Anxiety Disorders

2 CE Hours

Reviewed and edited by: Wade T. Lijewski, Ph.D.

Learning objectives

Upon completion of this course, the learner will be able to:

- Apply the diagnostic criteria for each type of anxiety disorder.
- Apply the different treatment models used with anxiety disorders, such as cognitive-behavioral therapy.
- Analyze the screening tools used to assess the various types of anxiety disorders.
- Describe recent research on the effectiveness of treatment for anxiety disorders.
- Facilitate strategies to help parents manage their children’s anxiety.
- Assess the different medications used to treat each type of anxiety disorder.

Introduction

Mandy is a 52-year-old woman who has a responsible job as an accountant. She appears to her friends and family to “have it all together.” However, in the last three months, Mandy has been more reluctant to go to places she describes as “open,” in particular, going to the mall.

Two months ago, while at the mall, Mandy felt her legs go numb and tingle. She just felt different and scared for no real reason, but it went away after a few minutes. The next week, while at the mall again, Mandy felt as if she were having a heart attack as her heart began to pound uncontrollably and she began shaking and gasping for her breath. A friend who was with her called 911, and Mandy was checked by the emergency medical personnel, who determined that nothing was wrong with her heart.

Mandy felt foolish and embarrassed afterwards and has become very reluctant to go out with friends and stays home more and more. She has made an appointment to go see her primary care doctor because she is convinced that something is wrong with her heart.

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James, 29, has always described himself as a “neurotic.” He is a perfectionist who worries over every detail of his life and his job as a nurse. Recently, he has begun to wake up in the middle of the night two or three times a week, worrying that he forgot to do something important at his job. He calls the hospital to check on patients and tasks he was assigned.

At first, his coworkers found this amusing, or just a sign of how conscientious he is as a nurse. But in the last week, his coworkers have begun to laugh at him and to appease him; they tell him that they have checked on things when they really haven’t done so.

James also worries constantly that something will happen to his young son, and he cannot stop worrying that his son will get cancer or have an accident. When these thoughts are happening, James cannot concentrate on anything else. He also forbids his son to participate in skateboarding or playing basketball with other kids, because he is afraid the boy will get hurt.

He has also begun to worry about his wife leaving him and asks her for daily reassurance that she will not divorce him. His wife is becoming increasingly annoyed by this questioning.

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Jordan is a 7-year-old boy who witnessed his father dying in a car accident three months ago. Jordan was a passenger in the car, but was unharmed. He has been having nightmares, and began sucking his thumb and wetting the bed. His mother noted that while playing, Jordan keeps acting out a car accident with his toys. Jordan is well behaved, but his mother is worried about his other behaviors.

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All of the persons in these vignettes are displaying symptoms consistent with some form of an anxiety disorder. Anxiety is a broad term that encompasses a broad spectrum of disorders, each with their own distinct features and course of treatment.

According to the Anxiety and Depression Association of America, (2013) anxiety disorders are the most common mental illness in the U.S., affecting about 18 percent of the U.S. adult population, or about 40 million people. Furthermore, about two-thirds of those persons who do have anxiety disorders do not seek treatment. Approximately 3 percent of the adult U.S. population has generalized anxiety disorder (GAD) in any given year; 8.7 percent of adults have specific phobias. Social phobia affects 6.8 percent of the population.

For post-traumatic stress disorder (PTSD), the rate is about 3.5 percent of the population. One percent of people in the U.S. have obsessive-compulsive disorder (OCD), and 2.7 percent have panic disorders.

Of course, many of these persons have dual diagnosis, with some having both PTSD and GAD, or co-occurring social phobia and OCD, for example. There are a large number of persons with anxiety disorders who also have co-occurring substance abuse issues. (National Institute of Mental Health, 2012)

The impact on society is enormous. In particular, those with anxiety disorders tend to have physical issues resulting from their anxiety that mimic a variety of physical ailments. Therefore, persons with anxiety disorders spend about $23 billion a year seeking treatment for these physical problems instead of getting treatment for the real cause, which is the underlying anxiety and its physiological impact on them. Furthermore, those with anxiety disorders are six times more likely to receive psychiatric treatment.

However, it is important to differentiate between ordinary stress of life and true anxiety. For example, stress or butterflies in the stomach experienced before giving a speech or presentation is normal.
However, being so afraid of speaking before a group that a person
resigns from a job rather than give a speech is a more serious form of
anxiety.

Worries about doing a good job on a paper for school and stressing
over the outcome is normal. Being so concerned about failing that a
student can never get past that anxiety enough to settle down and start
the project and fails the class is more in line with a person who has
generalized anxiety disorder.

Most people are hesitant to go into a new social setting and may
occasionally turn down an invitation because “I won’t know anyone
there.” However, someone who avoids social contact altogether has
more serious issues with social phobia.

Anxiety becomes a disorder when the anxiety interferes with daily
functioning.

Understanding the correct diagnosis is critical for choosing the
correct path to managing anxiety because treatment protocols and
best practices differ from one anxiety disorder to another. The DSM-5
defines several categories of anxiety disorders.

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**ANXIETY DISORDERS**

**Generalized anxiety disorder**

The Diagnostic and Statistical Manual of Mental Disorders (5th Ed;
DSM-5) \(^4\) is the book used by qualified mental health professionals
to make psychiatric diagnoses. In the DSM-5, there are specific criteria
for a diagnosis of generalized anxiety disorder (GAD). The following
is a summary of the required symptom makeup to be used as a guide.

However, it is important to know that only a qualified professional
who also relies on clinical judgment can make an accurate diagnosis.

A. Excessive anxiety and worry (apprehensive expectation), occurring
more days than not for at least six months, about a number of
events or activities (such as work or school performance).

B. The person 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 present for
more days than not for the past six months):

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 focus of the anxiety and worry is not confined to features of
another Axis I disorder (such as social phobia, OCD, PTSD, etc.).

E. The anxiety, worry, or physical symptoms cause clinically
significant distress or impairment in social, occupational, or other
important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a
substance (e.g., a drug of abuse, a medication) or a general medical
condition (e.g., hyperthyroidism), and does not occur exclusively
during a mood disorder, psychotic disorder, or a pervasive
developmental disorder.

**Social anxiety disorder**

Previously known in DSM-IV as social phobia, this disorder was
primarily diagnosed if an individual felt extreme discomfort or fear
when performing in front of others. Research has shown that this
definition is too narrow.

With DSM-5, social anxiety can be diagnosed because of an individual’s
response in a variety of social situations. The person, for example, may
be so uncomfortable carrying on a conversation that he is unable to
talk to others, particularly someone he doesn’t know. A person who is
anxious over being observed may be unable to go out to dinner because
she fears being watched while she is eating and drinking.

Social anxiety disorder is about more than just shyness and can be
considerably disabling. A diagnosis requires that a person’s fear
or anxiety be out of proportion—in frequency and/or duration—to
the actual situation. The symptoms must be persistent, lasting six
months or longer. In DSM-IV, the timeframe was required only for
children; DSM-5 expands this criterion to include adults as well. The
minimum symptom period reduces the possibility that an individual is
experiencing only transient or temporary fear.

To be diagnosed with social anxiety disorder, the person must
suffer significant distress or impairment that interferes with his or
her ordinary routine in social settings, at work or school, or during
other everyday activities. Unlike in DSM-IV, which requires that
the individual recognize that his or her response is excessive or
unreasonable, the DSM-5 criteria shift that judgment to the clinician.

According to the DSM-5:\(^4\)

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),
being observed (e.g., eating or drinking), or performing in front of
others (e.g., giving a speech).

B. The individual fears that he or she will act in a way or show
anxiety symptoms that will be negatively evaluated (e.g., be
humiliated, embarrassed, or rejected) or will offend others.

C. The social situation(s) almost always provoke fear or anxiety. (Note:
in children, the fear or anxiety may be expressed by crying, tantrums,
freezing, clinging, shrinking, or failure to speak in social situations.)

D. The social situation(s) are actively avoided or endured with
marked fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed
by the social situation. (Note: “Out of proportion” refers to the
sociocultural context.)

F. The fear, anxiety, or avoidance is persistent, typically lasting six or
more months.

G. The fear, anxiety, and avoidance cause clinically significant
distress or impairment in social, occupational, or other important
areas of functioning.

H. The disturbance is not attributable to the direct physiological
effects of a substance (e.g., a drug of abuse, a medication) or
another medical condition.

I. The disturbance is not better accounted for by another mental
disorder (e.g., anxiety about having Panic Attacks in Panic
Disorder, agoraphobia situations in Agoraphobia, separation from
attachment figures in Separation Anxiety Disorder, public exposure
to perceived physical flaws in Body Dysmorphic Disorder, or social
communication problems in Autism Spectrum Disorder). Failure
to speak is not better accounted for by stuttering or expressive
language problems in Communication Disorders, or refusal to
speak due to opposition in Oppositional-Defiant Disorder.
J. If another medical condition (e.g., stuttering, Parkinson’s disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is unrelated or is out of proportion to it.

Specify if: Performance Only: If the fear is restricted to speaking or performing in public.

Panic attacks

Panic disorder is commonly defined as a psychiatric disorder in which debilitating anxiety and fear arise frequently and without reasonable cause.

The DSM-IV-TR diagnostic criteria for panic disorder required “unexpected, recurrent panic attacks, followed in at least one instance by at least a month of a significant and related behavior change, a persistent concern of more attacks, or a worry about the attack’s consequences. Diagnosis is excluded by attacks due to a drug or medical condition, or by panic attacks that are better accounted for by other mental disorders.”

The most notable change that has occurred to the diagnosis of panic disorder is the way in which it is now classified in relation to agoraphobia. In the last edition of the DSM, panic disorder was diagnosed as occurring with or without agoraphobia. In the new DSM-5, panic disorder and agoraphobia are listed as two separate and distinct mental health disorders. Some additional changes have also occurred to the types of panic attacks defined in the DSM-5:

- **Panic disorder** has remained classified as an anxiety disorder with the main symptom being the experience of persistent and typically unanticipated panic attacks. The diagnostic criteria also specify that these panic attacks are marked by continual fear of having future attacks, shifts in one’s behaviors to avoid these attacks, or both of these issues for at least one month.

- Regarding **panic attacks**, the previous edition of the DSM distinguished the types of panic attacks as belonging to one of three categories: situationally bound/cued, situationally predisposed, or unexpected/uncued. The DSM-5 has removed some of this jargon and simplified panic attacks as fitting into two simplified types: expected or unexpected.

- **Expected panic attacks** are those that occur due to a specific fear, such as when a person with a fear of flying and has a panic attack when on an airplane.

- **Unexpected panic attacks** occur suddenly or out-of-the-blue without any external cue that the attack is about to occur. These unanticipated attacks are the hallmark feature of panic disorder.

Agoraphobia

In the current updated edition of the DSM-5, agoraphobia now stands apart from panic disorder as its own separate and codable diagnosis. The diagnostic criteria for agoraphobia now includes the experience of intense fear or anxiety in at least two agoraphobic situations, such as being outside the home alone, public transportation (i.e., airplanes, buses, subways, etc.), open spaces, public places (i.e. stores, theaters, or cinemas), crowds or standing in a line with other people, or a combination of two or more of these scenarios.

To be diagnosed with agoraphobia, the person will also need to be exhibiting avoidance behaviors. These avoidances occur out of a fear of experiencing a panic attack or anxiety-related symptoms in a situation from which it would be difficult to flee or no help would be available. Agoraphobics are greatly affected by avoidance behaviors, as these issues tremendously impair the sufferer’s quality of life and overall functioning.

Post-traumatic stress disorder

To diagnose a person with PTSD, the following criteria must exist, according to the DSM-5:

- Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

- Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.
Criterion A: stressor
The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)
1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms
The traumatic event is persistently re-experienced in the following way(s): (one required)
1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance
Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)
1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood
Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)
1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., “I am bad,” “The world is completely dangerous”).
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity
Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)
1. Irritable or aggressive behavior.
2. Self-destructive or reckless behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems in concentration.

Criterion F: duration
Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

Criterion G: functional significance
Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion II: exclusion
Disturbance is not due to medication, substance use, or other illness.
Specify if: With dissociative symptoms.
In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
1. Depersonalization: experience of being outside observer or detached from oneself (e.g., feeling as if “this is not happening to me” or one were in a dream).
2. Derealization: experience of unreality, distance, or distortion (e.g., “things are not real”).
Specify if: With delayed expression.
Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

Additionally, the DSM-5 updates include a new subtype of PTSD for children six years of age and younger called Posttraumatic Stress Disorder in preschool children. As the first developmental subtype of an existing disorder, this represents a significant step for the DSM taxonomy. Since an alternative diagnostic set of criteria was initially proposed by Michael Scheeringa and Charles Zeanah, the criteria have been refined empirically and endorsed by a task force of experts on early childhood mental health. While the bulk of the empirical research that supports this disorder was conducted on three- to six-year-old preschool children, the studies often included one- to two-year-old toddlers. These studies showed that when a developmentally-sensitive set of criteria were used approximately three to eight times more children qualified for the diagnosis compared to the DSM-IV.
Specific phobias

A phobia is an anxiety disorder involving a persistent fear of an object, place or situation disproportional to the threat or danger posed by the object of the fear. The person who has the phobia will go to great lengths to avoid the object of the fear and experience great distress if it is encountered. These irrational fears and reactions must result in interference with social and work life to meet the DSM-5 criteria. There are five subtypes of specific phobia: animal, natural environment, blood-injection-injury, situational and other. Social phobia, involving fear of social situations, is a separate disorder. Examples of specific phobias include fear of mice, vomiting, insects, and heights. Some phobias many of us can relate to such as dental work or mathematics; a normal response to these fears is proportional to the threat.

Under DSM-5, several changes have been made to prevent the over specification of diagnosis of specific phobias based on the overestimation of danger or occasional fears. A person no longer has to demonstrate excessive or unreasonable anxiety for a diagnosis of specific phobia. Instead, the anxiety must be “out of proportion” to the threat considering the environment and situation.

Obssessive-compulsive disorder

Obsessive-compulsive disorder is another form of an anxiety disorder. In this disorder, a person has obsessive, anxious thoughts, and develops rituals or compulsions to cope with those obsessive thoughts. According to the Anxiety and Depression Disorder Association of America (2012), the common symptoms of obsessive-compulsive disorder are:

- **Obsessions** – unwanted, intrusive thoughts, such as:
  - Constant, irrational worry about dirt, germs, or contamination.
  - Excessive concern with order, arrangement, or symmetry.
  - Fear that negative or aggressive thoughts or impulses will cause personal harm or harm to a loved one.
  - Preoccupation with losing or throwing away objects with little or no value.
  - Excessive concern about accidentally or purposefully injuring another person.
  - Feeling overly responsible for the safety of others.
  - Distasteful religious and sexual thoughts or images.
  - Doubting that is irrational or excessive.

- **Compulsions** – ritualistic behaviors and routines to ease anxiety or distress, such as:
  - Cleaning – Repeatedly washing one’s hands, bathing, or cleaning household items, often for hours at a time.
  - Checking – Checking and re-checking several to hundreds of times a day that the doors are locked, the stove is turned off, the hairdryer is unplugged, etc.
  - Repeating – Inability to stop repeating a name, phrase, or simple activity (such as going through a doorway over and over).
  - Hoarding – Difficulty throwing away useless items, such as old newspapers or magazines, bottle caps, or rubber bands.
  - Touching and arranging.
  - Mental rituals – Endless reviewing of conversations, counting; repetitively calling up “good” thoughts to neutralize “bad” thoughts or obsessions; or excessive praying and using special words or phrases to neutralize obsessions.

Examples of examples of obsessions and the compulsive behaviors associated with them noted by The American Association of Family Physicians (2012) are shown below:

<table>
<thead>
<tr>
<th>Common Obsessions and Compulsions</th>
<th>Type</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>Obsessions</td>
<td></td>
<td></td>
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<tr>
<td>Aggressive impulses</td>
<td>Images of hurting a child or parent</td>
<td></td>
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<tr>
<td>Contamination</td>
<td>Becoming contaminated by shaking hands with another person</td>
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<tr>
<td>Need for order</td>
<td>Intense distress when objects are disordered or asymmetric</td>
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<tr>
<td>Religious</td>
<td>Blasphemous thoughts, concerns about unknowingly sinning</td>
<td></td>
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<tr>
<td>Repeated doubts</td>
<td>Wondering whether a door was left unlocked</td>
<td></td>
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<tr>
<td>Sexual imagery</td>
<td>Recurrent pornographic images</td>
<td></td>
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<tr>
<td>Compulsions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking</td>
<td>Repeatedly checking locks, alarms, appliances</td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td>Hand-washing</td>
<td></td>
</tr>
<tr>
<td>Hoarding</td>
<td>Saving trash or unnecessary items</td>
<td></td>
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<tr>
<td>Mental acts</td>
<td>Praying, counting, repeating words silently</td>
<td></td>
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<tr>
<td>Ordering</td>
<td>Reordering objects to achieve symmetry</td>
<td></td>
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<tr>
<td>Reassurance-seeking</td>
<td>Asking others for reassurance</td>
<td></td>
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<tr>
<td>Repetitive actions</td>
<td>Walking in and out of a doorway multiple times</td>
<td></td>
</tr>
</tbody>
</table>

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), released in 2013, includes a new chapter for OCD and related disorders, including body dysmorphic disorder, hoarding disorder, trichotillomania, and excoriation disorder. Previously, OCD was grouped together with impulse control disorders (ICDs) not elsewhere classified.
The American Psychiatric Association defines OCD as the presence of obsessions, compulsions, or both. Obsessions are defined by (1) and (2) as follows:

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and cause marked anxiety and distress.
2. The person attempts to suppress or ignore such thoughts, impulses, or images or to neutralize them with some other thought or action.

Compulsions are defined by (1) and (2) as follows:

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a way that could realistically neutralize or prevent whatever they are meant to address, or they are clearly excessive.

DIAGNOSING ANXIETY DISORDERS

Assessing for generalized anxiety disorder

A common measure for both adults and adolescents is the Beck Anxiety Inventory (Beck and Steer, 1993). It is a screening tool designed to identify symptoms of anxiety that can be self-administered or scored by a practitioner while talking with the patient. The tool has been found to be an accurate assessment tool for anxiety disorders and can also be used to track progress over the course of treatment.

Another popular scale is the GAD-7, which was found to be accurate in assessing anxiety in studies by Swinson (2006). The GAD-7 is free and easily administered. However, the research for the validity and reliability of the GAD-7 is not as strong as that for the Beck Anxiety Inventory.

Assessing for social anxiety disorder

A commonly used screening tool is the Liebowitz Social Anxiety Scale (LSAS), developed by Liebowitz (1987). In studies, including Heimberg, et al., (1999), it was found to be a valid and reliable tool for assessing social phobia. This scale can be self-administered and is also available for free.

Assessing for panic disorders

The Panic Severity Disorder Scale (PDSS) is one of the most commonly used tools to screen for panic disorders. The scale was developed by Shear et al., (1997) and consists of seven items scored on a scale ranging from 0 to 4. The PDSS measures the areas of panic frequency, distress during panic, panic-focused anticipatory anxiety, phobic avoidance of situations, phobic avoidance of physical sensations, impairment in work functioning, and impairment in social functioning.

Studies have shown the instrument to be valid and reliable (Houck, Spiegel, Shear & Rucci, 2002; Shear et al., 2001). Another scale that is frequently used by clinicians is the Yale Brown Obsessive Compulsive Scale (Goodman, et al., 1989). This scale is administered by a clinician and assesses the impact of obsessions on the patient’s life, how much time the obsessions take from a patient’s day, and how much control the patient has over these obsessions.
Assessing for post-traumatic stress disorder

The National Center for PTSD lists several instruments that are used for adults in the assessment and diagnosis of PTSD:

- Clinician Administered PTSD Scale (CAPS).
- PTSD Symptom Scale – Interview version (PSS-I).
- Structured Clinical Interview for DSM-IV PTSD module (SCID).
- Structured Interview for PTSD (SI-PTSD).

All of these instruments assess the specific types of symptoms that are needed to meet the DSM-5 criteria for a diagnosis of PTSD. The CAPS measures not just symptoms, but also the impact of symptoms on daily functioning.17

Assessing PTSD in children and adolescents

Hawkins and Radcliff (2005) note that trauma in children clusters in eight domains: cancer, child abuse, death, injury, natural disaster, violence, war and a range of various traumatic events. The authors conclude that children and adolescents have different symptoms from PTSD than do adults, but there are few instruments designed specifically to assess children for PTSD.

Children tend to reenact the trauma, regress developmentally, and develop separation anxiety and other behaviors that are not seen in adults who have PTSD.28

Hawkins and Radcliffe cite a study by Scheeringa, Zeanah, Drell and Larrius (1995) that concluded that PTSD is underdiagnosed in children, particularly because of the DSM-IV criteria that requires verbal descriptions of eight of the criteria for diagnosis and fails to take into account the inability of some children to verbalize what they are experiencing.

Hawkins and Radcliffe also note that a similar study by Carrion, Weems, Ray and Reiss, (2002) noted that many children need treatment, but are not diagnosed with PTSD because of the inherent differences in children that make it difficult for them to demonstrate the DSM-IV criteria for a diagnosis of PTSD.28,29,30

While it is too early to assess the true impact, the recent changes to DSM-5 that now includes the separate PTSD diagnosis for children, the above studies and strong advocating by its researchers and supporters clearly resulted in significant change that may improve the diagnosis process and support services.

There are a number of instruments to assess PTSD symptoms in children. Hawkins and Radcliff (2005)43 discuss several of these instruments, noting that a definitive scale for children has yet to be developed. The Diagnostic Interview for Children and Adolescents Revised (Reich, Leacock and Shanfield, 1994) was used in several studies and includes a parental interview.31

Some instruments use only the child’s information and do not take into account the parent’s perspective on trauma symptoms. The authors note that the Child Post-Traumatic Stress Disorder Reaction Index (CPTSD-RI) was the most commonly used in their review of studies. It is not intended to be a diagnostic tool, but rather measures reactions to trauma.

Some of the most commonly used are the PTSD Symptom Scale (PSS), developed by Foa, Riggs, Dancu and Rothbaum (1993),32 but Hawkins and Radcliffe note that it has not been validated with children. However, a revised measure for children, the Child PTSD Symptom Scale (CPSS) was published by Foa, Johnson, Feeny and Treadwell (2001) and is being evaluated further. This tool does contain all symptoms of PTSD listed in the DSM-IV, and it is free and easily available.33 However, the CPSS has only been used with a fairly small sized sample thus far in the research, making it difficult to generalize. And some of the language may be too difficult for younger children to comprehend (Ghosh-Ippen, 2012).34

Another popular screening tool is the Trauma Symptom Checklist for Children (Briere, 1996). It assesses trauma exposure but is not designed to specifically diagnose children with a disorder.35 However, the use of the checklist in diagnosing PTSD is limited. As noted by Ohan, Myers and Collett (2002), the post-traumatic stress subscale does not contain enough types of symptoms to fully assess a child for PTSD. The instrument also does not directly correlate with the symptoms of PTSD listed in the DSM.36

Another criticism is the lack of an overall assessment of pre-existing trauma and too much focus on the most recent traumatic event. Hawkins and Radcliffe note that many adolescents have multiple traumas over time that need to be assessed as part of the overall diagnostic process.

Furthermore, the involvement of parents and caregivers in diagnosing PTSD provides unique challenges in assessing symptoms, because parents often overlook internalizing symptoms in children or they may not be aware of them. Consequently, a child who is not acting out may not be diagnosed correctly. And children may have difficulty expressing these symptoms to a practitioner because of their lack of verbal development.28

Assessing specific phobias

The clinical interview is the most commonly used method of assessment for specific phobias. In addition to establishing a diagnosis, the interview also allows for a comprehensive evaluation of the idiographic nature of the individual’s experience.

Another popular form of assessing phobias is the use of self-report tools. A commonly used tool for assessing specific phobias is the Fear Survey Schedule (FSS). It consists of 52 items asking participants to assess their level of fear on a scale of 0 to 5. It assesses phobia in five different areas:

1. Social fears.
2. Agoraphobia fears.
3. Injury fears.
4. Sex aggression fears.
5. Fear of harmless animals.

The FSS was developed by Wolpe and Lang (1977). The survey does include items related to the specific diagnostic criteria, such as a fear of dogs, and other fears, such as crowds and open spaces.37 Klieger and Franklin (1993) note that the scale does also correctly differentiate between a person who has a specific phobia and other forms of anxiety.38 There is also a Fear Survey Scale for Children called the FSSC-R (Ollendick, 1983).39

McCabe et al (2010) assessed a variety of phobia self-report measures [40], which include scales designed to measure a specific phobia, such as a fear of spiders, The Fear of Spiders Questionnaire (Szymanski and Donahue, 1995),41 The Dental Anxiety Inventory (Southard et al, 1993)42 which measures the blood, injection injury phobias; the Acrophobia Questionnaire (Cohen, 1977), which is used to assess a person’s fear of heights;44 and the Claustrophobia Questionnaire, (Radomsky et al., 2001)44 to name a just as few instruments.
ANXIETY DISORDER TREATMENTS

Treatment of general anxiety disorders

Establishing a diagnosis is only the beginning of treatment for any type of anxiety disorder. According the University of Maryland Medical Center, the standard approach for treating anxiety is a combination of cognitive-behavioral therapy and antidepressants.

Occasionally, people who do not respond to either a selective serotonin reuptake inhibitor (SSRI) or the serotonin norepinephrine reuptake inhibitors (SNRI) such as Effexor, may be prescribed benzodiazepines, such as Valium (University of Maryland, 2012).

In a similar recommendation, the British Association of Psychopharmacology (Baldwin, et al, 2005) also states that benzodiazepines should only be used for short-term treatment and only for cases that do not respond adequately to the SSRI drugs. In addition, the authors note that the use of SSRIs should be closely monitored because of the possible side effects of worsening anxiety or the occasional emergence of suicidal thoughts.

The University of Maryland also breaks down the treatment options for generalized anxiety disorder, and recommends they be treated with antidepressants, benzodiazepines and the experimental usage of pregabalin, an anticonvulsant. Cognitive behavioral therapy (CBT), which uses education, relaxation training and exposure to stimuli that produces anxiety, is also effective.

Social anxiety disorder is typically treated with an SSRI or SNRI. Sometimes benzodiazepines are used when the SSIR or SNRI does not work. The usual course of CBT is 6-12 weeks.

Barlow et al., (2004) note that with any form of anxiety disorder, the use of any type of therapy involves the selection of a particular treatment based upon the evidence supporting the treatment, the specific clinical features of each patient, the preference of the patient, and the actual availability of a treatment. Furthermore, it is noted that the treatment must be delivered by properly trained and supervised staff who follow evidence-based protocols.

Additionally, in the use of medication for anxiety, Barlow says all medications must be carefully discussed with patients to fully make them aware of the risks and benefits of the medication; and using other drugs, such as tricyclic antidepressants and anticonvulsants, should be done only after an examination of the evidence-based use of the drugs for a specific condition.

There have been suggestions that practitioners explore other forms of treatment, such as meditation. Krisanaprakornkit, et al., (2006) noted that the use of meditation could not be supported as an evidenced-based treatment and that the dropout rates in a study were high.

While CBT may be the front-line treatment for children with anxiety disorders, only about half of the children in one study showed improvement (James, Soler, & Weatherall, 2005). However, the format of the treatment, whether individual, group or family, did not affect the outcome.

Durham, et al (2005) noted that CBT was associated with a better long-term outcome than non-CBT treatments. More intensive forms of CBT did not change the long-term outcomes. The most important variable affecting outcome was the complexity of the anxiety.

Treating social anxiety disorder

According to the website Social Anxiety Support, CBT is the preferred treatment for social phobia and consists of the following elements:

- Psychoeducation, which aims to increase a person’s understanding of social phobia, where it came from and how to treat it.
- Cognitive restructuring, which helps people overcome their irrational thoughts and replace them with positive thoughts.
- In vivo exposure, in which a therapist guides the patient through exposure to anxiety-provoking situations.
- Interoceptive exposure, where a patient is helped to cope with the body sensations that arise in a socially anxious situation and which are also capable of producing anxiety in and of themselves (pounding heart, dizziness, etc.).
- Social skills training, which involves practicing various social situations to gain mastery of the skills necessary to feel comfortable in these situations.

In terms of medication, the University of Maryland (2012) recommends the use of SSRIs or venlafaxine. Benzodiazepines are sometimes used as well. Other drugs, such as the anticonvulsants Lyrica and Neurontin, are also being explored as a possible treatment for social phobia.

Treating PTSD

In evaluating the research for the treatment of PTSD, the University of Maryland (2012) noted that for PTSD, SSRIs are commonly prescribed, as well as the use of trauma-focused treatment, such as trauma-focused cognitive therapy and eye movement desensitization and reprocessing (EMDR).

It is important to note that when the Australian Centre for Post-traumatic Mental Health, published a list of guidelines for the treatment of PTSD in 2007, there was strong evidence to suggest that supportive counseling and relaxation therapy should not be used with adults with PTSD, and that CBT and EMDR should be utilized.

The Australian Centre also noted that while SSRIs are the first choice for pharmacological treatment, medication should not be the first treatment; rather, the first choice should be trauma-focused therapy approaches. It is noted as a best practice to use antidepressants when PTSD symptoms are so severe that the patient cannot benefit from the use of a trauma-focused therapy. In addition, medication should be used when a co-morbid condition, such as depression or anxiety, exists and it is severe enough to interfere with trauma-focused therapy.

The National Center for PTSD notes that several approaches to PTSD treatment have shown promise, including exposure therapy, which involves survivors experiencing their trauma and learning coping skills during this process. The center also notes that cognitive approaches, such as cognitive processing therapy, are also strongly supported in the literature. There is also support for the use of EMDR in treating persons with PTSD.

In working with children who have PTSD, the most commonly used form of treatment is trauma-focused cognitive-behavioral therapy (TF-CBT), which has been used with a variety of cultural groups, age groups ranging from 3-21, and persons with various forms of trauma, including exposure to natural disasters, sexual abuse, and terrorism.

TF-CBT (Cohen, Mannarino and Deblinger, 2006) involves gradual exposure and involves the following steps:
- Psychoeducation about trauma.
Parenting, including parenting skills.
Relaxation skills.
Affective modulation skills.

Cognitive coping: how to connect thoughts, feelings and behaviors.

In addition, there is free online training for practitioners in TF-CBT, which is available at www.musc.edu/tfcbt.

Treating panic disorder

According to Gatchel and Rawlings, (2008), CBT has six phases:
1. Assessment.
2. Reconceptualization.
3. Skills acquisition.
4. Skills consolidation and application training.
5. Generalization and maintenance.

These steps are followed in the treatment of a variety of anxiety disorders, including panic disorders [55]. Kumar and Oakley-Browne (2007) note in a systematic study of the treatment of panic disorders that CBT plus drug treatments are associated with better outcomes than drug therapy alone. The authors also found that CBT was superior to a placebo treatment in the treatment of panic disorders.

The authors also note that benzodiazepines are effective in treating panic disorders, but there are many risks associated with their usage and urged practitioners to exercise great caution when utilizing these drugs in treatment of panic disorders.66

Ham, Waters and Oliver (2005) noted these key recommendations for treating a panic disorder for the American Academy of Family Physicians:

- Antidepressants, either an SSRI or tricyclic are effective.
- Benzodiazepines as also useful, but usually in conjunction with other therapy.
- CBT, which is noted as being superior to supportive psychotherapy, is also effective.
- CBT with a therapist who uses exposure techniques in conjunction with antidepressants has shown positive outcomes.57

Clark (1986, 1988) developed a cognitive model of panic, in which he theorizes that persons who have panic attacks do so because they interpret various body sensations as more serious than they are. These sensations can include sweating, a pounding heart or dizziness. He states that there is a trigger of some form of stimulus, followed by apprehension, then body sensations and an interpretation of these sensations as catastrophic.58,59

Clark says the major goal of therapy for persons with panic disorders is “to modify patients’ catastrophic interpretations of bodily sensations which they experience during panic attacks.”

“Although discussion of the evidence for an alternative, noncatastrophic interpretation can be helpful, patients sometimes only believe that an alternative interpretation applies to them if its validity can be demonstrated by behavioral experiments in which their symptoms are reproduced or reduced. In a sense, panic patients are rather like Doubting Thomas: they are unlikely to believe the positive interpretation unless they can experience its effects.” (p. 83).

He gives an example of this type of experience in which he has patients voluntarily hyperventilate and then discuss how similar these body sensations were to a panic attack. He then asks them to compare how they interpreted the sensations in the session compared to how they would interpret those sensations outside of a session. He teaches them how to control their breathing in sessions to help them gain a sense of control over hyperventilation outside of sessions.60

According to the University of Maryland (2012), panic attacks are usually treated first with an SSRI. In the short-term, if the SSRI is not effective, then benzodiazepines and other types of antidepressants, such as tricycles, are used. The use of CBT for panic disorders involves a 12- to 16-session course of treatment that emphasizes the re-creation of fear in the sessions to teach patient to change their pattern of responses to fear.43

Treating obsessive-compulsive disorders

An article in the Canadian Journal of Psychiatry noted that about one-half of patients with obsessive-compulsive disorders (OCD) who are treated with an SSRI will respond, and a physician may have to try several drugs to achieve effective results (Abramovitz, 2006).64

The treatment of OCD is complex. Lambert (2008) notes that treating persons with OCD is difficult, and that practitioners should be aware that persons with OCD and other co-morbid diagnoses are at higher risk for suicide than the average person. Furthermore, it is also important to work with the family in situations in which the person with OCD has children, as parents with OCD can deeply affect their children through the issues associated with the disorder.

Lambert also notes that OCD has been shown to respond well to CBT techniques, but OCD does not work very well with supportive psychotherapy. Various drugs are effective, such as SSRI medications including Prozac, Luvox and Xoloft. Clomipramine (Anafranil), has also shown effectiveness with treating OCD, but should not be not used as a first treatment because it has more side effects than the SSRI drugs.52

For obsessive-compulsive disorders, SSRIs are the most common choice for psychopharmacological interventions, according to the University of Maryland (2012). For some patients, clomipramine, a tricyclic antidepressant, is used.

However, it should be noted that in children, the use of an SSRI does not seem to be as effective in the treatment of the obsessive-compulsive symptoms. Consequently, in treating children with an obsessive-compulsive disorder, CBT is the first choice.

In the treatment of adults with obsessive-compulsive disorders, either CBT or an SSRI may be used. For both children and adults, the CBT treatment focuses on exposure and response prevention.45

According to the Obsessive Compulsion Foundation, a consumer advocacy group for persons with OCD, many people with OCD avoid treatment out of shame over their compulsive behaviors. However, the foundation notes:

- For the people who benefit from CBT, they usually see their OCD symptoms reduced by 60-80 percent.
- For CBT to work, a patient must actively participate in the treatment. Unfortunately, about one in four OCD patients refuses to do CBT.
- There are different kinds of CBT, but the one that works best for OCD is called exposure and response prevention, or ERP. The “exposure” in ERP refers to confronting the thoughts, images, objects and situations that make a person with OCD anxious; “response prevention” refers to making a choice not to do a compulsive behavior after coming into contact with the things that make the person anxious. (http://www.ocfoundation.org/CBT.aspx).63

Pettinger et al. (2005), agree that ERP works best for persons with CBT. Essentially, in ERP, a patient is presented with the stimulus that provokes a desire to engage in a compulsion, but in the treatment session, the patient is prevented from engaging in the compulsion...
Pay attention to your child’s feelings. Stay calm when your child becomes anxious about a situation or plan for transitions (for example, allow extra time in the morning). Don’t punish mistakes or lack of progress. Modify expectations during stressful periods. Be.

Recognize and praise small accomplishments.

Not all children may meet the criteria for an anxiety disorder, but there are many tips that are helpful to parents in managing an anxious child, regardless of the child’s diagnosis.

The Anxiety and Depression Association of America gives the following tips for parents dealing with an anxious child:

- Pay attention to your child’s feelings.
- Stay calm when your child becomes anxious about a situation or event.
- Recognize and praise small accomplishments.
- Don’t punish mistakes or lack of progress.

Treat anxiety. Hood and Antony (2012) note that exposure treatment is the most well established and efficient treatment for any type of specific phobias. In exposure therapy, the patient confronts the anxiety-provoking object or situation, which prevents the patient from avoidance, the typical reaction of a phobic person, and also increases the skills necessary to cope with the feared object or situation.

Interestingly, some patients receive relief in just one prolonged session. However, many patients receive therapy over a number of weeks. There has been some controversy about “flooding” vs. gradual exposure to an object or situation. Craske et al., (2008) found no evidence that flooding was more or less effective than gradual exposure.

However, according to Hood and Antony, the gradual exposure approach is usually more accepted by patients, for whom the thought of flooding provokes too much anxiety for them to even consider the therapy. The authors note that treatment takes as long as it takes. A course of treatment that is too short can result in a return of the phobic responses. The goal of exposure therapy is an extinction of the phobic response, which the authors note is very context dependent.

Citing the research of Rowe and Craske (1998), Hood and Antony note that the practitioner must expose the patient to stimuli that is variable enough to replicate what the patient may subsequently encounter in real situations. For example, if a person is fearful of spiders, the exposure therapy shouldn’t be done with just tarantulas, but should include black widows, garden spiders, etc. Otherwise, the authors note, the first time a person encounters a spider different from the one used in exposure therapy, the phobic responses will return.

Another promising treatment for phobias is through the use of virtual reality (VR). Garcia-Palacios et al., (2007) note that the reason VR has shown such promising results in several studies is that the idea of being exposed to phobic stimuli through VR, rather than live in a session, makes the thought of exposure therapy more tolerable to potential patients and perhaps also decreases drop-out rates from therapy.

A recent study by Kircanski, Lieberman and Craske (2012), showed interesting results for the technique of affect labeling. In this approach, 88 subjects who had a spider phobia were treated with exposure therapy, but also told to label their apprehensive feelings as they were doing the exercise, which involved walking towards a tarantula in a glass cage and trying to touch it if they were able to. In exposure therapy, participants are encouraged to change their cognitive processes and are not typically encouraged to discuss the fear.

Participants were divided into four groups. The first group did the affective labeling exercise. The second group was instructed to engage in reappraisal, which involves relabeling the spider in a neutral way, stating things like “the spider is not dangerous.” The third group engaged in distraction, in which they made statements about something unrelated to the spider, and were instructed to say something about a piece of furniture in their home. The final group received no instructions.

There was a rather significant difference one week later in a follow-up study for participants who were part of the affective labeling group. Those participants were able to get closer to the spider than they could before the affective labeling, but no differences were found in the other groups before and after the interventions.

However, the groups did not differ in the amount of fear that the groups had expressed before and after the exposure. Obviously, more research needs to be done to determine how effective affective labeling may be for exposure therapy.

General considerations in the treatment of anxiety disorders

Regardless of the type of anxiety disorder, there are several issues related to the life of a person receiving intervention for anxiety disorders that are often overlooked in treatment. Levin (2010) noted that at an address at the conference of the Anxiety Disorders Association of America in March 2010, Dr. Margaret Altemus, a professor of psychiatry at Cornell University, noted that women’s hormonal changes can affect their response to the treatment of anxiety disorders.

Changes in women’s hormone levels after the age of 45 or after a complete hysterectomy can lead to a rise in anxiety. Furthermore, many women experience greater anxiety at specific times in their menstrual cycles. The types of treatment for these symptoms need to take into consideration individual variables.

Managing anxiety in children

All children experience a certain amount of anxiety. However, worry that interferes with daily functioning becomes a problem for children. Not all children may meet the criteria for an anxiety disorder, but there are many tips that are helpful to parents in managing an anxious child, regardless of the child’s diagnosis.

The Anxiety and Depression Association of America gives the following tips for parents dealing with an anxious child:

- Be flexible and try to maintain a normal routine.
- Modify expectations during stressful periods.
- Plan for transitions (for example, allow extra time in the morning if getting to school is difficult).
- Encourage children to face instead of avoid situations that provoke anxiety.

The Australian Capital Territory (ACT) also published a tip sheet for parents on managing their children’s anxiety, which also encourages parents to monitor their children’s viewing of anxiety-provoking programs on TV, such as the news; spending calm, relaxing time with children; encouraging physical activity to increase relaxation; encouraging self-soothing activities, such as listening to calm music or bathing; and encouraging children to face instead of avoid situations that provoke anxiety.
In treating the children and adolescents with anxiety, a meta-analysis of outcome studies explored the effectiveness of different approaches to treating anxiety. Weisz, Hawley, and Doss (2004) examined studies between 1965-2002 with children that were required to have a control group, random assignment of subjects to the control or treatment groups, and post-treatment assessments.

The authors note that three forms of treatment for anxiety showed the best outcomes over a number of studies over time.

- **Modeling**, in which a child observes someone else doing the activity the child is afraid of. This can be done live or by watching videos. In addition, this modality uses participant modeling, in which the child engages in the activity alongside a person who coaches and encourages him or her. Typically, modeling begins with low intensity and moves to a higher level of exposure to the anxiety-provoking objects or situation.

- **Reinforced exposure**, in which there are small incremental steps taken towards a feared object and exposure to it. A child with a fear of snakes, for example, may begin by looking at pictures of snakes and then watching a video of someone handling a snake before moving into live exposure.

- **Cognitive-behavioral therapy**, which identifies and adjusts the cognitive processes that lead to irrational fears and heightened anxiety. The therapist often uses relaxation techniques, self-talk and psychoeducation.

Of course, it should be noted here, the analysis did not differentiate between the multiple categories of anxiety diagnoses and the treatments that were best for each type of anxiety disorder.

### Treating the elderly

Often, the treatment of anxiety in the elderly has been to treat them with benzodiazepines; however, this is a concern because of the increased risk of falls and cognitive impairments related to their use (Lenze, et al, 2003). The authors’ research findings encourage practitioners to use antidepressants as a first-line treatment for anxiety in the elderly and to encourage the elderly to participate in CBT. However, the authors note that the use of CBT with the elderly is not well developed and is in need of revisions to be more effective with this age group.

### Evaluating treatment modalities

The use of CBT as an evidence-based practice for treating anxiety appears to be fairly well substantiated. However, Weisz and Gray (2007) note that evidence-based practices for treating many disorders do not always work as well in the average practitioner’s office.

They cite several reasons for this difference in the success of the treatments:

- Many studies use subjects with very specific diagnoses of only anxiety or depression, for example. However, in clinical practice, patients with at least one co-morbid diagnosis are more likely to be seen, and the co-morbid disorders may impact the effectiveness of the outcome of the treatment for anxiety.

- Mental health practitioners in clinical trials may see only one specific diagnosis over and over and therefore develop an expertise in treating that disorder. In a normal therapy practice, mental health practitioners typically see several patients a day with a wide range of diagnoses. Therefore, the average therapist could not be as immersed in the techniques of treating one specific diagnosis, and it is likely that the average therapist is not as skilled as the therapist in a clinical trial in treating the specific disorder.

- Evidence-based practices often are not tested against a course of what the authors call “usual clinical care.” Many studies only explore the outcomes of the evidence-based treatment, but do not compare it to a control group receiving another form of treatment. Furthermore, even when a comparison group exists, the characteristics of treatment protocols in the control group are poorly described and do not adequately explain what control treatment was taking place. Therefore, it is hard to prove the evidence-based practices are clearly superior to a treatment that is not evidence-based. Consequently, the outcomes for evidence-based practices are not what the practitioner and patient would like to see, perhaps because they are not as effective as some studies might lead practitioners and the public to believe.

Weisz and Gray (2007), also note other criticisms of evidence-based practices by mental health practitioners, including the concern that manuals and rigid step-by-step instructions stifle the creativity of the practitioner and interfere with the rapport building necessary to build a therapeutic bond with the patient.

In addition, the specific and rigid nature of some evidence-based practice protocols also do not lend themselves easily to treating individual differences in patients. This lack of individualization becomes particularly problematic when dealing with patients who do not fit the rigid diagnostic specifications of the original clinical trials.

As noted earlier in this section, clinical trials oftentimes enable researchers to be very specific in choosing participants who have only one diagnosis and not the co-morbid diagnoses that frequently occur in the general population. This co-morbidity of diagnoses often requires a more flexible and creative approach to treatment than the evidence-based practice protocol may allow.

### Conclusion

The various forms of anxiety disorders are distinctly different from each other. Each disorder has particular interventions that are more useful, whether the intervention is medication or therapy. Many forms of anxiety disorders respond well to treatment, but people are often reluctant to seek therapy because of embarrassment or beliefs that treatment cannot help them. More public education is needed for people who are suffering from these disorders to help them become aware of the effective treatments that exist.

### References


ANXIETY DISORDERS

Final Examination Questions

Select the best answer for each question and proceed to www.EliteCME.com to complete your final examination.

1. A symptom of generalized anxiety disorder includes excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least ________ about a number of events or activities (such as work or school performance).
   a. Two weeks.
   b. One month.
   c. Two months.
   d. Six months.

2. Social anxiety disorder diagnosis requires that a person’s fear or anxiety be out of proportion—in frequency and/or duration—to the actual situation. The symptoms must be persistent, lasting ________ or longer.
   a. Three months.
   b. Six months.
   c. Nine months.
   d. Twelve months.

3. Panic disorder is commonly defined as a ________ disorder in which debilitating anxiety and fear arise frequently and without reasonable cause.
   a. Psychotic.
   b. Cognitive.
   c. Psychiatric.
   d. Neurological.

4. In the new DSM-5, panic disorder and ________ are listed as two separate and distinct mental health disorders.
   a. Agoraphobia.
   b. Arachnophobia.
   c. Social phobia.
   d. Communal phobia.

5. The previous edition of the DSM distinguished the types of panic attacks as belonging to one of three categories: situationally bound/cued, situationally predisposed, or unexpected/uncued. The DSM-5 has removed some of this jargon and simplified panic attacks as fitting into two simplified types:
   a. Situational or unexpected.
   b. Expected or unexpected.
   c. Severe or non-severe.
   d. Chronic or fleeting.

6. Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in ________.
   a. Emotional response.
   b. Arousal and reactivity.
   c. Interpersonal relations.
   d. Cognitive behavior.

7. A person who has a __________ experiences significant and persistent fear when in the presence of, or anticipating the presence of, the object of fear, which may be an object, place or situation.
   a. Specific phobia disorder.
   b. General anxiety disorder.
   c. Specialized anxiety disorder.
   d. General phobia disorder.

8. Psychoeducation ____________.
   a. Is where a therapist guides the patient through exposure to anxiety-provoking situations.
   b. Aims to increase a person’s understanding of social phobia.
   c. Helps people overcome their irrational thoughts and replace them with positive thoughts.
   d. Involves practicing various social situations to gain mastery of the skills necessary to feel comfortable.

9. Another promising treatment for phobias is through the use of ____________.
   a. Hypnotherapy (HT).
   b. Outcome-based Reality (OR).
   c. Static stimuli (SS).
   d. Virtual Reality (VR).

10. The authors note that three forms of treatment for anxiety showed the best outcomes over a number of studies over time.
    a. Electroconvulsive therapy.
    c. Hypnosis and regression therapy.
    d. Massage therapy.