, standing in line or being in a crowd, being outside of the home alone.
- Fears that escape might be difficult or help unavailable

Epidemiology of Agoraphobia

- Peaks in late adolescence and early adulthood
- Females twice as likely as males – males may be perhaps forced into a situation where they have to be exposed, or it may be a biological factor
- 1.7% of adolescents and adults have diagnosis.
- Prevalence rates do not vary systematically across cultures.
- 2/3^{rds} of cases onset before 35, substantial incidence during adolescence and early adult then again at 40.
- Persistent and chronic full remission rare 10%

Treatment for Anxiety Disorders

- Medication
- Psychological treatment- esp. Cognitive behavioural therapy
  - The importance of exposure
- Other



ABC Model

- Cross-sectional formulation of problem;
- Assists in describing CBT model to patient.

The Basics

- Time-limited, problem focused approach based on the cognitive model;
- Relies on collaborative empiricism: scientist-practitioner model;
- Continuous measurement and evaluation of patient problems- used to test hypotheses concerning problem maintenance and to assess

treatment efficacy;

- Homework- integral part of treatment; in order for patients to remain conscious and aware of their improvement
- Socratic dialogue – important technique to enable transfer of information, and collaborative and supportive environment.
- *Dearousal techniques:* Teaching a patient how to relax in an attempt to help them relax and hope to help them face their fear e.g. slow breathing, progressive muscle relaxation, meditation and mental grounding
- Graded exposure: exposing the patient slowly to a graded progression of their phobia in an attempt to help them become comfortable. This is dependent on what the trigger is for their panic e.g. imaginal, real, graded
- Cognitive restructuring: think about the issue
- Structured problem solving: *see handout given in class