CHAPTER 1

Overview of the Anxiety Disorders

Description of the Anxiety Disorders

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (*DSM-IV;* American Psychiatric Association, 1994) includes six anxiety disorders: Panic Disorder, Specific Phobia, Social Phobia (also known as Social Anxiety Disorder), Obsessive-Compulsive Disorder (OCD), Posttraumatic Stress Disorder (PTSD), and Acute Stress Disorder. In this chapter, these disorders will be described and a case description of each will be introduced. These cases will be used in later chapters of the book to demonstrate treatment techniques. The chapter will conclude with a discussion of differential diagnosis (how to differentiate one anxiety disorder from another anxiety disorder, and from other disorders), comorbidity (which disorders tend to co-occur with each anxiety disorder), and prevalence of the anxiety disorders.

Panic Attacks, Agoraphobia, and Panic Disorder

Panic Attacks

Panic Disorder is characterized by recurrent, unexpected ("out of the blue") panic attacks. Prior to describing panic *disorder* in more detail, it is important to define panic *attacks*. A panic attack is an *experience,* not a psychiatric disorder. The experience of panic attacks is most associated with panic disorder, but in fact, panic attacks are seen across the anxiety disorders. A *panic attack* is characterized by a period of fear or discomfort during which a person experiences at least four panic symptoms. These symptoms come on abruptly and peak within ten minutes. This does not mean that a panic attack completely goes away within ten minutes; rather, the symptoms reach their peak severity and intensity very rapidly, and then recede gradually. The symptoms of panic attacks are listed in Table 1.1. Panic attacks can include cardiovascular and respiratory symptoms like heart palpitations and shortness of breath; gastrointestinal symptoms like nausea or abdominal distress; and

TABLE 1.1.

Symptoms of Panic Attacks

A discrete period of intense fear or discomfort, in which *at least four of the following symptoms develop abruptly* and *reach a crescendo within 10 minutes:*

1. Racing or pounding heart
2. Sweating
3. Trembling or shaking
4. Shortness of breath
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, or faint
9. Feeling unreal or detached
10. Tingling or numbness (usually in the hands and/or feet)
11. Chills or hot flashes
12. Fear of going crazy or losing control
13. Fear of dying

Source: DSM-IV (American Psychiatric Association, 1994).

cognitive symptoms like fear of losing control or going crazy. For some patients who experience panic attacks, the main symptom is a sense of derealization (feelings of unreality) or depersonalization (feeling detached from oneself). Clinicians should be aware that panic attacks can be quite variable from patient to patient since only four of 13 symptoms are required for a person to be considered to have panic attacks.

Agoraphobia

Like panic attacks, Agoraphobia is included in the anxiety disorders section of the *DSM*, but is not a diagnosable disorder. Agoraphobia is defined as anxiety about being in particular places or situations where escape might be difficult or help might not be available, should a panic attack or panic-like symptoms arise. Commonly feared situations include using public transportation, going to movie theatres, being away from home, and being in crowds. Agoraphobia leads to avoidance of these situations, or great distress when in these situations if they cannot be avoided.

Panic Disorder

With panic attacks and Agoraphobia defined, it is appropriate to return to the diagnostic criteria for *Panic Disorder*–the disorder most associated with these

experiences (see Table 1.2 for a summary of the diagnostic criteria). Panic Disorder is characterized by recurrent, unexpected panic attacks. The *DSM* defines "recurrent" as two or more unexpected panic attacks. When patients have had panic attacks for quite some time, they might deny the experience of unexpected attacks. This is because unexpected attacks usually happen early on in a patient's experience with the disorder. Gradually, patients come to associate panic attacks with specific situations. For example, a patient might have an "out of the blue" panic attack at the supermarket and then come to fear having additional panic attacks at the supermarket. This expectation can actually bring on attacks, as patients enter a situation already feeling anxious and being hypervigilant to their internal, physical state. Often, by the time a patient presents for treatment, he will report that all of his panic attacks are cued or expected (e.g., "I always have panic attacks in line at the supermarket and the bank."). The clinician should inquire if they *ever* experienced an "out of the blue" attack–particularly when they first started experiencing panic. Most will report that their first few attacks were indeed unexpected or surprising.

The *DSM* also requires that at least one panic attack has been accompanied by one month or more of concern about having additional attacks, worry about the consequences of having attacks (e.g., worrying about having a heart attack or going crazy), or change in behavior due to the attacks (e.g., avoiding the supermarket). Some of these behavioral changes can be subtle, like no longer drinking caffeine, having sex, or watching scary movies simply because they bring on the same physical sensations as those experienced during a panic attack.

TABLE 1.2

Summary of the Diagnostic Criteria for Panic Disorder

- **Defining characteristic:** Recurrent, unexpected panic attacks (see Table 1.1)

AND:

- One of the following (for one month or more):
  - — Worry about having additional attacks.
  - — Worry about the implications of having attacks (e.g., having a heart attack, going crazy).
  - — Change in behavior related to the attacks (e.g., will not exercise, see scary movies, have sex, drink caffeinated beverages, etc.).
- Not due to organic factors (e.g., medical problems, substance use).
- Not better accounted for by another disorder.

Source: DSM-IV (American Psychiatric Association, 1994).

It is also essential to rule out any physiological cause for panic symptoms. Panic symptoms can be brought on by various medical problems, like hyperthyroidism, or by the use of substances, like caffeine or marijuana. Particularly for patients who have never had problems with anxiety, it is advisable that they see their physician for a thorough medical evaluation to rule out any medical problems. When patients with panic disorder present for an evaluation by a mental health professional, it is often the case that they have already undergone medical evaluation–typically many times. Since patients often think that they are having a heart attack when they first experience panic attacks, it is not unusual for them to first present to emergency rooms. Once cardiac problems have been ruled out, many savvy physicians will suggest that anxiety might be the cause of the patients' difficulties and will recommend that they see a mental health professional.

Panic Disorder can be diagnosed with or without Agoraphobia. Clinicians should keep in mind that Panic Disorder with Agoraphobia would be diagnosed if (a) patients avoid situations because of their fear of having a panic attack while in them; (b) endure such situations with a great deal of distress; and/or (c) enter such situations but only with a safe person or by engaging in some other safety behavior such as carrying anti-anxiety medication, sitting near exits, or always having a cell phone available. Not surprisingly, most patients with Panic Disorder have at least mild Agoraphobia (White & Barlow, 2002).

Case Example: Panic Disorder with Agoraphobia

Susan was a 30-year old mother of a baby boy. She experienced her first panic attack a few months after her baby was born. She was alone at home with him at the time, and it was a particularly stressful day. The baby was inconsolable and would not eat or sleep. Susan was exhausted, frustrated, and worried. She suddenly became very dizzy, felt her heart racing, and experienced chest pain and pressure. She was terrified that she was "going crazy." Her brother was schizophrenic and she worried that she was developing the disorder too. Susan called her husband at work, and he came home and took her to the emergency room. After a thorough workup, Susan was deemed healthy. It was recommended that she cut back on caffeine and smoking (she was drinking many pots of tea and smoking up to two packs of cigarettes per day) and try to get some more rest and help around the house.

About a week later, Susan took the baby to the supermarket. She found the fluorescent lights to be very annoying and she started to feel anxious. Before she knew it, she was having another panic attack and had to leave her cart of food and rush from the store. Over the next few months, Susan had panic

attacks in more and more places and even started to have them at home. She was so scared of "going crazy" when home alone with the baby that her mother had to come over while her husband was at work. By the time she presented for treatment, she was totally housebound and was experiencing multiple panic attacks each day. Even once a panic attack had subsided, Susan was left with a chronic, low-level of anxiety throughout the day.

Specific Phobia and Social Phobia

Specific Phobia

The *DSM-IV* includes two types of phobias: Specific Phobia and Social Phobia. *Specific Phobia* is characterized by a "marked or persistent fear ... of a specific object or situation" (American Psychiatric Association, 1994, p. 410; see Table 1.3 for a summary of the diagnostic criteria). To be diagnosed with a simple phobia, patients must realize that their fears are excessive or unreasonable; this criterion is not applied to children, although they must exhibit symptoms of the specific phobia for at least 6 months in order to differentiate a clinically significant phobia from

TABLE 1.3

Summary of the Diagnostic Criteria for Specific Phobia

- **Defining characteristic:** Marked and persistent fear that is excessive or unreasonable, cued by the presence (or anticipation) of a specific object or situation.
- Must experience anxiety almost every time the feared stimuli is confronted.
- Must recognize that the fear is excessive or unreasonable.
- Must avoid the feared object, or endure exposure to it with intense anxiety.
- Must experience significant distress or impairment in functioning because of the fear/avoidance.
- Must have had the fear for more than 6 months.
- Not better accounted for by another disorder.

Subtypes of specific phobia:

— Animal type (e.g., fear of spiders, dogs).
— Natural environment type (e.g., fear of lightening/thunder, water).
— Blood-injection-injury type (e.g., fear of injections, having blood drawn).
— Situational type (e.g., fear of flying, driving).
— Other type (e.g., fear of choking, vomiting).

Source: DSM-IV (American Psychiatric Association, 1994).

TABLE 1.4

Lifetime Prevalence of Common Specific Phobias

Stimuli	Prevalence (%)
Storms	2.9
Water	3.4
Flying	3.5
Enclosed places	4.2
Blood	4.5
Heights	5.3
Animals	5.7

Source: Curtis et al. (1998).

the transient fears that are common during childhood. Specific Phobia is only diagnosed when patients report that their fear causes them significant distress or impairment in functioning. The *DSM-IV* includes five specific phobia subtypes: animal type, natural environment type (e.g., fear of storms, water, heights), blood-injection-injury type, situational type (e.g., flying, driving, bridges), and other type (e.g., fear of choking or vomiting, etc.). Common phobias include fear of heights, flying, being in enclosed places, storms, animals, blood, and water (see Table 1.4; Curtis, Magee, Eaton, Wittchen, & Kessler, 1998).

Social Phobia

Social Phobia shares similar diagnostic criteria with Specific Phobia, but the focus of concern is on social and/or performance situations (see Table 1.5 for diagnostic criteria). The core concerns of patients with Social Phobia are doing or saying something embarrassing (or exhibiting anxiety symptoms such as blushing, shaking, or sweating) that will lead to negative evaluation from others. Situations commonly feared by patients with Social Phobia include initiating and maintaining conversations, speaking up in groups, doing things in front of other people (e.g., eating, filling in a form), making requests of others, and asking others to change their behavior (see Table 1.6). The *DSM-IV* requires clinicians to specify if the social fears are "generalized," meaning that the individual fears most social situations. In contrast, some individuals with Social Phobia have very discrete social fears, such as a circumscribed fear of public speaking. Patients with generalized Social Phobia tend to experience more severe Social Phobia symptoms and suffer greater impairment in functioning (Mannuzza et al., 1995) than those with more discrete fears.

TABLE 1.5

Summary of Diagnostic Criteria for Social Phobia

- Defining characteristic: A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.
- Must experience anxiety almost every time the feared social or performance situations are confronted.
- Must recognize that the fear is excessive or unreasonable.
- Must avoid the feared situations, or endure exposure with intense anxiety.
- Must experience significant distress or impairment in functioning because of the fear/avoidance.
- Must have had the fear for more than 6 months.
- Not due to organic factors (e.g., medical problems, substance use).
- Not better accounted for by another disorder.

Source: DSM-IV (American Psychiatric Association, 1994).

TABLE 1.6

Situations Commonly Feared by Individuals with Social Phobia

- Public speaking (e.g., making a speech, making a toast at a wedding, doing a reading in church/synagogue, making a presentation in class).
- Being the center of attention (e.g., telling a story or a joke, receiving a compliment).
- Initiating and/or maintaining casual conversations.
- Meeting new people (e.g., introducing self, breaking into conversations, etc.).
- Eating, drinking, writing, working in front of others.
- Being assertive—asking others to change their behavior or refusing unreasonable requests.
- Voicing opinions, especially if they are controversial.
- Talking to authority figures.
- Interviewing for a job.
- Dating.
- Talking on the telephone.
- Going to the gym or participating in sports.
- Performing in front of an audience (e.g., playing an instrument, acting in a play).

Case Example: Specific Phobia

Felicia was a 19-year-old college student who had recently developed a terrible fear of pigeons. According to Felicia, she was walking through campus with a friend about six months prior to her evaluation when a pigeon suddenly landed on her friend's head, becoming entangled in her hair. Since that time, Felicia became terrified each time she saw a pigeon, which was many times a day around campus and the city where it was located. She feared that a pigeon would land on her head, just as had happened to her friend. When Felicia presented for treatment, she was not avoiding being outside, but was taking great pains to avoid pigeons. She would cross to the other side of the street each time she saw one (sometimes necessitating "multiple crossings" on a single block!) and often walking with an umbrella covering her head on a perfectly sunny day. She was prompted to enter treatment when a cousin invited her to visit him in Venice. The patient, knowing how common pigeons are in Venice, could not imagine going despite very much wanting to visit Italy and getting to know her extended family.

Case Example: Social Phobia

Jeff was a 27-year-old young man who had been working as a paralegal since finishing his undergraduate degree. He presented for treatment a few weeks before beginning law school. He had been accepted to law school many times since he graduated, but kept turning down his admission offers because of his social anxiety. Jeff dreaded being called on in law school classes. He worried that he would get questions wrong and embarrass himself in front of his classmates and professors. He was even more nervous, however, about having to argue cases in court. He could not imagine being able to speak coherently with all eyes on him in the courtroom. Jeff imagined stumbling over his words, or even completely forgetting what he had meant to say. Meeting with new clients also made him anxious. He worried about saying the wrong thing and making mistakes, and he also felt uncomfortable with the casual conversations that typically happened at the beginning of meetings.

Jeff felt at ease at his paralegal job. He interacted with a couple of lawyers with whom he felt very comfortable and all of his work happened "behind the scenes," doing research and preparing documents. Jeff felt he could stay in this job forever, but also recognized that he was not living up to his potential. He finally decided to enroll in law school and seek treatment for his social anxiety so that he could succeed at this life-long goal.

Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD)

This anxiety disorder is characterized by the presence of obsessions and/or compulsions (see Table 1.7). Typically, obsessions and compulsions occur together and are functionally related. Obsessions are defined as "recurrent and persistent thoughts, impulses, or images that are experienced ... as intrusive and inappropriate and that cause marked anxiety or distress" (American Psychiatric Association, 1994, p. 422). Common obsessions include fear of contamination, fear of acting on unwanted sexual or aggressive impulses, fear of throwing things away, and fear of making mistakes. In response to the anxiety caused by obsessions, patients with OCD engage in compulsions or rituals. Rituals are meant to

TABLE 1.7

Summary of Diagnostic Criteria for OCD

- **Defining characteristic:** OCD is characterized by the presence of obsessions and/or (but, most typically AND) compulsions.
- **Obsessions** are defined as:
  (1) Thoughts, impulses, or images that persist, are intrusive, and cause distress.
  (2) These thoughts, impulses, or images have different content than "every day worries."
  (3) The person attempts to get rid of the thoughts, impulses, or images.
  (4) The person recognizes that the thoughts, impulses, or images are a product of his or her own mind
- **Compulsions** are defined as:
  (1) Repetitive behaviors or mental acts that the person feels that they need to perform in response to an obsession.
  (2) Compulsions are meant to reduce anxiety brought on by obsessions or prevent feared outcomes.
- At some point during the disorder, the person must realize that the obsessions/compulsions are excessive or unreasonable.
- Obsessions and/or compulsions must cause distress or take up more than one hour per day or lead to interference in functioning.
- Not due to organic factors (e.g., medical problems, substance use).
- Not better accounted for by another disorder.

Source: DSM-IV (American Psychiatric Association, 1994).

decrease or prevent the experience of anxiety and prevent the occurrence of feared consequences. Rituals can be overt behaviors (e.g., washing hands after touching something contaminated to prevent sickness) or mental acts (e.g., saying a prayer to ward off the possibility of stabbing a loved one while making dinner). Common obsessions and compulsions are listed in Table 1.8.

A few important points regarding the diagnostic criteria should be highlighted. First, obsessions are not simply excessive worries about every day problems. The content of obsessions tends to be slightly more unusual or less reality-based than "every day worries" which are the defining feature of generalized anxiety disorder. This distinction can be challenging since there is great overlap in the themes of obsessions and worries. For example, worry about the health and safety of loved ones is seen in OCD and GAD (Generalized Anxiety Disorder). In GAD, patients might worry that their spouse will be in a terrible car crash on the way home from work. Clearly, this *could* happen (although the probability is very low). A patient with OCD, on the other hand, might worry that he will pass contaminants onto his wife if he doesn't shower after coming home from working from his office in the city. His carelessness will then cause his wife to get a rare illness and die a quick and tragic death. This outcome is highly unlikely, lending the feared consequence an "OCD feel" rather than a "GAD feel."

Another important point to keep in mind when considering a diagnosis of OCD is that patients must recognize that their obsessions are a product of their own mind. The content of obsessions is sometimes so bizarre that clinicians might question whether a patient in fact has schizophrenia or some other psychotic

TABLE 1.8

Common Obsessions and Compulsions

Obsessions	Compulsions
Harm-related obsessions	Checking rituals (can include reassurance seeking)
Contamination obsessions	Washing/cleaning rituals
Symmetry/Exactness	Repeating; ordering and arranging
Fear of throwing things away	Hoarding/acquiring rituals
Religious obsessions	Mental rituals (e.g., praying)
Sexual obsessions	Mental rituals (e.g., mental checking and reassuring self)

disorder. Patients should be asked where they believe their thoughts are coming from. Patients with OCD must recognize that the thoughts are their own and not being placed in their minds by some other force.

As in the case of Specific Phobia, patients with OCD must recognize at some point during the course of the disorder that their fears are excessive and unreasonable (this criterion does not apply to children). Clinicians should be aware that a broad range of insight is exhibited by patients with OCD. By the time patients present for treatment, 5 percent report *complete* conviction that their obsessions and compulsions are realistic, and an additional 20 percent report a strong, but not entirely fixed conviction (Kozak & Foa, 1994). When patients hold so strongly to their beliefs about the consequences of confronting their feared object that they seem to be delusional, they are considered to have overvalued ideation (OVI; Kozak & Foa, 1994). Determining whether clients have OVI is important because poor insight is predictive of poor treatment outcome (Foa, Abramowitz, Franklin, & Kozak, 1999).

Case Example: OCD

Phillip was an 18-year-old young man, just about to leave home for college, when he presented for treatment. For as long as he could remember, Phillip had been concerned about contamination. His obsessions were provoked by public bathrooms, like many patients with OCD, but also by many other stimuli. He feared walking by homeless people, touching old books in the library, and picking things up off the ground (like the ball during a baseball game). Phillip's greatest fear was breathing in particles of contaminants that would make him sick. He did not have a clear idea of what kind of illness he might contract, but he was sure that it would come on very quickly after the ingestion (e.g., within 24 hours) and result in death. In response to these concerns, Phillip engaged in a number of rituals and subtle avoidance behaviors. He would frequently spit to rid his mouth of contaminants and would often hold his breath when walking by a street person or bending down to get a baseball. He also engaged in elaborate hand-washing rituals to make sure that contaminants would not get from his hands into his mouth.

In general, Phillip was functioning quite well when he came in for treatment. He had done well in his senior year of high school and was attending college on a baseball scholarship. However, he found his obsessions and rituals terribly annoying and wished he could stop doing them. He also expressed concern about experiencing an exacerbation of his OCD in the college dorm, which he predicted would not be as pristinely clean as his parents' home! Phillip's parents, at times, seemed more distressed by his OCD than he was. They reported that he spent at least an hour at the end of the day washing up after baseball

practice, delaying their family dinner, and wasting a lot of water and soap. Phillip demanded a clean house but refused to help out with house cleaning, worrying that he would get sick either from germs and dirt in the house or from the cleaning products used to get rid of them. They also wondered how Phillip was going to be able to function in the dorms, particularly since he could not clean up the very germs and dirt that triggered his OCD symptoms.

Generalized Anxiety Disorder

Generalized Anxiety Disorder (GAD)

The core feature of Generalized Anxiety Disorder (GAD) is excessive worry about a number of events or activities that occurs more days than not, for six months or more. Typical areas of worry include health of self and others, relationships, minor matters (e.g., getting to places on time, fixing things around the house), and world affairs. Patients with GAD find it difficult to control their worry and experience accompanying somatic and affective symptoms like muscle tension, irritability, and sleep disturbance (American Psychiatric Association, 1994; see Table 1.9).

TABLE 1.9

Summary of Diagnostic Criteria for GAD

- **Defining characteristic:** Excessive anxiety and worry occurring more days than not for at least six months about a number of events and activities.
- Difficulty controlling worry.
- The anxiety and worry is associated with three or more of the following symptoms:
  - — Feeling restless, keyed up, or on edge
  - — Being easily fatigued
  - — Difficulty concentrating or mind going blank
  - — Irritability
  - — Muscle tension
  - — Sleep disturbance
- The anxiety, worry, or physical symptoms causes distress or impairment in functioning.
- Not due to organic factors (e.g., medical problems, substance use).
- Not better accounted for by another disorder.

Source: DSM-IV (American Psychiatric Association, 1994).

Case Example: GAD

For as long as she could remember, Rose was a "worry wart." As a child, she always worried about getting her schoolwork done on time and doing well in school. She worried that something bad was going to happen to her parents and sister. In college, these worries continued, but added to them were significant concerns about meeting the "right" person. Even at 20, years before she wanted to get married, she worried that she would never meet "the one," never have children, and grow old all by herself. At 30, Rose did get married, and a few years later had children. When she presented for treatment at age 40, her worries had become increasingly severe. Rose constantly worried about the health and safety of her husband and children, her performance at work, and the state of the world. She always worried about being on time and getting all the things done that she needed to accomplish. Ironically, Rose was typically quite unproductive. She worried so much about doing things well that she often procrastinated, spending all of her time making lists and planning how she was going to do her projects. Her worry also caused interpersonal problems. She called her husband many times a day to see if he was okay, which irritated him. She noticed that her children were "worriers," despite being just 5 and 8 years old! It seemed that she had taught them to worry.

When Rose began worrying, she found it impossible to stop. Not even the most engaging activity could get her mind onto something else. She had frequent migraines, terrible muscle tension in her back, shoulders, and neck, and often lay awake at night thinking of all of the things that could go wrong. Not surprisingly, Rose was always exhausted. She knew she had to do something to become a calmer person.

Posttraumatic Stress Disorder (PTSD)

PTSD will be described only briefly here because a whole volume of this series is dedicated to the disorder. Posttraumatic Stress Disorder is the only anxiety disorder with a required precipitant. In order to be diagnosed with PTSD, patients must have been exposed to a traumatic event that "involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" that the person responded to with "intense fear, helplessness, or horror" (American Psychiatric Association, 1994, p. 427–428). It is interesting to note that most people who experience a trauma do not go on to develop PTSD. In one study of rape survivors, for example, 94 percent of victims exhibited full PTSD symptoms 2 weeks post-trauma, but only 47 percent continued to exhibit symptoms 3 months post-trauma (Rothbaum & Foa, 1993). This suggests that many people who experience a trauma naturally recover without any specific intervention.

Some traumatic experiences seem to put people at elevated risk for the development of PTSD. In two studies using large, nationally representative samples, physical abuse, sexual abuse, and combat exposure were much more likely to lead to the development of PTSD than natural disasters and accidents (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). For example, in Resnick et al.'s study, 39 percent of women who experienced a physical assault and 30 percent of women who experienced a rape or other sexual assault developed PTSD, while only 9 percent of women developed PTSD following a natural disaster or accident.

For a diagnosis of PTSD to be made, patients must exhibit symptoms from three major categories: (1) re-experiencing symptoms; (2) avoidance and numbing symptoms; and (3) hyper-arousal symptoms. With respect to re-experiencing, patients might experience intrusive thoughts, distressing dreams or nightmares, and intense emotional upset or physical symptoms about the trauma. Some patients also experience flashbacks, during which they lose touch with reality and actually act or feel as if the trauma were re-occurring.

To be diagnosed with PTSD, patients must also experience three or more avoidance/numbing symptoms. These include concerted efforts to avoid thoughts or feelings associated with the trauma (i.e., trying very hard to *not* think about what happened); avoidance of activities, places, or people that remind patients of the trauma; inability to recall some parts of the trauma memory; loss of interest in previously enjoyed activities; feeling detached or cut off from others (often described as people not understanding what the client has been through); difficulty experiencing the whole range of emotion; and a sense of a foreshortened future. These criteria would only be met if the patient did not have these experiences before the trauma. For example, if a patient who lived in a dangerous neighborhood was mugged and beat up and reported feeling that he might not live until age 25, it would be important to ask if he felt this way before being attacked. Many clients who live in dangerous neighborhoods have *always* felt a sense of a foreshortened future. This, then, would not be coded as a symptom of PTSD.

Finally, to be diagnosed with PTSD, individuals must experience two or more symptoms of increased arousal; again, these must not have been present prior to the trauma. These symptoms include: difficulties with sleep; irritability or problems with anger; difficulty concentrating; hypervigilance (e.g., always being on the lookout for what is going on around you); and an exaggerated startle response.

PTSD is only diagnosed when symptoms have been present for one month or more. The *DSM-IV* also includes a diagnosis of *Acute Stress Disorder* for patients who have experienced a trauma and have had trauma symptoms for at least two days, but less than a month. This diagnosis can only be made within a month of the occurrence of the trauma. If a patient experiences a trauma, but his or her symptoms persist past one month, the diagnosis switches from acute stress disorder to PTSD.

Case Example: PTSD

John was a 50-year-old man who worked at a restaurant located just off the interstate highway. The restaurant was open until 11 PM, at which time most of the other staff left and John was in charge of the final evening cleanup. One evening, as John was vacuuming, he felt cold metal on the back of his neck. He turned around to find a man much larger than him, pointing a revolver right at him. Clearly, the employee in charge of locking the doors had not done so and the perpetrator had easily slipped into the restaurant. John quickly told the man that all of the deposits had already been taken to the bank by another employee, and that there was no cash at all in the restaurant. That was the last thing he remembered. John had been shot in the neck.

After a difficult recovery in the hospital, John felt like a changed person. He took a leave of absence from his job that continued long past his physical recovery had occurred. Throughout the day, he found himself continually thinking about the attack. He tried not to remember the horrifying incident but it continuously popped up in his mind. Everything he tried to do to distract himself, like reading or watching TV, ended up reminding him of the trauma. Every time he saw a crime scene on TV, his heart raced and he felt short of breath. John spent his days checking the locks and windows to ensure that no one could get in his house or trying to catch up on the sleep he was not able to get the night before.

John's wife of 30 years tried to be as supportive as possible. But John felt that she could just not understand what he was going through. He was constantly irritable, and often yelled at her. This was very out of character for such a mild-mannered man. Another major change in John was his social withdrawal. John no longer attended his weekly bowling game with his buddies, and simply could not get interested in any of the other activities he used to enjoy. He felt that life as he knew it had ended on the night that he was shot.

Differential Diagnosis

There is a great deal of overlap across the anxiety disorders, not only in terms of what patients fear, but also in terms of the symptoms that they experience (e.g., panic attacks can occur in all of the anxiety disorders). This makes differential diagnosis among the anxiety disorders both challenging and important. The key to proper differential diagnosis is to go beyond *what* the patient is afraid of, and gain a clear understanding of *why* patients fear a specific object or situation. The *why* that underlies the fear will help clinicians make an accurate diagnosis and an appropriate treatment plan.

Fear of flying is an excellent way to demonstrate how important it is to gain a clear understanding of the nature of a patient's fears. When a clinician hears that a patient has a fear of flying, the immediate assumption is that the client has a specific phobia. The client fears that the plane will crash. This is probably a correct diagnosis for most patients with a fear of flying.

Yet, there are many other possibilities. Some patients fear flying because they are scared of having a panic attack on the plane. The idea of not being able to escape from that situation is terrifying. This would point to a diagnosis of panic disorder. Although less likely, patients might fear flying because they are anxious about making casual conversation with a seatmate (Social Phobia), because they had a traumatic experience in the past while on an airplane (PTSD), or because they worry about contracting germs from being in such close proximity to so many people (OCD).

By asking patients detailed questions about the nature of their fears, clinicians can make accurate diagnoses and devise appropriate treatment plans. Clinicians can say, "What specifically do you fear could happen if you were to take a flight on a plane?" If a patient responds with a vague response such as "I would become nervous," the clinician can probe further to see what exactly the patient would be nervous about. If the patient is unable to articulate his fears, the clinician can provide examples such as those described previously to see which scenario the patient fears most.

While it is very important to correctly differentiate one anxiety disorder from another, it is also important to recognize that comorbidity (the co-occurrence of two or more disorders) among the anxiety disorders is very common. It is also very common to see comorbidity between anxiety disorders and other disorders, including mood disorders, substance-use disorders, and personality disorders.

Prevalence of Anxiety Disorders

Anxiety disorders are highly prevalent. Our most useful information on the prevalence of psychiatric disorders comes from The National Comorbidity Survey (NCS). The NCS was conducted in the early 1990s to assess the prevalence of psychiatric disorders in a representative sample of the U.S. population aged 18 years and older. The NCS was based on *DSM-III-R* criteria for psychiatric disorders. The NCS was then replicated (NCS-R) between 2001 and 2003 using a new sample of respondents in order to assess prevalence of psychiatric disorders based on *DSM-IV* criteria. The NCS-R also afforded the opportunity to examine the prevalence of disorders not included in the original NCS.

The NCS-R data (see Kessler et al., 2005; see also http://www.hcp.med.harvard.edu/ncs for the most up-to-date data) show that anxiety disorders are the most prevalent class of disorders, with 31.2 percent of the population meeting criteria

for at least one anxiety disorder at some time in their lives and 18.7 percent of the population meeting criteria for at least one anxiety disorder in the previous year. Phobias are particularly common, with 12.5 percent of the population meeting criteria for a specific phobia at some time in their lives and 12.1 percent meeting criteria for Social Phobia. The prevalence rates (both lifetime and 12-month) for all of the anxiety disorders are shown in Table 1.10.

The NCS-R also provides important data on the median age of onset of the anxiety disorders (Kessler et al., 2005). The median age of onset for all anxiety disorders is 11, much earlier than for substance use (median age 20) or mood disorders (median age 30). This suggests that anxiety disorders might be a risk factor for the later development of other disorders. This is not surprising–after years of avoidance and distress, it is easy to see how patients can become depressed or resort to alcohol and/or drugs as a means of self-medication. The median age of onset for anxiety disorders is diverse, with specific phobias having a very early age of onset (age 7) and other anxiety disorders (like GAD, age 31 and Panic Disorder, age 24) beginning much later. The median ages of onset for the anxiety disorders are shown in Table 1.10.

As has been shown repeatedly in the literature, including in the NCS-R, anxiety disorders are significantly more common in women than in men. This is also demonstrated in Table 1.10.

TABLE 1.10

Lifetime Prevalence and Median Age of Onset of *DSM-IV* Anxiety Disorders

Disorder	Total (%)	Female (%)	Male (%)	Median age of onset
Panic Disorder	4.7	6.2	3.1	24
Specific Phobia	12.5	15.8	8.9	7
Social Phobia	12.1	13.0	11.1	13
GAD	5.7	7.1	4.2	31
PTSD	6.8	9.7	3.6	23
OCD	1.8	2.6	1.0	19
Any anxiety disorder	31.2	36.3	25.3	11

Source: Table reproduced from http://www.hcp.med.harvard.edu/ncs and Kessler et al., 2005.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed). Washington, DC: Author.

Curtis, G. C., Magee, W. J., Eaton, W. W., Wittchen, H. U., & Kessler, R. C. (1998). Specific fears and phobias: Epidemiology and classification. *British Journal of Psychiatry, 173,* 212–217.

Foa, E. B., Abramowitz, J. S., Franklin, M. E., & Kozak, M. J. (1999). Feared consequences, fixity of belief, and treatment outcome in OCD. *Behavior Therapy, 30,* 717–724.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62,* 593–602.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048–1060.

Kozak, M. J., & Foa, E. B. (1994). Obsessions, overvalued ideas, and delusions in obsessive-compulsive disorder. *Behaviour Research and Therapy, 32,* 343–353.

Mannuzza, S., Schneier, F. R., Chapman, T. F., Liebowitz, M. R., Klein, D. F., & Fyer, A. J. (1995). Generalized Social Phobia: Reliability and validity. *Archives of General Psychiatry, 52,* 230–237.

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology, 61,* 984–991.

Rothbaum, B. O., & Foa, E. B. (1993). Subtypes of posttraumatic stress disorder and duration of symptoms. In J. R. T. Davidson & E. B. Foa (Eds.), *Posttraumatic Stress Disorder:* DSM-IV *and beyond* (pp. 23–35). Washington, DC: American Psychiatric Press.

White, K. S., & Barlow, D. H. (2002). Panic Disorder and Agoraphobia. In D. H. Barlow (Ed.), *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed., pp. 328–379). New York: Guilford.