Chapter 11: Anxiety Disorders and Obsessive-Compulsive Disorder

# 11.1 Anxiety Disorders in Childhood & Adolescence

## What is the Difference between Normal Anxiety and an Anxiety Disorder?

* Anxiety is a complex state of psychological distress that reflects emotional, behavioral, physiological, and cognitive reactions to threatening stimuli. Fear is primarily a behavioral and physiological reaction to immediate threat, whereas worry is primarily a cognitive reaction to the anticipation of future misfortune.
* Maladaptive anxiety can be differentiated from adaptive anxiety by its (1) intensity, (2) chronicity, and (3) degree of impairment.
* Children’s anxiety symptoms reflect their level of cognitive and social-emotional development.

## How Common are Childhood Anxiety Disorders?

* Separation Anxeity, Selective Mutism, Specific Phobia, Social Anxiety, and Generalized Anxiety Disorder disorder typically emerge in childhood, whereas Panic Disorder and Agoraphobia typically emerge in late adolescence or early adulthood.
* Approximately 5% of youths have an anxiety disorder at any point in time; approximately 20% of youths will experience an anxiety disorder prior to adulthood.

## What is Separation Anxiety Disorder?

* Separation Anxiety Disorder (SAD) is characterized by a developmentally inappropriate and excessive fear of separation from attachment figures. It lasts at least 4 weeks in children and causes distress or impairment.
* Onset of SAD is typically in early childhood, although adolescents and adults can also develop SAD. It affects approximately 3-4% of school-age youths.
* Insecure attachment and perceived environmental threat can trigger the development of SAD in youths with genetic or biological risk for the disorder.

## What is Selective Mutism?

* Selective Mutism is characterized by consistent failure to speak in some specific social situations in which there is an expectation for speaking (e.g., at school). It lasts for at least 1 month and impairs functioning.
* Selective Mutism tends to emerge in early childhood and affects less than 1% of preschoolers and young school-age children.
* Young children with temperaments characterized by high behavioral inhibition may be at risk for anxiety disorders in general and Selective Mutism in particular.

## What is Specific Phobia?

* Specific Phobia is characterized by marked fear or anxiety about a specific object or situation. It persists for at least 6 months and must cause distress or impairment.
* Between 2 and 9% of youths meet criteria for Specific Phobia; fear of animals and natural environment stimuli are most common. Children’s phobias usually reflect their level of cognitive and social-emotional development.
* Phobias can be acquired through classical conditioning, observational learning, or informational transmission. They are often maintained through avoidance (i.e., negative reinforcement).

## What is Social Anxiety Disorder?

* Social Anxiety Disorder is characterized by marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. It lasts at least 6 months and causes distress or impairment.
* Social Anxiety Disorder usually emerges in late childhood or early adolescence. It affects 3-6% of youths.
* Approximately 50% of the variance in Social Anxiety Disorder symptoms is attributable to genetics. Among children who inherit genetic risk, overprotective and highly controlling parenting behavior is associated with the emergence of the disorder.

## What is Panic Disorder?

* Panic Disorder is characterized by recurrent, unexpected panic attacks and 1 month of worry about future attacks or a change in behavior because of the attacks.
* Panic attacks affect approximately 18% of adolescents; however, Panic Disorder is relatively rare, affecting only 1% of youths.
* Youths with Panic Disorder often show unusually high anxiety sensitivity. They may worry about future panic attacks or modify their behavior in response to these attacks because they experience anxiety as unusually distressing.
* Cognitive distortions, such as personalization and catastrophic thinking, can exacerbate panic attacks and lead to Panic Disorder.

## What is Agoraphobia?

* Agoraphobia is characterized by marked anxiety about places or situations from which escape or help is not possible without considerable effort or embarrassment. It lasts at least 6 months and causes distress or impairment.
* Agoraphobia usually develops in early adulthood. Its prevalence among adolescents is < 0.5%.
* Agoraphobia has high heritability.
* Between 50- 75% of adolescents develop Agoraphobia after a history of Panic Disorder. Agoraphobia can develop without comorbid panic attacks, however.

## What is Generalized Anxiety Disorder?

* GAD is characterized by persistent worry, that is difficult to control, and associated with restlessness, poor concentration, fatigue, irritability, tension , and/or sleep problems. It lasts at least 6 months and causes distress or impairment.
* GAD differs from the other anxiety disorders because (1) it is characterized by worry, and (2) it is most closely associated with depression.
* Cognitive avoidance theory posits that youths use worry to avoid emotionally and physically arousing negative mental images.
* Youths with GAD often engage in cognitive distortions that exacerbate their worries.

# 11.2 Obsessive-Compulsive & Related Disorders

## What is Obsessive-Compulsive Disorder?

* OCD is characterized by obsessions and/or compulsions that are time consuming and cause significant distress or impairment.
* Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that a person feels driven to perform in response to an obsession or according to specific, inflexible rules.
* OCD tends to emerge in late childhood or early adolescence. In children, it disproportionately affects boys. Approximately 1-2% of youths have OCD.
* The cortico-basal-ganglionic neural circuit likely underlies OCD. It consists of the (1) orbitofrontal cortex, (2) cingulate gyrus, and (3) caudate.
* Youths with OCD often show cognitive distortions, such as inflated sense of personal responsibility and though-action fusion, which exacerbate their symptoms.

## What disorders are related to OCD?

* Tics are involuntary and sudden, rapid, non-rhythmic, stereotyped behaviors. They can be motoric or vocal. Tourette’s Disorder is defined by the presence of multiple motor and vocal tics lasting for more than one year.
* Trichotillomania is characterized by the repeated pulling out of hair, resulting in hair loss, which causes distress or impairment.
* Excoriation Disorder is characterized by recurrent skin picking that results in lesions and causes distress or impairment.

# 11.3 Evidence-Based Treatment

## How Can Behavior Therapy Be Used to Treat Phobias and Selective Mutism?

* Exposure therapy is a behavioral intervention used to treat anxiety and related disorders. It involves repeatedly confronting feared stimuli for discrete periods of time until anxiety or negative affect dissipates.
* Specific behavioral techniques that are effective for childhood anxiety disorders include contingency management, systematic desensitization, and modeling.
* Behavioral interventions based on exposure are efficacious in reducing anxiety in children and adolescents.

## How can Cognitive-Behavior Therapy be used to Treat SAD, GAD, and Social Anxiety Disorder?

* CBT involves the integration of cognitive and behavioral interventions to produce behavior change. It relies on the premise that changes in thoughts or overt actions can affect emotions.
* CBT consists of (1) learning the association between thoughts, actions, and feelings; (2) identifying and challenging cognitive biases or distortions that exacerbate anxiety; and (3) altering environmental contingencies to promote adaptive coping.
* Children can develop FEAR plans to cope with anxious stimuli or situations.

## How can Cognitive-Behavior Therapy be used to treat Panic Disorder?

* Relaxation training is a cognitive-behavioral intervention designed to reduce physiological arousal and avoid panic. It often involves muscle relaxation, controlled breathing, and generating pleasant imagery.
* Interoceptive exposure is a behavioral intervention unique to the treatment of Panic Disorder. The person intentionally produces physiological symptoms of panic and then uses relaxation techniques to cope with these symptoms.
* Cognitive restructuring can be used to challenge biases and distortions that lead to panic. Clients learn to look at panic-inducing situations more realistically and less catastrophically.

## How can Cognitive-Behavior Therapy be used to treat OCD and Related Disorders?

* Exposure and response prevention (EX/RP) is a first-line behavioral treatment for OCD. It involves exposing oneself to a series of stimuli that elicit obsessions and avoiding their corresponding compulsive behaviors.
* Tics, trichotillomania, and excoriation can be treated using behavioral techniques such as self-monitoring and habit reversal training.

## Is Medication Effective in Treating Childhood Anxiety Disorders?

* The Research Unit on Pediatric Psychopharmacology study showed that SSRIs, like fluoxetine (Prozac), reduce anxiety in children and adolescents.
* The Child-Adolescent Anxiety Multimodal Study (CAMS) demonstrated that CBT with SSRI led to better anxiety reduction than either treatment alone.
* The Pediatric OCD Treatment Studies (POTS I & II) showed that the combination of EX/RP and SSRI led to better OCD symptom reduction than either treatment alone. Furthermore, treatment was most effective when administered by trained therapists.
* Certain atypical antipsychotic medications (e.g., risperidone) and α2-agonists (guanfacine) are effective in reducing tics and related problems in children.