Anxiety Disorders

Chapter 5

Anxiety

- What distinguishes fear from anxiety?
  - Fear is a state of immediate alarm in response to a serious, known threat to one's well-being
  - Anxiety is a state of alarm in response to a vague sense of being in danger
  - Both have the same physiological features – increase in respiration, perspiration, muscle tension, etc.

- Although unpleasant, experiences of fear and anxiety often are useful
  - They prepare us for action – for “fight or flight” – when danger threatens
  - However, for some people, the discomfort is too severe or too frequent, lasts too long, or is triggered too easily
    - These people are said to have an anxiety or related disorder
Anxiety Disorders

- Most common mental disorders in the U.S.
  - In any given year, 18% of the adult population in the U.S. experiences one of the six DSM-IV-TR anxiety disorders
    - Close to 29% develop one of the disorders at some point in their lives
    - Only one-fifth of these individuals seek treatment
  - Most individuals with one anxiety disorder also suffer from a second disorder
    - In addition, many individuals with an anxiety disorder also experience depression

Anxiety Disorders

- Six disorders:
  - Generalized anxiety disorder (GAD)
  - Phobias
  - Panic disorder
  - Obsessive-compulsive disorder (OCD)
  - Acute stress disorder
  - Posttraumatic stress disorder (PTSD)

Generalized Anxiety Disorder (GAD)

- Characterized by excessive anxiety under most circumstances and worry about practically anything
  - Often called “free-floating” anxiety
- Symptoms include: feeling restless, keyed up, or on edge; fatigue; difficulty concentrating; muscle tension, and/or sleep problems
- Symptoms must last at least six months
Generalized Anxiety Disorder (GAD)

- The disorder is common in Western society
  - As many as 4% of the US population have symptoms in any given year and ~6% at some time during their lives
- Usually first appears in childhood or adolescence
- Women are diagnosed more often than men by a 2:1 ratio
- Around one-quarter of those with GAD are currently in treatment
- A variety of theories have been offered to explain the development of the disorder...

GAD: The Sociocultural Perspective

- According to this theory, GAD is most likely to develop in people faced with social conditions that truly are dangerous
  - Research supports this theory (example: Three Mile Island in 1979, Hurricane Katrina in 2005, Haiti earthquake in 2010)
- One of the most powerful forms of societal stress is poverty
  - Why? Run-down communities, higher crime rates, fewer educational and job opportunities, and greater risk for health problems
  - As would be predicted by the model, there are higher rates of GAD in lower SES groups

GAD: The Sociocultural Perspective

- Since race is closely tied to stress in the U.S., it is not surprising that it is also tied to the prevalence of GAD
  - In any given year, African Americans are 30% more likely than white Americans to suffer from GAD
  - Multicultural researchers have not consistently found a heightened rate of GAD among Hispanics in the U.S., although they do note the prevalence of nervios in that population
GAD: The Sociocultural Perspective

- Although poverty and other social pressures may create a climate for GAD, other factors are clearly at work
  - How do we know this?
    - Most people living in “dangerous” environments do not develop GAD
    - Other models attempt to explain why some people develop the disorder and others do not...

GAD: The Psychodynamic Perspective

- Freud believed that all children experience anxiety
  - **Realistic anxiety** when they face actual danger
  - **Neurotic anxiety** when they are prevented from expressing id impulses
  - **Moral anxiety** when they are punished for expressing id impulses
  - Some children experience particularly high levels of anxiety, or their defense mechanisms are particularly inadequate, and they may develop GAD

GAD: The Psychodynamic Perspective

- Today’s psychodynamic theorists often disagree with specific aspects of Freud’s explanation
- Researchers have found some support for the psychodynamic perspective:
  - People with GAD are particularly likely to use defense mechanisms (especially repression)
  - Adults, who as children suffered extreme punishment for expressing id impulses, have higher levels of anxiety later in life
  - Some scientists question whether these studies show what they claim to show
    - Discomfort with painful memories or “forgetting” in therapy is not necessarily defensive
GAD: The Psychodynamic Perspective

- Psychodynamic therapists use the same general techniques to treat all psychological problems:
  - Free association
  - Therapist interpretations of transference, resistance, and dreams
  - Specific treatments for GAD
    - Freudians focus less on fear and more on control of id
    - Object-relations therapists attempt to help patients identify and settle early relationship problems

GAD: The Psychodynamic Perspective

- Controlled studies have typically found psychodynamic treatments to be of only modest help to persons with GAD
  - Short-term psychodynamic therapy may be the exception to this trend

GAD: The Humanistic Perspective

- Theorists propose that GAD, like other psychological disorders, arises when people stop looking at themselves honestly and acceptingly
- This view is best illustrated by Carl Rogers's explanation:
  - Lack of "unconditional positive regard" in childhood leads to "conditions of worth" (harsh self-standards)
  - These threatening self-judgments break through and cause anxiety, setting the stage for GAD to develop
GAD: The Humanistic Perspective

- Practitioners using this “client-centered” approach try to show unconditional positive regard for their clients and to empathize with them
  - Despite optimistic case reports, controlled studies have failed to offer strong support
  - In addition, only limited support has been found for Rogers’s explanation of GAD and other forms of abnormal behavior

GAD: The Cognitive Perspective

- Followers of this model suggest that psychological problems are often caused by dysfunctional ways of thinking
- Given that excessive worry – a cognitive symptom – is a key characteristic of GAD, these theorists have had much to say

GAD: The Cognitive Perspective

- Initially, theorists suggested that GAD is caused by maladaptive assumptions
  - Albert Ellis identified basic irrational assumptions:
    - It is a dire necessity for an adult human being to be loved or approved of by virtually every significant person in his community
    - It is awful and catastrophic when things are not the way one would very much like them to be
  - When these assumptions are applied to everyday life and to more and more events, GAD may develop
GAD: The Cognitive Perspective

- Aaron Beck, another cognitive theorist, argued that those with GAD constantly hold silent assumptions that imply imminent danger:
  - A situation/person is unsafe until proven safe
  - It is always best to assume the worst
- Researchers have repeatedly found that people with GAD do indeed hold maladaptive assumptions, particularly about dangerousness

GAD: The Cognitive Perspective

- New wave cognitive explanations
  - In recent years, several new explanations have emerged:
    - Metacognitive theory
      - Developed by Wells; suggests that the most problematic assumptions in GAD are the individual’s worry about worrying (meta-worry)
    - Intolerance of uncertainty theory
      - 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
  - All of these theories have received considerable research support

GAD: The Cognitive Perspective

- Two kinds of cognitive approaches:
  - Changing maladaptive assumptions
    - Based on the work of Ellis and Beck
  - Helping clients understand the special role that worrying plays, and changing their views and reactions to it
GAD: The Cognitive Perspective

• Cognitive therapies
  – Changing maladaptive assumptions
    • Ellis’s rational-emotive therapy (RET)
      – Point out irrational assumptions
      – Suggest more appropriate assumptions
      – Assign related homework
      – Studies suggest at least modest relief from treatment

GAD: The Cognitive Perspective

• Cognitive therapies
  – Breaking down worrying
    • Therapists begin by educating clients about the role of worrying in GAD and have them observe their bodily arousal and cognitive responses across life situations
    • In turn, clients become increasingly skilled at identifying their worrying and their misguided attempts to control their lives by worrying

GAD: The Cognitive Perspective

• Cognitive therapies
  – Breaking down worrying
    • With continued practice, clients are expected to see the world as less threatening, to adopt more constructive ways of coping, and to worry less
    • Research has begun to indicate that a concentrated focus on worrying is a helpful addition to traditional cognitive therapy
    • This approach is similar to mindfulness-based cognitive therapy
GAD: The Biological Perspective

- Biological theorists believe that GAD is caused chiefly by biological factors
  - Supported by family pedigree studies
    - Biological relatives more likely to have GAD (~15%) than general population (~6%)
    - The closer the relative, the greater the likelihood
      - There is, however, a competing explanation of shared environment

GAD: The Biological Perspective

- GABA inactivity
  - 1950s – Benzodiazepines (Valium, Xanax) found to reduce anxiety
  - Why?
    - Neurons have specific receptors (like a lock and key)
    - Benzodiazepine receptors ordinarily receive gamma-aminobutyric acid (GABA, a common neurotransmitter in the brain)
      - GABA carries inhibitory messages; when received, it causes a neuron to stop firing

GAD: The Biological Perspective

- In normal fear reactions:
  - Key neurons fire more rapidly, creating a general state of excitability experienced as fear or anxiety
  - A feedback system is triggered – brain and body activities work to reduce excitability
    - Some neurons release GABA to inhibit neuron firing, thereby reducing experience of fear or anxiety
  - Malfunctions in the feedback system are believed to cause GAD
    - Possible reasons: Too few receptors, ineffective receptors
GAD: The Biological Perspective

- Promising (but problematic) explanation
  - Recent research has complicated the picture:
    - Other neurotransmitters also bind to GABA receptors
  - Issue of causal relationships
    - Do physiological events CAUSE anxiety? How can we know? What are alternative explanations?

GAD: The Biological Perspective

- Biological treatments
  - Antianxiety drug therapy
    - Early 1950s: Barbiturates (sedative-hypnotics)
    - Late 1950s: Benzodiazepines
      - Provide temporary, modest relief
      - Rebound anxiety with withdrawal and cessation of use
      - Physical dependence is possible
      - Produce undesirable effects (drowsiness, etc.)
      - Mix badly with certain other drugs (especially alcohol)
    - More recently: Antidepressant and antipsychotic medications

GAD: The Biological Perspective

- Biological treatments
  - Relaxation training
    - Non-chemical biological technique
    - Theory: Physical relaxation will lead to psychological relaxation
    - Research indicates that relaxation training is more effective than placebo or no treatment
    - Best when used in combination with cognitive therapy or biofeedback
GAD: The Biological Perspective

- Biological treatments
  - Biofeedback
    - Therapist uses electrical signals from the body to train people to control physiological processes
    - Electromyograph (EMG) is the most widely used; provides feedback about muscle tension
    - Found to have a modest effect but has its greatest impact when used as an adjunct to other methods for treatment of certain medical problems (headache, back pain, etc.)

Phobias

- From the Greek word for “fear”
  - Formal names are also often from the Greek (see PsychWatch, p. 129)
- Persistent and unreasonable fears of particular objects, activities, or situations
- People with a phobia often avoid the object or thoughts about it

Phobias

- We all have our areas of special fear; this is a normal and common experience
  - How do such common fears differ from phobias?
    - More intense and persistent fear
    - Greater desire to avoid the feared object or situation
    - Distress that interferes with functioning
Phobias

• Most phobias technically are categorized as “specific”
  – Also two broader kinds:
    • Social phobia
    • Agoraphobia

Specific Phobias

• Persistent fears of specific objects or situations
• When exposed to the object or situation, sufferers experience immediate fear
• Most common: Phobias of specific animals or insects, heights, enclosed spaces, thunderstorms, and blood

Specific Phobias

• Each year close to 9% of all people in the U.S. have symptoms of specific phobia
  • More than 12% develop such phobias at some point in their lives
• Many suffer from more than one phobia at a time
• Women outnumber men at least 2:1
• Prevalence differs across racial and ethnic minority groups; the reason is unclear
• Vast majority of people with a specific phobia do NOT seek treatment
What Causes Specific Phobias?

- Each model offers explanations, but evidence tends to support the behavioral explanations:
  - Phobias develop through conditioning
    - Once fears are acquired, the individuals avoid the dreaded object or situation, permitting the fears to become all the more entrenched
    - Behaviorists propose a classical conditioning model...

Classical Conditioning of Phobia

![Classical Conditioning Diagram]

What Causes Specific Phobias?

- Other behavioral explanations
  - Phobias develop through modeling
    - Observation and imitation
  - Phobias are maintained through avoidance
  - Phobias may develop into GAD when a person acquires a large number of them
    - Process of stimulus generalization: Responses to one stimulus are also elicited by similar stimuli
What Causes Specific Phobias?

- Behavioral explanations have received some empirical support:
  - Classical conditioning study involving Little Albert
  - Modeling studies
    - Bandura, confederates, buzz, and shock
  - Although it appears that a phobia can be acquired in these ways, researchers have not established that the disorder is ordinarily acquired in this way

What Causes Specific Phobias?

- A behavioral-evolutionary explanation
  - Some specific phobias are much more common than others
  - Theorists argue that there is a species-specific biological predisposition to develop certain fears

What Causes Specific Phobias?

- A behavioral-evolutionary explanation
  - Called “preparedness” because human beings are theoretically more “prepared” to acquire some phobias than others
  - Model explains why some phobias (snakes, spiders) are more common than others (meat, houses)
    - Researchers do not know if these predispositions are due to evolutionary or environmental factors
How Are Specific Phobias Treated?

- Surveys reveal that 19% of those with specific phobia are currently in treatment
- Each model offers treatment approaches but behavioral techniques are most widely used
  - Include desensitization, flooding, and modeling—together called “exposure treatments”

How Are Specific Phobias Treated?

- **Systematic desensitization**
  - Technique developed by Joseph Wolpe
  - Teach relaxation skills
  - Create fear hierarchy
  - Pair relaxation with the feared objects or situations
    - Since relaxation is incompatible with fear, the relaxation response is thought to substitute for the fear response
  - Several types:
    - In vivo desensitization (live)
    - Covert desensitization (imaginal)

How Are Specific Phobias Treated?

- Other behavioral treatments:
  - Flooding
    - Forced non-gradual exposure
  - Modeling
    - Therapist confronts the feared object while the fearful person observes
  - Clinical research supports each of these treatments
    - The key to success is ACTUAL contact with the feared object or situation
      - A growing number of therapists are using virtual reality as a useful exposure tool
Social Phobia

- Severe, persistent, and irrational fears of social or performance situations in which embarrassment may occur
  - May be narrow – talking, performing, eating, or writing in public
  - May be broad – general fear of functioning poorly in front of others
  - In both forms, people rate themselves as performing less competently than they actually do
- Given its broad scope, this disorder is also known as social anxiety disorder

This disorder can greatly interfere with one's life

- Often kept a secret
- Surveys reveal that 7.1% of people in the U.S. experience a social phobia in any given year
  - Women outnumber men 3:2
- Phobias often begin in childhood and may persist for many years
- Research finds the poor people are 50% more likely than wealthier people to experience social phobia
  - There also are some indications of racial/ethnic differences

What Causes Social Phobia?

- The leading explanation for social phobia has been proposed by cognitive theorists and researchers
  - They contend that people with this disorder hold a group of social beliefs and expectations that consistently work against them, including:
    - Unrealistically high social standards
    - Views of themselves as unattractive and socially unskilled
What Causes Social Phobia?

- Cognitive theorists hold that, because of these beliefs, people with social phobia anticipate that social disasters will occur and they perform “avoidance” and “safety” behaviors to prevent them.
- In addition, after a social event, they review the details and overestimate how poorly things went or what negative results will occur.

Treatments for Social Phobia

- Only in the past 15 years have clinicians been able to treat social phobia successfully.
- Two components must be addressed:
  - Overwhelming social fear
    - Address fears behaviorally with exposure
  - Lack of social skills
    - Social skills and assertiveness trainings have proved helpful.

Treatments for Social Phobia

- Unlike specific phobias, social phobias are often reduced through medication (particularly antidepressants).
- Several types of psychotherapy have proved at least as effective as medication:
  - People treated with psychotherapy are less likely to relapse than people treated with drugs alone.
  - One psychological approach is exposure therapy, either in an individual or group setting.
  - Cognitive therapies have also been widely used.
Treatments for Social Phobias

• Another treatment option is social skills training, a combination of several behavioral techniques to help people improve their social functioning
  – Therapists provide feedback and reinforcement
  – In addition, social skills training groups and assertiveness training groups allow clients to practice their skills with other group members

Panic Disorder

• Panic, an extreme anxiety reaction, can result when a real threat suddenly emerges
• The experience of “panic attacks,” however, is different
  • Panic attacks are periodic, short bouts of panic that occur suddenly, reach a peak, and pass
  • Sufferers often fear they will die, go crazy, or lose control
  • Attacks happen in the absence of a real threat

Panic Disorder

• 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, unexpectedly, and without apparent reason
• Diagnosis: Panic disorder
  • Sufferers also experience dysfunctional changes in thinking and behavior as a result of the attacks
    • For example, they may worry persistently about having an attack or plan their behavior around possibility of future attack
Panic Disorder

- Panic disorder often (but not always) accompanied by agoraphobia
  - People are afraid to leave home and travel to locations from which escape might be difficult or help unavailable
  - Intensity may fluctuate
  - Until recently, clinicians failed to recognize the close link between agoraphobia and panic attacks (or panic-like symptoms)

Panic Disorder

- DSM-IV-TR distinguishes panic disorder without agoraphobia from panic disorder with agoraphobia
  - Around 2.8% of U.S. population affected in a given year
  - Close to 5% of U.S. population affected at some point in their lives
  - Both kinds are likely to develop in late adolescence and early adulthood
  - Women are twice as likely as men to be affected
  - Poor people are 50% more likely than wealthier people to experience these disorders
  - The prevalence is the same across cultural and racial groups in the U.S. and seems to occur in cultures across the world
  - Approximately 35% of those with panic disorder are in treatment

Panic Disorder: The Biological Perspective

- In the 1960s, clinicians discovered that people with panic disorder were not helped by benzodiazepines, but were helped by antidepressants
  - Researchers worked backward from their understanding of antidepressant drugs
Panic Disorder: The Biological Perspective

• What biological factors contribute to panic disorder?
  • Neurotransmitter at work is norepinephrine
    • Research suggests that panic reactions are related to changes in norepinephrine activity in the locus ceruleus
  • Research conducted in recent years has examined brain circuits and the amygdala as the more complex root of the problem
    • It is possible that some people inherit a predisposition to abnormalities in these areas

Panic Disorder: The Biological Perspective

• If a genetic factor is at work, close relatives should have higher rates of panic disorder than more distant relatives – and they do:
  – Among monozygotic (MZ, or identical) twins, the rate is as high as 31%
  – Among dizygotic (DZ, or fraternal) twins, the rate is only 11%
    • Issue is still open to debate

Panic Disorder: The Biological Perspective

• Drug therapies
  • Antidepressants are effective at preventing or reducing panic attacks
    • Function at norepinephrine receptors in the panic brain circuit
    • Bring at least some improvement to 80% of patients with panic disorder
    • Improvements require maintenance of drug therapy
    • Some benzodiazepines (especially Xanax [alprazolam]) have also proved helpful
Panic Disorder: The Cognitive Perspective

- Cognitive theorists recognize that biological factors are only part of the cause of panic attacks.
  - In their view, full panic reactions are experienced only by people who misinterpret bodily events.
  - Cognitive treatment is aimed at correcting such misinterpretations.

- Misinterpreting bodily sensations
  - Panic-prone people may be very sensitive to certain bodily sensations and may misinterpret them as signs of a medical catastrophe, which leads to panic.
  - Why might some people be prone to such misinterpretations?
    - Experience more frequent or intense bodily sensations.
    - Have experienced more trauma-filled events over the course of their lives.

- Misinterpreting bodily sensations
  - Whatever the precise cause, panic-prone people generally have a high degree of “anxiety sensitivity”.
    - They focus on bodily sensations much of the time, are unable to assess the sensations logically, and interpret them as potentially harmful.
Panic Disorder: The Cognitive Perspective

- Cognitive therapy
  - Tries to correct people’s misinterpretations of their bodily sensations
    - Step 1: Educate clients
      - About panic in general
      - About the causes of bodily sensations
      - About their tendency to misinterpret the sensations
    - Step 2: Teach clients to apply more accurate interpretations (especially when stressed)
    - Step 3: Teach clients skills for coping with anxiety
      - Examples: relaxation, breathing

Panic Disorder: The Cognitive Perspective

- Cognitive therapy
  - May also use “biological challenge” procedures to induce panic sensations
    - Induce physical sensations, which cause feelings of panic:
      - Jump up and down
      - Run up a flight of steps
    - Practice coping strategies and making more accurate interpretations

Panic Disorder: The Cognitive Perspective

- Cognitive treatments often help people with panic disorder
  - Around 80% of treated patients are panic-free for two years compared with 13% of control subjects
  - Such treatments also are helpful for treating panic with agoraphobia; in those cases, therapists often add exposure techniques to the cognitive aspects of treatment
  - At least as helpful as antidepressants
- Combination therapy may be most effective
  - Still under investigation
Obsessive-Compulsive Disorder

- Made up of two components:
  - Obsessions
    - Persistent thoughts, ideas, impulses, or images that seem to invade a person's consciousness
  - Compulsions
    - Repetitive and rigid behaviors or mental acts that people feel they must perform to prevent or reduce anxiety

- Diagnosis is called for when symptoms:
  - Feel excessive or unreasonable
  - Cause great distress
  - Take up much time
  - Interfere with daily functions

- Classified as an anxiety disorder because obsessions cause anxiety, while compulsions are aimed at preventing or reducing anxiety
  - Anxiety rises if obsessions or compulsions are resisted
  - Between 1% and 2% of U.S. population suffer from OCD in a given year; as many as 3% over a lifetime
  - It is equally common in men and women and among different racial and ethnic groups
  - It is estimated that more than 40% of those with OCD seek treatment
What Are the Features of Obsessions and Compulsions?

- **Obsessions**
  - Thoughts that feel both intrusive and foreign
  - Attempts to ignore or resist them trigger anxiety

- Take various forms:
  - Wishes
  - Impulses
  - Images
  - Ideas
  - Doubts

- Have common themes:
  - Dirt/contamination
  - Violence and aggression
  - Orderliness
  - Religion
  - Sexuality

- **Compulsions**
  - “Voluntary” behaviors or mental acts
  - Feel mandatory/unstoppable
  - Most recognize that their behaviors are unreasonable
    - Believe, though, that something terrible will occur if they do not perform the compulsive acts
  - Performing behaviors reduces anxiety
    - ONLY FOR A SHORT TIME!
  - Behaviors often develop into rituals

• Common forms/themes:
  - Cleaning
  - Checking
  - Order or balance
  - Touching, verbal, and/or counting
What Are the Features of Obsessions and Compulsions?

• Most people with OCD experience both
• Compulsive acts often occur in response to obsessive thoughts
  – Compulsions seem to represent a yielding to obsessions
  – Compulsions also sometimes serve to help control obsessions

What Are the Features of Obsessions and Compulsions?

• Many with OCD are concerned that they will act on their obsessions
  – Most of these concerns are unfounded
  – Compulsions usually do not lead to violence or “immoral” conduct

Obsessive-Compulsive Disorder

• Was once among the least understood of the psychological disorders
• In recent decades, however, researchers have begun to learn more about it
• The most influential explanations are from the psychodynamic, behavioral, cognitive, and biological models
OCD: The Psychodynamic Perspective

- Anxiety disorders develop when children come to fear their id impulses and use ego defense mechanisms to lessen their anxiety.
- OCD differs from other anxiety disorders in that the “battle” is not unconscious; it is played out in overt thoughts and actions.
  - Id impulses = obsessive thoughts
  - Ego defenses = counter-thoughts or compulsive actions

- The battle between the id and the ego
  - Three ego defense mechanisms are common:
    - Isolation: Disown disturbing thoughts
    - Undoing: Perform acts to “cancel-out” thoughts
    - Reaction formation: Take on lifestyle in contrast to unacceptable impulses
  - Freud believed that OCD was related to the anal stage of development.
    - Period of intense conflict between id and ego
    - Not all psychodynamic theorists agree

- Psychodynamic therapies
  - Goals are to uncover and overcome underlying conflicts and defenses
  - Main techniques are free association and interpretation
  - Research has offered little evidence
    - Some therapists now prefer to treat these patients with short-term psychodynamic therapies
OCD: The Behavioral Perspective

• Behaviorists have concentrated on explaining and treating compulsions rather than obsessions
• They propose that people happen upon their compulsions quite randomly...

OCD: The Behavioral Perspective

• In a fearful situation, they happen to perform a particular act (washing hands)
  • When the threat lifts, they associate the improvement with the random act
• After repeated associations, they believe the compulsion is changing the situation
  • Bringing luck, warding away evil, etc.
• The act becomes a key method to avoiding or reducing anxiety

OCD: The Behavioral Perspective

• Key investigator: Stanley Rachman
  – Compulsions do appear to be rewarded by an eventual decrease in anxiety
OCD:
The Behavioral Perspective

- Behavioral therapy
  - Exposure and response prevention (ERP)
    - Clients are repeatedly exposed to anxiety-provoking stimuli and are told to resist performing the compulsions
    - Therapists often model the behavior while the client watches
    - 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% fail to improve at all, and the approach is of limited help to those with obsessions but no compulsions

OCD:
The Cognitive Perspective

- Cognitive theorists begin by pointing out that everyone has repetitive, unwanted, and intrusive thoughts
  - People with OCD blame themselves for normal (although repetitive and intrusive) thoughts and expect that terrible things will happen as a result

OCD:
The Cognitive Perspective

- To avoid such negative outcomes, they attempt to “neutralize” their thoughts with actions (or other thoughts)
- Neutralizing thoughts/actions may include:
  - Seeking reassurance
  - Thinking “good” thoughts
  - Washing
  - Checking
OCD: The Cognitive Perspective

- When a neutralizing action reduces anxiety, it is reinforced
  - Client becomes more convinced that the thoughts are dangerous
  - As fear of thoughts increases, the number of thoughts increases

OCD: The Cognitive Perspective

- If everyone has intrusive thoughts, why do only some people develop OCD?
  - People with OCD tend to:
    - Be more depressed than others
    - Have exceptionally high standards of conduct and morality
    - Believe thoughts are equal to actions and are capable of bringing harm
    - Believe that they can, and should, have perfect control over their thoughts and behaviors

OCD: The Cognitive Perspective

- Cognitive therapists focus on the cognitive processes that help to produce and maintain obsessive thoughts and compulsive acts
  - May include:
    - Psychoeducation
    - Guiding the client to identify, challenge, and change distorted cognitions
OCD: The Cognitive Perspective

• Cognitive-Behavioral Therapy (CBT)
  – Research suggests that a combination of the cognitive and behavioral models is often more effective than either intervention alone
  – These treatments typically include psychoeducation as well as exposure and response prevention exercises

OCD: The Biological Perspective

• Family pedigree studies provided the earliest clues that OCD may be linked in part to biological factors
  – Studies of twins found a 53% concordance rate in identical twins, versus 23% in fraternal twins

• Two recent lines of research provide more direct evidence:
  • Abnormal serotonin activity
    – Evidence that serotonin-based antidepressants reduce OCD symptoms; recent studies have suggested other neurotransmitters also may play important roles
  • Abnormal brain structure and functioning
    – OCD linked to orbitofrontal cortex and caudate nuclei
      • Frontal cortex and caudate nuclei compose brain circuit that converts sensory information into thoughts and actions
      • Either area may be too active, letting through troublesome thoughts and actions
OCD: The Biological Perspective

- Some research provides evidence that these two lines may be connected
  - Serotonin (with other neurotransmitters) plays a key role in the operation of the orbitofrontal cortex and the caudate nuclei
  - Abnormal neurotransmitter activity could be contributing to the improper functioning of the circuit

OCD: The Biological Perspective

- Biological therapies
  - Serotonin-based antidepressants
    - Clomipramine (Anafranil), fluoxetine (Prozac), fluvoxamine (Luvox)
    - Bring improvement to 50–80% of those with OCD
    - Relapse occurs if medication is stopped
  - Research suggests that combination therapy (medication + cognitive behavioral therapy approaches) may be most effective

Call for Change: DSM-5

- The DSM-5 Task Force has proposed several changes that would affect the anxiety disorders:
  - Regrouping several disorders
    - Acute stress disorder and posttraumatic stress disorder (discussed in Chapter 6) should be listed under “Trauma and Stressor Related Disorders”
    - Obsessive-compulsive disorder should be listed under “Obsessive-Compulsive and Related Disorders”
      - May be joined by hoarding disorder, hair pulling disorder and skin picking disorder
Call for Change: DSM-5

• The DSM-5 Task Force has proposed several changes that would affect the anxiety disorders:
  – Replace the term social phobia with social anxiety disorder
  – List agoraphobia as a distinct category
  – Create a new category called mixed anxiety/depression