Chapter 7: Anxiety Disorders:

Anxiety Disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat.

-Definition: Vague, subjective, nonspecific feeling of uneasiness, tension, apprehension, and sometimes dread or impending doom.
-Symptoms of anxiety: hypertension, tachycardia, muscle hypertonia, hyperactivity, irritability.

-Common disorders that have anxiety symptoms:
  1. Neurotic Disorders: Hysterical Disorder, Depression, PTSD.
  3. Mood Disorders: Major depressive disorder

Predisposing factors:
1. Hereditary factors:
   -Average of anxiety in identical twins is more than 50%.
2. Age:
   -Anxiety increases in Children (Immature nervous system).
   -Anxiety increases in Elderly (Atrophic nervous system).
Symptoms in pediatric: phobia in night, phobia from strangers, animals, older children, being alone, nightmares, urinal or fecal incontinence, walking during sleeping.
Symptoms in adolescent: unsuitability, irritability, social embarrassment especially when facing or meeting the other sex, guilty feeling, anxious about genital area, being very shy, speech stutter.
Symptoms in Adulthood: Decrease.
Symptoms in elderly: Increase (regarding disease, death).

Types of anxiety (according to level):
1. Mild anxiety:
   a. Physiologic: Vital signs are normal, minimal muscle tension, pupils normal, constricted.
   b. Cognitive: perceptual field is broad
   -Thought may be random but controlled.
   c. Emotional/Behavioral: relative comfort and safety, relaxed, calm appearance and voice.
2. Moderate Anxiety:
   a. Physiologic: Vital signs are normal or slightly elevated, Tension experienced, may be uncomfortable.
   b. Cognitive: alert; perception narrowed, focused (Optimum state for solving and learning), Attentive.
   c. Emotional/Behavioral: Readiness and challenge (energize), engage in competitive activity and learn new skills, voice and facial expression concerned.
3. Severe Anxiety: symptoms
a. Physiologic: Fight or flight, autonomic nervous system excessively stimulated (highly increase in vital signs, diaphoresis, urine urgency and frequency, diarrhea, dry mouth, decrease appetite, dilated pupil), muscles rigid, tension, decrease heating and pain sensation.

b. Cognitive / perceptual: Perceptual field greatly narrowed, problem solving: difficult, automatic behavior, selective attention (focus on one detail).

c. Emotional/Behavioral: Feels threatened, seem or feel depressed, becomes very disorganized or withdrawn, may close eyes to shut out environment.

Separation Anxiety Disorder

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:
1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
7. Repeated nightmares involving the theme of separation.
8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.

C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.

Prevalence:
Separation anxiety disorder decreases in prevalence from childhood through adolescence and adulthood and is the most prevalent anxiety disorder in children younger than 12 years. In clinical samples of children, the disorder is equally common in males and females. In the community, the disorder is more frequent in females.
Selective Mutism

Diagnostic Criteria
A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
B. The disturbance interferes with educational or occupational achievement or with social communication.
C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
E. The disturbance is not better explained by a communication disorder (e.g., childhood onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

Prevalence
Selective mutism is a relatively rare disorder and has not been included as a diagnostic category in epidemiological studies of prevalence of childhood disorders. The prevalence of the disorder does not seem to vary by sex or race/ethnicity. The disorder is more likely to manifest in young children than in adolescents and adults.

Development and Course
The onset of selective mutism is usually before age 5 years, but the disturbance may not come to clinical attention until entry into school, where there is an increase in social interaction and performance tasks, such as reading aloud. The persistence of the disorder is variable.

Panic Disorder
Diagnostic Criteria
A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:
Note: The abrupt surge can occur from a calm state or an anxious state.
1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or “going crazy.”
Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).
D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder, in response to circumscribed phobic objects or situations, as in specific phobia, in response to obsessions, as in obsessive-compulsive disorder, in response to reminders of traumatic events, as in posttraumatic stress disorder: or in response to separation from attachment figures, as in separation anxiety disorder).

**Phobias**
-The patient experiences panic attack in response to particular situations or learns to avoid situations that evoke panic attack.
-Phobia results even the patient knows that it won’t happen and no danger if exposed to situation.
-Even the patient knows that very well he/she can’t control phobia and doesn’t confront internal conflict but convert it into external symptoms.

**Types of phobias:**
**Specific Phobia**

**Diagnostic Criteria**
A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.
B. The phobic object or situation almost always provokes immediate fear or anxiety.
C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.
D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more. 
F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. 
G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

- Includes specifies conditions: 
  3. Acrophobia: fear of heights.  
  4. Zoophobia: fear of animals.  
  5. Aqua phobia (or hydrophobia): fear of water.  
  7. Pyrophobia: fear of fire.  
  10. Xenophobia: fear of strangers.  
  11. Astrophobia: fear of lightening.

Course and prognosis: 
- Beginning of simple phobias is varied.  
- Zoophobia starts in childhood.  
- Hematophobia often starts in adolescence or early adulthood.  
- Acrophobia often starts in the fourth decade.  
- Most of other phobias that start in childhood disappear without treatment.  
- Disability results from simple phobias is slight if avoidance was easy as zoophobia, but disability is increasing if stimulus is common, spread and not avoidable as fear of riding cars for student.

Prevalence 
Prevalence rates are approximately 5% in children and are approximately 16% in 13- to 17-year-olds. Prevalence rates are lower in older individuals (about 3%-5%). Females are more frequently affected than males, at a rate of approximately 2:1, although rates vary across different phobic stimuli.
Suicide Risk
Individuals with specific phobia are up to 60% more likely to make a suicide attempt than are individuals without the diagnosis.

2-Social Anxiety Disorder (Social Phobia)
Diagnostic Criteria

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).
Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.
B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).
C. The social situations almost always provoke fear or anxiety.
Note: In children, the anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.
D. The social situations are avoided or endured with intense fear or anxiety.
E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
J. If another medical condition (e.g., Parkinson’s disease, obesity, disfigurement from bums or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Course and prognosis:
-Usually starts in late childhood and early adolescence.
-May become chronic and decreases after midlife.
-Rarely that disorder is severe and interfere with vocational performance because of avoidance.

Complications:
-Addiction (Alcohol, anti-anxiety).
-Depression.
3. Agoraphobia

The individual with agoraphobia experiences fear of being in places or situations from which escape might be difficult or in which help might not be available in the event that panic symptoms should occur.

Diagnostic Criteria
A. Marked fear or anxiety about two (or more) of the following five situations:
1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
3. Being in enclosed places (e.g., shops, theaters, cinemas).
4. Standing in line or being in a crowd.
5. Being outside of the home alone.
B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence).
C. The agoraphobic situations almost always provoke fear or anxiety.
D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.
E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.
F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. If another medical condition (e.g., inflammatory bowel disease, Parkinson’s disease) is present, the fear, anxiety, or avoidance is clearly excessive.
I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder—for example, the symptoms are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder): and are not related exclusively to obsessions (as in obsessive-compulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder).

Note: Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual’s presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

Prevalence
Every year approximately 1.7% of adolescents and adults have a diagnosis of agoraphobia. Females are twice as likely as males to experience agoraphobia. Agoraphobia may occur in childhood, but incidence peaks in late adolescence and early adulthood. Twelve-month prevalence in individuals older than 65 years is 0.4%. Prevalence rates do not appear to vary systematically across cultural/racial groups.
Treatment:
1-Drugs: anti-anxiety or anti-depression.

2-Psychotherapy:
a. Behavioral psychotherapy: with drugs in severe cases by Gradual Desensitization by exposing him to the fear object gradually and could be accompanied by some drugs or relaxation training or Flooding therapy: by exposing the patient suddenly to fear object in reality or imagination.
b. Insight psychotherapy: To make the patient understand the cause phobia and secondary gain symptoms, role of resistance and this will make him able to find methods more acceptable to control anxiety with motivating the patient to be exposed to phobia situation.

Generalized Anxiety Disorder
Diagnostic Criteria
A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
   Note: Only one item is required in children.
   1. Restlessness or feeling keyed up or on edge.
   2. Being easily fatigued.
   3. Difficulty concentrating or mind going blank.
   4. Irritability.
   5. Muscle tension.
   6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder), separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).
**Prognosis:**
- May start in any age but is more in 20s and 30s.
- Mainly chronic and may continue for life.

- **Complication:** panic attack.

**Treatment:**
1. **Drugs:** should decrease prescribed anti-anxiety as possible (because disorder is chronic).

2. **Psychotherapy:** the treatment of choice.
   a. **Psychoanalytic psychotherapy:** through long-term insight.
   b. **Behavioral psychotherapy:** focuses on desensitization with entrance to cognitive therapy aims to stop conditioning in addition to relaxation and modifying behavior.

**Substance/Medication-Induced Anxiety Disorder**
**Diagnostic Criteria**

A. Panic attacks or anxiety is predominant in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
   2. The involved substance/medication is capable of producing the symptoms in Criterion A.
C. The disturbance is not better explained by an anxiety disorder that is not substance/medication-induced. Such evidence of an independent anxiety disorder could include the following:
   The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication: or there is other evidence suggesting the existence of an independent non-substance/medication-induced anxiety disorder (e.g., a history of recurrent non-substance/medication-related episodes).
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Anxiety Disorder Due to Another Medical Condition

Diagnostic Criteria

A. Panic attacks or anxiety is predominant in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder.
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Other Specified Anxiety Disorder

This category applies to presentations in which symptoms characteristic of an anxiety disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the anxiety disorders diagnostic class. The other specified anxiety disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific anxiety disorder. This is done by recording “other specified anxiety disorder” followed by the specific reason (e.g., “generalized anxiety not occurring more days than not”).

Unspecified Anxiety Disorder

This category applies to presentations in which symptoms characteristic of an anxiety disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the anxiety disorders diagnostic class. The unspecified anxiety disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific anxiety disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).