Assessment of Symptoms

- **Agoraphobia Scale**
  - rated panic-related fear and avoidance of particular situations from 0 (never) ⇒ 4 (extreme/always)

- **Panic Disorder Severity Scale**
  - 7 items
  - assesses frequency, distress, and avoidance caused by panic attacks from 0 (none/mild) ⇒ 4 (extreme/severe)

- **Structured Interview Guide for the Hamilton Anxiety/Depression Rating Scale**
  - structured format to measure depression and anxiety
  - good inter-rater and test-retest reliability

- **Anxiety Sensitivity Index**
  - 16 items, self-report
  - evaluates anxiety focused on panic-related body sensations

- **Work and Social Adjustment Scale (WSAS)**
  - 5 items
  - rating degree of interference caused by symptoms in 5 life domains
  - 0 (no interference) ⇒ 8 (severe interference)

Procedure: Acute Phase

- 11 individual sessions of CBT for PD delivered via a manualized protocol
  - typically 12 sessions
  - go thru a typical CBT course (psychoeducation, relaxation, monitoring of thoughts/behaviors/symptoms, CBT restructuring (identifying problematic thoughts, finding ways to alter them), exposure)
  - “manualized protocol” = therapy is the same, but custom made for the individual

- **Cog Recturing**
  - heart rate increase could cause heart problems, then death
  - but how many times in your life have you died when your heart rate increases?
  - you have no proof to back up your panicked claim

- **Exposure**
  - what is your greatest fear?
  - engage in activities to increase the heart rate
    - running in place, going up and down stairs
  - therapist often models the activity while patient is going through it
  - engage in activity until anxiety goes down
    - actually EXPERIENCING anxiety - not avoiding it
  - **USUALLY**, these activities don’t bring on anxiety
    - patient feels safe in the session
    - your INTERPRETATION matters to how you feel in the setting
    - usually, when they do the exposure at home, they feel more anxiety again, but it goes down quicker

Procedure: Post-Acute Phase

- **Treatment Responders**
  - Received a “2” (much improved) or a “1” (very much improved) on the clinical global impressions scale (CGI)
  - 40% reductions in PDSS-IE score from pretreatment
  - Panic-free status
● marked physiological reactions to cues that symbolize or represent trauma
  ○ interoceptive cues- internal cues like heart rate, respiration- become cues for psych distress (looks like PD)

■ Persistent Avoidance (one or both)
  ● avoidance of the consequences of trauma (thoughts, feelings, memories)
  ● avoidance of trauma triggers

■ Negative alterations in cog and mood (two or more)
  ● inability to remember aspects of the trauma
  ● persistent or exaggerated beliefs/expectations about oneself, others, the world
  ● persistent, distorted cognitions about the causes or consequences of the trauma (“it’s my fault” (guilty cog), “I’ll never be the same”)
  ● Persistent negative emotional state
  ● Diminished interest or participation in activities
  ● feelings of detachment or estrangement from others
  ● persistent inability to experience positive emotions
    ○ high rate of comorbidity btw PTSD and depression, PD

■ Marked alterations in arousal and reactivity (two or more) (change in baseline):
  ● irritable behavior and angry outbursts
  ● reckless or self-destructive behavior
  ● hypervigilance
  ● exaggerated startle response
  ● problems w/ concentration
  ● sleep disturbances
    ○ the state of increased arousal is incompatible w/ sleep
    ○ also afraid to sleep b/c of nightmares

■ Duration of Disturbance is over 1 month
  No current medical condition or substance use causing symptoms
  Symptoms cause distress or impairment in everyday function
  Specify Whether:
    ● w/ dissociative symptoms:
      ○ depersonalization: feeling detached from one’s body and feeling as if they are an outside observer of their mental processes and behaviors (detachment from oneself)
      ○ derealization: experiences of unreality of surroundings (external world is experienced as dreamlike, distant or distorted) (detachment from reality)
        ■ do they have dissociative symptoms? what is the severity?
    ● w/ delayed onset: full criteria are met after 6 months of trauma
          ○ some individuals experience trauma reactions a long time after the trauma happens
    ■
          ○ if someone is going to recover, it’s likely to happen w/in one month
    ● the more traumas experienced, the more complicated the PTSD reaction

○ Statistics
  ■ traumas which have no life threat/injury- LOWER prevalence rate of eventual PTSD diagnosis
  ■ traumas which have to do w/ life threat only or injury only, prevalence rate is higher
  ■ traumas which involve both life threat and injury have the highest prevalence rate for PTSD
● large range in type of experiences which cause it
● definition of stressor is subject to interpretation
● EX: job loss- can cause sig distress

- Symptoms are clinically sig in one or both:
  ● distress is out of proportion
  ● sig impairment
- Doesn’t meet criteria for another disorder or exacerbation of another disorder
- symptoms are NOT normative bereavement
- does NOT persist for more than 6 mo
  ● if it does persist, they probably meet criteria for some other disorder
- SPECIFY: w/ depressed mood, anxiety, mixed anx/dep, disturbance of conduct, disturbance of conduct/emotions, unspecified
  ● do NOT have to meet criteria for depression or anxiety
  ● beh expression- angry outbursts

### Obsessive Compulsive and Related Disorders

- OCD
  - Clinical Description
    - presence of obsessions, compulsions, or both
      - Obsessions: recurrent and persistent thoughts, urges or images which are intrusive/unwanted and result in marked anxiety or distress
        ○ attempts made to suppress or neutralize experiences
        ○ can experience as a picture, video in their minds
        ○ “sticky” thoughts- have an urge, image, video, etc.- b/c it’s so upsetting, you try to avoid thinking about it
          - this INCREASES the thought
        ○ some obsessions can shift and change- going from one obsession to another
      - Compulsions: repetitive behaviors or mental acts performed in response to an obsession or according to specified rules
        ○ aimed at preventing or reducing anxiety or distress
        ○ avoiding some disastrous outcome
        ○ NO REALISTIC CONNECTION to what they’re trying to prevent
        ○ often linked to obsession, but not necessarily
          - many times, sufferers forget WHY they started doing these compulsive behaviors
      - obsessions or compulsions are time-consuming or cause clinical sig distress or impairment
        - Common Obsessions:
          ○ contamination (by germs, dirt)
          ○ perfectionistic tendencies ("just right” OCD)
          ○ violent obsessions (concerns that someone will engage in violent behaviors and harm another person)
            - EX: vision of stabbing your own SO
              - causes distress b/c you don’t WANT to
          ○ sexual obsessions
            - are often tied to religious obsessions- concern about sinning in some way