

Generalized Anxiety Disorder, Obsessive Compulsive Disorder

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Generalized Anxiety Disorder

For some people, worry about many different aspects of life (including minor events) becomes chronic, excessive, and unreasonable, this is generalized anxiety disorder (GAD). DSM-5 criteria specify that the worry must occur on more days than not for at least 6 months and that it must be experienced as difficult to control. People suffering from GAD live in a relatively constant, future-oriented mood state of anxious apprehension, chronic tension, worry, and diffuse uneasiness that they cannot control.

Prevalence, Age of onset and gender differences

Approximately 3 percent of the population suffers from GAD in any 1-year period and 5.7 percent at some point in their lives . It also tends to be chronic. After age 50 the disorder seems to disappear for many people , it often tends to be replaced by a somatic symptom disorder and characterized by physical symptoms and health concerns. GAD is approximately twice as common in women as in men . Although GAD is quite common, most people with this disorder manage to function in spite of their high levels of worry and low perceived well-being . They are less likely to go to clinics for psychological treatment than are people with panic disorder or major depressive disorder. However, people with GAD do frequently show up in physicians' offices with medical complaints (such as muscle tension or gastrointestinal and/or cardiac symptoms) and are known to be over users of health care resources. Age of onset is often difficult to determine because 60 to 80 percent of people with GAD remember having been anxious nearly all their lives.

Psychological causal factors

- **THE PSYCHOANALYTIC VIEWPOINT**

Generalized or free-floating anxiety results from an unconscious conflict between ego and id impulses that is not adequately dealt with because the person's defense mechanisms have either broken down or have never developed. Freud believed that it was primarily sexual and aggressive impulses that had been either blocked from expression or punished upon expression that led to free floating anxiety. Defense mechanisms may become overwhelmed when a person experiences frequent and extreme levels of anxiety, as might happen if id impulses are frequently blocked from expression.

- **PERCEPTIONS OF UNCONTROLLABILITY AND UNPREDICTABILITY**

Uncontrollable and unpredictable aversive events are much more stressful than controllable and predictable aversive events.

- **A SENSE OF MASTERY: THE POSSIBILITY OF IMMUNIZING AGAINST ANXIETY**

A person's history of control over important aspects of his or her environment is another significant experiential variable strongly affecting reactions to anxiety-provoking situations. Although we cannot study this experimentally in humans, we can learn a lot from laboratory analogue studies in animals.

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- **THE REINFORCING PROPERTIES OF WORRY**

The worry process is now considered the central feature of GAD and has been the focus of much research in the past 20 years.

- **THE NEGATIVE CONSEQUENCES OF WORRY**

Although worry can be reinforcing, some of its effects are clearly negative (Mineka, 2004). For example, worry itself is certainly not an enjoyable activity and can actually lead to a greater sense of danger and anxiety.

- **COGNITIVE BIASES FOR THREATENING INFORMATION**

Not only do people with GAD have frequent frightening thoughts, they also process threatening information in a biased way, perhaps because they have prominent danger schemas. Anxious people tend to preferentially allocate their attention toward threatening cues when both threat and non threat cues are present in the environment. Non anxious people do not show a bias except under limited circumstances, in which they actually may show the opposite bias.

Biological causal factors

- **GENETIC FACTORS**

Evidence for genetic factors in GAD is mixed, but there does seem to be a modest heritability, although perhaps smaller than that for most other anxiety disorders except phobias.

- **NEUROTRANSMITTER AND NEUROHORMONAL ABNORMALITIES**

A Functional Deficiency in GABA In the 1950s, the benzodiazepine category of medications was found to reduce anxiety. It appears that highly anxious people have a kind of functional deficiency in GABA, which ordinarily plays an important role in the way our brain inhibits anxiety in stressful situations. Serotonin—is also involved in modulating generalized anxiety. At present, it seems that GABA, serotonin, and perhaps norepinephrine all play a role in anxiety, but the ways in which they interact remain largely unknown.

- **NEUROBIOLOGICAL DIFFERENCES BETWEEN ANXIETY AND PANIC**

Fear and panic involve activation of the fight-or-flight response, and the brain areas and neurotransmitters that seem most strongly implicated in these emotional responses are the amygdala (and locus coeruleus) and the neurotransmitters norepinephrine and serotonin. Generalized anxiety (or anxious apprehension) is a more diffuse emotional state than acute fear or phobia that involves arousal and a preparation for possible impending threat; and the brain area, neurotransmitters, and hormones that seem most strongly implicated are the limbic system, GABA, and CRH . Although serotonin may play a role in both anxiety and panic, it probably does so in somewhat different ways. Recently, people with GAD have been found to have a smaller left hippocampal region similar to what is seen with major depression.

Treatments

- **MEDICATIONS**

Many clients with generalized anxiety disorder consult family physicians, seeking relief from their “nerves” or anxieties or their various functional (psychogenic) physical problems. Most often in such cases, medications from the benzodiazepine (anxiolytic) category such as Xanax or Klonopin are used—and misused—for tension relief, reduction of other somatic symptoms, and relaxation.

- **COGNITIVE-BEHAVIORAL TREATMENT CBT**

It usually involves a combination of behavioral techniques, such as training in applied muscle relaxation, and cognitive restructuring techniques aimed at reducing distorted cognitions and information-processing biases associated with GAD as well as reducing catastrophizing about minor events.

Obsessive Compulsive Disorder

Obsessive-compulsive and related disorders used to be classified in the DSM as anxiety disorders; however, as of DSM-5 they have been classified separately as their own type of disorder. This new category includes not only OCD but also body dysmorphic disorder, hoarding disorder, excoriation (skin-picking) disorder, and trichotillomania (compulsive hair pulling).

Obsessive-compulsive disorder is defined by the occurrence of both obsessive thoughts and compulsive behaviors performed in an attempt to neutralize such thoughts. Obsessions are persistent and recurrent intrusive thoughts, images, or impulses that are experienced as disturbing, inappropriate, and uncontrollable. People who have such obsessions actively try to resist or suppress them or to neutralize them with some other thought or action. Compulsions involve overt repetitive behaviors that are performed as lengthy rituals (such as hand washing, checking, putting things in order over and over again). Compulsions may also involve more covert mental rituals (such as counting, praying, or saying certain words silently over and over again). A person with OCD usually feels driven to perform this compulsive, ritualistic behavior in response to an obsession, and there are often very rigid rules regarding exactly how the compulsive behavior should be performed. The compulsive behaviors are performed with the goal of preventing or reducing distress or preventing some dreaded event or situation. OCD is often one of the most disabling mental disorders in that it leads to a lower quality of life and a great deal of functional impairment

Prevalence, Age of onset and gender differences

Approximately 2 to 3 percent of people meet criteria for OCD at some point in their lifetime, and approximately 1 percent meet criteria in a given year . Over 90 percent of treatment-seeking people with OCD experience both obsessions and compulsions . When mental rituals and compulsions such as counting are included as compulsive behaviors, this figure jumps to 98 percent. Divorced (or separated) and unemployed people are somewhat overrepresented among people with OCD. One British epidemiological study found a gender ratio of 1.4 to 1 (women to men). OCD typically begins in late adolescence or early adulthood, but also can occur in children, where its symptoms are strikingly similar to those of adults. Childhood or early adolescent onset is more common in boys than in girls and is often associated with greater severity.

Psychological causal factors

- **OCD AS LEARNED BEHAVIOR**

The dominant behavioral or learning view of obsessive-compulsive disorder is derived from Mowrer's two-process theory of avoidance learning (1947). According to this theory, neutral stimuli become associated with frightening thoughts or experiences through classical conditioning and come to elicit anxiety. For example, touching a doorknob or shaking hands might become associated with the "scary" idea of contamination. Once having made this association, the person may discover that the anxiety produced by shaking hands or touching a doorknob can be reduced by hand washing. Washing his or her hands extensively reduces the anxiety, and so the washing response is reinforced, which makes it more likely to occur again in the future when other situations evoke anxiety about contamination.

- **OCD AND PREPAREDNESS**

The preparedness concept considers the evolutionarily adaptive nature of fear and anxiety for our early ancestors also can help us to understand the occurrence and persistence of OCD. The fact that many people with OCD have obsessions and compulsions focused on dirt, contamination, and other potentially dangerous situations has led many researchers to conclude that these features of the disorder likely have deep evolutionary roots.

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- **COGNITIVE CAUSAL FACTORS**

People with normal and abnormal obsessions differ primarily in the degree to which they resist their own thoughts and find them unacceptable. Thus, one factor contributing to the frequency of obsessive thoughts, and the negative moods with which they are often associated, may be these attempts to suppress them. For example, when people with OCD are asked to record intrusive thoughts in a diary, both on days when they were told to try to suppress those thoughts and on days without instructions to suppress, they reported approximately twice as many intrusive thoughts on the days when they were attempting to suppress them (Salkovskis & Kirk, 1997). In addition, thought suppression leads to a more general increase in obsessive-compulsive symptoms beyond just the frequency of obsessions.

Biological causal factors

- **GENETIC FACTORS**

Evidence from twin studies reveals a moderately high concordance rate for OCD for monozygotic twins and a lower rate for dizygotic twins. One review of 14 published studies included 80 monozygotic pairs of twins, of whom 54 were concordant for the diagnosis of OCD, and 29 pairs of dizygotic twins, of whom 9 were concordant.

- **OCD AND THE BRAIN**

The research has revealed that abnormalities occur primarily in ***certain cortical and subcortical structures such as the basal ganglia***. The basal ganglia are in turn linked at the ***amygdala to the limbic system***, which controls emotional behaviors. Findings from a good number of studies using PET scans have shown that people with OCD have abnormally ***high levels of activity in two parts of the frontal cortex (the orbital frontal cortex and the cingulate cortex/gyrus)***, which are also linked to the limbic area. People with OCD also have abnormally high levels of activity in the subcortical caudate nucleus, which is part of the basal ganglia.

- **NEUROTRANSMITTER ABNORMALITIES**

Current evidence suggests that increased serotonin activity and increased sensitivity of some brain structures to serotonin are involved in OCD symptoms.

Treatments

- **BEHAVIORAL AND COGNITIVE-BEHAVIORAL TREATMENTS**

- **Exposure and response prevention**

- The exposure component involves having individuals with OCD repeatedly expose themselves (either in guided fantasy or directly) to stimuli that provoke their obsessions. The response prevention component requires that they then refrain from engaging in the rituals that they ordinarily would perform to reduce their anxiety or distress. Preventing the rituals is essential so that they can see that if they allow enough time to pass, the anxiety created by the obsession will dissipate naturally down to at least 40 to 50 on a 100-point scale, even if this takes several hours.

- **MEDICATIONS**

Whereas the other anxiety disorders respond to a range of drugs, OCD seems to respond best to medications that affect the serotonin system. These medications, such as **clomipramine** (Anafranil) and **fluoxetine** (Prozac) reduce the intensity of OCD symptoms, with approximately 40 to 60 percent of people showing at least a 25 to 35 percent reduction in symptoms . Some clients show greater improvement than this, but about 30 to 50 percent do not show any clinically significant improvement .