Anxiety Stops Here: 10 Powerful Interventions

Dr. Sue Futeral, PhD, LCSW-C

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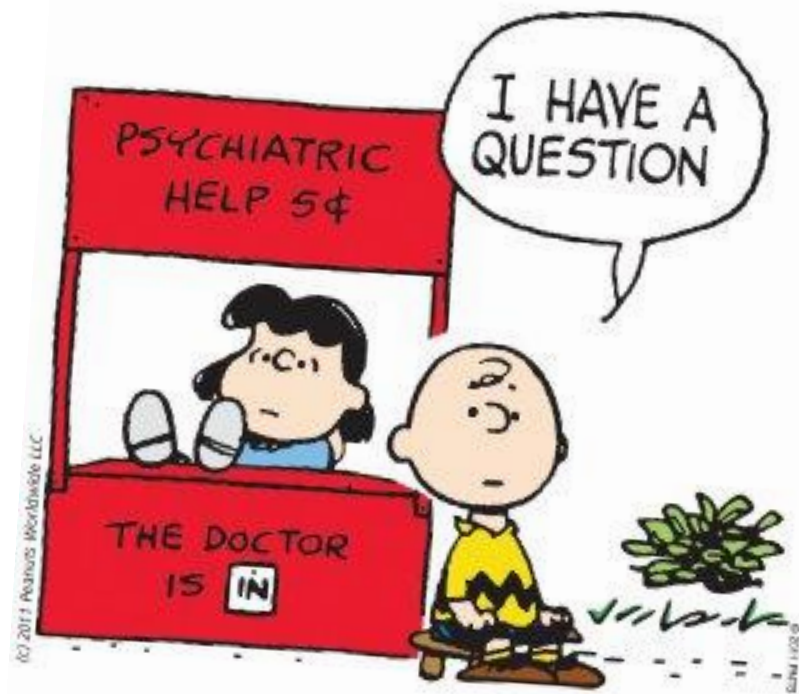
About the Presenter

Dr. Sue Futeral, PhD, LCSW-C, C-EAT, is a two-time graduate of the University of Maryland, School of Social work, earning both her Masters and PhD degrees there. She has won two awards from the University of Maryland, 50 heroes of Social Justice and Outstanding Social Worker, Alumni Association. Sue has served as a school counselor in BCPS as well as working in private practice and is known for her engaging presentations delivered with skill, passion and expertise.

Sue is married and has three adult children and one cat as well. Sue plays violin, piano, trombone, recorder, and many percussion instruments. She enjoys drawing, painting, sculpting, clay and crafts such as knitting.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THE DOCTOR IS IN
I HAVE A QUESTION
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Schedule

- Part 1: Assessment and Differential Diagnosis
- Part 2: 5 Techniques for physiological anxiety and
- Panic disorder
- Part 3: 5 Techniques for Social Anxiety and severe cases: Q&A

OBJECTIVES

- Review basic concepts related to anxiety disorders, including safety behaviors/signals and primary features.
- Outline the epidemiology of anxiety disorders in the United States.
- Describe general risk factors for and comorbidities of anxiety disorders.
- Describe risk factors for and the clinical course of specific anxiety disorders.
- Discuss the pathogenesis of anxiety disorders in relation to contributing genetic, physiologic, and psychologic factors.

OBJECTIVES

Review the pathophysiology of specific anxiety disorders, including social anxiety disorder, agoraphobia, and specific phobia.
Evaluate the clinical and diagnostic criteria for anxiety disorders presented in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).
Analyze key components of screening for anxiety disorders.
List conditions to consider in the differential diagnosis of anxiety disorders.
Describe general treatment considerations for anxiety disorders, including predictors of response or nonresponse to therapy.

OBJECTIVES

- Discuss the role of various psychotherapy approaches in the treatment of anxiety disorders.
- Outline pharmacotherapy options for the treatment of anxiety disorders.
- Recognize clinical issues related to the treatment of anxiety disorders.
- Compare and contrast the treatment recommendations for specific anxiety disorders.
- Analyze the evidence base supporting the efficacy of novel, emerging, and alternative/complementary approaches to the treatment of anxiety disorders.

What is ANXIETY?

- https://www.youtube.com/watch?v=9mPwQTiMSj8/
- You Tube video on GAD

"Of course you feel great. These things are loaded with antidepressants."

WHY CAN'T I EAT LUNCH WITH THAT LITTLE RED-HAIRED GIRL? THEN I'D BE HAPPY...

RATS! NOBODY IS EVER GOING TO LIKE ME..

LUNCH HOUR IS THE LONELIEST HOUR OF THE DAY!
Tm. Reg. U. S. Pat. Off.—All rights reserved
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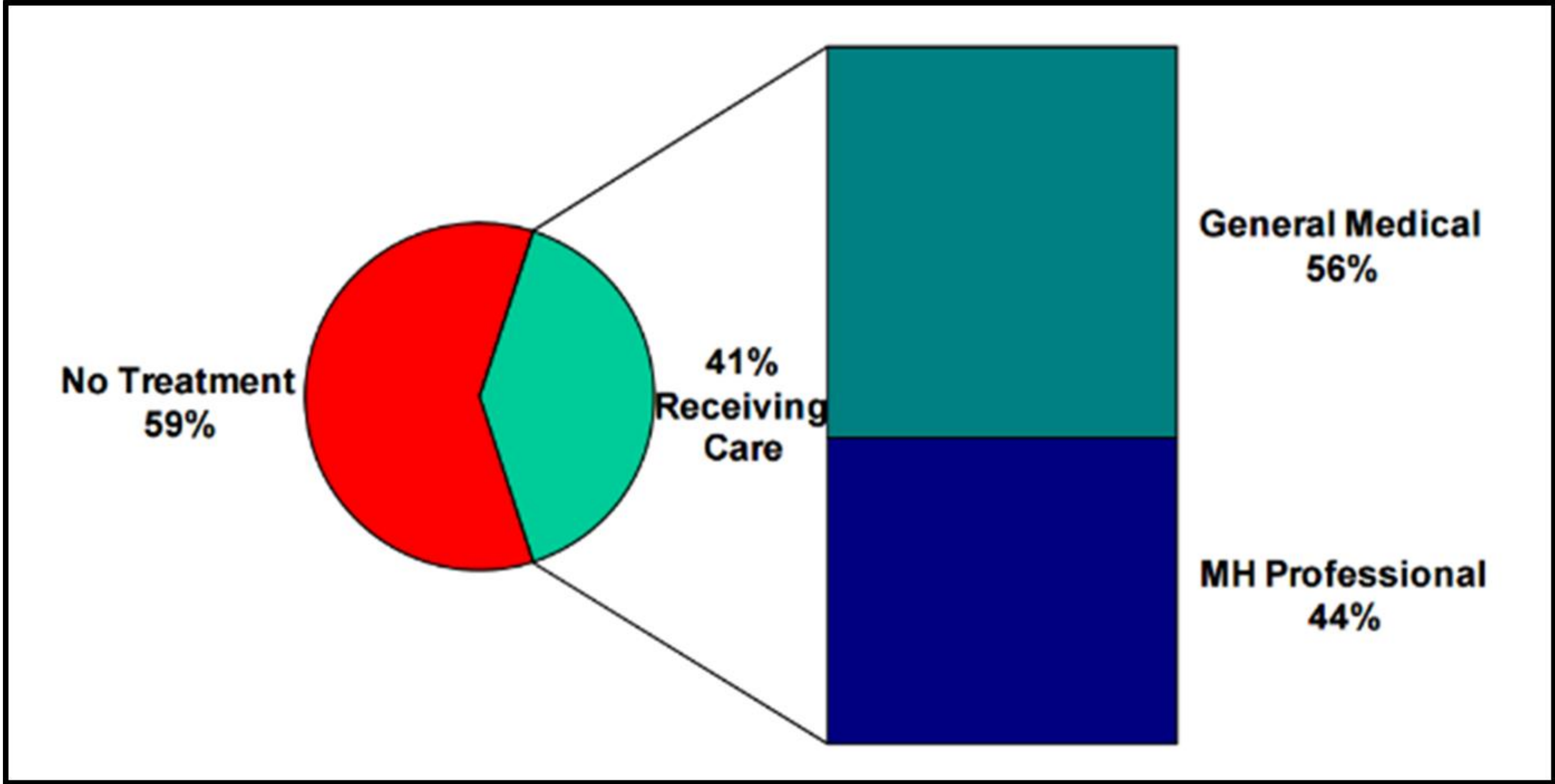
SCHULZ


No Treatment
59%
41%
Receiving
Care
General Medical
56%
MH Professional
44%

Anxiety Disorders

- Often have an early onset- teens or early twenties
- Show 2:1 female predominance
- Have a waxing and waning course over lifetime
- Similar to major depression and chronic diseases such as diabetes in functional impairment and decreased quality of life

Normal vs Pathological Anxiety

- Normal anxiety is adaptive. It is an inborn response to threat or to the absence of people or objects that signify safety can result in cognitive (worry) and somatic (racing heart, sweating, shaking, freezing, etc.) symptoms.
- Pathologic anxiety is anxiety that is excessive, impairs function.

Neuroanatomy Review

- Amygdala- involved with processing of emotionally salient stimuli
- Medial prefrontal cortex (includes the anterior cingulate cortex, the subcallosal cortex and the medial frontal gyrus)- involved in modulation of affect
- Hippocampus- involved in memory encoding and retrieval

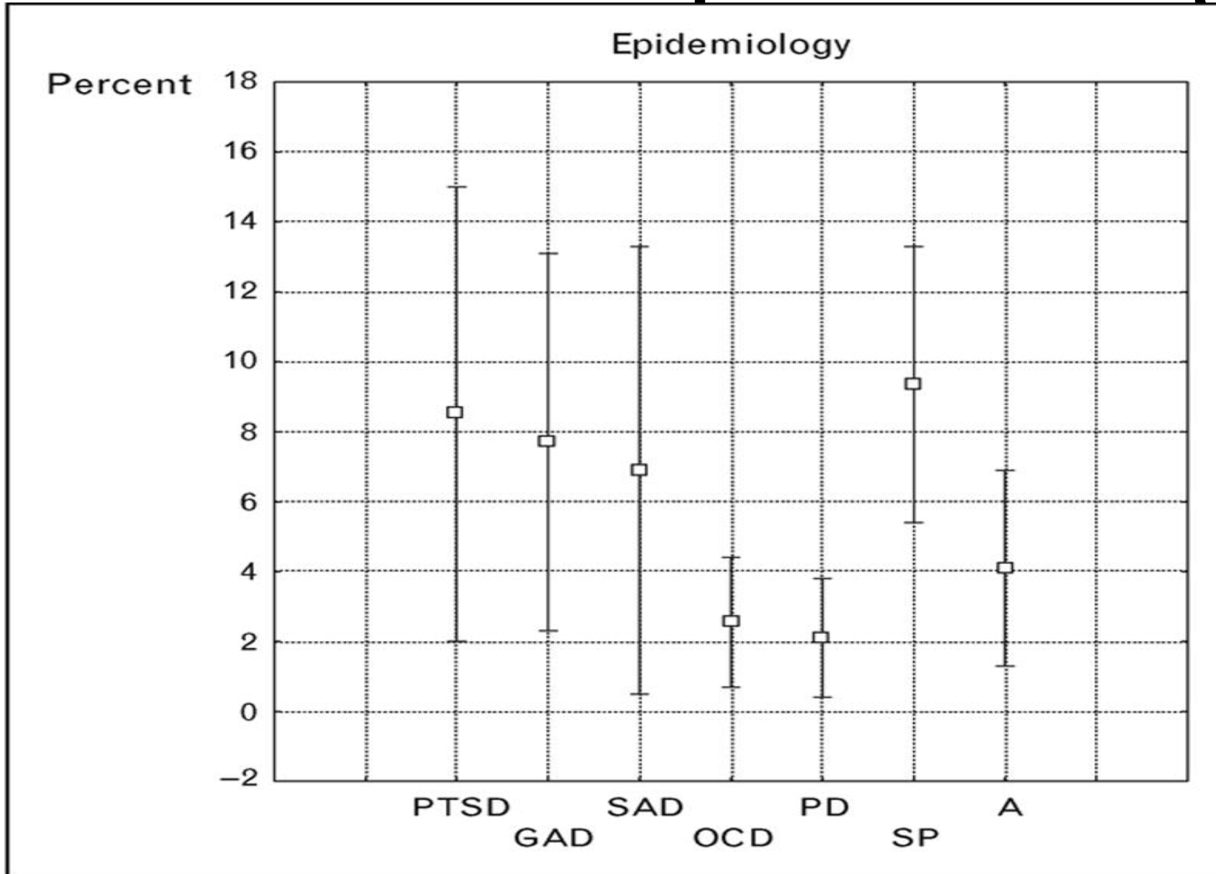
- Anxiety may be due to one of the primary anxiety disorders OR secondary to substance abuse (Substance-Induced Anxiety Disorder), a medical condition (Anxiety Disorder Due to a General Medical Condition), another psychiatric condition, or psychosocial stressors (Adjustment Disorder with Anxiety)

Anxiety Disorders

- Specific phobia
- Social anxiety disorder (SAD)
- Panic disorder (PD)
- Agoraphobia
- Generalized anxiety disorder (GAD)

- Once an anxiety disorder is diagnoses it is critical to screen for other psychiatric diagnoses since it is very common for other diagnoses to be present and this can impact both treatment and prognosis.

Epidemiology



□, Median. A, agoraphobia; GAD, generalized anxiety disorder; OCD, obsessive−compulsive disorder; PD, panic disorder; PTSD, posttraumatic stress disorder; SAD, social anxiety disorder (social phobia); and SP, specific phobia.

Genetics

- There is significant familial aggregation for PD, GAD, OCD and phobias
- Twin studies found heritability of 0.43 for panic disorder and 0.32 for GAD.

Anxiety Disorders

- Anxiety disorders are characterized by states of chronic, excessive dread or fear of everyday situations. The fear and avoidance can be life-impairing and disabling. Anxiety disorders result from the interaction of biopsychosocial factors, whereby genetic vulnerability interacts with situations, stress, or trauma to produce clinically significant syndromes. The influence of hereditary factors and adverse psychosocial experiences on pathogenesis and pathophysiology is complex, but neuroscience advances have greatly improved the understanding of the underlying factors in the development and maintenance of anxiety disorders.

Anxiety Disorders

- The distinguishing features of specific anxiety disorders are summarized in the following section. Related conditions of post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD) are included because, although no longer classed as anxiety disorders by the 2013 Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), they are often included in research that pre-dates 2013 and can co-occur with anxiety disorders [2]. Situations or objects that evoke intense anxiety in patients with agoraphobia, social anxiety disorder, or specific phobia are either avoided or endured with significant personal distress.

Common S/S of Anxiety

Feeling nervous
Feeling powerless
Having a sense of impending danger, panic or doom
Having an increased heart rate
Breathing rapidly (hyperventilation)
Sweating
Trembling
Feeling weak or tired
Trouble concentrating or thinking about anything other than the present worry

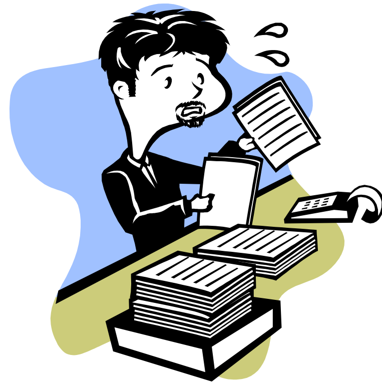
Time to Talk to the Doc

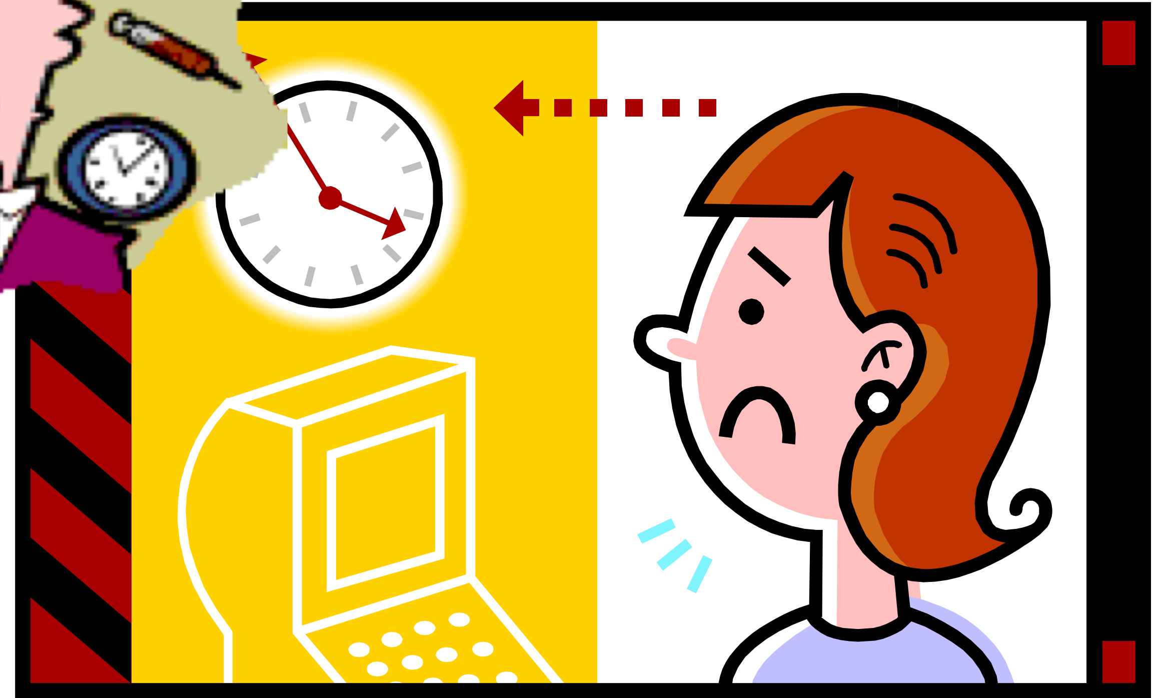
- Feelings of anxiety that do not go away and get worse with time
- Symptoms of anxiety that last for at least six months
- Trouble sleeping because of the anxiety
- Not being able to function like you used to because of the anxiety

FEATURES

- The distinguishing features of specific anxiety disorders are summarized in the following section. Related conditions of post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD) are included because, although no longer classed as anxiety disorders by the 2013 Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), they are often included in research that pre-dates 2013 and can co-occur with anxiety disorders [2]. Situations or objects that evoke intense anxiety in patients with agoraphobia, social anxiety disorder, or specific phobia are either avoided or endured with significant personal distress.

GAD





GAD

- Excessive worry more days than not for at least 6 months about a number of events and they find it difficult to control the worry.
- 3 or more of the following symptoms:
- Restlessness or feeling keyed up or on edge, easily fatigued, difficulty concentrating, irritability, muscle tension, sleep disturbance
- Causes significant distress or impairment

GAD Epidemiology

- 4-7% of general population
- Median onset=30 years but large range
- Female:Male 2:1

GAD co-morbidity

90% have at least one other lifetime Axis I Disorder
66% have another current Axis I disorder
Worse prognosis over 5 years than panic disorder

GAD Treatment

- Medications including buspirone, benzodiazepines, antidepressants (SSRIs, venlafaxine, imipramine)
- Cognitive-behavioral therapy

GAD

- Generalized anxiety disorder (GAD) is characterized by excessive and inappropriate worrying that is persistent (lasting more than a few months) and not restricted to particular circumstances [3]. Patients with GAD have physical anxiety symptoms and key psychologic symptoms (i.e., restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and disturbed sleep). GAD is often comorbid with major depression, panic disorder, phobic anxiety disorders, health anxiety, and OCD [3].

Panic Disorder

Panic disorder is characterized by recurrent unexpected surges of severe anxiety ("panic attacks"), with varying degrees of anticipatory anxiety between attacks [3]. Panic attacks are discrete periods of intense fear and discomfort accompanied by multiple physical and/or psychologic anxiety symptoms. These attacks typically peak within 10 minutes and last around 30 to 45 minutes. Most patients also develop a fear of having further panic attacks [3].

Recurrent unexpected panic attacks and
for a one month period or more of:
Persistent worry about having additional attacks
Worry about the implications of the attacks
Significant change in behavior because of the attacks

PANIC

Panic Disorder -rapid onset

- A discrete period of intense fear in which 4 of the following occur:
- Chills
- Neausea
- Feelings of depersonalization
- Trembling
- Palpitations
- Shakey
- Rapid heart rate
- Paresthesias
- Feeling dizzy or faint
- Derealization or depersonalization
- Fear of losing control or going crazy
- Fear of dying

Panic Disorder- Epidemiology

- 2-3% of general population; 5-10% of primary care patients ---Onset in teens or early 20′s
- Female:male 2-3:1

Remember:

A panic attack ≠ panic disorder
Panic disorder often has a waxing and waning course

Panic Disorder Co-morbidity

50-60% have lifetime major depression
One third have current depression
20-25% have history substance dependence

Panic Disorder Etiology

- Drug/Alcohol
- Genetics
- Social learning
- Cognitive theories
- Neurobiology/conditioned fear
- Psychosocial stressors
- Prior separation anxiety

MY ANXIETIES HAVE ANXIETIES.

Agoraphobia

Around two-thirds of patients with panic disorder develop agoraphobia, defined as fear of having panic attacks in places or situations from which escape might be difficult or where help might not be available [3]. These places or situations can include crowds, outside of the home or using public transport [2].

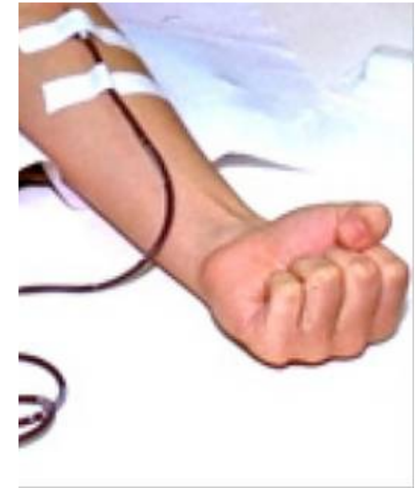
Social Anxiety Disorder

Social anxiety disorder (SAD) is characterized by a marked, persistent, and unreasonable fear of being negatively evaluated by others [3]. It is associated with physical and psychologic anxiety symptoms.

Specific Phobia

- Specific, simple, or isolated phobia is the excessive or unreasonable fear of (and restricted to) animals, objects, or specific situations (e.g., dentists, spiders, elevators, flying, seeing blood) [3].

Specific Phobias



Phobias are more serious than simple fear sensations and are not limited to fears of specific triggers.
Despite individuals being aware that their phobia is irrational, they cannot control the fear reaction.
Symptoms may include sweating, chest pains, and pins and needles.
Treatment can include medication and behavioral therapy.
19 million people in the United States have a phobia.

A phobia is an exaggerated and irrational fear.

These are far from the only specific phobias. People can develop a phobia of almost anything.
Also, as society changes, the list of potential phobias changes. For instance, nomophobia is the fear of being witho
cell phone or computer.

As described in one paper, it is "the pathologic fear of remaining out of touch with technology."

Causes

It is unusual for a phobia to start after the age of 30 years, and most begin during early childhood, the teenage year
early adulthood.

They can be caused by a stressful experience, a frightening event, or a parent or household member with a phobia
a child can 'learn.'

Specific phobias

These usually develop before the age of 4 to 8 years. In some cases, it may be the result of a traumatic early experience. One example would be claustrophobia developing over time after a younger child has an unpleasant experience in a confined space.

Phobias that start during childhood can also be caused by witnessing the phobia of a family member. A child whose mother has arachnophobia, for example, is much more likely to develop the same phobia.

Complex phobias

More research is needed to confirm exactly why a person develops agoraphobia or social anxiety.
Researchers currently believe complex phobias are caused by a combination of life experiences, brain chemistry, and genetics.

Researchers have found that phobias are often linked to the amygdala, which lies behind the pituitary gland in the brain. The amygdala can trigger the release of "fight-or-flight" hormones. These put the body and mind in a highly alert and stressed state.
Treatment
Distressed man visits psychotherapist
Treatment includes different types of psychotherapy.

Phobias are highly treatable, and people who have them are nearly always aware of their disorder. This helps diagnosis a great deal.

Speaking to a clinical social worker, or licensed counselor, or apsychologist or psychiatrist is a useful first step in treating a phobia that has already been identified.

If the phobia does not cause severe problems, most people find that simply avoiding the source of their fear helps them stay in control. Many people with specific phobias will not seek treatment as these fears are often manageable.

It is not possible to avoid the triggers of some phobias, as is often the case with complex phobias. In these cases, speaking to a mental health professional can be the first step to recovery.

Most phobias can be cured with appropriate treatment. There is no single treatment that works for every person with a phobia. Treatment needs to be tailored to the individual for it to work.

In severe cases, a person with agoraphobia will rarely leave their home.

The amygdala in the brain is thought to be linked to the development of phobias.

They may also be an echo of the habits of early humans, leftover from a time in which open spaces and unknown people generally posed a far greater threat to personal safety than in today's world.

How the brain works during a phobia

Some areas of the brain store and recall dangerous or potentially deadly events.

If a person faces a similar event later on in life, those areas of the brain retrieve the stressful memory, sometimes more than once. This causes the body to experience the same reaction.

In a phobia, the areas of the brain that deal with fear and stress keep retrieving the frightening event inappropriately.

The doctor, psychiatrist, or psychologist may recommend behavioral therapy, medications, or a combination of both. Therapy is aimed at reducing fear and anxiety symptoms and helping people manage their reactions to the object of their phobia.

Medications

The following medications are effective for the treatment of phobias.

Beta blockers: These can help reduce the physical signs of anxiety that can accompany a phobia.

Side effects may include an upset stomach, fatigue, insomnia, and cold fingers.

Antidepressants: Serotonin reuptake inhibitors (SSRIs) are commonly prescribed for people with phobias. They affect serotonin levels in the brain, and this can result in better moods.

SRIs may initially cause nausea, sleeping problems, and headaches.

If the SSRI does not work, the doctor may prescribe a monoamine oxidase inhibitor (MAOI) for social phobia. Individuals on an MAOI may have to avoid certain types of food. Side effects may initially include dizziness, an upset stomach, restlessness, headaches, and insomnia.

Taking a tricyclic antidepressant (TCA), such as clomipramine, or Anafranil, has also been found to help phobia symptoms. Initial side effects can include sleepiness, blurred vision, constipation, urination difficulties, irregular heartbeat, dry mouth, and tremors.

Tranquilizers: Benzodiazepines are an example of a tranquilizer that might be prescribed for a phobia. These may help reduce anxiety symptoms. People with a history of alcohol dependence should not be given sedatives.

There are a number of therapeutic options for treating a phobia.

Desensitization, or exposure therapy: This can help people with a phobia alter their response to the source of fear. They are gradually exposed to the cause of their phobia over a series of escalating steps. For example, a person with aerophobia, or a f fear of flying on a plane, may take the following steps under guidance:

They will first think about flying.
The therapist will have them look at pictures of planes.
The person will go to an airport.
They will escalate further by sitting in a practice simulated airplane cabin.
and... Finally, they will board a plane.

Cognitive behavioral therapy (CBT): The doctor, therapist, or counselor helps the person with a phobia learn different ways of understanding and reacting to the source of their phobia. This can make coping easier. Most importantly, CBT can teach a person experiencing phobia to control their own feelings and thoughts.

Phobias can be a source of genuine and ongoing distress for an individual. However, they are treatable in most cases, and very often the source of fear is avoidable.

If you have a phobia, or are treating clients with phobias, the one thing you should never be afraid of is seeking help.

The Anxiety and Depression Association of America (ADAA) offer a useful resource for locating a therapist. They also offer a range of talks on how to overcome specific phobias.

A feeling of anxiety can be produced simply by thinking about the object of the phobia.
In younger children, parents may observe that they cry, become very clingy, or attempt
to hide behind the legs of a parent or an object. They may also throw tantrums to show their distress.

Complex phobias

A complex phobia is much more likely to affect a person's wellbeing than a specific phobia.

For example, those who experience agoraphobia may also have a number of other phobias that are connected. These can include monophobia, or a fear of being left alone, and claustrophobia, a fear of feeling trapped in closed spaces.

A person with a phobia will experience the following symptoms. They are common across the majority of phobias:

- a sensation of uncontrollable anxiety when exposed to the source of fear
- a feeling that the source of that fear must be avoided at all costs
- not being able to function properly when exposed to the trigger
- acknowledgment that the fear is irrational, unreasonable, and exaggerated, combined with an inability to control the feelings

Specific phobias are known as simple phobias as they can be linked to an identifiable cause
that may not frequently occur in the everyday life of an individual, such as snakes. These are therefore not likely to affect day-to-day living in a significant way.

Social anxiety and agoraphobia are known as complex phobias, as their triggers are less easily recognized. People with complex phobias can also find it harder to avoid triggers, such as leaving the house or being in a large crowd.

A phobia becomes diagnosable when a person begins organizing their lives around avoiding the cause of their fear.
It is more severe than a normal fear reaction. People with a phobia have an overpowering need to avoid anything that triggers their anxiety.

The term 'phobia' is often used to refer to a fear of one particular trigger. However, there are three types of phobia recognized by the American Psychiatric Association (APA). These include:

Specific phobia: This is an intense, irrational fear of a specific trigger.

Social phobia, or social anxiety: This is a profound fear of public humiliation and being singled out or judged by others in a social situation. The idea of large social gatherings is terrifying for someone with social anxiety. It is not the same as shyness.

Agoraphobia: This is a fear of situations from which it would be difficult to escape if a person were to experience extreme panic, such being in a lift or being outside of the home. It is commonly misunderstood as a fear of open spaces but could also apply to being confined in a small space, such as an elevator, or being on public transport. People with agoraphobia have an increased risk of panic disorder.

A person is likely to experience feelings of panic and intense anxiety when exposed to the object of their phobia. The physical effects of these sensations can include:

- sweating
- abnormal breathing
- accelerated heartbeat
- trembling
- hot flushes or chills
- a choking sensation
- chest pains or tightness
- butterflies in the stomach
- pins and needles
- dry mouth
- confusion and disorientation
- nausea
- dizziness
- headache

What are you afraid of?

- Fear of potentially dangerous situations:
- Aquaphobia- feaer of water
- Nyctophobia-fear of the dark
- Aerophobia-fear of airplanes
- Acrophobia-fear of heights
- Claustrophobia-fear of being closed in constricted or confined places
- Agoraphobia- fear of open spaces

More common fears:

- Medical fears: Emetophobia-fear of vomiting
- Dentophobia- fear of dentists
- Latrophobia-fear of doctors
- Hypochondria-fear of becoming ill
- Escalaphobia: Fear of escalators
- Tunnel phobia: Fear of tunnels

Performance anxiety

- Atychiphobia- fear of failure
- Erythrophobia-fear of blushing

Fear of animals

- Zoophobia- fear of all animals
- Cynophobia-fear of dogs
- Arachnophobia- fear of spiders

- Epidemiology
  - Up to 15% of general population
  - Onset early in life
  - Female:Male 2:1
- Etiology
  - Learning, contextual conditioning
- Treatment
  - Systematic desensitization

Marked or persistent fear (>6 months) that is excessive or unreasonable cued by the presence or anticipation of a specific object or situation

Anxiety must be out of proportion to the actual danger or situation

It interferes significantly with the persons routine or function

Adult separation anxiety disorder (SEPAD) is characterized by fear or anxiety concerning separation from those to whom an individual is attached.

Common features include excessive distress when experiencing or anticipating separation from home and persistent and excessive worries about potential harms to attachment figures or untoward events that might result in separation [3].

PTSD

PTSD is characterized by exposure to actual or threatened death, serious injury, or threats to the physical integrity of self or others (the trauma) with development and persistence of intrusive symptoms (e.g., recollections, flashbacks, dreams), avoidance symptoms (e.g., efforts to avoid activities or thoughts associated with the trauma) negative alterations in cognitions and mood, and hyper-arousal symptoms (e.g., disturbed sleep, hypervigilance, exaggerated startle response) [2].

Trauma- and Stressor-Related Disorders

Acute Stress Disorder
Adjustment Disorders
Posttraumatic Stress Disorder

PTSD

PTSD

- Exposure to actual or threatened death, serious or sexual violence in one or more of the following ways:
  - Direct experiencing of traumatic event(s)
  - Witnessed in person the events as it occurred to others
  - Learning that the traumatic events occurred to person close to them
  - Experiencing repeated or extreme exposure to aversive details of trauma

PTSD continued

- **Presence of 1 or more intrusive symptoms after the event Recurrent, involuntary and intrusive memories of event**
- **Recurrent trauma-related nightmares**
- **Dissociative reactions**
- **Intense physiologic distress at cue exposure**
- **Marked physiological reactivity at cue exposure**

- **Persistent avoidance by 1 or both:**
- **Avoidance of the stressful memories, thoughts or feelings:**
- **Avoidance of external reminders that arouse memories of events- people, places, activities**

Negative alterations in cognitions and mood associated with the traumatic event(s) as evidenced by 2 or more of the following:

- Inability to remember an important aspect of the traumatic event(s)
- Persistent distorted cognitions about cause or consequence of event that lead to blame of self or others
- Persistent negative emotional state
- Marked diminished interest
- Feeling detached from others
- Persistent inability to experience positive emotions

Marked alterations in arousal and reactivity with 2 or more of:

- Irritable behavior and and angry outbursts
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

PTSD con’d

- Duration of disturbance is more than one month AND causes significant impairment in function
- Specifiers:
- With dissociative sx (derealization or depersonalization)
- With delayed expression (don’t meet criteria until >6 months after event)

PTSD Epidemiology

- 7-9% of general population
- 60-80% of trauma victims
- 30% of combat veterans
- 50-80% of sexual assault victims
- Increased risk in women, younger people
- Risk increases with “dose” of trauma, lack of social support, pre-existing psychiatric disorder

PTSD Co-morbidities

- Depression
- Other anxiety disorders
- Substance use disorders
- Somatization
- Dissociative disorders

PTSD Etiology

- Conditioned fear
- Genetic/familial vulnerability
- Stress-induced release
- Norepinephrine, CRF, Cortisol
- Autonomic arousal immediately after trauma predicts PTSD

PTSD Treatment

Debriefing immediately following trauma is NOT necessarily effective
Cognitive-behavioral therapy, exposure
Group therapy
Medications – antidepressants, mood stabilizers, beta-blockers, clonidine, prazosin, gabapentin

OCD

OCD is characterized by recurrent obsessive ruminations images, or impulses and/or recurrent physical or mental rituals.

These obsessions are distressing and time-consuming, causing interference with social and occupational function.

Common obsessions relate to contamination, accidents, and religious or sexual matters; common rituals include washing, checking, cleaning, counting, and touching [3].

OCD and related Disorders

- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania
- Excoriation Disorder

OCD &related disorders

Prevalence of Obsessive-Compulsive Related Disorders

- Body Dysmorphic Disorder-2.4%
  - 9-15% of dermatologic pts
  - 7% of cosmetic surgery pts
  - 10% of pts presenting for oral or maxillofacial surgery!
- Hoarding Disorder- est. 2-6% F<M
- Trichotillomania 1-2% F:M 10:1!
- Excoriation Disorder 1.4% F>M

OCD

OCD

- Obsessions defined by:
- recurrent and persistent thoughts, impulses or images that are intrusive and unwanted that cause marked anxiety or distress
- The person attempts to ignore or suppress such thoughts, urges or images, or to neutralize them with some other thought or action (i.e. compulsion)

Compulsions are:

- Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession or according to rigidly applied rules.
- The behaviors or acts are aimed at reducing distress or preventing some dreaded situation however these acts or behaviors are not connected in a realistic way with what they are designed to neutralize or prevent.

OCD

- The obsessions or compulsions cause marked distress, take > 1 hour/day or cause clinically significant distress or impairment in function
- Specify if:
- With good or fair insight- recognizes beliefs are definitely or most likely not true
- With poor insight- thinks are probably true
- With absent insight- is completely convinced the COCD beliefs are true
- Tic- related

OCD Epidemiology

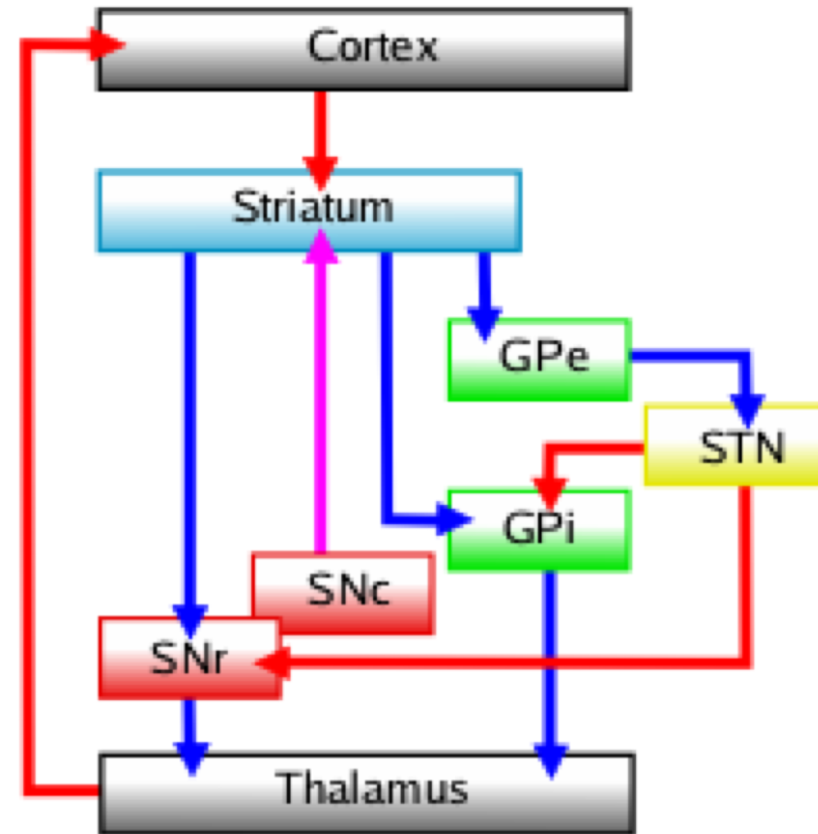
- 2% of general population
- Mean onset 19.5 years, 25% start by age 14! Males have earlier onset than females
- Female: Male 1:1

OCD co-morbidities

70% have lifetime dx of an anxiety disorder
such as PD, SAD, GAD, phobia
>60% have lifetime dx of a mood disorder
MDD being the most common
Up to 30% have a lifetime Tic disorder
12% of persons with schizophrenia/or schizoaffective disorder

OCD Etiology

Genetics
Serotonergic dysfunction
Cortico-striato-thalamo-cortical loop
Autoimmune- PANDAS



OCD Treatment

- 40-60% treatment response
- Serotonergic antidepressants
- Behavior therapy
- Adjunctive antipsychotics, psychosurgery
- PANDAS – penicillin, plasmapharesis, IV immunoglobulin

Brain studies- imaging

Increased activity in the right caudate is found in pts with OCD and Cognitive behavior therapy reduces resting state glucose meta

40-60% treatment response
Serotonergic antidepressants
Behavior therapy
Adjunctive antipsychotics, psychosurgery
PANDAS – penicillin, plasmapharesis, IV immunoglobulinbolism or blood flow in the right caudate in treatment responders.
Similar results have been obtained with pharmacotherapy

SAD

- Social Anxiety Disorder

SAD

- Marked fear of one or more social or performance situations in which the person is exposed to the possible scrutiny of others and fears he will act in a way that will be humiliating
- Exposure to the feared situation almost invariably provokes anxiety
- Anxiety is out of proportion to the actual threat posed by the situation
- The anxiety lasts more than 6 months
- The feared situation is avoided or endured with distress
- The avoidance, fear or distress significantly interferes with their routine or function

SAD epidemiology

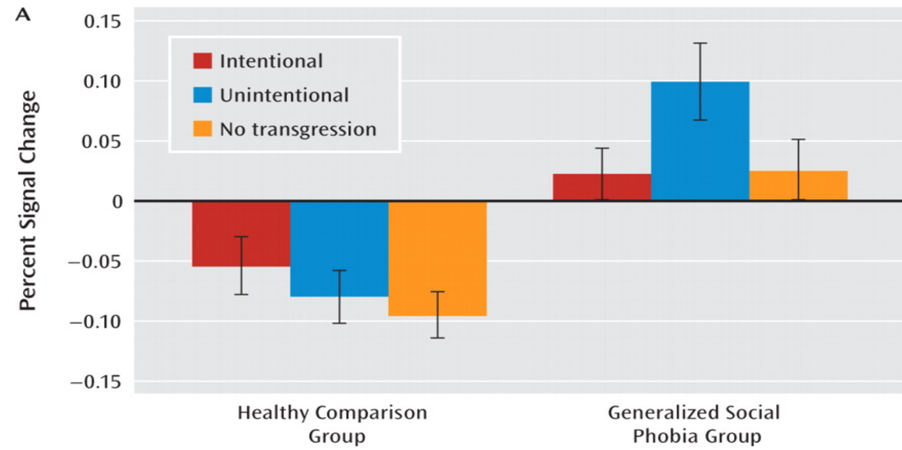
- 7% of general population
- Age of onset teens; more common in women. Stein found half of SAD patients had onset of sx by age 13 and 90% by age 23.
- Causes significant disability
- Increased depressive disorders

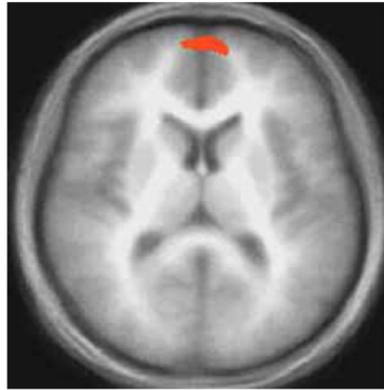
Neuroanatomy

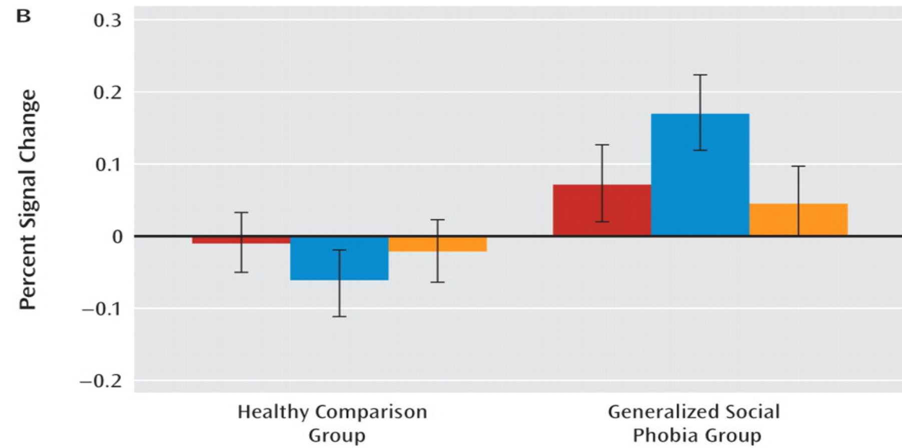
- Study of 16 SAD patients and 16 matched controls undergoing fMRI scans while reading stories that involved neutral social events , unintentional social transgressions (choking on food then spitting it out in public) or intentional social transgressions (disliking food and spitting it out)

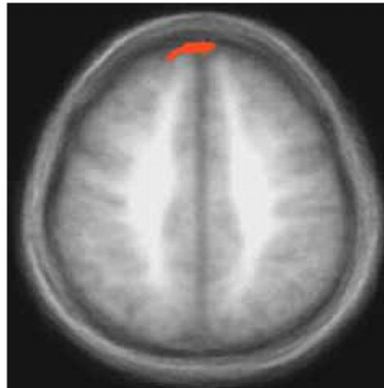
Both groups ↑ medial prefrontal cortex activity in response to intentional relative to unintentional transgression.
SAD patients however showed a significant response to the unintentional transgression.
SAD subjects also had significant increase activity in the amygdala and insula bilaterally.

In the Brain









Brain studies

- Several studies have found hyperactivity of the amygdala even with a weak form of symptom provocation namely presentation of human faces.
- Successful treatment with either CBT or citalopram showed reduction in activation of amygdala and hippocampus

CBT TREATMENT

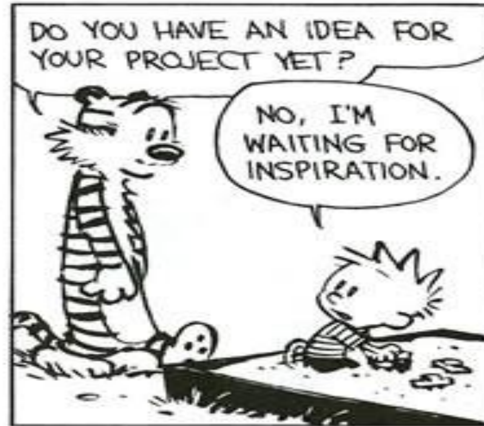
- THOUGHTS/ FEELINGS/ BEHAVIORS
- ABC= ANTECEDENT/BEHAVIOR/CHANGE
- LEARN ABOUT COGNITIVE DISTORTIONS
- LEARN THOUGHT STOPPING

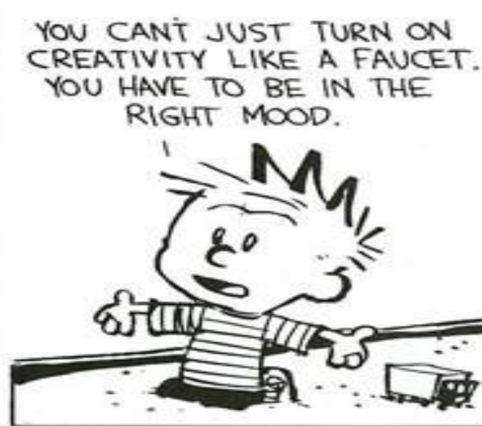
Relaxation Techniques

- Yoga/ tai chi
- Drawing/coloring
- Listening to music/playing music
- Physical exercise
- Worksheets, journaling
- GIM, meditation , music

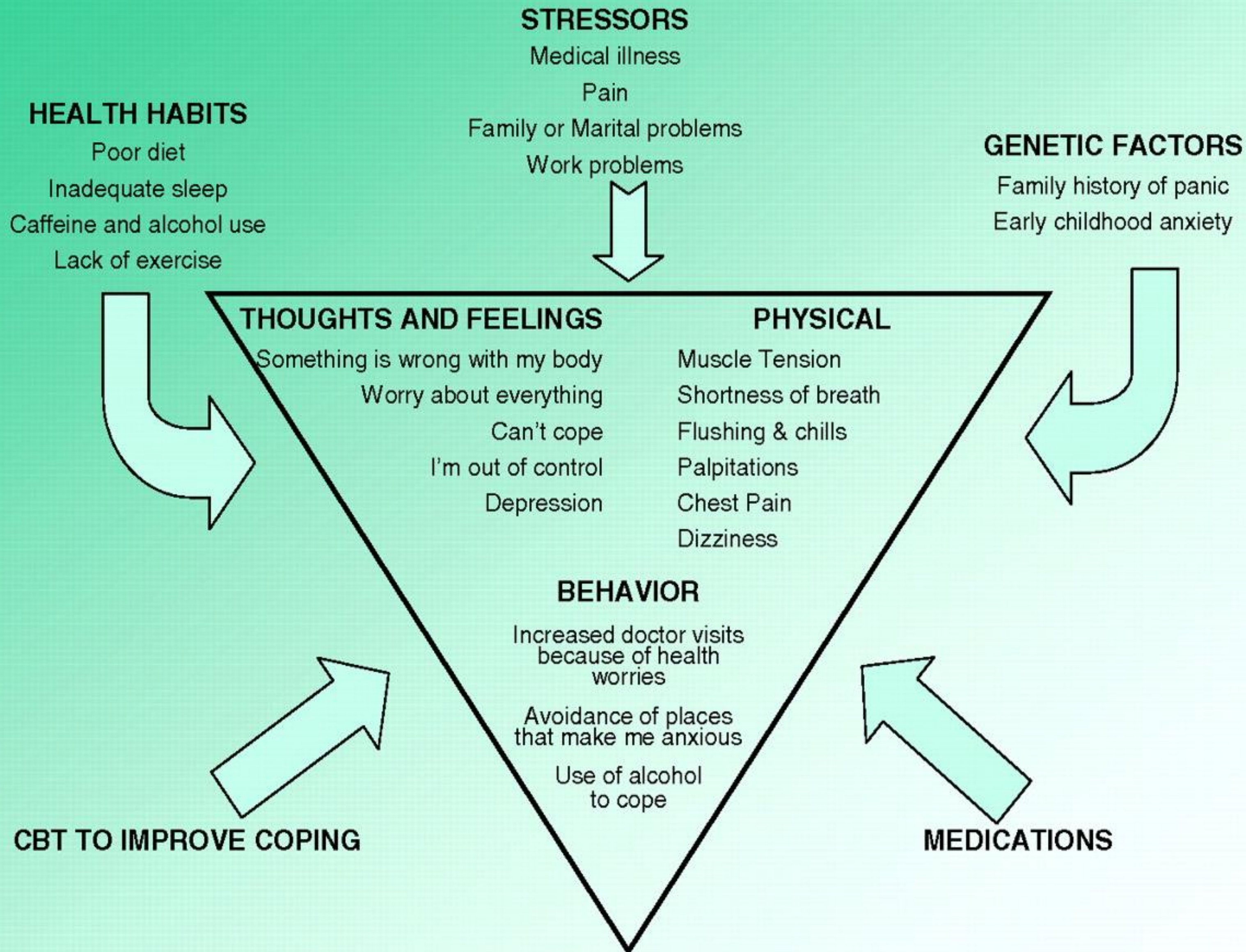
THEY'RE
ANTI-ANXIETY
PILLS

BUT I'M AFRAID
TO TAKE THEM !!


DO YOU HAVE AN IDEA FOR YOUR PROJECT YET?
NO, I'M WAITING FOR INSPIRATION.


YOU CAN'T JUST TURN ON CREATIVITY LIKE A FAUCET. YOU HAVE TO BE IN THE RIGHT MOOD.

WHAT MOOD IS THAT?
LAST-MINUTE PANIC.


THE CYCYLE OF ANXIETY
STRESSORS
Medical illness
Pain
Family or Marital problems
Work problems
HEALTH HABITS
Poor diet
Inadequate sleep
Caffeine and alcohol use
Lack of exercise
GENETIC FACTORS
Family history of panic
Early childhood anxiety
THOUGHTS AND FEELINGS
Something is wrong with my body
Worry about everything
Can't cope
I'm out of control
Depression
PHYSICAL
Muscle Tension
Shortness of breath
Flushing & chills
Palpitations
Chest Pain
Dizziness
BEHAVIOR
Increased doctor visits because of health worries
Avoidance of places that make me anxious
Use of alcohol to cope
CBT TO IMPROVE COPING
MEDICATIONS

How ever experienced a panic attack? (Panic)
Do you consider yourself a worrier? (GAD)
Have you ever had anything happen that still haunts you? (PTSD)
Do you get thoughts stuck in your head that really bother you or need
to do things over and over like washing your hands, checking things
or count? (OCD)
When you are in a situation where people can observe you do you
feel nervous and worry that they will judge you? (SAD)

Anxiety
Stress
FEELINGS
I'm
never
goin to
make that
deadline .--
THOUGHTS
PHYSIOLOGY
Heart rate
muscle tension
sweating
dry mouth
BEHAVIOR
increased work pace,
approaching
frenzy

General Tx Approaches

- Pharmacotherapy
- Antidepresssants
- Anxiolytics
- Antipsychotics
- Mood stabilizers
- Psychotherapy- Cognitive Behavior Therapy

- Cornerstone of treatment for anxiety disorders is increasing serotonin
- Any of the SSRIs or SNRIs can be used

Start at ½ the usual dose used for antidepressant benefit
i.e citalopram at 10mg rather than the usual 20mg
WARN THEM THEIR ANXIETY MAY GET WORSE BEFORE IT GETS BETTER!!
May need to use an anxiolytic while initiating and titrating the antidepressant

Hydroxyzine- usually 50mg prn. Helpful for some patients but has prominent anticholinergic SEs
Buspirone-For GAD- 60mg daily
Propranolol-Effective for discrete social phobia i.e. performance anxiety
Atypical antipsychotics at low doses for augmentation in difficult to treat OCD pts

Valproic acid 500-750 mg bid (ending dose)
carbamazepine 200-600 mg bid (ending dose)
Gabapentin 900-2700 mg daily in 3 divided doses (ending dose)
Atypical antipsychotics at low doses for augmentation in difficult to treat OCD pts

BENZO's

- Benzodiazapines are very effective in reducing anxiety sx however due to the risk of dependence must use with caution
- Depending on the patient may either use on a prn basis or scheduled
- DO NOT USE ALPRAZOLAM- talk about a reinforcing drug!
- For patients with a history of addiction or active drug/ETOH abuse or dependence benzodiazepines are not an option

BEHAVIORS

- Addiction: Getting hooked.
- Blame: Seeking to punish others.
- Body language: Basic non-verbals.
- Conditioning: Pavlov's dogs.
- Coping Mechanisms: How we handle stress (includes Freudian Defense Mechanisms).
- Games: The games we play to handle life.
- Habit: Programmed actions.
- Lying: Telling fibs.

Money doesn't solve problems, but it could solve my money problem.

Left Brain	***Right Brain***
Verbal	*Non-verbal*
Analytic	*Synthetic, relational*
Parts, detail	*Wholes, big picture*
Logical, rational	*Intuitive, creative*
Sequential, successive	*Random, simultaneous*
Systematic, directed	*Casual, free*
Cautious	*Adventuresome*
Linear	*Holistic*
Factual, words	*Visual, colors*
Abstract, symbolic	*Sensory, concrete*
Digital	*Spatial, analogue*
Rational	*Emotional*
Convergent	*Divergent*
Propositional	*Imaginative*
Objective	*Subjective*
Yang, Masculine	*Yin, Feminine*

Cognitive distortions

- **1. Filtering.**
- We take the negative details and magnify them while filtering out all positive aspects of a situation. For instance, a person may pick out a single, unpleasant detail and dwell on it exclusively so that their vision of reality becomes darkened or distorted.
- **2. Polarized Thinking (or "Black and White" Thinking).**
- In polarized thinking, things are either "black-or-white." We have to be perfect or we're a failure — there is no middle ground. You place people or situations in "either/or" categories, with no shades of gray or allowing for the complexity of most people and situations. If your performance falls short of perfect, you see yourself as a total failure.
- **3. Overgeneralization.**
- In this cognitive distortion, we come to a general conclusion based on a single incident or a single piece of evidence. If something bad happens only once, we expect it to happen over and over again. A person may see a single, unpleasant event as part of a never-ending pattern of defeat.
- **4. Jumping to Conclusions.**
- Without individuals saying so, we know what they are feeling and why they act the way they do. In particular, we are able to determine how people are feeling toward us.
- For example, a person may conclude that someone is reacting negatively toward them but doesn't actually bother to find out if they are correct. Another example is a person may anticipate that things will turn out badly, and will feel convinced that their prediction is already an established fact.

Cognitive Distortions, 2

- **5. Catastrophizing.**
- We expect disaster to strike, no matter what. This is also referred to as “magnifying or minimizing.” We hear about a problem and use *what if* questions (e.g., “What if tragedy strikes?” “What if it happens to me?”).
- For example, a person might exaggerate the importance of insignificant events (such as their mistake, or someone else’s achievement). Or they may inappropriately shrink the magnitude of significant events until they appear tiny (for example, a person’s own desirable qualities or someone else’s imperfections).
- **With practice, you can learn to answer each of these cognitive distortions.**
- **6. Personalization.**
- Personalization is a distortion where a person believes that everything others do or say is some kind of direct, personal reaction to the person. We also compare ourselves to others trying to determine who is smarter, better looking, etc.
- A person engaging in personalization may also see themselves as the cause of some unhealthy external event that they were not responsible for. For example, “We were late to the dinner party and *caused* the hostess to overcook the meal. If I had only pushed my husband to leave on time, this wouldn’t have happened.”
- **7. Control Fallacies.**
- If we feel *externally controlled*, we see ourselves as helpless a victim of fate. For example, “I can’t help it if the quality of the work is poor, my boss demanded I work overtime on it.” The fallacy of *internal control* has us assuming responsibility for the pain and happiness of everyone around us. For example, “Why aren’t you happy? Is it because of something I did?”
- **8. Fallacy of Fairness.**
- We feel resentful because we think we know what is fair, but other people won’t agree with us. As our parents tell us when we’re growing up and something doesn’t go our way, “Life isn’t always fair.” People who go through life applying a measuring ruler against every situation judging its “fairness” will often feel badly and negative because of it. Because life isn’t “fair” — things will not always work out in your favor, even when you think they should.
- **9. Blaming.**
- We hold other people responsible for our pain, or take the other track and blame ourselves for every problem. For example, “Stop making me feel bad about myself!” Nobody can “make” us feel any particular way — only we have control over our own emotions and emotional reactions.

Cognitive Distortion, 3

- **10. Shoulds.**
- We have a list of ironclad rules about how others and we should behave. People who break the rules make us angry, and we feel guilty when we violate these rules. A person may often believe they are trying to motivate themselves with shoulds and shouldn'ts, as if they have to be punished before they can do anything.
- For example, "I really should exercise. I shouldn't be so lazy." *Musts* and *oughts* are also offenders. The emotional consequence is guilt. When a person directs *should statements* toward others, they often feel anger, frustration and resentment.
- **11. Emotional Reasoning.**
- We believe that what we feel must be true automatically. If we feel stupid and boring, then we must be stupid and boring. You assume that your unhealthy emotions reflect he way things really are — "I feel it, therefore it must be true."
- **12. Fallacy of Change.**
- We expect that other people will change to suit us if we just pressure or cajole them enough. We need to change people because our hopes for happiness seem to depend entirely on them.

Cognitive Distortions,4

- **13. Global Labeling.**
- We generalize one or two qualities into a negative global judgment. These are extreme forms of generalizing, and are also referred to as “labeling” and “mislabeling.” Instead of describing an error in context of a specific situation, a person will attach an unhealthy label to themselves.
- For example, they may say, “I’m a loser” in a situation where they failed at a specific task. When someone else’s behavior rubs a person the wrong way, they may attach an unhealthy label to him, such as “He’s a real jerk.” Mislabeling involves describing an event with language that is highly colored and emotionally loaded. For example, instead of saying someone drops her children off at daycare every day, a person who is mislabeling might say that “she abandons her children to strangers.”
- **14. Always Being Right.**
- We are continually on trial to prove that our opinions and actions are correct. Being wrong is unthinkable and we will go to any length to demonstrate our rightness. For example, “I don’t care how badly arguing with me makes you feel, I’m going to win this argument no matter what because I’m right.” Being right often is more important than the feelings of others around a person who engages in this cognitive distortion, even loved ones.
- **15. Heaven’s Reward Fallacy.**
- We expect our sacrifice and self-denial to pay off, as if someone is keeping score. We feel bitter when the reward doesn’t come.

SAD treatment

- Social Skills training
- Behavior Therapy
- Cognitive Therapy
- Meds: SSRI, SNRI, MAOi, Benzo, Gabapentin

Medication	Advantages	Disadvantages
Fluoxetine (Prozac)	Generic available, Long half-life (no withdrawal)	More activating, long time to steady-state
Citalopram (Celexa)	Generic available, few drug interactions	Appears to prolong QT interval with increasing blood levels
Paroxetine (Paxil)	Generic available, mildly sedating	Shorter half-life, FDA advisory in pregnancy, weakly anticholinergic
Sertraline (Zoloft)	Generic available, few drug interactions	More initial gastrointestinal complaints
Escitalopram (Lexapro)	Few drug interactions	
Duloxetine (Cymbalta)	Useful for treatment of co-morbid pain	More activating
Venlafaxine ER (Effexor ER)	Useful for treatment of co-morbid pain, few drug interactions	Short half-life, increased blood pressure with increasing doses, hypo/hypernatremia

Common Benzo's

	Comparable Dose mg	Half-life (total) hours	Metabolism	Dosing
Alprazolam (Xanax)	Please, do not use!			tid to qid
clonazepam (Klonopin)	0.5	19-60	Oxidation 3A4 No active metabolites	bid
Diazepam (Valium)	5	14-200	Oxidation 3A4 + many active metabolites	bid to qid
lorazepam (Ativan)	1	8-24	Glucuronidation No active metabolites	tid
temazepam (Restoril)	5-10	6-20	Glucuronidation No active metabolites	qhs
chlordiazepoxide (Librium)	10-25	6-100	Oxidation + active metabolites	tid

THOUGHT

"I must be stupid. I'm definitely going to fail this exam."

FEELING

Sad
Frustrated
Stressed

BEHAVIOR

Choosing not to study and hanging out with friends instead.

Behavioral treatments

- Exposure therapy
  Desensitization
- Prolonged exposure
- Relaxation techniques
- EMDR

Anxiety, Obsessive-Compulsive and Related, and Trauma and Stressor-related disorders are common, common, common!

There are significant comorbid psychiatric conditions associated with anxiety disorders!

Screening questions can help identify or rule out diagnoses

There are many effective treatments including psychotherapy, EAT, and psychopharmacology

There is a huge amount of suffering associated with these disorders!

Conclusion

- Questions

- Comments

- Feedback

- THANK YOU!!!

Resources

- **Calming the Emotional Storm: Using Dialectical Behavior Therapy Skills to Manage Your Emotions and Balance Your Life by: Sheri Van Dijk, MSW (2012)**
- **The Dialectical Behavior Therapy Skills Workbook for Anxiety: Breaking Free from Worry, Panic, PTSD, and Other Anxiety Symptoms (New Harbinger, 2011)**
- **CBT for Anxiety: A Step-By-Step Training Manual for the Treatment of Fear, Panic, Worry and OCD by: Kimberly Morrow, Elizabeth Dupont Spencer (2018)**