| Subject Name | Subject Code | Prepared by |
|---|---|---|
| **ABNORMAL PSYCHOLOGY - I** | 18BPS33C | Dr. S. Rajakumari<br>M.A, M. Phil, MBA, Ph.D.<br>Dept. Of Psychology,<br>Ph- 9442525919 |

## ANXIETY DISORDERS

**Anxiety** refers to a sense of agitation or nervousness, which is focused on an upcoming potential danger. The anxiety response pattern is a complex blend of unpleasant emotions and cognitions that is more oriented to the future and much more diffuse than fear.

It has cognitive/subjective, physiological and behavioural components:

- At the cognitive/subjective level, anxiety involves negative mood, worry about possible future threats or danger, self-preoccupation, and a sense of being unable to predict the future threat or to control it if it occurs.

- At a physiological level, anxiety often creates a state of tension and chronic over-arousal, which lead to risk assessment and readiness for dealing with danger if it occurs.

- At a behavioural level, anxiety may create a strong tendency to avoid situations where danger might be encountered.

The adaptive value of anxiety is that it helps to plan and prepare for possible threat. In mild to moderate degrees, anxiety actually enhances learning and performance. It is maladaptive when it becomes chronic and severe, as in people diagnosed with anxiety disorders.

**Anxiety disorders** refer to a category of psychological disorders in which the primary symptoms involve extreme anxiety, intense arousal, and/or extreme attempts to avoid stimuli that lead to fear and anxiety.

For a person with an anxiety disorder, the anxiety does not go away and can get worse over time. The feelings can interfere with daily activities such as job performance, school work, and relationships. When people perceive a threat, the fight-or-flight response (the automatic neurological and bodily response) arises. This response

underlies the fear and anxiety involved in almost all anxiety disorders.
When the arousal feels out of control the person may experience panic. In response to the panic, some people develop a phobia of stimuli related to their panic and anxiety symptoms.

Anxiety disorders frequently co-occur with other psychological disorders, such as depression or substance-related disorders. The high comorbidity of depression and anxiety disorders suggests that the two disorders share some of the same features, specifically high levels of negative emotions and distress, which can lead to concentration and sleep problems and irritability.

Mental health clinicians must determine whether the anxiety symptoms are the primary cause of the problem or are the by-product of another type of disorder.

***The different types of anxiety disorders are described below.***

**PHOBIAS**

A phobia is a persistent and disproportionate fear of some specific object or situation that presents little or no actual danger but leads to greater avoidance of these feared situations. There are three main categories of phobias:

(1) Specific phobia,
(2) social phobia, and
(3) agoraphobia.

**SPECIFIC PHOBIA**

This anxiety disorder is characterized by excessive or unreasonable anxiety or fear related to a specific situation or object. Specific phobias include claustrophobia (fear of small spaces), arachnophobia (spiders), and acrophobia (heights). DSM-IV-TR lists five types or categories of specific phobias as shown below.

| **Phobia Type** | **Examples** |
|---|---|
| Animal | Snakes, spiders, dogs, insects, birds |
| Natural Environment | Storms, heights, water |
| Blood-Injection-Injury | Seeing blood or an injury, receiving an injection,<br>seeing a person in a wheelchair |
| Situational | Public transportation, tunnels, bridges, elevators,<br>flying, driving, enclosed spaces |
| Other | Choking, vomiting, “space phobia” (fear of falling<br>down if away from walls or other support) |

When individuals with specific phobias encounter a phobic stimulus, they

often show an immediate fear response, similar to a panic attack. Such individuals also experience anxiety if they anticipate they may encounter a phobic object or situation and hence try to avoid encounters with the phobic stimulus. They even avoid seemingly innocent representations of it such as photographs or television images

## DSM-IV-TR DIAGNOSTIC CRITERIA

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack.

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

D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships

F. In individuals under age 18 years, the duration is at least 6 months.

G. The anxiety, Panic Attacks, or phobic avoidance are not better accounted for by another mental disorder.

## CAUSAL FACTORS

- Neurotransmitters including GABA, serotonin, acetylcholine, and norepinephrine and role of genes

- Psychological factors include operant conditioning (negative reinforcement of avoiding the feared stimulus), and cognitive biases related to the stimulus (such as overestimating the probability that a negative event will occur following contact with the feared stimulus).

- Observational learning—a social factor—can influence what particular stimulus a person comes to fear.

## TREATMENT

- Medication (targeting neurological factors), specifically a benzodiazepine.

- CBT is extremely effective, particularly when exposure is part of the treatment

## SOCIAL PHOBIA

Social phobia is an intense fear of public humiliation or embarrassment, together with an avoidance of social situations which may cause this fear. When such social situations cannot be avoided, they trigger panic or anxiety. Social phobia may be limited to specific types of performance-related situations or may be generalized to most social situations.

The anxiety about performing poorly and being evaluated by others can, in turn, impair an individual's performance, creating a vicious cycle. The symptoms of social phobia may lead individuals with this disorder to be less successful than they could otherwise be, because they avoid job-related social interactions that are required for advancement.

## DSM-IV-TR DIAGNOSTIC CRITERIA

A. 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 social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack.

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

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

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships

F. In individuals under age 18 years, the duration is at least 6 months

G. The fear or avoidance is not due to the direct physiological effects of a substance or a general medical condition and is not better accounted for by another mental disorder

## CAUSAL FACTORS

- Neurological factors include an amygdala that is more easily activated in response to social stimuli, too little dopamine in the basal ganglia, too little serotonin, and a genetic predisposition toward a shy temperament.

- Psychological factors include cognitive distortions and hypervigilance for social threats— particularly about being (negatively) evaluated. Classical conditioning of a fear response in social situations may contribute to social phobia; avoiding feared social situations is then negatively reinforced (operant conditioning).

- Social factors that give rise to social phobia include parents' modelling or encouraging a child to avoid anxiety-inducing social interactions.

## TREATMENT

- Medication, specifically, beta-blockers for periodic performance anxiety, and Selective Serotonin Reuptake Inhibitors (SSRIs) or Selective Norepinephrine Reuptake Inhibitors (SNRIs) for more generalized social phobia.

- CBT, specifically, exposure and cognitive restructuring.

- Treatments that target social factors include group CBT and exposure to feared social stimuli.

## AGORAPHOBIA

Agoraphobia involves persistent avoidance of situations that might trigger panic symptoms or from which escape would be difficult. Many patients with agoraphobia may avoid places in which it would be embarrassing or hard to obtain help in case of a panic attack.

For these reasons, tunnels, bridges, crowded theatres, and highways are typically avoided or entered with difficulty by people with agoraphobia.

## DSM-IV-TR DIAGNOSTIC CRITERIA

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or paniclike symptoms. Agoraphobic fears typically involve characteristic situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.

C. The anxiety or phobic avoidance is not better accounted for by another mental disorder.

Agoraphobia is not a separate DSM-IV-TR disorder. Patients who meet the criteria for agoraphobia are diagnosed with either panic disorder with agoraphobia or agoraphobia without history of panic disorder, depending on the presence or absence of panic disorder

. When agoraphobia develops, it usually does so within the first year of recurrent panic attacks. For some individuals, as panic attacks decrease, agoraphobia decreases; for others, there is no such relationship. Because people with agoraphobia avoid situations that are associated with past panic attacks, they do not learn that they can be in such situations without having a panic attack.

## PANIC ATTACKS

**Panic attack refers to** a specific period of intense dread, fear, or a sense of imminent doom, accompanied by physical symptoms of a pounding heart, shortness of breath, shakiness, and sweating.
During a panic attack, the symptoms generally begin quickly, peak after a few minutes, and disappear within an hour. In some cases, panic attacks are cued—they are associated with particular objects, situations, or sensations.

In other cases, panic attacks are uncued—they are spontaneous—they come out of the blue, and are not associated with a particular object or situation. Panic attacks can occur at any time, even while sleeping (referred to as nocturnal panic attacks).

Recurrent panic attacks may interfere with daily life (for example, if they occur on a bus or at work) and cause the individual to leave the situation to return home or seek medical help. The symptoms of a panic attack are so unpleasant that people who suffer from this disorder may try to prevent another attack by avoiding environments and activities that increase their heart rates.

A typical panic attack involves a discrete period of intense fear or discomfort, in which at least four of the following symptoms develop abruptly 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
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- feeling dizzy, unsteady, lightheaded, or faint
- Derealization (feelings of unreality) or depersonalization (being detached from oneself )
- Fear of losing control or going crazy
- Fear of dying
- Paraesthesia (numbness or tingling sensations)
- Chills or hot flushes

## PANIC DISORDER

**Panic disorder** is anxiety disorder characterized by frequent, unexpected panic attacks, along with fear of further attacks and possible restrictions of behaviour in order to prevent such attacks.

Panic disorder is most likely to arise during two phases of life: the teenage years or the mid-30s. The frequency of panic attacks varies from person to person and over time. The diagnostic criteria for panic disorder without agoraphobia is given below.

## DSM-IV-TR DIAGNOSTIC CRITERIA

A. Both (1) and (2):

(1) recurrent unexpected Panic Attacks

(2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:

(a) persistent concern about having additional attacks
(b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)
(c) a significant change in behaviour related to the attacks

B. Absence of Agoraphobia

C. The Panic Attacks are not due to the direct physiological effects of a substance or a general medical condition

D. The Panic Attacks are not better accounted for by another mental disorder

**CAUSAL FACTORS**

- Neurological factors that contribute to panic disorder and agoraphobia include a heightened sensitivity to detect breathing changes, involving withdrawal emotions and the right frontal lobe, the amygdala, and the hypothalamus; too much norepinephrine, which increases heart and respiration rates and other aspects of the fight-or-flight response; and a genetic predisposition to anxiety disorders.

- Psychological factors include conditioning of the bodily sensations of panic or of external cues related to panic attacks; heightened anxiety sensitivity and misinterpretation of bodily symptoms of arousal as symptoms of a more serious problem, such as a heart attack, which can, in turn, lead to hypervigilance and fear of further sensations, causing increased arousal.

- Social factors include greater than average number of social stressors during childhood and adolescence; the presence of a safe person, which can decrease catastrophic thinking and panic; and cultural factors, which can influence whether people develop panic disorder.

**TREATMENT**

- Medication, specifically benzodiazepines for short-term relief and antidepressants for long-term use.

- CBT is the first-line treatment for panic disorder. Behavioural methods focus on the bodily signals of arousal, panic, and agoraphobic avoidance. Cognitive methods (psychoeducation and cognitive restructuring) focus on the misappraisal of bodily sensations and on mistaken inferences about them.

• Treatments that target social factors include group therapy focused on panic disorder, and couples or family therapy, particularly when a family member is a safe person.

## GENERALIZED ANXIETY DISORDER

**Generalized anxiety disorder (GAD) is the** anxiety disorder characterized by uncontrollable worry and anxiety about a number of events or activities that are not solely the focus of another Axis I disorder. The worry and anxiety among individuals suffering from GAD primarily focus on family, finances, work, and illness. Their worries intrude into their awareness when they are trying to focus on other thought and they cannot stop worrying.

People with GAD feel a chronic, low level of anxiety or worry about many things. Moreover, the fact that they constantly worry in itself causes them distress. Most people with GAD also have comorbid depression.

## DSM-IV-TR DIAGNOSTIC CRITERIA

A. Excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities

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

(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

D. The focus of the anxiety and worry is not confined to features of an 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 effects of a substance a general medical condition.

## CAUSAL FACTORS

- Neurological factors include unusually strong activation in the right front lobe, abnormal activity of serotonin, dopamine, and other neurotransmitters, and a genetic predisposition to become anxious and/or depressed.

- Psychological factors that contribute to GAD include being hypervigilant for possible threats, a sense that the worrying is out of control, and the reinforcing experience that worrying prevents panic.

- Social factors that contribute to GAD include stressful life events.

## TREATMENT

- medication which targets neurological factors

- CBT (which targets psychological factors), including breathing retraining, muscle relaxation training, worry exposure, cognitive restructuring, self-monitoring, problem solving, psychoeducation, and/or meditation. CBT may be employed in a group format.

## POSTTRAUMATIC STRESS DISORDER (PTSD)

**Posttraumatic stress disorder (PTSD)** is diagnosed when people who have experienced a trauma persistently re-experience the traumatic event, avoid stimuli related to the event, and have symptoms of anxiety and hyperarousal; these symptoms must persist for at least a month.

An event is considered traumatic if the individual experienced or witnessed an actual or threatened death or serious injury and responded with intense fear, helplessness, or horror.

Types of traumatic events are large-scale events with multiple victims, unintended acts involving smaller numbers of people, and interpersonal violence. Interpersonal violence is more likely to lead to a stress disorder, as are other events in which the trauma is severe, of long duration, and of close proximity.

In PTSD a traumatic event is thought to cause a pathological memory that is at the centre of the characteristic clinical symptoms of the disorder. These memories are often brief fragments of the experience and have events that happened just before the moment with the largest emotional impact.

**DSM-IV-TR DIAGNOSTIC CRITERIA**

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions

(2) Recurrent distressing dreams of the event.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes)

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning..

**CAUSAL FACTORS**

- High levels of norepinephrine, abnormal serotonin function and decreased production of cortisol in response to the traumatic event.

- Psychological factors that exist before a traumatic event include a history of depression or other psychological disorders, a belief in being unable to control stressors, the conviction that the world is a dangerous place, and lower IQ. After a traumatic event, classical and operant conditioning contribute to the avoidance symptoms.

- **S**ocial factors include low socioeconomic status and a relative lack of

social support for the trauma victim. Culture can influence the ways that individuals cope with traumatic stress.

## TREATMENT

- Medication, specifically an SSRI.

- CBT, specifically psychoeducation, exposure, relaxation, breathing retraining, and cognitive restructuring.

- Treatments that target social factors are designed to ensure that the individual is as safe as possible from future trauma and to increase social support through group therapy or family therapy.

## SOMATOFORM DISORDERS

Somatoform disorders are psychological disorders characterized by complaints about physical well-being that cannot be entirely explained by a medical condition, substance use, or another psychological disorder. Somatoform disorders are relatively rare in the general population but are the most common type of psychological disorder in medical settings. A third of patients visiting their primary care physician have symptoms that are not adequately explained by a medical condition. Somatoform disorders must be distinguished from factitious disorder, in which people intentionally induce symptoms or falsely report symptoms that they do not have to receive attention from others. Those with a somatoform disorder neither pretend to have symptoms nor intentionally induce physical symptoms for any type of gain. By their very nature, however, somatoform disorders are "rule out" diagnoses, meaning that the clinician must make sure that there aren't medical conditions or other psychological disorders that can better explain the patients' physical symptoms.

***Somatoform disorders share two common features:***

1. *bodily preoccupation*, which is similar to the heightened awareness of panicrelated
bodily sensations experienced by people with panic disorder, except that with somatoform disorders the patient can be preoccupied with any aspect of bodily functioning; and

2. *Symptom amplification*, or directing attention to bodily symptoms, which in turn intensifies the symptoms. A common example of symptom amplification occurs when someone with a headache pays attention to the headache–and the

pain worsens.