## ANXIETY DISORDERS (PHOBIAS)

- A phobia is an extreme and irrational fear of an object or situation, which is disproportionate to the actual danger involved, and leads to avoidance of that object or situation.
- A fear becomes a phobia when it begins to be maladaptive, i.e. when it begins to interfere with everyday life.
- > The typical symptoms of phobias are:
  - Intense and irrational feelings of fear and anxiety, which may be a severe panic attack
  - Avoidance behaviour, where a person may engage in extreme and complicated behaviour in order to avoid the object or situation that causes the panic attacks
  - They may have a gradual onset or may happen very quickly as a result of a particular experience
- ➤ 3 types of phobia:
  - Specific phobia-
    - Triggered immediately on exposure to a specific stimulus
    - Strong fear and avoidance of a particular object/situation
    - Quite common- affecting 10% of population
    - More common in women than men
    - E.g. fear of dogs, insects, closed room, driving
    - Blood phobia is different from other specific phobias as the person may actually faint at the sight of blood and may therefore avoid seeking medical attention
  - Social phobia-
    - Fear of social situations and of being judged by others
    - Individuals avoid social gatherings due to the irrational fear of being judged by other attendees
    - The victim feels that he will be singled out and scrutinised in the crowd, thereby leading to an embarrassing situation
    - Individuals are often very able but do not demonstrate this in front of the others because the anxiety is so debilitating
    - When social anxiety interferes with work and social life, it becomes a clinical condition
    - Occur more in women and men
    - Tend to start in early adolescence

- Seem to be more common in families where parents and relatives use shame as a way of controlling a child's behaviour
- o Agoraphobia-
  - A particular fear of open spaces
  - Suffered by 2-3% of population and majority are women
  - Research has shown that agoraphobia develops as a result of severe panic attacks that the person does not expect to happen (Barlow 2002)
  - 2 types-
    - <u>Agoraphobia as a complication of panic attacks</u>agoraphobics are anxious about having panic attacks in a public place and not being unable to find help or escape.
    - <u>Agoraphobia without panic attacks</u>- This type is less common and is characterised by a spreading fear of the environment outside the safety of the individual's own home. This fear increases gradually until the person can become housebound.
- Explanations of phobias
  - o Behavioural- classical conditioning
    - Learning through association
    - Form of conditioning where the organism associates an <u>unconditional stimulus</u> with a <u>neutral stimulus</u>. After repeated associations, the organism then responds to the neutral stimulus (now called a <u>conditional stimulus</u>) without having the unconditional stimulus present anymore.
    - The case of Little Albert
      - Watson and Reyner (1920) had 2 aims-
        - Can we condition fear in an animal (e.g. a white rat by visually presenting it and simultaneously striking a steel bar)?
        - If such a conditioned emotional response can be established, will there be a transfer to other animals or other objects?
      - Albert (11 months and 3 days old) was presented with a white rat again and as before showed no fear.

However, as he reached out to tough the rat, Watson struck an iron bar immediately behind Albert's head, who jumped violently and fell forward burying his face in the mattress. After 7 such associations, he began to cry when presented with the white rat itself.

- He began to have negative reactions towards a rabbit and a fur coat. He did not quite like cotton wool either. He even began to fear a Santa Claus mask.
- Classical conditioning may be able to explain why some of our phobias form:
  - Generalisation- when we produce a conditioned response to a stimulus that is similar to the conditioned stimulus.
  - Extinction-
- Classical conditioning procedure-
  - A conditioned stimulus (CS) happens to occur at the same time as an unconditioned stimulus (US)- or traumatic event in the case of fear conditioning- which evokes a strong unconditioned response (UR).
  - Thereafter, the previously neutral CS produces a conditioned response (CR) that resembles the UR.
  - The CR is the phobic response and the CS is the phobic object.
  - A child might by mistake startle a dog while it is eating. The startled dog (CS) jumps on the child and bites him (US). The child becomes terrified (UR) and develops a dog phobia (CR).
  - Every time he sees a dog (CS), the child is now terrified and phobic (CR).
- Maintenance of phobias can be explained by Mowrer's (1947) <u>two-process theory</u> which involves both classical and operant conditioning and is generally known as avoidance conditioning.
- It suggests that the fear develops through classical conditioning – we learn to associate an object or situation with being frightened. This fear is then maintained by operant conditioning because the person learns that their fear

is reduced by avoiding the stimulus. People will avoid contact with mice and therefore do not get the fearful response – negative reinforcement.

- The Social Learning Theory suggests that phobias can develop by observing another person's fear towards an object/situation and then modelling that behaviour when confronted with the same object/situation.
- o <u>Psychoanalytical</u>
  - Freud's theory is based on the idea that people have unconscious wishes and thoughts that cause unconscious conflict between the ego and the id or superego. The ego is threatened by unconscious conflict and fears that the anxiety caused by the conflicts will overwhelm it. Because the entire ego's energy is being used trying to cope with the anxiety or feelings of panic the ego may not be able to function at all.
  - To cope with this, the ego uses the defence mechanism <u>DISPLACEMENT</u> – the anxiety is displaced onto another object or situation. This results in a specific phobia, it is less threatening to the individual to have a phobia than it is to have the unconscious thoughts and conflicts without trying to do anything about them. Either way the person is trapped in a no-win situation since the phobia can be as debilitating as the original unconscious thoughts and desires.
  - Little Hans (1909) had unconscious sexual desires towards his mother (Oedipus complex) which caused a conflict as such desires are not socially accepted. As a result of this, he developed resentment towards his father. At the same time, he underwent a traumatic event when he watched a horse collapse and die before his eyes. Thus his anxiety and fear of castration was displaced onto horses and he developed a phobia of horses.
  - The psychodynamic approach explains **agoraphobia** as resulting from separation anxiety experienced by a young child. This is at the unconscious level and is to do with irrational thoughts that the child has about being separated from the mother and the realisation of dependency on the

caregivers. Agoraphobia serves the function of keeping the person at home, and for the unconscious, irrational mind this reduced separation anxiety. This is because, unconsciously, the person thinks that separation from either or both parents is less likely if the person is at home all the time.

- o Biomedical/Genetic-
  - Suggests that we inherit the vulnerability to develop phobias rather than the phobia itself.
  - Ost (1992) Blood-phobic (n = 81) and injection-phobic (n =59) patients fulfilling the DSM-III-R criteria for simple phobia were compared on a number of variables. There were no differences between the samples in age at onset, age at treatment, marital and occupational status, history of fainting in the phobic situation, and impairment. Higher proportions of blood-phobic subjects than of injection-phobic subjects reported having first-degree relatives with the same phobia (61% vs. 29%) and reported fearing that they were going to faint in the phobic situation (77% vs. 48%). In both samples, these proportions were higher in the subgroup with a history of fainting. Overall 62% of people with a blood and injection phobia reported a 1st-degree relative who shares the same disorder. The prevalence rate for the general population is just 3%. Injection-phobic subjects rated 2 of 11 physiological items higher than did blood-phobic subjects, but the groups did not differ on behavioural variables. Overall, the similarities were more marked than the differences, and it is suggested that these two specific phobias should be regarded as one diagnostic entity.
  - The 'preparedness explanation suggests that human beings have a genetic predisposition to develop phobias to certain items and situations, such as fear of darkness, heights open spaces and strangers. These were potential sources of danger to us thousands of years ago. Those individuals who developed such phobias would avoid harmful objects or situations and would be favoured by evolution.
  - Seligman (1971) suggested that there was a 'preparedness' (a physiological predisposition) to be sensitive to certain stimuli. It is not the fears themselves that are inborn, rather

there is an innate (in-born) tendency to rapidly acquire a phobia to potentially harmful events – we are biologically prepared from birth.

- Evidence-
  - Ohman et al (1975) conducted a study to investigate the preparedness explanation of phobia acquisition.
  - METHOD -Participants were shown pictures of houses, snakes, spiders and faces of people. Half the participants received an electric shock whenever they were presented with a picture of a house or a face. The other half received an electric shock whenever they were presented with a picture of a snake or spider.
  - RESULTS- Both groups of Pp's showed fear when subsequently shown pictures they had experienced with an electric shock. This was measured by their skin reaction called galvanic skin response (GSR). Following a period in which Pp's received no electric shocks it was found that the GSR was higher for those shocked when shown snakes and spiders.
  - CONCLUSION- Human beings may be more biologically prepared or ready to develop phobias for animals such as snakes and spiders, which may threaten survival.

## o Cognitive-

- Suggests that the fearful response is experienced due to the interpretation or appraisal of events. It is the interpretation of an event that triggers the emotion and not the event itself.
- Phobias form and persist due to three main factors-
  - Sensitisation: The sufferer becomes unusually 'sensitive' to an object. Anxiety becomes associated with a particular object/situation so that the presence of (or thinking about) it is enough to automatically trigger anxiety. They may also be hypersensitive to their own body's anxious responses - e.g. their breathing or heart rate. This has been described as cognitive vulnerability (Clark, 1996).

- Avoidance: After sensitisation occurs a person will avoid an object/situation and this becomes rewarding because the anxiety decreases.
- Irrational or negative thought processes: Negative self-talk/negative images – these include 3 basic distortions:
  - Over-estimating a negative outcome 'what if the snake bites me and is poisonous'
  - Catastrophising 'There would be antidote and I would be disabled or die'
  - Under-estimating ability to cope 'I'd never be able to cope in a wheelchair'
- **DiNardo et al. (1988)** reported that 56% of dog phobics had an unpleasant encounter but about 50% of normal controls had also had such experiences and did not develop a phobia. Behaviourism ignores cognitive factors and so cannot account for individual variation. The fact that not all phobics have had a bad experience and some non-phobics have had a bad experience and not developed phobia is probably due to the patients' perception and interpretation, and so *cognitive* rather than behavioural factors are important.

## Treating phobias

• Systematic desensitisation-

- Involves the gradual exposure of the sufferer to the phobic object
- Developed by Wolpe (1958) is based on the idea that two emotions cannot occur at the same time (reciprocal inhibition).
- It is also based on the idea that since according to behaviourism, a phobia is learned, it can be unlearned. The end point should recondition the patient so that the conditioned stimulus (phobic stimulus) produces a conditioned response of relaxation and not fear.
- It involves 3 phases:

- Training in relaxation- getting the patient to practise relaxation techniques when feelings of tension and anxiety arise
- Hierarchy construction- a stepped approach to getting the patient to face the object or situation of their phobia
- Counter-conditioning- uses extinction (when the conditioned stimulus no longer produces a conditioned response. This could be because the conditioned stimulus has no longer been paired with the unconditioned stimulus). A new response of relaxation is made to neutralise the old response of fear in the presence of the conditioned stimulus.

## o Flooding

- Involves sudden, overweening exposure to the phobic object
- overwhelming the individual's senses with the item or situation that causes anxiety so that the person realises that no harm will occur and in fact there is no objective basis for their fear
- it uses the idea behind classical conditioning in a less gentle manner
- The patient is exposed to the largest anxiety-provoking stimuli straight away (usually direct contact with the stimulithis is called in vivo). Obviously, the patient is going to feel extreme levels of fear and anxiety. However, this dies off rapidly as the body cannot sustain such a high level of arousal for a long time.
- Therefore, the fear and anxiety will diminish. As a result of the phobic stimulus not causing any more fear, the patient quickly learns that there is nothing to be afraid off.
- The association between phobic stimulus and fear has been broken to form a new relationship of phobia stimulus producing calm.
- Applied tension
  - Applied muscle tension is a technique developed by Ost in 1989 to help people with blood and injury phobias.
  - Ost noted that when confronted with the phobic stimulus of blood, people with blood phobia have the opposite bodily

reaction to that of people with other phobias when confronted with their phobic stimulus: people with blood phobia have a drop in blood pressure and heart rate and they often faint.

- Ost reasoned that making these people tense their muscles would raise their bp and heart rate, so that they could not have the phobic reaction of fainting at the sight of blood.
- They had to repeatedly contract the major muscle groups of the arms and legs to decrease vasovagal (fainting) reactions when highly anxious. It has been reported to increase cerebral blood flow.
- Ost compared the applied tension technique to the relaxation technique and found that both helped considerably, but applied tension produced clinically meaningful improvement in 90% while relaxation only in 60%. (Ost et al, 1989 and 19991).
- o CBT
  - Aims to replace unrealistic and fearful thinking about phobias with more realistic mental habits.
  - It teaches patients to identify, challenge and replace counterproductive thoughts with more constructive thinking patters.
  - Ost and Westling (1995):
  - Aim To compare cognitive behaviour therapy (CBT) with applied relaxation as therapies for panic disorder.

Method - A longitudinal study with patients undergoing therapy for panic disorder.

Design - Independent measures design with patients being randomly assigned to either applied relaxation or CBT.

Participants - 38 patients with DSM diagnosis of panic disorder, with or without agoraphobia. Recruited through referrals from psychiatrists and newspaper advertisements. 26 females and 12 males, mean age 32.6 years (range 23–45 years). From a variety of occupations and some married, some single and some divorced. Procedure - Pre-treatment: baseline assessments of panic attacks, using a variety of questionnaires (e.g. the Panic Attack Scale, Agoraphobic Cognitions Questionnaire, etc.). Patients recorded details of every panic attack in a diary. Each patient was then given 12 weeks of treatment (50–60 minutes per week), with homework to carry out between appointments.

Findings - Applied relaxation showed 65% panic-free patients after the treatment, 82% panic-free after one year. CBT showed 74% panic-free patients after the treatment and 89% panic-free after a year. These differences were not significant. Complications such as generalised anxiety and depression were also reduced to within the normal range after one year.

Conclusion - Both CBT and applied relaxation worked at reducing panic attacks, but it is difficult to rule out some cognitive changes in the applied relaxation group even though this is not focused on in this research.