# Chapter 6
# Anxiety disorders

**LEARNING OBJECTIVES**

After reading and studying this chapter and participating in lectures and discussions, students should have an understanding of:

1. The common biological bases of anxiety disorders.
2. The nature, aetiology, and treatment of specific phobias.
3. The nature, aetiology, and treatment of panic disorder.
4. The nature, aetiology, and treatment of Generalized Anxiety Disorder.
5. The nature, aetiology, and treatment of Obsessive-Compulsive Disorder.

**CHAPTER OUTLINE**

6.1 A common biological pathway

6.2 Specific phobias
- Aetiology of phobias
- Socio-economic status
- Psychoanalytic models
- Behavioural models
- A cognitive behavioural model
- Biological/evolutionary model
- Biological mechanisms

Treatment of phobias
- Cognitive/behavioural treatments
- Pharmacological treatments

6.3 Panic disorder
- Aetiology of panic disorder
- Biological mechanisms

Social factors
Psychological explanations
Treatment of panic disorder
Cognitive behavioural interventions
Pharmacological treatments

6.4 Generalized anxiety disorder (GAD)
Aetiology of GAD
Biological mechanisms
Psychoanalytic explanations
Humanistic explanations
Socio-cultural factors
Cognitive explanations
Treatment of generalized anxiety disorder
Cognitive behavioural treatment
Psychoanalytic therapy
Pharmacological therapy

6.5 Obsessive compulsive disorder
Aetiology of obsessive-compulsive disorder
Biological mechanisms
Psychoanalytic explanations
Behavioural explanations
Cognitive explanations
Treatment of obsessive-compulsive disorder
Behavioural and cognitive behavioural approaches
Pharmacological interventions

**QUESTIONS FOR DISCUSSION**

These may be helpful to include at the beginning of the teaching session to get a sense of where students lie on these issues, to spark some interest in them, and as a link to refer to as the lecture progresses.

1. Which of the following brain areas/networks is *not* associated with anxiety?

a. Septo-hippocampal system
b. Papez circuit
c. Temporo-frontal network

2. What is the key approach used in the treatment of most anxiety disorders?
    a. exposure with response prevention
    b. cognitive restructuring
    c. behavioural hypothesis testing

3. Panic disorder is defined by…
    a. Increases in panic in response to an initially feared context
    b. The onset of panic with no obvious initial trigger
    c. A slow increase in anxiety leading to panic associated with a specific stimulus

4. In the context of anxiety disorders, what is a compulsion?
    a. A thought or feeling of anxiety that can only be relieved by engaging in some sort of safety behaviour
    b. An internal or external action designed to reduce the threat associated with a particular context
    c. A need to engage in a form of behaviour that places the individual at risk of anxiety or distress

**LECTURE SUGGESTIONS**

The lecture can be framed as a transtheoretical approach to anxiety disorders (including OCD, which no longer has this designation in DSM, but fits from a theoretical perspective), in that there are common biological pathways to anxiety and many commonalities in their aetiology and treatment.

Although specific theories do differ in detail, with the exception of panic disorder, they all have a central tenet: long-term anxiety problems are initiated by contexts that evoke fear and are maintained by cognitive distortions and attempts at avoidance of the feared context. Where this is not possible (such as in OCD), coping behaviours have the same function; to reassure that the threat has been diminished in some way. As such, each response can be seen as a form of *safety behaviour* – either avoidance of things that *can* be identified and avoided, or compulsions as a means of reducing the threat associated with stimuli or contexts that *cannot* be avoided.

although the details may differ, the key intervention in all anxiety conditions involves exposure with response prevention, where exposure to the feared stimulus and response prevention involves not engaging in safety behaviours, whether these are internal such as compulsive thoughts, or external: avoidance of compulsive behaviours. Other adjunctive therapeutic strategies and skills such as cognitive reframing, mindfulness, and relaxation are likely to be effective only as much as they facilitate this exposure process.

Of note, where an individual experiences panic in relation to specific contexts, such as a phobic stimulus, this may be the same 'experience' of panic in panic disorder, but it does not lead to a diagnosis of panic disorder. Central to this is that the episodes of panic are, at least initially, 'out of the blue' and triggered by usually innocuous circumstances (feeling short of breath, high arousal associated with anger and so on). Only in time do they become conditioned responses to identifiable stimuli. Also of note is that while descriptions of panic often describe catastrophic thoughts during a panic, such as 'I am going to have a heart attack... I could die', more frequent thoughts are often less catastrophic but still distressing and may be more focused on 'fainting and making a fool of myself'.

## CLASSROOM ACTIVITIES

**Homework:** as a clinical psychologist, I used to find large roller coaster rides very intimidating… yes, even frightening. But on the odd occasion I went to a leisure park I would make myself ride on them, on the basis that if I asked my clients to do scary things, so should I. So, on this basis, why not encourage students to find something that makes them anxious (presentations to the class, spiders, 'chatting up' people you find attractive, etc.) and develop a hierarchy of steps and potential coping strategies to help them overcome this. If they feel really brave... give them a try!

**Case discussion in pairs:** construct a hierarchy of exposure for someone with one of the following fears: (i) driving in traffic, (ii) speaking in public, or (iii) snakes. Bear in mind that the gradation of exposure within any hierarchy has to be large enough to make the person feel they are progressing, while not so large that they are overwhelmed and cannot cope. Also to consider, are issues of the controllability of the environment. In the context of car driving, the behaviours of other road users are inherently unpredictable, so how would you work around this? Speaking in public may also be problematic. If the fear is incapacitating, how would you begin? What it the person is a poor speaker and are likely to get audiences showing boredom or disengagement, should you consider teaching speaking skills? The basics of graded exposure are pretty simple; the reality can be quite different.

**Small group discussion**: should the government support people experiencing significant anxiety as a consequence of population level issues such as covid-19. If so, how should they do this? Think beyond simply providing online anxiety management and explore other issues. What impact are the health messages given out through health and government agencies, the way the media handles the issue, the confidence we have in politicians and health providers? How can communities identify and support individuals experiencing problems within them? Should we be providing pharma treatments or psychological treatment – and if the latter, who should provide – there are not enough psychologists to do this role? What about online support? And so on….