

Anxiety Disorders

TOPIC OVERVIEW

Generalized Anxiety Disorder

- The Sociocultural Perspective: Societal and Multicultural Factors
- The Psychodynamic Perspective
- The Humanistic Perspective
- The Cognitive Perspective
- The Biological Perspective

Phobias

- Specific Phobias
- Social Phobias
- What Causes Phobias?
- How Are Phobias Treated?

Panic Disorder

- The Biological Perspective
- The Cognitive Perspective

Obsessive-Compulsive Disorder

- What Are the Features of Obsessions and Compulsions?
- The Psychodynamic Perspective
- The Behavioral Perspective
- The Cognitive Perspective
- The Biological Perspective

Putting It Together: Diathesis-Stress in Action

LECTURE OUTLINE

- I. ANXIETY
 - A. What distinguishes fear from anxiety?
 1. Fear is a state of immediate alarm in response to a serious threat to one's well-being

2. Anxiety is a state of alarm in response to a vague sense of threat or danger
 3. Both fear and anxiety have the same physiological features: increase in respiration, perspiration, muscle tension, etc.
- B. Although unpleasant, experiences of fear/anxiety are adaptive
1. Fight or flight response is protective when danger threatens
 2. However, when triggered by “inappropriate” situations, or when it is too severe or long-lasting, this response can be disabling and can lead to the development of anxiety disorders

II. ANXIETY DISORDERS

- A. Anxiety disorders are the most common mental disorders in the United States
- B. In any given year, 18 percent of the adult population suffer from one or another of the six DSM-IV-TR anxiety disorders; close to 29 percent develop one of the disorders at some point in their lives
- C. Only around one-fifth of these individuals seek treatment
- D. Anxiety disorders cost \$42 billion each year in health care, lost wages, and lost productivity
- E. There are six disorders characterized as anxiety disorders:
1. Generalized anxiety disorder (GAD)
 2. Phobia
 3. Panic disorder
 4. Obsessive-compulsive disorder (OCD)
 5. Acute stress disorder
 6. Posttraumatic stress disorder (PTSD)
- F. Most individuals with one anxiety disorder suffer from a second as well
1. In addition, more than 90 percent of people with one of the anxiety disorders also experience a different kind of psychological disorder at some point in their lives

III. GENERALIZED ANXIETY DISORDER (GAD)

- A. This disorder is characterized by excessive anxiety under most circumstances and worry about practically anything
1. GAD often is called “free-floating” anxiety
 2. The “danger” of the situation is not a factor
- B. Symptoms include restlessness, easy fatigue, irritability, muscle tension, and/or sleep disturbance and last at least six months
- C. The disorder is common in Western society
1. Affects about 3 percent of the population in any given year and about 6 percent at some time during their lives
- D. It usually first appears in childhood or adolescence
- E. Women are diagnosed more than men by 2:1
- F. Around one-quarter are currently in treatment
- G. Various theories have been offered to explain development of the disorder:
1. The sociocultural perspective: Societal and Multicultural Factors
 - a. GAD is most likely to develop in people faced with social conditions that truly are dangerous
 - (a) Research supports this theory (e.g., nuclear disaster at Three Mile Island (TMI) in 1979)
 - b. One of most powerful forms of societal stress is poverty
 - (a) Why? Less equality, less power, and greater vulnerability; run-down communities, higher crime rates, fewer educational and job opportunities, and greater risk for health problems
 - c. As would be predicted by the model, rates of GAD are higher in lower SES groups
 - d. Since race is closely tied to income and job opportunities in the United States, it also is tied to the prevalence of GAD
 - (a) In any given year, about 6 percent of African Americans vs. 3.1 percent of white Americans suffer from GAD

- (b) African American women have the highest rates (6.6 percent)
 - (c) If, however, income and job opportunity are held steady across races, this racial difference disappears
 - (d) Multicultural researchers have not found a heightened rate of GAD among Hispanics in the United States
 - e. Although poverty and other social pressures may create a climate for GAD, other factors clearly are at work
 - (a) Most people living in dangerous environments do not develop GAD
 - (b) Other models attempt to explain why some develop the disorder and others do not
2. The psychodynamic perspective
- a. Freud believed all children experience anxiety and use ego defense mechanisms to help control it
 - (a) Realistic anxiety results from actual danger
 - (b) Neurotic anxiety results when children are prevented from expressing id impulses
 - (c) Moral anxiety results when children are punished for expressing id impulses
 - (d) Some children experience particularly high levels of anxiety, or their defense mechanisms are particularly inadequate, and they may develop GAD
 - b. Today's psychodynamic theorists often disagree with specific aspects of Freud's explanation but most continue to believe the disorder can be traced to inadequate parent-child relationships
 - c. Some researchers have found some support for the psychodynamic perspective:
 - (a) People with GAD are particularly likely to use defense mechanisms (especially repression)
 - (b) Children who were severely punished for expressing id impulses have higher levels of anxiety later in life
 - d. Some scientists question whether these studies show what they claim to show, for example
 - (a) Discomfort with painful memories or "forgetting" in therapy is not necessarily defensive
 - e. Some data contradict the model:
 - (a) Many (if not most) GAD clients report normal childhood upbringings
 - f. Psychodynamic therapies
 - (a) Use the same general techniques for treating all dysfunction:
 - (i) Free association
 - (ii) Therapist interpretation of transference, resistance, and dreams
 - (b) Specific treatment for GAD:
 - (i) Freudians focus less on fear and more on control of id
 - (ii) Object-relations therapists attempt to help patients identify and settle early relationship conflicts
 - (c) Overall, controlled research has not typically shown psychodynamic approaches to be helpful in treating cases of GAD
 - (d) Short-term dynamic therapy may be beneficial in some cases
3. The humanistic perspective
- a. Theorists propose that GAD, like other psychological disorders, arises when people stop looking at themselves honestly and acceptingly
 - b. This view is best illustrated by Carl Rogers's explanation:
 - (a) Lack of "unconditional positive regard" in childhood leads to harsh self-standards, known as "conditions of worth"
 - (b) These threatening self-judgments break through and cause anxiety, setting the stage for GAD to develop
 - c. Practitioners of Rogers's treatment approach, "client-centered" therapy, focus on the creation of an accepting environment where they can show positive regard and empathize with clients

- (a) Although case reports have been positive, controlled studies have only sometimes found client-centered therapy to be more effective than placebo or no therapy
 - (b) Further, only limited support has been found for Rogers's explanation of causal factors
4. The cognitive perspective
- a. Proponents believe that psychological problems are caused by dysfunctional ways of thinking
 - b. Since GAD is characterized by excessive worry (a cognitive symptom), this model is a good start
 - c. Initially, cognitive theorists suggested that GAD is caused primarily by maladaptive assumptions
 - d. Albert Ellis proposed that the presence of basic irrational assumptions lead people to act in inappropriate ways, for example:
 - (a) It is a necessity for humans to be loved by everyone
 - (b) It is catastrophic when things are not as I want them
 - (c) If something is fearful, I should be terribly concerned and dwell on the possibility of its occurrence
 - (d) I should be competent in all domains to be a worthwhile person
 - (e) When these assumptions are applied to everyday life, GAD may develop
 - e. Similarly, another theorist is Aaron Beck, who argued that those with GAD hold unrealistic silent assumptions implying imminent danger:
 - (a) Any strange situation is dangerous
 - (b) A situation/person is unsafe until proven safe
 - f. Research supports the presence of both of these types of assumptions in GAD, particularly about dangerousness
 - g. What kinds of people are likely to have exaggerated expectations of danger?
 - (a) Those whose lives have been filled with unpredictable negative events
 - (i) To avoid being "blindsided," they try to predict events; they look everywhere for danger (and therefore see danger everywhere)
 - (b) Studies have found some support for this explanation
 - h. New Wave Cognitive Explanations
 - (a) In recent years, three new explanations have emerged:
 - (i) Metacognitive theory developed by Wells; holds that people with GAD implicitly hold both positive and negative beliefs about worrying
 - (ii) Intolerance of uncertainty theory; holds that certain individuals believe that any possibility of a negative event occurring means it is *likely* to occur and they are prone to worry about it
 - (iii) Avoidance theory developed by Borkovec; holds that worrying serves a "positive" function for those with GAD by reducing unusually high levels of bodily arousal
 - (b) Both theories have received considerable research support
 - i. There are two kinds of cognitive therapy:
 - (a) Changing maladaptive assumptions—based on the work of Ellis & Beck:
 - (i) Ellis's rational-emotive therapy (RET):
 1. Point out irrational assumptions
 2. Suggest more appropriate assumptions
 3. Assign related homework
 4. This model has limited research, but findings are positive
 - (ii) Beck's cognitive therapy
 1. Similar to his depression treatment (see Ch. 8)
 2. Shown to be helpful in reducing anxiety to tolerable levels
 - (b) Helping clients understand the special role that worrying plays and changing their views about it
 - (i) Focusing on worrying

1. Therapists begin with psychoeducation about worrying and GAD
2. Assign self-monitoring of bodily arousal and cognitive responses
3. As therapy progresses, clients become increasingly skilled at identifying their worrying and its counterproductivity
4. With continued practice, clients are expected to see the world as less threatening; to adopt more constructive ways of coping; and to worry less
- (ii) Research has begun to indicate that a concentrated focus on worrying is a helpful addition to traditional cognitive therapy
5. The biological perspective
 - a. Biological theorists hold that GAD is caused chiefly by biological factors
 - b. This model is supported by family pedigree studies
 - (a) Blood relatives more likely to have GAD (~15 percent) compared to general population (~6 percent); The closer the relative, the greater the likelihood
 - (i) There is, however, the issue of shared upbringing
 - c. One biological factor that has been examined is GABA inactivity
 - (a) In the 1950s, researchers determined that benzodiazepines (Valium, Xanax) reduced anxiety—Why?
 - (i) Neurons have specific receptors (lock and key)
 - (ii) Benzodiazepine receptors ordinarily receive gamma-aminobutyric acid (GABA, a common NT in the brain)
 - (iii) GABA is an inhibitory messenger; when received, it causes a neuron to STOP firing
 - (b) In the normal fear reaction:
 - (i) Key neurons fire more rapidly creating general state of excitability experienced as fear/anxiety
 - (ii) Continuous firing triggers a feedback system; brain & body activities work to reduce the level of excitability
 - (iii) Some neurons release GABA to inhibit neuron firing, thereby reducing experience of fear/anxiety
 - (iv) Problems with the feedback system are theorized to cause GAD
 1. It may be: GABA too low, too few receptors, ineffective receptors
 - (c) Promising (but problematic) explanation:
 - (i) Other NTs also bind to GABA receptors
 - (ii) Research conducted on lab animals—is fear in animals really like anxiety in humans?
 - (iii) Issue of causal relationships—do physiological events *cause* anxiety? How can we know? What are alternative explanations?
 - d. Biological treatments
 - (a) Antianxiety drugs
 - (i) Pre-1950s treatments were barbiturates (sedative-hypnotics)
 - (ii) Post-1950s treatments were benzodiazepines:
 1. Benzodiazepines provide temporary, modest relief but can cause rebound anxiety with withdrawal and cessation of use
 2. Physical dependence is possible
 3. Benzodiazepines also have undesirable effects (drowsiness, etc.)
 4. Benzodiazepines also multiply the effects of other drugs (especially alcohol)
 - (iii) In recent decades, still other drugs have become available
 1. These medications work on different receptors but boast the same effectiveness with fewer problems
 - (b) Relaxation training
 - (i) Theory: Physical relaxation leads to psychological relaxation

- (ii) Research indicates that relaxation training is more effective than placebo or no treatment
- (iii) Best when used in combination with cognitive therapy or biofeedback
- (c) Biofeedback
 - (i) Uses electrical signals from the body to train people to control physiological processes
 - (ii) Most widely used = EMG; provides feedback about muscle tension
 - (iii) Found to be most effective when used in combination for the treatment of certain medical problems (e.g., headache, back pain, etc.)

IV. PHOBIAS

- A. From the Greek word for “fear,” phobias are defined as persistent and unreasonable fears of particular objects, activities, or situations
 - 1. Formal names also are often from the Greek (See A Closer Look on p. 138 in the text)
- B. People with phobia often avoid the object or thoughts about it
- C. All of us have our areas of special fear—it is a normal and common experience
 - 1. How do these “normal” experiences differ from phobias?
 - a. More intense and persistent fear
 - b. Greater desire to avoid the feared object/situation
 - c. Distress which interferes with functioning
- D. Most phobias are categorized as “specific;” there also are two broader kinds: social phobia and agoraphobia (discussed later):
 - 1. Specific phobias
 - a. Specific phobias are defined as persistent fears of specific objects or situations
 - b. When exposed to the object or situation, sufferers experience immediate fear
 - c. The most common specific phobias are of specific animals or insects, heights, enclosed spaces, thunderstorms, and blood
 - d. Specific phobias affect about 8.7 percent of the U.S. population in any given year and about 12 percent at some point in their lives
 - (a) Many sufferers have more than one at a time
 - (b) Women outnumber men 2:1
 - (c) The prevalence of the disorder differs across racial and ethnic minority groups
 - (d) Vast majority of sufferers *do not* seek treatment
 - 2. Social phobias
 - a. Social phobias are defined as severe, persistent, and irrational fears of social or performance situations in which embarrassment may occur
 - (a) They may be *narrow*—talking, performing, eating, or writing in public
 - (b) They may be *broad*—general fear of functioning inadequately in front of others
 - (c) In *both* cases, people judge themselves as performing more inadequately than they actually did
 - b. Social phobias can greatly interfere with functioning and often are kept secret
 - c. Social phobias affect about 7.1 percent of U.S. population in any given year
 - (a) Women outnumber men 3:2
 - d. The disorders often begin in childhood and may persist for many years
 - e. There are some indications that social phobias may be more common among African Americans and Asian Americans than white Americans
- E. What Causes Phobias?
 - 1. Each model offers explanations, but evidence tends to support the behavioral explanations:
 - a. Phobias develop through classical conditioning
 - (a) Once fears are acquired, they are continued because feared objects are avoided
 - b. Phobias develop through modeling, that is, through observation and imitation

- c. Phobias may develop into GAD when large numbers are acquired through the process of stimulus generalization: responses to one stimulus also are produced by similar stimuli
 - d. Behavioral explanations have received some empirical support:
 - (a) Classical conditioning studies with Little Albert
 - (b) Modeling studies by Bandura including confederates, buzz, and shock
 - e. The research conclusion is that phobias *can* be acquired in these ways, but there is no evidence that the disorder is *ordinarily* acquired in this way
2. Another promising model is the behavioral-biological explanation
- a. Theorists argue that there is a species-specific biological *predisposition* to develop certain fears
 - (a) Called “preparedness,” this theory posits that humans are more “prepared” to acquire phobias around certain objects or situations and not others
 - (b) The model explains why some phobias (snakes, heights) are more common than others (grass, meat)
 - (c) It is unknown if these predispositions are due to evolutionary or environmental factors
- F. How Are Phobias Treated?
- 1. Surveys reveal that about 19 percent of those with specific phobia and 24.7 percent of those with social phobia currently are in treatment
 - 2. All models offer treatment approaches
 - 3. Behavioral techniques (exposure treatments) are most widely used, especially for *specific phobias*
 - a. They are shown to be highly effective and fare better in head-to-head comparisons
 - b. These models include desensitization, flooding, and modeling:
 - (a) Systematic desensitization, a technique developed by Joseph Wolpe
 - (i) Teach relaxation skills
 - (ii) Create fear hierarchy
 - (iii) Pair relaxation with feared object or situations
 - 1. Since relaxation is incompatible with fear, the relaxation response is thought to substitute for the fear response
 - (iv) Two types:
 - 1. In vivo desensitization—Live
 - 2. Covert desensitization—Imaginal
 - (b) Flooding
 - (i) Forced nongradual exposure to feared objects or situations
 - (c) Modeling
 - (i) Therapist confronts the feared object while the fearful person observes
 - c. Clinical research supports these treatments
 - d. The key to success is *actual* contact with the feared object or situation
 - 4. Treatments for social phobias have only recently been successful
 - a. Two components must be addressed:
 - (a) Overwhelming social fear—address behaviorally with exposure
 - (b) Lack of social skills—social skills and assertiveness trainings have proved helpful
 - b. Unlike specific phobias, social phobias respond well to medication (particularly antidepressant drugs)
 - c. Several types of psychotherapy have proved at least as effective as medication
 - (a) People treated with psychotherapy are less likely to relapse than people treated with medication alone
 - (b) One psychological approach is exposure therapy, either in an individual or group setting
 - (c) Cognitive therapies also have been widely used

- d. Another treatment option is social skills training, a combination of several behavioral techniques to help people improve their social skills
 - (a) Therapist provides feedback and reinforcement

V. PANIC DISORDER

- A. Panic, an extreme anxiety reaction, can affect anyone when a real threat suddenly emerges; the experience of “panic attacks,” however, is different
- B. Panic attacks are periodic, short bouts of panic that occur suddenly, reach a peak, and pass
 - 1. Sufferers often fear they will die, go crazy, or lose control, in the presence of no *real* threat
- C. Lots of people can experience a panic attack but some people have panic attacks *repeatedly* and *unexpectedly* and *without apparent reason*
 - 1. They may be suffering from panic disorder
 - 2. Sufferers also experience dysfunctional changes in thinking and behavior as a result of the attacks (i.e., worry persistently about having an attack; plan)
- D. Panic disorder is often (but not always) accompanied by agoraphobia (Greek for “fear of the marketplace”)
 - 1. There has only recently been a recognition of the link between agoraphobia and panic attacks (or panic-like symptoms)
 - 2. Those with panic disorder and agoraphobia are afraid to leave home and travel to locations from where escape might be difficult or help unavailable
 - a. The intensity of the disorder may fluctuate
 - 3. There are two related diagnoses: Panic disorder with (or without) agoraphobia
- E. Panic disorder affects about 2.8 percent of U.S. population per given year and close to 5 percent of U.S. population in their lifetime
 - 1. The disorder is likely to develop in late adolescence and early adulthood
 - 2. The ratio of women to men is 2:1
 - 3. The prevalence of the disorder is the same across various cultural and racial groups in the United States and seems to occur in equal numbers in cultures across the world
 - 4. Around 35 percent of those with panic disorder are in treatment
- F. The biological perspective
 - 1. In the 1960s, it was recognized that people with panic disorder were helped more by antidepressants than by the benzodiazepines use for treating anxiety
 - 2. Researchers worked backward from their understanding of antidepressant drugs
 - a. What biological factors contribute to panic disorder?
 - (a) NT at work is norepinephrine—it is irregular in folks with panic attacks
 - (b) Research suggests that panic reactions are related to changes in norepinephrine activity in the locus cereleus
 - (c) While norepinephrine clearly is linked to panic disorder, recent research indicates that the root of panic attacks is more complicated; they tie the experience to brain circuits, especially including the amygdala
 - (d) It also is unclear as to why some people have such biological abnormalities:
 - (i) An inherited biological predisposition is possible
 - (ii) If so, prevalence should be (and is) greater among close relatives:
 - 1. Among monozygotic (MZ or identical) twins = 24 to 31 percent
 - 2. Among dizygotic (DZ or fraternal) DZ twins = 11 percent
 - 3. Drug therapies
 - a. Antidepressants are effective at preventing or reducing panic attacks, whether or not the panic disorder is accompanied by depressive symptoms
 - b. These drugs restore proper activity of norepinephrine in the locus ceruleus and other parts of the panic brain circuit
 - c. They bring at least some improvement to 80 percent of patients with panic disorder

- (a) About half recover markedly or fully, and improvements can last indefinitely as long as the drugs are continued
 - d. Some benzodiazepines (especially Xanax (alprazolam)) also have proved helpful
 - e. Both antidepressants and benzodiazepines also are helpful in treating panic disorder with agoraphobia
 - (a) As the drugs eliminate or reduce panic attacks, confidence to journey out into public places returns
 - (b) Some people need combination treatment (medications + behavioral exposure therapy) to overcome their agoraphobic fears fully
- G. The cognitive perspective
 1. Cognitive theorists have come to recognize that biological factors are only part of the cause of panic attacks
 2. In their view, full panic reactions are experienced only by people who *misinterpret* physiological events occurring within the body
 3. Cognitive treatment is aimed at changing such misinterpretations
 4. Panic-prone people may be very sensitive to certain bodily sensations and may misinterpret them as signs of a medical catastrophe (leading to panic)
 5. In biological challenge tests, researchers produce hyperventilation or other biological sensations by administering drugs or by instructing clinical research participants to breathe, exercise, or simply think in certain ways
 - a. Participants with panic disorder experience greater upset than those without the disorder
 6. Why might some people be prone to such misinterpretations?
 - a. Experience more frequent or intense bodily sensations
 - b. Poor coping skills
 - c. Lack of social support
 - d. Unpredictable childhoods
 - e. Overly protective parents
 7. Whatever the precise causes, panic-prone people generally have a high degree of “anxiety sensitivity”
 - a. They focus on bodily sensations much of the time, are unable to assess them logically, and interpret them as potentially harmful
 8. Cognitive therapy
 - a. Cognitive therapists try to correct people’s misinterpretations of their bodily sensations:
 - (a) Step 1: Educate clients:
 - (i) About the general nature of panic attacks
 - (ii) About the actual causes of bodily sensations
 - (iii) About their tendency of misinterpretation
 - (b) Step 2: Teach the application of more accurate interpretations (especially when stressed)
 - (c) Step 3: Teach anxiety coping skills, for example, relaxation, breathing
 - b. May also use “biological challenge” procedures to induce panic sensations so that clients can apply their new skills under watchful supervision
 - (a) Induce physical sensations which cause feelings of panic:
 - (i) Jump up and down
 - (ii) Run up a flight of steps
 - c. According to research, cognitive therapy often is helpful in panic disorder:
 - (a) 85 percent panic-free for two years vs. 13 percent for controls
 - (b) Cognitive therapy is only sometimes helpful for panic disorder with agoraphobia
 - (c) Cognitive therapy is at least as helpful as antidepressants
 - (d) Combination therapy may be most effective and is still under investigation

VI. OBSESSIVE-COMPULSIVE DISORDER

- A. Obsessive-compulsive disorder is comprised of two components:
 1. Obsessions—persistent thoughts, ideas, impulses, or images that seem to invade a person’s consciousness
 2. Compulsions—repetitive and rigid behaviors or mental acts that people feel they must perform in order to prevent or reduce anxiety
- B. This diagnosis may be called for when symptoms:
 1. Feel excessive or unreasonable
 2. Cause great distress
 3. Take up much time
 4. Interfere with daily functions
- C. This disorder is classified as an anxiety disorder because obsessions cause intense anxiety while compulsions are aimed at preventing or reducing anxiety
 1. Anxiety rises if obsessions or compulsions are resisted
- D. Between 1 and 2 percent of people throughout the world has OCD in a given year, between 2–3 percent at some point during their lifetime
 1. It is equally common in men and women and among different racial and ethnic groups
- E. It is estimated that more than 40 percent of these with OCD seek treatment
- F. What are the Features of Obsessions and Compulsions?
 1. Obsessions are thoughts that feel intrusive and foreign; attempts to ignore or resist them trigger anxiety
 - a. They take various forms: wishes, impulses, images, ideas, or doubts
 - b. They have common themes: dirt/contamination, violence/aggression, orderliness, religion, sexuality
 2. Compulsions are “voluntary” behaviors or mental acts that feel mandatory/unstoppable
 - a. Many individuals recognize that their behaviors are irrational but they believe, though, that without them, something terrible will happen
 - b. Performing the behaviors reduces anxiety but ONLY FOR A SHORT while
 - c. Behaviors often develop into detailed *rituals*
 - d. Compulsions also have common forms/themes: cleaning, checking, order or balance, touching, verbal &/or counting
- G. Are obsessions and compulsions related?
 1. Most (but not all) people with OCD experience both
 - a. Compulsive acts are often a response to obsessive thoughts
 - b. Compulsions seem to represent a *yielding* to obsessions
 - c. Also compulsions sometimes serve to help *control* obsessions
 2. Many with OCD worry that they will act on their obsessions but most of these concerns are unfounded
 - a. Compulsions usually do not lead to violence or “immoral” conduct
- H. OCD was once among the least understood of the psychological disorders
 1. In recent decades, however, researchers have begun to learn more about it
 2. The most influential explanations are from the psychodynamic, behavioral, cognitive, and biological models:
 - a. The psychodynamic perspective
 - (a) Anxiety disorders develop when children come to fear their id impulses and use ego defense mechanisms to lessen the anxiety
 - (b) OCD differs in that the “battle” is not unconscious—it is played out in dramatic thoughts and actions
 - (i) Id impulses = obsessive thoughts
 - (ii) Ego defenses = counter-thoughts or compulsive actions
 - (c) According to psychodynamic theorists, three ego defense mechanisms are particularly common:
 - (i) Isolation—Disown disturbing thoughts
 - (ii) Undoing—Perform acts to “cancel out” thoughts
 - (iii) Reaction formation—Take on lifestyle in contrast to unacceptable impulses

- (d) Freud traced OCD to the anal stage of development
 - (i) Not all psychodynamic theorists agree
- (e) Psychodynamic therapies
 - (i) Therapy goals are to uncover and overcome underlying conflicts and defenses
 - (ii) The main techniques are free association and interpretation
 - (iii) Research has offered little evidence; some therapists now prefer to treat these patients with short-term psychodynamic therapies
- b. Behaviorists have concentrated on explaining and treating compulsions rather than obsessions
 - (a) The model focuses on learning by chance; people happen on compulsions randomly:
 - (i) In a fearful situation, they coincidentally perform a particular act (washing hands)
 - (ii) When the threat lifts, they link the improvement with the random act
 - (iii) After repeated associations, they believe the compulsion is changing the situation—bringing luck, warding away evil, etc.
 - (iv) The act becomes a key method of avoiding or reducing anxiety
 - (b) The key investigator is Stanley Rachman
 - (i) Compulsions do appear to be rewarded by an eventual decrease in anxiety
 - (c) Behavioral Therapy: Exposure & Response Prevention (ERP)
 - (i) Clients repeatedly are exposed to anxiety-provoking stimuli and told to resist responding with compulsions
 - (ii) Therapists often model the behavior while the client watches
 - (iii) Treatment is offered in individual and group settings
 - (iv) Between 55 and 85 percent of clients have been found to improve considerably with ERP, and improvements often continue indefinitely
 - (v) However, as many as 25 percent fail to improve at all, and the approach is of limited help to those with obsessions but no compulsions
- c. The cognitive perspective
 - (a) Cognitive theorists point out that everyone has repetitive, unwanted, and intrusive thoughts
 - (b) Those with OCD, however, blame themselves for such thoughts and expect that terrible things will happen as a result
 - (c) To avoid such negative outcomes, they try to neutralize their thoughts with actions (or other thoughts)
 - (i) Neutralizing thoughts/actions may include:
 1. Seeking reassurance
 2. Thinking “good” thoughts
 3. Washing
 4. Checking
 - (ii) When a neutralizing action reduces anxiety, it is reinforced
 - (iii) The client becomes more convinced that the thoughts are dangerous
 - (iv) As fear of thoughts increases, the number of thoughts increases
 - (d) In support of this explanation, studies have found that people with OCD experience intrusive thoughts more often than other people. If everyone has intrusive thoughts, why do only some people develop OCD?
 - (i) According to this model, people with OCD tend:
 1. To be more depressed than others
 2. To have exceptionally high standards of conduct and morality
 3. To believe thoughts are equivalent to actions and are capable of bringing harm
 4. To believe that they should have perfect control over their thoughts and behaviors
 - (e) Cognitive therapists focus on the cognitive processes that help to produce and maintain obsessive thoughts and compulsive acts and may include:

- (i) Psychoeducation
- (ii) Habituation training
- (f) Research suggests that a combination of the cognitive and behavioral models (CBT) often is more effective than either intervention alone
- d. The biological perspective
 - (a) Family pedigree studies provided the earliest hints that OCD may be linked in part to biological factors
 - (i) Studies of twins found a 53 percent concordance rate in identical twins versus 23 percent in fraternal twins
 - (ii) Currently, more direct genetic studies are being conducted to try to pinpoint the cause of the genetic predisposition
 - (b) In recent years, two additional lines of research have uncovered promising evidence:
 - (i) NT = Serotonin
 - 1. Evidence that serotonin-based antidepressants reduce OC symptoms
 - 2. Recent studies have suggested that other NTs may also play important roles in OCD
 - (ii) Abnormal functioning in key regions of the brain
 - 1. OCD linked to orbitofrontal cortex and caudate nuclei which compose brain circuit that converts sensory information into thoughts and actions
 - 2. Either area may be too active, letting through troublesome thoughts and actions
 - (iii) Some research support and evidence that these two lines may be connected:
 - 1. Serotonin plays a key role in the operation of the orbitofrontal cortex and the caudate nuclei
 - 2. Abnormal NT activity might interfere with the proper functioning of those brain parts
 - (c) Biological therapies include serotonin-based antidepressants, including Anafranil (clomipramine), Prozac (fluoxetine), Luvox (fluvoxamine)
 - (i) These medications bring improvement to 50 to 80 percent of those with OCD
 - (ii) Relapse occurs if medication is stopped
 - (d) Research suggests that combination therapy (medication + cognitive behavioral therapy approaches) may be most effective and may have same effect on the brain

LEARNING OBJECTIVES

1. Distinguish between fear and anxiety.
2. Describe each of the anxiety disorders and how common these disorders are.
3. Discuss the major theories and treatments for generalized anxiety disorder.
4. Describe the features of panic disorder and discuss the biological and cognitive explanations and therapies of this disorder.
5. Define phobia; then describe agoraphobia, social phobia, and specific phobia; discuss the major theories and treatments for phobias.
6. Distinguish between obsessions and compulsions. Discuss the major theories and treatments for obsessive-compulsive disorder.

KEY TERMS

agoraphobia	exposure and response prevention	norepinephrine
alprazolam	exposure treatments	obsession
amygdala	family pedigree study	obsessive-compulsive disorder
anal stage	fear	orbitofrontal cortex
antianxiety drug	fear hierarchy	panic attacks
antidepressant drugs	flooding	panic disorder
anxiety	fluoxetine	panic disorder with agoraphobia
anxiety disorder	fluvoxamine	participant modeling
anxiety sensitivity	free association	phobia
assertiveness training	free-floating anxiety	preparedness
avoidance theory	gamma-aminobutyric acid (GABA)	rational-emotive therapy
basic irrational assumptions	generalized anxiety disorder	reaction formation
benzodiazepines	intolerance of uncertainty theory	realistic anxiety
biofeedback	in vivo desensitization	relaxation training
biological challenge test	isolation	resistance
bupirone	locus ceruleus	sedative-hypnotic drugs
caudate nuclei	lorazepam	serotonin
classical conditioning	maladaptive assumptions	social phobia
client-centered therapy	metacognitive theory	social skills training
clomipramine	metaworries	specific phobia
cognitive therapy	modeling	stimulus generalization
compulsion	moral anxiety	systematic desensitization
conditioned response	neuromodulator	transference
conditioned stimulus	neurotic anxiety	unconditional positive regard
conditions of worth	neutralizing	unconditioned response
covert desensitization	new wave cognitive explanations	unconditioned stimulus
diathesis-stress		undoing
dreams		unpredictable negative events
diazepam		virtual reality
electromyograph (EMG)		

MEDIA RESOURCES

Abnormal Psychology Student Tool Kit

Produced and edited by Ronald J. Comer, Princeton University and Gregory Comer, Princeton Academic Resources. Tied directly to the CyberStudy sections in the text, this Student Tool Kit offers 57 intriguing Video Cases running three to seven minutes each. The Video Cases focus on persons affected by disorders discussed in the text. Students first view the video and then answer a series of thought-provoking questions. Additionally, the Student Tool Kit contains multiple-choice practice test questions with built-in instructional feedback for every option.

Video Cases and Discussions:

- How does worrying affect psychological functioning?
- How disruptive are obsessions and compulsions?
- Observe treatments for anxiety disorders.

Practical, Research, and Decision-Making Exercises:

- Identifying and correcting irrational assumptions
- Distinguishing bothersome fears from phobias
- Detecting superstitions and habits in everyday life

PowerPoint Slides

Available at the Instructor's site on the companion Web site are comprehensive PowerPoint slide presentations and supplemental student handouts for Chapter 5. The slide files reflect the main points of the chapter in significant detail. Student handouts were created using the instructor slides as a base, with key points replaced as "fill-in" items. Answer keys and suggestions for use also are provided.

DSM-IV-TR Masters

- B-9 DSM-IV-TR Diagnostic Criteria for Generalized Anxiety Disorder
- B-10 DSM-IV-TR Diagnostic Criteria for Specific Phobia
- B-11 DSM-IV-TR Diagnostic Criteria for Social Phobia
- B-12 Criteria for Panic Attack
- B-13 Criteria for Agoraphobia
- B-14 DSM-IV-TR Diagnostic Criteria for Panic Disorder without Agoraphobia
- B-15 DSM-IV-TR Diagnostic Criteria for Obsessive-Compulsive Disorder

Internet Sites

Please see Appendix A for full and comprehensive references.

Sites relevant to Chapter 5 material are:

<http://www.ocfoundation.org>

This comprehensive site, homepage of the Obsessive Compulsive Foundation, details both research and treatment of obsessive-compulsive disorder.

<http://www.anxietynetwork.com/gahome.html>

This site is the Anxiety Network International's Generalized Anxiety Home Page, filled with information about the disorder.

<http://www.socialphobia.org/>

This site is the home page of the Social Phobia/Social Anxiety Association.

<http://www.nimh.nih.gov/health/publications>

This site provided by the National Institute of Mental Health supplies downloadable links to PDF files and booklets on a variety of mental health topics.

<http://anxiety.psy.ohio-state.edu/>

This Web site is part of the Anxiety and Stress Disorders Clinic at Ohio State University. It offers informa-

tion to understand anxiety as well as a link for treatment options and therapies.

<http://www.adaa.org/>

Homepage of the Anxiety Disorders Association of America, this site is dedicated to the research, education, and treatment of anxiety disorders. It includes helpful links to finding a therapist, the different types of anxiety disorders, support groups, and other resources.

<http://www.npadnews.com/>

This Web site is concerned with anxiety, panic attacks, and other phobias. It offers links to different forms of anxiety disorders including social anxiety disorder, posttraumatic stress disorder, and obsessive-compulsive disorder. It also has current articles on the topic.

<http://www.mentalhealth.com/dis/p20-an03.html>

This is the "Internet Mental Health Site" page for social phobia and includes an assessment measure.

<http://www.apa.org/topics/topicanxiety.html>

Run by the APA, this site is home to very good information on panic disorder and its treatments.

<http://www.geonius.com/ocd>

This site provides links to various sites on obsessive-compulsive disorder.

Mainstream Films

Films relevant to Chapter 5 material are listed and summarized below.

Key to Film Listings:

P = psychopathology focus

T = treatment focus

E = ethical issues raised

Please note that some of the films suggested may have graphic sexual or violent content due to the nature of certain subject matters.

As Good as It Gets

From 1997, this Academy award-winning film details the trials and tribulations of a writer (Jack Nicholson) dealing with obsessive-compulsive disorder. **P, comedy**

The Aviator

From 2004, this biopic stars Leonardo DiCaprio as the obsessive Howard Hughes. **P, serious film**

Copycat

This 1996 film stars Sigourney Weaver as a forensic psychologist who develops agoraphobia as the result of an assault. Her help is needed to capture a psychopath who is copying the crimes of renowned serial killers. **P, T, serious/commercial film**

Matchstick Men

From 2003, this Nicholas Cage film follows Roy, a grifter with obsessive-compulsive tendencies. **P, commercial film**

Unstrung Heroes

This comedy-drama follows a boy who moves in with his “crazy” uncles. **P, commercial film**

Vertigo

This Hitchcock classic from 1958 stars Jimmy Stewart as a police detective overcome with a severe case of acrophobia—a deep fear of heights. **P, serious/commercial film**

What About Bob?

From 1991, this comedy stars Bill Murray as a neurotic, insecure new patient attempting to see a pre-eminent psychiatrist (played by Richard Dreyfuss). Failing that, Murray stalks Dreyfuss and his family while they vacation. **P, T, E, comedy/commercial film**

Other Films:

Annie Hall (1977) anxiety disorder. **P, comedy**

Compulsion (1959) compulsion. **P, serious film**

Fear Strikes Out (1957) anxiety disorder and depression. **P, T, serious film**

High Anxiety (1977) anxiety, treatment. **T, comedy/commercial film**

Punch-Drunk Love (2002) social phobia, Type A personality pattern. **P, commercial/serious film**

Comer Video Segments

Available as a supplement, this revised set of videotapes contains short clips depicting various topics related to abnormal psychology. Please see the accompanying Video Guide for specific clips linked to Chapter 5.

Recommendations for Purchase or Rental

The Comer Video Segments include excerpts from many superb clinical documentaries. While the seg-

ments alone are ideal for use in lectures, it often is useful to assign the entire documentary for special class screenings or library use by students. The following videos and other media are available for purchase or rental and appropriate for use in class or for assignment outside of class.

Phobias: Overcoming the Fear

Filmmakers Library, Inc.
122 E. 58th Street, Suite 703A
New York, NY 10022
(212) 889-3820

Anxiety Disorders: Psychology of Abnormal Behavior

Magic Lantern Communications
1075 North Service Road West, Suite 27
Oakville, ON L6M 2G2 Canada
Phone: 905-827-2755
Fax: 905-827-2655
TOLL-FREE:
Phone: 800-263-1717
Fax: 866-852-2755
www.magiclantern.ca

Fight or Flight?: Overcoming Panic and Agoraphobia

Guilford Publications, Inc.
72 Spring Street
New York, NY 10012
tel: (800) 365-7006
or (212) 431-9800
fax: (212) 966-6708
(800) 365-7006
www.guilford.com

I Think They Think . . . : Overcoming Social Phobia

Guilford Publications, Inc.
72 Spring Street
New York, NY 10012
tel: (800) 365-7006
or (212) 431-9800
fax: (212) 966-6708
(800) 365-7006
www.guilford.com

CLASS DEMONSTRATIONS AND ACTIVITIES

Case Study

Present a case study to the class.

Relaxation Training

Invite students to participate in a mini-session of relaxation training. Students who choose not to participate should be encouraged to sit quietly. Lead the class in a 15-minute session of progressive muscle relaxation, meditation, or autogenic training. Several excellent books are available for such activities.

Panel Discussion

Have students volunteer (or assign them) to portray mental health “workers” from different theoretical perspectives in a panel discussion. Each student should present the main explanation and treatment for the anxiety disorders from his or her theoretical background. Students in the audience can ask questions of the panelists. Additionally, other students can role-play patients suffering from particular anxiety disorders. [NOTE: A brief reminder about sensitivity and professionalism is worthwhile here.] Have the panelists or audience members attempt to make a diagnosis.

“It’s Debatable: Psychotherapy or psychopharmacology?” (see Preface instructions for conducting this activity)

Have students volunteer (or assign them) in teams to opposite sides of the debate topic. Have students present their cases in class following standard debate guidelines.

Group Work: Rational and Irrational Fears (Phobias)

Phobia was the Greek god of fear. The scary face of Phobia was painted on the shields of Greek warriors to strike fear into the hearts of their opponents. Ask different groups of students to generate lists of rational and irrational fears. A comparison of the lists will generate disagreement. Inevitably, an irrational fear on one list will appear on the rational fear list of another group. Discuss how mental health professionals distinguish irrational from rational fears, given that there is no easy agreement. Phobias evoke intense anxiety and avoidant behaviors that interfere greatly with everyday living and usually require professional treatment.

Group Work: Common Student Phobias

Before dividing into groups, ask the whole class to generate a list of typical situations that make students

anxious. Next, divide the class into small groups, then ask each group to develop a strategy for coping with one of the situations. This is a good method to create a discussion and solicit suggestions to change behaviors without embarrassing students.

A complementary exercise is to tally the fears of class members (you can ask students to write them down to preserve anonymity), then discuss the most common fears. If the class is typical of the American population, public speaking will rank very high. It is beneficial to have the class determine which of the fears are specific and which are social phobias. Sometimes this is easy (e.g., fear of storms, fear of spiders, fear of bats), but social phobias may be mislabeled as specific (e.g., fear of eating in restaurants, fear of blushing).

Diathesis-Stress Model

Direct genetic causation of illness and abnormal behavior is rare. Recent research has indicated that many illnesses are now understood in terms of the interaction of hereditary and environmental factors, the diathesis-stress model. According to this theory, certain genes or hereditary vulnerability give rise to a diathesis or a constitutional predisposition. When an individual’s predisposition is then combined with certain kinds of environmental stress, illness may result. With diseases like heart disease, high blood pressure, and cancer, both hereditary and environmental factors play a role. A major effort in abnormal research and clinical practice is to identify specific risk factors in a given individual, including both family history and personal lifestyle, then predict the onset of a mental disorder.

Howard Hughes and Obsessive-Compulsive Disorder

The following list provides an interesting look at Howard Hughes’s obsessive-compulsive behavior. You can display this information about his odd behavior in the form of an overhead transparency. Use this list to start a discussion of any relative’s or friend’s behaviors that might also be considered obsessive-compulsive. Be certain the students do not become too personal in their discussions.

- Hughes would not touch any object unless he first picked up a tissue (which he called “insulation”) so that he would never directly touch an object that might expose him to germs.
- Hughes saved his own urine in mason jars; hundreds of them were stored in his apartment. From

time to time a staff member would covertly empty some of the filled jars.

- Hughes saved his newspapers in high stacks—so many of them that visitors sometimes had to weave carefully through a room to avoid toppling them.
- Hughes sometimes watched one film (his favorite was *Ice Station Zero*) more than a hundred times before switching to another. Similarly, he might have gone for days eating the same food (e.g., chicken noodle soup and one flavor of Baskin-Robbins ice cream) and no others.
- Hughes used heroin and other drugs.

“Pretend, for a moment, that you just had a panic attack . . .”

On an overhead or slide, show the symptoms of panic attacks. Ask students to pretend that they have just experienced one (be aware that some have actually had panic attacks). Ask students what their reaction to these symptoms might be. Students likely will suggest that they would go to a hospital emergency room or assume that there was something seriously wrong. Encourage them to imagine that the panic attack was the worst experience of their life. Lead them to see that

they would be intensely fearful of another panic attack. Using the process of questioning, help them to see how panic disorder (fear of more panic attacks, leading to misinterpretation of otherwise benign somatic experiences) can lead to more panic attacks.

“Here’s \$25,000 to be awarded to . . .”

Divide students into groups, then ask each group to propose a method to reduce the occurrence of one of the causes of heart disease, such as smoking, drinking, and being overweight. Have the groups present their ideas, then have a class vote to see which group receives the grant to implement the group’s idea.

Let’s Write a Self-Help Best-Seller (see Preface instructions for conducting this activity)

Ask students for ideas on how to write a self-help manual on overcoming severe shyness (which might be diagnosable as social phobia), a traumatic experience (such as childhood abuse), or panic. Ideas for self-help interventions should include a rationale for why they might work.

SUGGESTED TOPICS FOR DISCUSSION

Open Discussion: How Fears Change with Age

Lead a discussion of how an individual’s fears change with age. Many fears increase or decrease during certain stages of life. Cite examples such as the young child’s fear of the dark and the college student’s fear of academic failure. What are some major fears of college students? Discuss how certain fears increase with age, whereas other fears decrease.

Open Discussion: Student Phobias

Make an overhead transparency or slide of A Closer Look, p. 138 in the text, and discuss the list. State that students should mention only phobias that “friends” have. Have students speculate on why phobias were given such technical and complicated labels. One clever explanation is that when professionals can’t treat and understand something, they give it an unpronounceable name so that the patient can understand why progress is slow. Until behavioral therapy techniques proved successful, phobias were resistant to change.

Brainstorming Session: Reducing Stress

Ask students to volunteer something that students could do to alleviate stress. This generally evokes a wide variety of suggestions, illustrating how personal the experience of stress can be.

Psychology and Medical Health

The major causes of morbidity (illness) and mortality (death) have changed in the last century. In the early 1900s, viruses and bacteria were the leading causes of death. Ask students what happened to change this. (Medical and scientific advances such as antibiotics, vaccinations, and improvements in sanitation helped stamp out these causes of death.) Presently, leading causes of death include heart disease (related to smoking, eating, not exercising, being overweight, drinking too much), cancer, motor vehicle accidents, and suicide. Ask students what these causes have in common (all are related to behavior). Psychology is thus becoming increasingly important in overall health care. In particular, the field of health psychology is emerging as an important area of the health care system.

ASSIGNMENTS/EXTRA CREDIT SUGGESTIONS

“Write a Pamphlet”

With the use of a software program like Microsoft Publisher or simply paper and markers, students can create a pamphlet on one or all of the anxiety disorders. Students should be encouraged to be as accurate and up-to-date as possible and also to present all sides of the disorder (e.g., alternate treatment approaches or theories).

Keep a Journal

In addition to helping students synthesize material, this activity also is helpful in developing writing skills. Have students keep a journal of their thoughts on course material through the semester. This can be done in the first or last five minutes of class or as an out-of-class assignment. Faculty generally should have students submit their journals for review on an ongoing basis as students can have the tendency to delay writing until the end of the semester. Some suggestions for journal topics include: reactions to the case examples; strengths and weaknesses of prevailing theoretical explanations; hypothetical conversations with sufferers of specific disorders, etc.

Anxiety Disorders on Television and in the Movies

To emphasize the idea that disorders have specific criteria, have students report on diagnosable mental illnesses they encounter on television or in the movies. Students should document the specific behaviors or experiences that a character is exhibiting that fulfill the diagnostic criteria. This assignment helps emphasize the difference between the appearance of a disorder and meeting criteria for a disorder, that is, the difference between popular and professional conceptions of mental illness. If assignments are turned in prior to the lecture on particular disorders, you can use the information generated to enhance your lecture and to give these disorders a more personal touch.

Abnormal Psychology Student Tool Kit Video Questions

As a homework assignment, have students watch a video clip and answer the accompanying questions. Students can answer the questions directly into the online assessment feature. The results of these quizzes report to the site's built-in grade book.

Web Site Quiz

For homework or extra credit, have students complete the Web site quiz for Chapter 5 located on the companion Web site. Students can complete an on-line test of the key chapter material (using questions NOT from the test bank) and have their scores e-mailed directly to the course instructor.

Essay Topics

For homework or extra credit, have students write an essay addressing the following topic:

Write an essay comparing and contrasting the various anxiety disorders. Do you agree with the diagnostic criteria? Is it too “easy” or “hard” to get a particular diagnosis?

Research Topics

For homework or extra credit, have students write a research report addressing one (or more) of the following topics:

- (1) Conduct a “Psych Info” search and write an annotated bibliography on treatments for the various anxiety disorders. What model(s) are the current studies examining?
- (2) Choose a popular press book on anxiety disorders/anxiety disorder treatment from the Self-Help section of your local bookstore. Read and review the text and critically evaluate the findings. What theoretical model does the text endorse? Do you agree with the author's presentation of the disorder/treatment?
- (3) Write a research report on the various biological treatments for anxiety disorders.
- (4) Conduct an Internet search on the various drugs listed in Table 5-4. What is their availability online? What is the popular press about them?

Film Review

To earn extra credit, have students watch one (or more) of the mainstream films listed earlier in this chapter and write a brief (3–5) page report. Students should summarize the plot of the film in sufficient detail to demonstrate familiarity, but should focus their papers on the depiction of psychological abnormality. What errors or liberties did the filmmaker take? What is the

message (implicit or explicit) concerning the mentally ill?

Case Study Evaluations

To complement the Comer and Gorenstein supplemental case study text, case study evaluations have been created. Students can be assigned the appropriate case study and evaluation as homework or for class discussion. While case study evaluation questions are listed in their entirety on the companion Web site at www.worthpublishers.com/comer, the relevant case studies are referenced below.

Case Study 2: Panic Disorder

Case Study 3: Obsessive-Compulsive Disorder

Web-Based Case Study

Nine Web-based case studies have been created and posted on the companion Web site. These cases describe the individual's history and symptoms and are

accompanied by a series of guided questions which point to the precise DSM-IV-TR criteria for each disorder. Students can both identify the disorder and suggest a course of treatment. Students can be assigned the appropriate case study and questions as homework or for class discussion. The cases relevant to Chapter 5 are referenced below.

The Case of Tina: Anxiety and Panic Disorders

The Case of Jake: Obsessive-Compulsive Disorder

The Case of Allison: Generalized Anxiety Disorder

Crossword Puzzles

As a homework assignment or for extra credit, have students complete and submit Crossword Puzzle #5.

Word Searches

As a homework assignment or for extra credit, have students complete and submit Word Search #5.

