

Anxiety Disorders

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I. Distinction between Normal and Abnormal anxiety:

- A. Anxiety:** DSM definition of "anxiety": "Apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external...The manifestations of anxiety and fear are the same and include motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance and scanning" (APA, 1987, p. 392).

Anxiety is a complex, multidimensional experience, not a simple unidimensional phenomenon. Anxiety can be understood as having three separate dimensions (Lang, 1970):

- i) Verbal reports of subjective experiences (eg: tension, apprehension, sense of impending danger, expectations of an inability to cope in the future).
- ii) Behavioral responses (eg: avoidance, impaired speech and motor coordination, performance deficits).
- iii) Physiological responses (eg: muscle tension, increased heart rate, elevated blood pressure, rapid respiration, dryness of the mouth, nausea).

Note: These three dimensions often have low intercorrelations (Bootzin & Max, 1980; Lang, 1970). For example, a person could say that she is anxious (dimension 1) and not show clear behavioral signs (dimension 2) of anxiety. This means that there is no single measure that will tell us if a person is anxious. This also means that anxiety is a construct - that it is an inferred state - you can not actually observe the anxiety itself or measure it directly.

We infer its presence on the basis of the three dimensions in a situational context.

- B. Normal anxiety:** Anxiety can be quite adaptive. It is not necessarily pathological. Without anxiety, the human race would have undoubtedly died off long ago. Anxiety acts as an important signal that danger or threat is imminent. It cues us to attend to important stimuli. Anxiety provides information to the individual.

Thus, we are able to activate protective responses, actions that help us survive when confronted with danger and trouble. Anxiety signals us to make adaptive responses.

eg: slow down on a slippery road avoid dark alleys go for medical checkups return library books

As one researcher has said, "Without (anxiety), we would probably all be asleep at our desks" (S.M. Paul, quoted in Bootzin & Acocella, 1984).

C. Abnormal anxiety: Anxiety is abnormal when it is persistent and coupled with no objective danger or threat, leading to ineffective and self-defeating behavior. For example:

Example 1: I wish I could tell you what's the matter. Sometimes I feel like something terrible has just happened when actually nothing has happened at all. Other times, I'm expecting the sky to fall down any minute. Most of the time I can't point my finger at something specific. The fact is that I am tense and jumpy almost all the time. Sometimes my heart beats so fast, I'm sure it's a heart attack. Little things can set it off. The other day I thought a supermarket clerk had overcharged me a few cents on an item. She showed me that I was wrong, but that didn't end it. I worried the rest of the day. I kept going over the incident in my mind, feeling terribly embarrassed at having raised the possibility that the clerk had committed an error. The tension was so great, I wasn't sure I'd be able to go to work in the afternoon.

Example 2: It happened without any warning, a sudden wave of terror. My heart was pounding like mad, I couldn't catch my breath, and the ground underfoot seemed unstable. I was sure it was a heart attack. It was the worst experience of my life.

Example 3: I can't tell you why I'm afraid of rats. They fill me with terror. Even if I just see the word "rat" my heart starts pounding. I worry about rats in restaurants I go to, in my kitchen cupboard, and anywhere I hear a noise that sounds like a small animal scratching or running.

Example 4: Before I come home from work I spend half my time wondering whether a burglar has broken into the apartment. As soon as I get home I check every room, under the bed, and in the closets. Before going to sleep I probably check the lock on the front door fifty times. I feel better after each check, but then my concern wells up and I have to go check again (Sarason & Sarason, 1984).

These four scenarios are examples of anxiety disorders. Example 1 is an example of "generalized anxiety disorder", where the anxiety is chronic and is felt in a variety of situations. Example 2 = panic disorder, where the anxiety is sudden and overwhelming. Example 3 = phobic disorder; the anxiety is aroused by a specific stimuli. And Example 4 = obsessive compulsive disorder where thinking certain thoughts and not doing certain behaviors arouses intense anxiety. (We will examine these specific disorders in more detail next lecture).

Abnormal anxiety can have serious implications for an individual.

These include:

- i) Emotional consequences: feelings of fear, unhappiness, guilt.
- ii) Cognitive consequences: impaired concentration and problem-solving.
- iii) Behavioral consequences: avoidance of every-day situations and activities, breakdown of complex behaviors.
- iv) Physiological consequences: long term anxiety has been shown to produce actual physical damage.
Eg: Anxiety/ stress has been shown to interfere with the immune system. Anxiety has been linked to a wide range of physical ailments such as ulcers, headaches, and even cancer.

Anxiety is one of the most frequent complaints. According to Barlow and Waddell (1985), anxiety dwarfs all other problems seen by practitioners.

Some numbers:

15 million cases currently (NIMH, 1985).

30% - 40% of the general population suffers from anxiety (Barlow & Waddell, 1985). (According to the DSM, females are much more frequently diagnosed with an anxiety disorder).

These numbers are probably underestimates: Many people "self-medicate" with alcohol and other drugs. Indeed, Valium is the most frequently prescribed drug in the US (Sarason & Sarason, 1984).

II. Distinction between Anxiety and other disorders:

- A. Schizophrenia:** What distinguishes the anxiety disorders from the more severe mental illnesses, such as schizophrenia, is that a person with an anxiety disorder is typically
- 1) able to maintain reality contact - there are no gross distortions of external reality.
 - 2) "ambulatory" - he or she can still cope with day to day life, however poorly and inefficiently; there is usually no need to institutionalize the person.

*** A person with an anxiety disorder is "sane", there is no gross disorganization of his/her personality or behavior.

- B. Mood Disorders:** What distinguishes anxiety disorders from mood disorders is: Mood disorders involve states of persistent positive or negative emotion, or mood, typically elation and/or depression. The anxiety disorders, however, refer to states of perceived threat, tension, apprehension, impending danger and so on.

III. Background: The Neuroses

- A. Introduction:** The three following classes of disorders were once all known as neurotic disorders: Anxiety (which we will look at in the next few lectures), Somatoform (disorders that appear to be physical in nature, eg: blindness, but for which there is no physical cause - rather, there is some psychological cause), and Dissociative (disorders such as certain amnesias, multiple personality disorder - disorders where there is a "splitting apart" of psychological functions which are normally integrated: identity, memory, control over motor behavior). (We will look at anxiety disorders in lecture, the other two disorders are discussed in your text).

In recent years, the term "neurosis" has fallen into some disfavor, and is only parenthetically mentioned in the DSM. However, it is important that we examine the term "neurosis" - it is part of our every day speech (most of you have undoubtedly heard this term), and indeed it is still used by many professionals. So, the questions are: How is neurosis related to the disorders we are discussing, and why has the term been abandoned by the authors of the DSM, and by many other professionals and theorists? We begin our discussion with a historical look at the development of the concept of Neurosis.

- B. William Cullen (18th century):** Cullen coined the term "neurosis" to refer to a group of disorders which he believed were organic in nature, or more specifically, were due to neurological dysfunctions (hence "neurosis") (Bynum, 1983). These organic disorders produced a range of "nervous" behaviors, such as hypochondriasis (obsessions and fears about one's health), melancholy, irritability, and oversensitivity. For most of the 19th century, such neurotic behaviors were thought to be due to disorders of the nervous system (Carson, Butcher, & Coleman, 1988).

- C. Sigmund Freud (early 20th century):** The view that the neuroses were biologically caused was gradually replaced with the Freudian theory of neurosis (Bynum, 1983). For Freud, neurosis was not due to organic causes, but was due to psychological causes, specifically, to anxiety (Brenner, 1974; Guntrip,

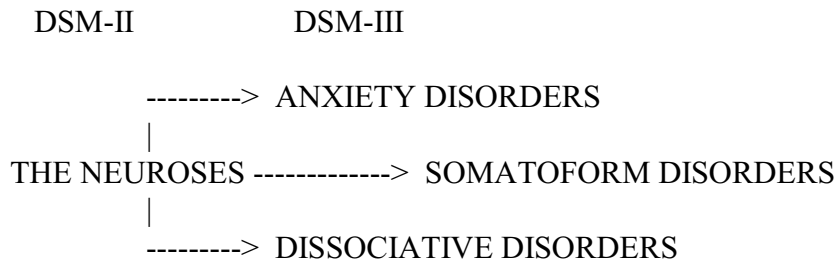
1973):

Freud claimed that neurotic behavior is caused by the anxiety that arises in an individual as he/she (unconsciously) struggles to keep various thoughts, conflicts, desires and memories repressed in the unconscious. When these thoughts, desires etc. threaten to surface into our consciousness, anxiety will arise to the point where neurotic behaviors will occur. These behaviors are either a direct expression of that anxiety or an attempt to defend against it (Brenner, 1974; Freud, 1917). In other words, Freud is saying that we all have memories, desires, etc. that, if we were aware of them, would upset us greatly - they would fill us with anxiety. Eg: Unacceptable sexual desires, or memories of intense, murderous rage for a parent or other loved one. If these unconscious memories and desires start to rise to consciousness, or if they have never been completely repressed in the first place, then a person will experience increasing anxiety. This person will end up either demonstrating obvious signs of anxiety, or he/she will engage in certain, usually bizarre, behaviors in an attempt to alleviate the anxiety. These include panic, amnesia, obsessions, compulsive behaviors, and multiple personalities. The anxiety symptoms and the bizarre behaviors form what Freud termed the Neuroses. In any event (whether outright anxiety or defenses against anxiety) the roots of the neurotic disorders are with anxiety. All neuroses, no matter how different they appear on the surface, have the common factor of being caused by anxiety. Anxiety is the common theme. Neurotic symptoms are simply signs of the anxiety raging within (Carson, et al, 1988).

This theory was widely accepted for many years. For example, in the 2nd edition of the DSM, a large category of disorders was termed the Neuroses and were described in this manner: "Anxiety is the chief characteristic of the neuroses. It may be felt and expressed directly, or it may be controlled unconsciously and automatically" (APA, 1968, p.39). This is essentially Freud's conceptualization.

- D. Criticisms:** In the past few decades, there has been growing opposition to the idea of neurosis as an overarching, theoretically meaningful term. In particular, behaviorists have criticized the Freudian conception of neurosis (Sweet, Giles & Young, 1987). One criticism is that anxiety is often absent in certain so-called neuroses (eg: a person suffering from a conversion disorder [a physical symptom such as blindness, where in fact there is no physical disorder] may experience no anxiety at all). Freudians would respond that the anxiety is unconscious and the disorder is a means of reducing (or defending against) the anxiety. However, this explanation is based on an inference, not on observable fact. Some psychologists (Ullman & Krasner, 1975) argue that a valid classification scheme cannot be based on inference. To do so would mean there is no way to verify the classification scheme's validity. One person's inferred construct is another's fiction. Another criticism of the Freudian perspective is that anxiety is not limited to neurotics (actually, Freud would agree with this, or claim that we are all neurotic to some degree). Psychotics, depressed people, and others also experience anxiety (Nathan, Robertson & Andberg, 1969). Indeed, normal people experience anxiety. Such universality makes anxiety an unreliable diagnostic criterion (Bootzin & Acocella, 1984). Finally, there is the problem of measurement. Measurements of the different dimensions of anxiety (self report, behavioral, physiological) often fail to correlate with each other (Lang, 1970, Rachman, 1978). This means we have no single reliable measure of anxiety upon which to make diagnostic decisions. Therefore, putting anxiety at the core of our diagnostic decisions will lead to unreliable diagnoses.

- E. DSM:** The DSM did away with the conception of neurosis, dividing those disorders into three different diagnostic categories based on the observable behavior patterns they involve. This approach is consistent with the DSM's goal of being descriptive and atheoretical.



- F. A final note:** Although dropped from the DSM-III (and is not included in the DSM-IV-TR), the term "neurosis" is still used. Psychodynamic (Freudian) theorists and practitioners find it a central concept in the study of psychopathology (eg: Murphy, 1983; Nov, 1982). Psychodynamic theorists, however, are not the only ones to believe in the concept of neurosis - there are many others who continue to use the term (eg: Wolpe, 1952, 1982). In particular, however, the term is still widely used by most mental health professionals as simply a generic descriptive label - to make general distinctions between milder disorders and the more seriously debilitating "psychotic" disorders.

III. Conclusion

In this lecture we have looked at the distinction between normal and abnormal anxiety, and the relation of anxiety to the more historical term "neurosis". All of the various forms of anxiety examined in class will be as described in the DSM-IV-TR.