Anxiety Disorders - Outline

• Normal fears and compulsions
• Anxiety in general
• General etiologies
• Assessment of anxiety disorders
• General treatments
• Specific disorders
Normal fears, worries, and “compulsions”

- Anxiety is a basic human emotion
- Onset
  - Infancy – immediate environment (loud noises, etc.)
  - 6-9 months – fear of strangers, strange objects, and heights; separation anxiety (require capacity to remember and distinguish novel)
  - Year 2 – fear of imaginary threats (creatures, etc.)
  - Preschool – the dark, being alone, animals
  - School-age (~6-12) – supernatural phenomena, social fears, fears of failure, bodily injury, school
  - Older adolescents – global fears (economy, political concerns), death and danger (continue through adulthood)
Normal Fears

Fears are common in children
Parents may underreport fears
Girls exhibit more fears than boys
Girls exhibit more intensity than boys
Fears decline with age
Worry becomes more prevalent and complex with age
Fears coincide with different stages of development
Few cultural differences
Normal Fears

- Frequent in children
- Parents may underreport fears
- Girls exhibit more fears than boys
- Girls exhibit more intensity than boys
- Fears decline with age
- Worry becomes more prevalent and complex with age
- Fears coincide with different stages of development
- Few cultural differences
Anxiety disorders

• What differentiates an anxiety disorder from normal anxiety?
  – Definition of a clinical disorder

• Prevalence rates [12% to 20% of children and adolescents]

• Comorbidity/co-occurrence [most have multiple diagnoses at different points in time]
Anxiety

• Anxiety vs. fear

• Tripartite model
  – 3 types of reactions to perceived threat
    • Behavioral (running away, closing eyes)
    • Cognitive (worry, images of bodily harm, thoughts of fear)
    • Physiological (↑ heart rate, respiration, sweating, upset stomach)
Anxiety — future-oriented emotion, characterized by perceptions of uncontrollability and unpredictability, over potentially aversive events, and a rapid shift in attention to the focus of potentially dangerous events or one’s own affective response to those events.

Fear — reaction to an immediate/present threat characterized by an alarm reaction.

Worry — thoughts about possible negative outcomes that are intrusive and difficult to control (cognitive component of anxiety).
Hypothesized Etiologies

• Genetic/biological predisposition
• Temperament [high on behavioral inhibition]
• Psychosocial factors
  – Parenting (reaction of parents to stress/traumatic events, intrusive parenting style; failure to model appropriate coping behavior; allowing avoidance/escape behavior)
  – Prompting, modeling, reinforcing
• Attachment style
  – More anxious/resistant as infants
Hypothesized Etiologies

• Temperament
  – Behavioral inhibition system (Kagan, based on Gray and Quay)
    • Related to emotions of fear and anxiety
    • Inhibits action in novel or fearful situations, or with punishment
  – Negative affectivity (Clark & Watson)
    • General and persistent negative (nervous, sad, angry) mood
  – Positive affectivity (Lonigan)
    • Pleasurable mood
    • Associated with depression but not anxiety
  – Effortful control (Lonigan)
    • Ability to employ self-regulative processes
    • Anxiety D/O youths may have bias toward attending to threatening potentially stimuli

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The first of two cohorts were selected at either 21 or 31 months of age to include approximately equal numbers of children who were either consistently shy, quiet, and timid (inhibited) or consistently sociable, talkative, and affectively spontaneous (uninhibited) when exposed to unfamiliar people, procedures, and objects in unfamiliar laboratory settings. About 15% of a total sample of 400 children evaluated was classified as belonging to one of the two extreme groups with similar proportions of boys and girls in each group.
Descriptions of procedures. The children in cohort 1, selected at 21 months, were observed on two occasions with unfamiliar women and objects in several unfamiliar laboratory rooms. The major behavioral signs of inhibition coded from videotape were prolonged clinging to or remaining proximal to the mother, cessation of vocalization, and reluctance to approach or actual retreat from the unfamiliar events. The children who displayed these behaviors consistently across most incentives, as well as those who did not, were selected to form one group of 28 inhibited and another group of 30 uninhibited children.

The initial selection of children for cohort 2 at 31 months was based on behavior with an unfamiliar child of the same sex and age in the same laboratory playroom, with both mothers present, and a subsequent episode in which the child encountered an unfamiliar woman dressed in an unusual costume. The indexes of inhibition, similar to those used with cohort 1, were long latencies to play, speak, and interact with the unfamiliar child and woman, as well as long periods of time proximal to the mother. This selection process yielded 26 consistently inhibited and 23 consistently uninhibited children.
Each of these two cohorts was observed on three additional occasions. Cohort 1 was observed subsequently at 4, 5.5, and 7.5 years of age; cohort 2 at 3.5, 5.5, and 7.5 years, with about 20 percent attrition by the time of the last assessment at 7.5 years when there were 41 children in each cohort. The phenotypic display of the two temperamental tendencies changes with age because of learning and maturation. A 2-year-old will become uncertain in an unfamiliar room with unfamiliar objects, but older children require more potent incentives, especially unfamiliar children and adults. Thus, the specific laboratory procedures we used changed for the four evaluations.
Biological Bases of Childhood Shyness
Author(s): Jerome Kagan, J. Steven Reznick, Nancy Snidman
Published by: American Association for the Advancement of Science

Fig. 2. Relation between latency to the sixth spontaneous comment and total number of spontaneous comments at 7.5 years for cohort 1 children selected at 21 months and cohort 2 children selected at 31 months. I, inhibited; Not I, uninhibited.
Fig. 3. Relation between the original index of inhibition at 21 months and the aggregate index of inhibition (z score) at 7.5 years for cohort 1 children. I, inhibited; Not I, uninhibited.
Fig. 4. Mean heart rate (z score) for cohort 1 children at each of the four assessments (stable I refers to 12 children who were inhibited at every age; less stable I, to 10 children who were inhibited originally but were uninhibited on one or more of the later assessments; stable not I, to 12 children who were consistently uninhibited; and less stable not I, to 7 children who were classified as uninhibited originally but were inhibited on one or more of the later assessments). The standard errors of the mean for each of the four groups at the four ages averaged 0.29, 0.26 for the consistently inhibited children, and 0.34 for the consistently uninhibited children.
**Biological Preparedness**

Different organisms are biologically prepared to learn some associations more easily than others; **Phobias may develop through a non-declarative memory** – a classical conditioning process of which the person is unaware.

**Stimulus-Response Associations:**

- **Unconditioned Stimulus** → **Response**
- **Neutral Stimulus**

**Stimulus-Stimulus Associations:**

- **Memory Trace of the Unconditioned Stimulus**
- **Conditioned Stimulus** → **Response**

**CS is directly associated with a memory representation of the US, which then leads to the production of the CR (i.e., CS predicts the onset of the US, so this elicits a CR).**
**Declarative memories**: The type of memories that one is conscious of and can talk about. Scoville and Milner [1957] established the role of the hippocampus in the consolidation of declarative memories.

**Nondeclarative memories**: the types of memories that one is not aware of or only partially aware of such as the ability to ride a bicycle or tie one’s shoes. Nondeclarative memories do not depend on the hippocampus but instead require portions of the basal ganglia and cerebellum.

Another type of nondeclarative memory is exemplified by an individual with alcoholism or drug abuse who is flooded with the urge to drink or satisfy a drug habit when passing a particular bar or alleyway where this habit was satisfied in the past. These types of associations can be robust and long lasting, as exemplified by the relapse rates of these disorders.
Nondeclarative memories:

An example of why nondeclarative memories are particularly relevant to several psychiatric disorders. For example, why do posttraumatic stress disorder and phobias occur in some individuals but not in others?

These disorders are thought to rely on nondeclarative associations being formed, although in this case, declarative memories often are also formed. Many laboratories over the years have developed sophisticated paradigms to study the formation of nondeclarative memory in animal models.

A form of this type of learning is called fear conditioning, and the consolidation of these fearful memories requires the amygdala.
Typical Experimental Set-up of Cued Conditioning

In a typical experiment, a rodent is placed into a small cage. A tone sounds, and after 20 seconds or so, a **mild shock** is delivered through the floor of the cage. Animals learn after only one or two sessions to fear the tone.

This **cued conditioning**, with the cue being the tone, is distinguished from **contextual conditioning**, in which the rodent is placed into a cage that it can explore and then receives a mild shock. Lesion studies in rodents were able to establish the brain regions that are involved in these two types of learning.

In the case of contextual learning, **both the hippocampus and the amygdala** are required, with the **hippocampus involved in learning the spatial cues of the cage**, whereas the **amygdala is involved in the fear memories themselves**.

In contrast, **only the amygdala is necessary for the consolidation of fear memories in the case of cued conditioning**. (Obviously, other brain regions are involved, as we process, for example, the initial sensory cues; here, we are referring to the brain regions involved in the **consolidation of fear memories**.)

[Adapted from LOMBROSO, M.D., AND MARILEE P. OGREN, JAACAP, 2008, 47]
Dissecting the cued condition training:

The incoming sounds of the tone are detected and activate the auditory nerve that makes synaptic contact with the neurons of the cochlear nucleus.

Several synaptic connections later, the signal arrives to the thalamus, where part of the signal is projected to the lateral amygdala, whereas others move on to the auditory cortex for processing.

It is the portion that arrives at the lateral amygdala that is of interest. At the end of the period that the mouse is hearing the tone, the mild shock is given. It is initially sensed by nerve terminals in the paws and is passed up the spinal cord to reach the thalamus.

Part of the incoming signal is passed to neurons that are found in the lateral amygdala, whereas another portion moves on for processing by the sensory cortex (see schematic – next slide).
Neurons of the lateral amygdala receive the synaptic inputs of the tone and the shock on their dendritic arbors. This is the critical event: the arrival of two synaptic inputs at the same time and to the same neuron and, in fact, to the same spine of this neuron.

Something happens to the recipient spine when these two inputs arrive within milliseconds of each other. There is a strengthening of the connection for the signal representing the tone. Yesterday, the mouse would have heard the same tone and done nothing particularly dramatic.

Once the association of the tone to the shock occurs and a fear memory is made, later, the mouse needs to only hear the tone to freeze in its tracks. It has learned that something bad happens when it hears this tone.

Following the pathway that leads to the freezing behavior is instructive. At the test session 24 hours after the fear-conditioning training, the mouse is exposed to the tone only. The tone is now able to depolarize the postsynaptic neuron in the lateral amygdala sufficiently for an action potential to be produced within this neuron and passed on to the next relay station, a neuron within the central nucleus of the amygdala.
Tone alone generates signal that is passed along to the central nucleus.

Thalamus sends signals of the tone & shock to the lateral amygdala.

Afterwards, the tone alone generates an action potential from these neurons, & this signal is passed along to the central nucleus, then transferred to deeper structures that produce PTSD/phobic symptoms.

Fig. 3 The thalamus sends signals representing both the tone and shock to neurons of the lateral amygdala. If consolidation of the fear memory occurs, then this can be measured at a later testing time (24 hours) in which only the tone is presented to the test animal. If consolidation has happened, then the tone alone is sufficient to generate an action potential from these neurons, and this signal is passed along to the central nucleus (CE) and, from there, is transmitted to a number of deeper structures responsible for the behaviors observed. AST = amygdala striatal transition zone; BLA = basolateral amygdala; MLA = mediolateral amygdala; VLA = ventrolateral amygdala.
Fig. 4  Schematic diagram indicating the connections between the central nucleus and a variety of target nuclei within the hypothalamus and brainstem that together are responsible for the symptoms of fear and anxiety. Reprinted with permission from the Annual Review of Neuroscience, Davis M. The Role of the Amygdala in Fear and Anxiety. Annual Review of Neuroscience. 1992;15:353-375. www.annualreviews.org.
Hypothesized Etiologies

• Psychosocial factors
  – Impact: Children’s experiences with and perceptions of control
  – Parenting (reactions, intrusive style)
    • Intrusive parenting – excessive regulation, overprotection, more critical ("helicopter parents")
    • Reactions
    • Prompting, modeling, reinforcing → behavioral
  – Gerull & Rapee, 2002
    • Toddler’s approach/avoidance of rubber snakes/spiders
    • Measured toddler’s initial approach
    • Measured parental reaction (facial expression)
    • Measured approach again
      – Negative maternal expression vs. positive maternal expression
Hypothesized Etiologies

• Attachment style
  – Insecure mother-child attachments
    • Anxious/avoidant attachment → 28% develop anxiety disorder by age 18 (Warren et al., 1997) vs. 13% who were not anxious/avoidant temperament
      – Even after accounting for maternal anxiety
Classifying Anxiety

• Specific Phobia
  – Animal
  – Natural/environment
  – Blood-injection-injury
  – Situational
  – Other (e.g., costumed figures)
  – Child shows fear in response to object
  – Avoids situations
  – Fear causes impairment
  – Most common anxiety disorder diagnosis in children
  – Comorbid with other disorders
  – Persistent
  – e.g., Frog Phobia: RANIDAPHOBIA (or Batrachophobia – fear of amphibians)
Examples of Specific Phobias

**Acrophobia**, Altophobia — fear of heights.

**Agoraphobia** — fear of a place or event where escape is impossible.

**Algophobia** — fear of pain.

**Androphobia** — fear of males.

**Aquaphobia, Hydrophobia** — fear of water

**Astraphobia**, Astrapophobia, Brontophobia, Keraunophobia — fear of thunder, lightning and storms; especially common in young children.

**Autophobia** — fear of being alone.

**Aviophobia**, Aviatophobia — fear of flying.

**Bacillophobia**, Bacteriophobia, Microbiophobia — fear of microbes and bacteria.

**Cibophobia, Sitophobia** — aversion to food, synonymous to Anorexia nervosa.

**Claustrophobia** — fear of confined spaces.

**Coulrophobia** — fear of clowns (not restricted to evil clowns).

**Dental phobia**, Dentophobia, Odontophobia — fear of dentists and dental procedures.

**Dysmorphophobia**, or body dysmorphic disorder — a phobic obsession with a real or imaginary body defect.

**Emetophobia** — fear of vomiting.
Examples of Specific Phobias

Ergasiophobia, Ergophobia — fear of work or functioning.
Erotophobia — fear of sexual love or sexual questions.
Erythrophobia — pathological blushing.
Gephyrophobia — fear of bridges.
Genophobia, Coitophobia — fear of sexual intercourse.
Glossophobia — fear of speaking in public or of trying to speak.
Gymnophobia — fear of nudity.
Gynophobia — fear of women.
Heliophobia — fear of sunlight.
Hemophobia, Haemophobia — fear of blood.
Hexakosioihexekontahexaphobia — fear of the number 666.
Hoplophobia — fear of firearms (guns).
Lalophobia, Laliophobia — fear of loud noises.
Mysophobia — fear of germs, contamination or dirt.
Necrophobia — fear of death, the dead.
Examples of Specific Phobias

**Neophobia** — fear of newness, novelty.

**Nosophobia** — fear of contracting a disease

**Nyctophobia**, Achluophobia, Lygophobia, Scotophobia — fear of darkness.

**Osmophobia**, Olfactophobia — fear of smells.

**Paraskavedekatriaphobia** — fear of Friday the 13th.

**Panphobia** — fear of everything or constantly afraid without knowing what is causing it

**Phonophobia** — fear of loud sounds.

**Pyrophobia** — fear of fire.

**Radiophobia** — fear of radioactivity or X-rays.

**Sociophobia** — fear/dislike of society or people in general (see also "sociopath").

**Taphophobia** — fear of the grave, or fear of being placed in a grave while still alive.

**Technophobia** — fear of technology (see also Luddite).

**Tetraphobia** - fear of the number 4.

**Tokophobia** — fear of childbirth.

**Triskaidekaphobia**, Terdekaphobia — fear of the number 13.

**Trypanophobia** — fear of needles or injections

**Xenophobia** — fear of strangers, foreigners, or aliens.
Examples of Specific Phobias

Zoophobias

Ailurophobia -- fear of cats
Apiphobia, Melissophobia — fear of bees
Arachnophobia — fear of spiders
Chiroptophobia — fear of bats
Cynophobia — fear of dogs
Entomophobia — fear of insects
Equinophobia, Hippophobia — fear of horses
Herpetophobia — fear of reptiles
Musophobia — fear of mice and/or rats
Ophidiophobia — fear of snakes
Ornithophobia — fear of birds
Ranidaphobia -- fear of frogs
Zoophobia — a generic term for animal phobias
Ichthyophobia -- Fear of Fish
Medical Conditions Emulating Specific Phobias

The following medical conditions have nothing to do with irrational fears. However, each usually has a psychological disorder of the same name which is an irrational fear. The behavior of an individual with the medical condition can be similar to the behavior of an individual with the psychological disorder of the same name (e.g., for both usages of Photophobia the person avoids light). The difference in usage is that for the medical term there is an underlying physiological condition that results in the behavior. For example, with medical Photophobia the hypersensitivity to light is sufficient such that at some light levels the person experiences pain which they avoid by seeking darkness. Removing the physiological cause of the hypersensitivity to light results in the person no longer avoiding light. With psychological Photophobia the person fears the light even though there is no current physiological pain caused by light.

Hydrophobia — fear of water (a symptom of rabies).
Photophobia — hypersensitivity to light causing aversion to light (a symptom of Meningitis).
Phonophobia — hypersensitivity to sound causing aversion to sounds.
Osmophobia — hypersensitivity to smells causing aversion to odors.
Specific Phobia

• Primary treatments:
  – “relaxation + desensitization”, CBT
  • Fear Hierarchy

Sample Dog Phobia Fear Hierarchy
Walking in dog park without therapist
Walking beside therapist in the dog park
Sitting in car at dog park watching dogs play
Walking dog on leash; therapist nearby
Walking dog on leash; therapist walks with
Walking beside ther., who walks leashed dog
Holding the puppy
Watching therapist handle a puppy while standing five feet away
Going to pet store and watching puppies who are in their cages
Looking at photos of dogs
Anxiety — future-oriented emotion, characterized by perceptions of uncontrollability and unpredictability, over potentially aversive events, and a rapid shift in attention to the focus of potentially dangerous events or one’s own affective response to those events.

Fear — reaction to an immediate/present threat characterized by an alarm reaction.

Worry — thoughts about possible negative outcomes that are intrusive and difficult to control (cognitive component of anxiety).
Social Phobia/Social Anxiety Disorder

- **Primary symptom:** Persistent fear of acting in an embarrassing or humiliating way in social or performance situations
  - **Situations:**
    - Speaking
    - Reading
    - Writing
    - Eating
    - Maintaining conversations
    - Public performances
    - Speaking to authority figures
Social Phobia/Social Anxiety Disorder

• **Secondary symptoms:**
  – Okay with familiar adults
  – Problems with unfamiliar peers and adults
  – Somatic complaints
    – Blushing, restlessness, sweating, complaints of illness, stomachaches
  – Miss school
  – Recreational activities
  – Avoidance (e.g., eating in public)
  – Report lower self-worth
  – Selective mutism
  – Sadness, loneliness
  – Educational achievement
Social Phobia/Social Anxiety Disorder

• Fear causes impairment
• Prevalence: 1% - 2%
• Onset: middle- to late-teens
  – Requires
    • Abilities to see oneself as a social object & feel embarrassment (age 4-5)
    • Envisioning perspective of others and experiencing concern re: possible (-) eval (age 8)
    • Environmental demands to perform tasks with social-evaluative component (speaking in class, band performances, etc; late childhood, early adolescence)

• Course: chronic
• Duration: often remits by adulthood
Social Phobia/Social Anxiety Disorder

- **Severity**: differential between normal social anxiety and SAD
- **Comorbidity**: most, esp. other anxiety disorders
- **Treatment**: CBT, relaxation + exposure, systematic desensitization (imaginal or *in vivo*), participant modeling, contingency management (reinforced practice)
Separation Anxiety Disorder

• Primary symptom: Excessive anxiety about separation from, or harm befalling, one or more major attachment figures
Separation Anxiety Disorder

• Secondary symptoms:
  – Clingy; follow parents around
  – Express general fear/apprehension
  – Nightmares
  – Somatic complaints
  – Depression, apathy
  – Reluctance to leave home
  – ↓ peer activities
  – Threats of self-harm (actual self-harming behavior is rare)
  – Sleep in bed with parents (frequently or nightly)
Separation Anxiety Disorder

• **Prevalence**: 3-12%

• **Onset**: age 9-13, insidious
  – Age 1 – preschool: periodic distress/worry when separated from parents is expected
  – May follow stress or trauma

• **Course**: variable, often increasing in severity

• **Duration**: usually remits by adolescence; rare in older adolescents
Separation Anxiety Disorder

- **Comorbidity:** esp. Generalized Anxiety Disorder
- **Severity:** differentiate from homesickness, developmentally appropriate levels of separation anxiety
- **Treatments:** CBT, relaxation + exposure, systematic desensitization (imaginal or *in vivo*), participant modeling, contingency management (reinforced practice)
School Refusal

Often associated with SAD
Other causes possible
Need to do functional analysis to understand motivation
1-2% of general population
No gender differences
Important to get child back to school
Generalized Anxiety Disorder

• Primary symptom: Excessive anxiety and worry that the child/adolescent finds difficult to control
  – Not situation-limited
  – Not due to a recent stress
Generalized Anxiety Disorder

• Secondary symptoms:
  – Exhibit extensive fearful behavior
  – Excessive concern re: competence across several areas (peer relations, sports, academics)
  – Perfectionism
  – Unreasonably high standards for self
  – “Little worriers” – worry about family finances, natural disasters, etc.
  – Repeated approval/reassurance seeking
  – Sleep disturbances
  – Headaches, stomachaches
  – Increased risk of alcohol use
Generalized Anxiety Disorder

• **Prevalence:** 2-14%
  – Most common anxiety disorder in adolescents
  – May be overdiagnosed

• **Onset:** median age = 10

• **Course:** increase in number and severity of symptoms

• **Comorbidity:** esp. Depression, separation anxiety, and phobias
Generalized Anxiety Disorder

• **Duration**: chronic

• **Reification error?**: GAD may reflect general constitutional vulnerability toward anxiety or emotional reactivity
  – As opposed to a discrete nosological entity

• **Treatments**: CBT, relaxation + exposure, systematic desensitization (imaginal or *in vivo*), participant modeling, contingency management (reinforced practice)
Panic Attacks/Panic Disorder

• Panic attack vs. panic disorder
  – Panic disorder = at least one previous panic attack plus worry that another attack will occur without warning

• With and without agoraphobia

• Cued vs. uncued
  – Panic disorder vs. specific phobia?
  – Developmental issues
Panic Attacks & Panic Disorder

Panic attack - period of intense fear or terror with sudden onset; need 4 or more of the following:
- Pounding heart
- Sweating
- Trembling
- Shortness of breath
- Choking
- Chest pain
- Nausea
- Dizzy or faint
- Feelings of unreality or detachment
- Fear of losing control or going crazy
- Fear of dying
- Numbness
- Chills or hot flashes
Panic Disorder

• Primary symptoms: Prev. panic attack + worry

• Secondary symptoms:
  – Behavior changes
  – Agoraphobia
  – May be homebound
  – Fear of going crazy
  – Fear of dying
Panic Disorder

• Prevalence:
  – Panic attack: 16% (age 12-17)
  – Panic disorder: 0.5%

• Onset: mid to late adolescence (diagnosed)

• Course: variable

• Duration: variable

• Severity: variable
Panic Disorder

- Treatments: CBT, relaxation + exposure, systematic desensitization (imaginal or *in vivo*), participant modeling, contingency management (reinforced practice)
Acute Stress Disorder and PTSD

• **Person exposed to traumatic event**
  – Includes threats of death or serious injury to self or others
  – Person feels fear, helplessness or horror

• **Person experiences triad of symptoms**
  – Re-experiencing
  – Avoidance of trauma-related stimuli and numbing
  – Symptoms of increased arousal
Acute Stress Disorder and PTSD

- Onset: acute or delayed
- Course: variable
Acute Stress Disorder and PTSD

- **Secondary symptoms:**
  - Repetitive play
  - School refusal
  - Increased fears
  - May be clingy or dependent
  - Depression
  - Survivor guilt
  - Sleep disturbance (esp. onset of sleep)
  - Decreased planning for future (adolescents)
  - Irritability
  - Angry/aggressive outbursts
  - Anhedonia
  - Poor school performance
Acute Stress Disorder and PTSD

• Differential diagnosis:
  – Course and duration:
    • ASD: >2 days and < 4 weeks, immediate onset
    • PTSD: > 1 month, or has delayed onset
  – Secondary symptoms
    • ASD: must have dissociative symptoms
    • PTSD: may be present, but not required
Acute Stress Disorder and PTSD

- Prevalence: 1/3 of children exposed to trauma
- Onset: acute or delayed
Acute Stress Disorder and PTSD

- Course: Variable, often somewhat over time
  - La Greca et al. (1996)
  - 3rd – 5th graders and Hurricane Andrew
Acute Stress Disorder and PTSD

• Duration: dependent on type of stressor
  – Acute, non-abusive
  – Chronic or abusive

• Severity: dependent on
  – Degree of exposure
  – Individual differences (e.g., resilience studies)
Acute Stress Disorder and PTSD

- Treatments: CBT, relaxation + exposure, systematic desensitization (imaginal or in vivo), participant modeling, contingency management (reinforced practice)
Obsessive Compulsive Disorder

• Primary symptoms
  – Obsessions – unwanted repetitive intrusive thoughts
  – Compulsions – repetitive, stereotype behaviors
  – DSM criteria: Don’t need to have both ....
Obsessive Compulsive Disorder

• Secondary symptoms
  – Poor school performance
  – Behavior problems (e.g., periodic inattention)

• Often kept a “secret” – parents/teachers/etc. may not know
Obsessive Compulsive Disorder

• **Prevalence:** 1% of adolescents

• **Onset:**
  – Boys: age 9 (prepubertal)
  – Girls: age 11 (pubertal)

• **Course:** changes in content and intensity over time

• **Duration:** lifelong
Obsessive Compulsive Disorder

• Severity:
  – Normal “obsessions/compulsions”:
    • Stepping over cracks, touching every 3rd fence post, etc. – very common in 8-10 year olds (“games”)
    • Repetitive play, preference for sameness
    • Routines

• Differential:
  – Interference with functioning; dominate child’s life
  – Content
  – Onset
Obsessive Compulsive Disorder

• Comorbidity: anxiety, depression, Tourette’s, ADHD, conduct problems

• Treatment
  – CBT
    • Exposure + response prevention
      – Imaginal (embellished description of feared situation) and *in vivo*
      – Continue exposure until anxiety is reduced
  – Medication
    • SSRIs (30-40% reduction in severity)
    • Safety?
Assessment

• Interviews
  – Clinic
  – Semi-structured

• Self report inventories
  – Global ratings
  – State trait inventory for children
  – Reynolds
  – Cognitive measures
  – Behavioral observations
  – Physiological recordings
Assessment of anxiety disorders

• Developmental issues
  – Younger children
    • Difficulty labeling and communicating feelings
    • May not have noticed that worry/fear occurs in specific contexts/in response to specific triggers

• Cultural issues
Assessment of anxiety disorders

- Functional analysis
- Tripartite assessment
- Multiple informants
- Ask the parent vs. ask the child?
Treatment

- **Psychological**
  - Relaxation
    - Muscle
    - Imagery
  - Systematic desensitization: pairing relaxation with exposure
    - Imagery
    - In vivo
  - Modeling
    - Participant modeling
  - Contingency Management
    - Stop reinforcing for avoidance
    - Reinforce improvement
Treatment

- Psychological
  - Cognitive behavioral
    - Recognize signs of anxious arousal
    - Identify cognitive processes associated with anxiety
    - Develop skills for managing anxiety
    - FEAR program by Kendall et al.
    - Research supports these methods
  - Exposure with Response Prevention for OCD
  - Pharmacological
    - SSRIs, TCAs, and antianxiety medications used
    - SSRI have support for treating OCD
    - Otherwise not a lot of support for these methods