The Anxiety Disorders: What Are They?

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Learning Objectives

1. Understand how the anxiety disorders are defined, including epidemiology and common presentations

2. Learn about evidence-based psychological treatment
The Anxiety Disorders

- Panic Disorder (with/without Agoraphobia)
- Social Anxiety Disorder
- Generalized Anxiety Disorder
- (Previously in DSM 4) Obsessive Compulsive Disorder

At the Frederick W. Thompson Anxiety Disorders Centre, our clinical focus involves OCD and OCD spectrum conditions including:
  - Obsessive Compulsive Disorder
  - Skin Picking / Hair Pulling Disorders
  - Body Dysmorphic Disorder
The Nature of Anxiety

- Anxiety is a natural response to perceived threat.
- Anxiety may be unpleasant, but it is not inherently dangerous – it has adaptive qualities.

**Client Treatment Goal:** Eliminate Anxiety – *Unrealistic!*

- Fight/flight response

**Goal of CBT Treatment:** Develop skills to understand and manage anxiety, rather than complete elimination.
Psychoeducation: The Anxiety Response

Perceived Threat

Fight or Flight Response

Autonomic Nervous System

Sympathetic Nervous System
Releases adrenalin & noradrenalin

Parasympathetic Nervous System
Releases Acetylcholine
Calms body down

Points to emphasize:

- Anxiety is normative and time-limited
- Staying in the situation leads to habituation
Panic Disorder (Video)
Panic Disorder

- Recurrent unexpected panic attacks
- 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
- Not better accounted by another disorder
- May include agoraphobia (anxiety about being in situations from which escape might be difficult; situations are avoided or endured with marked distress)
Panic Attack Symptoms

- Difficulty breathing
- Sweating
- Chest pain/discomfort
- Dizziness, faintness
- Tingling or numbness
- Trembling or shaking
- Nausea
- Palpitations

- Choking or smothering sensations
- Hot flashes or chills
- Feelings of unreality or detachment
- Fear of dying
- Fear of going crazy
- Fear of losing control
Prevalence and Course

- 1-year prevalence = 2.3%
- Lifetime prevalence = 3.5% (Kessler et al, 1994)
- ~ 15% of population have had a panic attack
- More common in women
- Age of onset: typically mid-teens or early adulthood
CBT Panic Model – An Example

Environment: Sitting in a meeting

Physical Sensations
Dizziness, flushed

Thoughts
“There must be something wrong with me.”
“There these symptoms are dangerous.”

Emotions
Anxiety, fear

Behavioural Responses
Monitoring of symptoms
Escape / Avoidance
Social Anxiety Disorder (Video)
Social Anxiety Disorder

A. Marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.

B. Exposure to the feared situation invariably provokes anxiety, which may involve a situationally bound panic attack.

C. The person recognizes that the fear is excessive or unreasonable

D. The feared social or performance situations are avoided or endured with intense anxiety or distress.

E. The avoidance, anxious anticipation or distress causes significant impairment
Prevalence and Course

Lifetime prevalence rate: 15.5% females, 11.1% males (National Comorbidity Survey; Kessler et al., 1994)

Six-month prevalence 1.2%-2.2% (Eaton et al., 1991)

Comorbidity: 46% meet criteria for another anxiety or mood disorder, 28% another anxiety disorder alone, 29% another mood disorder alone (MDD) (Brown, Campbell, Lehman, Grisham & Mancill, 2001)
CBT Social Anxiety Model – Example

**Environment:** Social Interaction
(Focus of Attention Changes)

**Physical Sensations**
Blushing, sweating, breathing changes, racing heartbeat, abdominal distress

**Behavioural Responses**
- Monitoring of symptoms
- Escape / Avoidance
- Monitor self/others
- Rehearsal
- Plan an “Exit Strategy”

**Thoughts**
- Mindreading: “I think….they think”
- Anticipatory: “I’ll make a social error and be rejected”

**Emotions**
Anxiety, fear
Generalized Anxiety Disorder: Diagnostic Criteria

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not 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

continued…
Generalized Anxiety Disorder: Diagnostic Criteria

D. The focus of the anxiety and worry is not confined to features of another Axis I disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effect of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.
Generalized Anxiety Disorder: Prevalence and Course

**Lifetime prevalence rate:** 5% (American Psychiatric Association, 2000)

**Six-month prevalence** 3% (American Psychiatric Association, 2000)

**Comorbidity:** 40% meet criteria for another anxiety or mood disorder, (Brown, Campbell, Lehman, Grisham & Mancill, 2001)
CBT GAD Model – An Example

Environment: Uncertainty – What if?
(Domains: Finances, health, safety, job performance)

Physical Sensations
Blushing, sweating, breathing changes, racing heartbeat, abdominal distress

Thoughts
What if “chain”:
What if… I make a mistake at work?
Then get reprimanded…
Then lose my job…
Then fail to make my mortgage payment…
Then my partner will leave me…

Emotions
Anxiety, fear

Behavioural Responses
Monitoring of symptoms
Escape / Avoidance
Checking Behaviours
Reassurance Seeking
Procrastination
Obsessive-Compulsive Disorder (OCD) (Video)
Obsessive-Compulsive Disorder (OCD) Diagnosis

Presence of obsessions, compulsions, or both

Obsessions
- persistent unwanted thoughts, urges or images
- intrusive, unwanted, uncontrollable/excessive
- provoke marked anxiety or distress

Compulsions
- repetitive behaviours (e.g., hand washing, ordering, checking), or mental acts (e.g., praying, counting, repeating
- performed in response to an obsession, in ritualistic fashion
- intended to reduce discomfort or prevent feared event
OCD

Facts & Figures

Lifetime prevalence: 2-3%

BUT significant OC symptoms found in up to 10% of psychiatric outpatients

Metropolitan Toronto: estimated 6,055,724 people

Severe – WHO10th leading cause of disability

High comorbidity:

- Depression, anxiety disorders, spectrum conditions

Typically chronic, lifelong

- 20% remission over 40 years
OCD

Quality of Life

Associated with functional impairment:

• education
  • 58% ↓ academic achievement

• employment
  • 66% ↓ career aspirations
  • 40% unable to work

• relationships (family, romantic, social)
  • 62% fewer friends/difficulty maintaining friends

• 13% attempted suicide

Hollander et al, J Clin Psych, 1996
Obsessive Thought/Images Domains

Doubting (e.g., lock doors, turn appliances off, completion and/or accuracy of tasks)

Rituals: Checking
Obsessive Thought/Images Domains

- Contamination (e.g., contracting germs from doorknobs, toilets, money, etc.)

Rituals: Elaborate washing, checking
Obsessive Thought/Images Domains

- **Aggressive impulses** (hurting self or others, destroying objects)

- **Rituals:** Checking, reassurance seeking, mental rituals (thought suppression, thought replacement, protective phrases / numbers / prayers / behaviours)
Obsessive Thought/Images

Domains

- **Symmetry/exactness** (objects are misaligned, in disarray, or not “perfect”)

- **Rituals**: Ordering, arranging, placing objects “correctly”
**Obsessive Thought/Images Domains**

- Sexual thoughts/images
- Religious/Satanic thoughts/images

- **Rituals:** Checking, mental rituals (thought suppression, thought replacement, protective phrases / numbers / prayers / behaviours)
Compulsions: Domains

- Washing  Checking  Counting  Internal Repetition
- Adhering to rules or sequences (e.g., assuring symmetry, adhering to specific routines)
- What is the function of the compulsion?
CBT for OCD
CBT Model of OCD

**Trigger**
Some wants to shake hands

**Intrusive Thought or Image**
This is filthy – I’m going to become sick and make everyone sick”

**Anxiety**
80%

**Ritual**
Fist bump, excessive cleaning, washing, checking

**Anxiety Reduction**
Intrusive thoughts become associated through classical conditioning processes, with anxiety that has subsequently failed to extinguish. This occurs due to rituals that prevent the extinction of the anxiety. Cognitive appraisals of intrusive thoughts further reinforce this pattern.
• When experiencing a triggering stimulus, patients experience a steep increase in anxiety and an accompanying urge to carry out a relevant compulsive ritual.
• If the compulsive ritual is carried out, anxiety declines.
• Clients continue to engage in rituals continue because the rituals function to reduce anxiety symptoms.
Behaviours That Maintain Anxiety

- Escape
- Avoidance
- Cognitive Distraction
- Thought Control
- Covert/Overt Rituals
- Neutralization Behav
- Mental Ruminaton

SAFETY BEHAVIOURS

ANXIETY

TIME

Anxiety Trigger
Process of Exposure/Response Prevention (ERP) Treatment

• Define a range of obsessional triggers
• Establish the range of discomfort associated with each trigger
• Establish a hierarchy
• Therapy would progress by systematically exposing the patient to each of these 10 situations with prevention of rituals or avoidance activity
# Contamination Hierarchy

![Image of Contamination Hierarchy]

<table>
<thead>
<tr>
<th>DISTRESSING SITUATION/OBJECT</th>
<th>DISTRESS (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most distressing: reading or moving school papers, ads, newspapers; eating or cooking with high allergic foods</td>
<td>70</td>
</tr>
<tr>
<td>2\textsuperscript{nd} most distressing: pumping gas</td>
<td>70</td>
</tr>
<tr>
<td>3\textsuperscript{rd} most distressing: gardening with gloves, turning stove on/off</td>
<td>65</td>
</tr>
<tr>
<td>4\textsuperscript{th} most distressing: washing off cans, bottles, bags</td>
<td>60</td>
</tr>
<tr>
<td>5\textsuperscript{th} most distressing: turning off light switches, sweeping</td>
<td>55</td>
</tr>
<tr>
<td>6\textsuperscript{th} most distressing: vacuuming</td>
<td>50</td>
</tr>
<tr>
<td>7\textsuperscript{th} most distressing: placing dish on floor</td>
<td>45</td>
</tr>
<tr>
<td>8\textsuperscript{th} most distressing: opening cupboards during cooking</td>
<td>40</td>
</tr>
<tr>
<td>9\textsuperscript{th} most distressing: petting cats / dogs</td>
<td>35</td>
</tr>
<tr>
<td>10\textsuperscript{th} most distressing: sorting dirty laundry, adding dirty laundry to machine, killing insects with Kleenex</td>
<td>30</td>
</tr>
</tbody>
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What is a Body-Focused Repetitive Behaviour (BFRB)?

• A BFRB can be defined as any self-grooming behaviour that an individual engages in for non-cosmetic reasons.
• The self-grooming behaviour can include pulling, picking, biting, scraping of hair, skin, nails, etc.
• Common examples include:
  • Hair pulling
  • Skin picking
  • Nail biting
  • Cheek biting or chewing
  • Thumb sucking
  • Knuckle cracking

Epidemiology and Course

- Non-cosmetic hair pulling in college students – 10% to 15%
- 2-5% of the population meet diagnostic criteria for Trichotillomania (TTM), with estimates changing depending on the diagnostic criteria used.
- 5% of the population meet diagnostic criteria for compulsive skin picking (CSP)
- Adult women diagnosed with TTM outnumber men (80-90% female).
  - May be more related to women being more likely to seek treatment or present for research studies than the actual prevalence rates.
  - It is also often easier for men to conceal the hair loss (e.g., shave to conceal pulling from the beard) and is more socially accepted for males to experience hair loss on the scalp.
Online Resources

Frederick W. Thompson Anxiety Disorders Centre:  www.sunnybrook.ca/thompsoncentre

Canadian OCD Network  www.canadianocdnetwork.com

Canadian Institute for Obsessive Compulsive Disorders  www.ictoc.org

Anxiety Disorders Association of Canada  www.anxietycanada.ca

Anxiety Disorders Association of Ontario  www.anxietydisordersontario.ca

Obsessive-Compulsive Foundation  www.ocfoundation.org

Anxiety Disorders Clinic, McMaster University website  www.macanxiety.com

Ontario Obsessive-Compulsive Disorder Network  www.ocdontario.org