CHAPTER SUMMARY

Although everyday experiences of fear and anxiety are not pleasant, they often are useful. Unfortunately, some people suffer from such disabling fear and anxiety that they cannot lead normal lives. Their discomfort is too severe or too frequent, lasts too long, or is triggered too easily. These people are said to have an anxiety disorder or a related kind of disorder, such as obsessive-compulsive disorder, all of which are examined in this chapter.

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
- Agoraphobia
- What Causes Phobias?
- How Are Phobias Treated?

**Social Anxiety Disorder**
- What Causes Social Anxiety Disorder?
- Treatments for Social Anxiety Disorder

**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
Obsessive-Compulsive-Related Disorders: Finding a Diagnostic Home

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 being in danger
      3. Both fear and anxiety have the same physiological features: increase in respiration, perspiration, muscle tension, and so on
   B. Although unpleasant, experiences of fear/anxiety are useful
      1. They prepare us for action—for “fight or flight”—when danger threatens
      2. However, for some people, the discomfort is too severe or too frequent, lasts too long, or is triggered too easily
      a. These people are said to have an anxiety or related disorder

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 suffers from one or another of the DSM-5 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 five disorders characterized as anxiety disorders:
      1. Generalized anxiety disorder (GAD)
      2. Specific phobia
      3. Agoraphobia panic disorder
      4. Social anxiety disorder
      5. Panic disorder
   F. Anxiety also plays a major role in a different group of problems called obsessive-compulsive and related disorders
   G. Most individuals with one anxiety disorder suffer from a second as well
      1. In addition, many individuals with an anxiety disorder also experience depression

III. GENERALIZED ANXIETY DISORDER (GAD)
[Video: How Does Anxiety Affect Pain?]?
   A. This disorder is characterized by excessive anxiety under most circumstances and worry about practically anything
      1. GAD sometimes is called “free-floating” anxiety
   B. Symptoms include restlessness, easy fatigue, irritability, muscle tension, and/or sleep disturbance and last at least 6 months
   C. The disorder is common in Western society
      1. As many as 4 percent of the U.S. population have symptoms of the disorder 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, Hurricane Katrina in 2005, Haiti earthquake in 2010)
      b. One of most powerful forms of societal stress is poverty
         (a) Why? Less equality, less power, and greater vulnerability; rundown
             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. Because race is closely tied to stress in the United States, it also is tied to the
         prevalence of GAD
         (a) In any given year, African Americans are 30 percent more likely than
             white Americans to suffer from GAD
         (b) Multicultural researchers have not consistently found a heightened rate of
             GAD among Hispanics in the United States, although they do note the
             prevalence of nervios in that population
      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. Psychodynamic therapies
         (a) Use the same general techniques for treating all dysfunction:
             (i) Free association
Therapist interpretation of transference, resistance, and dreams

(b) Specific treatment for GAD:
   (i) Freidians 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 typically shown psychodynamic approaches to be of only modest help in treating cases of GAD

(d) Short-term dynamic therapy may be the exception to this trend

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’ 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’ 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’ explanation of GAD and other forms of abnormal behavior

4. The cognitive perspective
   a. Followers of this model suggest that psychological problems are caused by dysfunctional ways of thinking
   b. Because GAD is characterized by excessive worry (a cognitive symptom), these theorists have had much to say
   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; when these assumptions are applied to everyday life, GAD may develop—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. 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. 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 maintains that certain individuals consider it unacceptable that negative events may occur, even if the possibility is very small; they worry in an effort to find “correct” solutions
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) All of these theories have received considerable research support.

h. There are two kinds of cognitive approaches:

(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.
   (b) Helping clients understand the special role that worrying plays and changing their views about it:
      (i) Breaking down 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 their misguided attempts to control their lives by worrying
         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) Biological relatives more likely to have GAD (~15 percent) compared to the general population (~6 percent); the closer the relative, the greater the likelihood.
   (i) There is, however, the competing explanation 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 (like a lock and key)
      (ii) Benzodiazepine receptors ordinarily receive gamma-aminobutyric acid (GABA, a common neurotransmitter 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 a general state of excitability experienced as fear/anxiety
      (ii) Continuous firing triggers a feedback system; brain and body activities work to reduce the level of excitability
      (iii) Some neurons release GABA to inhibit neuron firing, thereby reducing the 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 neurotransmitters may play important roles in anxiety and GAD
      (ii) Research conducted on lab animals—is fear in animals really like anxiety in humans? (See sidebar on text p. 139.)
      (iii) Issue of causal relationships—do physiological events cause anxiety? How can we know? What are alternative explanations?
Research conducted in recent years indicates that the root of GAD is probably more complicated than a single neurotransmitter.

d. Biological treatments
(a) Anti-anxiety 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. In particular, it has been discovered that a number of antidepressant and antipsychotic medications are helpful in the treatment of GAD
(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 = electromyograph (EMG); provides feedback about muscle tension
(iii) Found to have a modest effect but has its greatest impact when used in combination for the treatment of certain medical problems (e.g., headache, back pain, etc.)

IV. PHOBIAS
[Video: Agoraphobia; Avatars Online: A New Direction In Psychotherapy; Exposure Treatment for an Elevator Phobia; Overcoming A Dog Phobia; Social Anxiety Disorder and Cognitive Behavioral Therapy: A Case Study; Specific Phobias, Panic Disorder, and Social Anxiety Disorder: 3 Cases]

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 Greek words
B. People with phobias often avoid the object or situation as well as 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 that interferes with functioning
   2. Most phobias technically are categorized as “specific”; there also are two broader kinds: agoraphobia and social anxiety disorder
D. Specific phobias
   1. Specific phobias are defined as a persistent fear of a specific object or situation
   2. When exposed to the object or situation, sufferers experience immediate fear
   3. The most common specific phobias are of specific animals or insects, heights, enclosed spaces, thunderstorms, and blood
   4. Specific phobias affect about 9 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 phobia at a time  
b. Women outnumber men at least 2:1  
c. The prevalence of the disorder differs across racial and ethnic minority groups;  
   the reason is unclear  
d. The vast majority of sufferers do not seek treatment  

E. What causes specific 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 and Rosenthal included 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)  

F. How are specific phobias treated?  
   1. Surveys reveal that 19 percent of those with a specific phobia currently are in  
      treatment  
   2. All models offer treatment approaches  
   3. Behavioral techniques (exposure treatments) are the most widely used  
      a. 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. Because 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—Imagined  
         (b) Flooding  
            (i) Forced nongradual exposure to feared objects or situations  
         (c) Modeling  
            (i) Therapist confronts the feared object while the fearful person  
                observes  
      b. Clinical research supports these treatments  
      c. The key to success is actual contact with the feared object or situation  
      d. A growing number of therapists are using virtual reality as a useful exposure  
         tool  

G. Agoraphobia
People with agoraphobia are afraid of being in situations where escape might be difficult, should they experience panic or become incapacitated. In any given year, about 2 percent of adults experience this problem, women twice as frequently as men. The disorder also is twice as common among poor people versus wealthy ones. At least one-fifth of those with agoraphobia are in treatment. People typically develop agoraphobia in their 20s or 30s. It is typical of people with agoraphobia to avoid crowded places, driving, and public transportation. In many cases the intensity of the agoraphobia fluctuates.

Explanation for agoraphobia

1. Although broader than specific phobias, agoraphobia is often explained in ways similar to specific phobias.
2. Many also are prone to experience extreme and sudden explosions of fear—called “panic attacks”—and may receive a second diagnosis of panic disorder.

How is agoraphobia treated?

1. Behavioral therapy with an exposure approach is the most common and effective treatment for agoraphobia. Therapists help clients venture farther and farther from their homes to confront the outside world. Therapists use exposure techniques similar to those used for treating a specific phobia but, in addition, use support groups and home-based self-help programs.
2. Between 60–80 percent of clients with agoraphobia who receive exposure treatment find it easier to enter public places and the improvement lasts for years. Unfortunately, improvements are often partial, rather than complete, and relapses are common.

V. SOCIAL ANXIETY DISORDER

A. Social anxiety disorder is defined as severe, persistent, and irrational fears of social or performance situations in which scrutiny by others and embarrassment may occur.
   1. They may be narrow—talking, performing, eating, or writing in public.
   2. They may be broad—general fear of functioning inadequately in front of others.
   3. In both forms, people judge themselves as performing less competently than they actually did.

B. This disorder was called social phobia in past editions of the DSM.

C. This disorder can greatly interfere with functioning and often is kept secret.

D. Social phobias affect about 7.1 percent of U.S. population in any given year.
   1. Sixty percent of those affected are women.

E. The disorders often begin in childhood and may continue into adulthood.

F. Research finds that poor people are 50 percent more likely than wealthier people to experience social phobia.

G. There are some indications that social phobias may be more common among African Americans and Asian Americans than white Americans.

H. What causes social anxiety disorder?
   1. The leading explanation has been proposed by cognitive theorists and researchers.
   2. They contend that people with this disorder hold a group of social beliefs and expectations that consistently work against them, including:
      a. Unrealistically high social standards.
      b. Views of themselves as unattractive and socially unskilled.
   3. Cognitive theorists hold that, because of these beliefs, people with social anxiety disorder anticipate that social disasters will occur, and they perform “avoidance” and “safety” behaviors to prevent them.
   4. In addition, after a social event, they review the details and overestimate how poorly things went or what negative results will occur.
I. Treatments for social anxiety disorder
   1. Only in the past 15 years have clinicians been able to treat social anxiety disorder successfully
   2. 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
   3. Unlike specific phobias, social fears respond well to medication (particularly antidepressant drugs)
   4. 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
   5. Social skills training, a combination of several behavioral techniques, also is used to help people improve their social skills
      a. Therapist provides feedback and reinforcement
      b. In addition, social skills training groups and assertiveness training groups allow clients to practice their skills with other group members

VI. 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. More than one-quarter of all people have one or more panic attacks at some point in their lives, 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 affects about 2.8 percent of the U.S. population per given year and close to 5 percent of the U.S. population in their lifetimes
      1. The disorder is likely to develop in late adolescence and early adulthood
      2. The ratio of women to men is 2:1
      3. Poor people are 50 percent more likely than wealthier people to experience these disorders
      4. 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
      5. Around one-third of those with panic disorder are in treatment
   E. Panic disorder is often (but not always) accompanied by agoraphobia
      1. 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. In such cases, the panic disorder typically sets the stage for the development of agoraphobia
   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 used for treating anxiety
      2. Researchers worked backward from their understanding of antidepressant drugs
         a. What biological factors contribute to panic disorder?
(a) Norepinephrine is the NT at work—it is irregular in folks with panic attacks.
(b) Research suggests that panic reactions are related to changes in norepinephrine activity in the locus coeruleus.
(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, the rate is as high as 31 percent.
      2. Among dizygotic (DZ or fraternal) twins, the rate is only 11 percent.
      3. Drug therapies:
         a. Antidepressants are effective at preventing or reducing panic attacks.
         b. These drugs restore proper activity of norepinephrine in the locus coeruleus and other parts of the panic brain circuit.
         c. They bring at least some improvement to 80 percent of patients with panic disorder.
            i. Improvements can last indefinitely, as long as the drugs are continued.
         d. Some benzodiazepines (especially Xanax [alprazolam]) also have proved helpful.
            i. They seem to indirectly affect the activity of norepinephrine in the brain.

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. Have experienced more trauma-filled events over the course of their lives.
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 that 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) Around 80 percent panic-free for 2 years vs. 13 percent for controls
(b) Cognitive therapy is at least as helpful as antidepressants
(c) Combination therapy may be most effective and is still under investigation

VII. OBSESSIVE-COMPULSIVE DISORDER

A. Obsessive-compulsive disorder comprises 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 to prevent or reduce anxiety

B. This diagnosis is 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 suffer from OCD in a given year, as many as 3 percent at some point during their lifetimes
1. It is equally common in men and women and among different racial and ethnic groups
2. The disorder usually begins by young adulthood and typically persists for many years, although symptoms may fluctuate over time

E. It is estimated that more than 40 percent of these individuals 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 unreasonable, but they believe 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, and/or counting

G. Are obsessions and compulsions related?
1. Most 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 unreasonable 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 a lifestyle in contrast to unacceptable impulses
      (d) Freud traced OCD to the anal stage of development
         (i) Overall, research has not supported the psychodynamic explanation
      (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 (e.g., 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, and so on
         (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 and response prevention (ERP)
         (i) Clients repeatedly are exposed to anxiety-provoking stimuli and told to resist responding with compulsions
         (ii) Many behavior therapists now use this technique in individual and group therapy formats
         (iii) Homework is an important component
         (iv) Between 55 and 85 percent of clients have been found to improve considerably with ERP, and improvements often continue indefinitely
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) Guiding the client to identify, challenge, and change distorted cognitions.
   (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 clues 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.
   (b) In recent years, two additional lines of research have uncovered more direct evidence:
      (i) Abnormal serotonin activity
         1. Evidence that serotonin-based antidepressants reduce OCD 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 the brain circuit that converts sensory information into thoughts and actions
         2. Either area may be too active, letting through troublesome thoughts and actions.
Some research supports 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 1 cognitive behavioral therapy approaches) may be most effective

I. Obsessive-Compulsive-Related Disorders
1. In recent years, a growing number of clinical researchers have linked some excessive behavior patterns (e.g., hoarding, hair pulling, shopping, sex) to obsessive-compulsive disorder
2. DSM-5 has created the group name “Obsessive-Compulsive-Related Disorders” and assigned four patterns to that group: hoarding disorder, hair-pulling disorder, excoriation (skin-picking) disorder, and body dysmorphic disorder
3. Theorists typically account for obsessive-compulsive-related disorders by using the same kinds of explanations that have been applied to obsessive-compulsive disorder
4. Similarly, clinicians typically treat clients with these disorders by applying the kinds of treatment used with OCD, particularly antidepressant drugs, exposure and response prevention, and cognitive therapy
5. With their addition to the DSM, it is hoped that they will be better researched, understood, and treated

LEARNING OBJECTIVES

5.1. Distinguish between fear and anxiety.
5.2. Describe each of the anxiety disorders and how common these disorders are.
5.3. Discuss the major theories and treatments for generalized anxiety disorder.
5.4. Define phobia; then distinguish between specific phobias and agoraphobia; discuss the major theories and treatments for each type.
5.5. Discuss the characteristics, theories, and treatment of social anxiety disorder.
5.6. Describe the features of panic disorder, with or without agoraphobia, and discuss the biological and cognitive explanations and therapies of this disorder.
5.7. Distinguish between obsessions and compulsions. Discuss the major theories and treatments for obsessive-compulsive disorder.
5.8. Describe the new Obsessive-Compulsive-Related Disorders in DSM-5.
KEY TERMS

agoraphobia
amygdala
anxiety
anxiety sensitivity
basic irrational assumptions
benzodiazepines
biofeedback
biological challenge test
body dysmorphic disorder
caudate nuclei
classical conditioning
client-centered therapy
compulsion
electromyograph (EMG)
excoriating disorder
exposure and response prevention
exposure treatments
family pedigree study
fear
flooding
gamma-aminobutyric acid (GABA)
generalized anxiety disorder
hoarding disorder
isolation
locus coeruleus
modeling
neutralizing
norepinephrine
obsession
obsessive-compulsive disorder
obsessive-compulsive-related disorders
orbitofrontal cortex
panic attacks
panic disorder
phobia
preparedness
rational-emotive therapy
reaction formation
relaxation training
sedative-hypnotic drugs
serotonin
social anxiety disorder
social skills training
specific phobia
stimulus generalization
stress-management program
systematic desensitization
trichotillomania
undoing
MEDIA RESOURCES

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://anxietrynetwork.com/generalized-anxiety
The Anxiety Network International’s Generalized Anxiety Page is filled with information about the disorder.

http://www.socialphobia.org/
This site is the homepage of the Social Phobia/Social Anxiety Association.

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, including anxiety disorders.

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 Website is concerned with anxiety, panic attacks, and other phobias. It offers links to information on 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.

Created by the APA, this Fact Sheet is home to very good information on panic disorder and its treatments.

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 1995 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 preeminent 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**

Recommendations for Purchase or Rental
Films on Demand is a Web-based digital delivery service that has impressive psychology holdings. Their catalog can be accessed at [http://ffh.films.com/digitallanding.aspx](http://ffh.films.com/digitallanding.aspx). In addition, 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: (800) 263-1717
Fax: (866) 852-2755
[www.magiclantern.ca](http://www.magiclantern.ca)
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. In addition, 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 the Preface of this Instructor’s Resource Manual 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, and 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) and 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 psychology research and clinical practice is to identify specific risk factors in a given individual, including both family history and personal lifestyle, and then predict the onset of a mental disorder.

Howard Hughes and Obsessive-Compulsive Disorder

The following list provides an interesting look at Howard Hughes’ 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 100 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 lives. 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.

Let’s Write a Self-Help Best-Seller (See the Preface of this Instructor’s Resource Manual 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 anxiety disorder), 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.

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. Encourage students to be as accurate and up-to-date as possible and 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 throughout the semester. This can be done in the first or last 5 minutes of class or as an out-of-class assignment. 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, and so on.
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 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 before the lecture on particular disorders, you can use the information generated to enhance your lecture and to give these disorders a more personal touch.

Essay Topics

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

(1) 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?

(2) Describe the features of trichotillomania that are similar to those of anxiety disorders and the features that are similar to those of obsessive-compulsive disorders.

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 report (3 to 5 pages). Students should summarize the plot of the film in sufficient detail to demonstrate familiarity, but they 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 people with mental illness?