UNIT 1 ANXIETY DISORDERS, PANIC AND PHOBIAS

Structure

1.0 Introduction

1.1 Objectives

1.2 Nature of Anxiety and Anxiety Disorders

1.3 Panic Attack: Symptoms and Clinical Features
- 1.3.1 A Case Study of Panic Attack

1.4 Epidemiology of Panic Attacks

1.5 Aetiology of Panic Disorder
- 1.5.1 Biological Factors
- 1.5.2 Psychological Factors

1.6 Treatment of Panic Disorder

1.7 Phobia: Symptoms and Clinical Features
- 1.7.1 A Case Study of Specific Phobia

1.8 Epidemiology of Phobic Disorder

1.9 Aetiology of Phobic Disorder
- 1.9.1 Biological Factors
- 1.9.2 Psychological Factors

1.10 Treatment of Phobic Disorder

1.11 Let Us Sum Up

1.12 Unit End Questions

1.13 Glossary

1.14 Suggested Readings

1.0 INTRODUCTION

Feeling anxious about how to finish this large course within stipulated time? You may welcome this anxiety, at least to a certain extent. It would help you learn quickly and to get good marks. Anxiety is, indeed, a common reaction to stress. It saves us from being careless and hence from accidental disasters. Unless you have anxiety about your examination, you would not study. Unless the mother has anxiety over her baby's health she might forget to care for the infant. Unless you have anxiety you would step over the snake and get bitten. But anxiety turns into a disorder when you are so anxious that you have a breakdown at the examination hall, forgetting everything. Anxiety is a disorder when the mother is so anxious that her baby may fall ill that she spends the day and night praying to God, and ultimately fails to feed the baby. Anxiety is a disorder when you faint if somebody names a snake.

You can readily remember many such examples from your daily life. How would you recognise pathological anxiety as different from normal anxiety? What are the various patterns that anxiety disorder may take? What are the causes of anxiety disorders?

How should you deal with it? In this Unit, and also in the following Units you would learn about some such anxiety disorders.

Anxiety disorder is a group of disorders each of which need special attention and understanding. You know that in classifying disorders, we usually follow either the Diagnostic and statistical Manual, Version IV TR (DSM IV TR) or International Classification of Diseases, Version 10 (ICD 10). According to DSM IV TR, the primary types of Anxiety disorders include:

- Panic disorder with or without agoraphobia
- Phobic disorders of the specific or social type
- Generalised anxiety disorder
- Obsessive compulsive disorder
- Post traumatic stress disorder

However in this unit, we would focus on two specific anxiety disorders in detail: Panic Disorders and Phobias. You would also read case studies exemplifying the typical symptoms. The names in all case studies are fictitious and all important identifying information has been changed to maintain anonymity of the persons.

1.1 OBJECTIVES

After you complete this unit, you will be able to:

- Define and explain anxiety and fear;
- Distinguish between normal and pathological anxiety;
- Describe the nature of anxiety disorders;
- Elucudate the symptoms of Panic disorder;
- Discuss the aetiology of Panic disorder;
- Elucidate the treatment of Panic disorder;
- Analyse Panic disorder from real life;
- Describe the symptoms of Phobic disorder;
- Explain the types of Phobic disorders;
- Discuss the aetiology of Phobic disorder; and
- Elucidate the treatment of Phobic disorder.

1.2 NATURE OF ANXIETY AND ANXIETY DISORDERS

Anxiety Disorder is a blanket term that covers a number of disorders. In this context, you must be aware of the difference between fear and anxiety. Fear is a basic emotion of human beings. It is associated with the perception of a real threatening situation and involves the 'fight or flight' response activated by the sympathetic nervous system. If a thug attacks you in the street, you would feel intense fear. Then, you would either run for dear life, or hit him back. Thus fear involves cognition of the threatening object, subjective cognition of being in danger, physiological components like increased heart rate, and behavioural components like running or hitting.

Anxiety also involves subjective perception of threat, physiological changes and some kind of behavioural reaction. But unlike fear, it has no immediate threat. If you cannot go out of your home because you are always apprehending an attack from

a hoodlum, it is anxiety. You are projecting the threatening situation in future and reacting to it as if it is imminent.

You may note that anxiety serves a kind of adaptive function as well, because it prepares a person for fight or flight if the danger really comes. But if the person avoids the very situation that in her perception may cause the danger, and if such imagined situations are unrealistic, then the effect becomes debilitating. Thus you may distinguish between adaptive anxiety and pathological anxiety by assessing the realistic probability of the occurrence of the object of anxiety and by assessing how dysfunctional it makes the person.

Before you go into learning the specific symptoms of each, you should know the common characteristics of anxiety disorders.

Cognition or subjective perception of danger which may be accompanied by vivid and occasionally morbid images of the difficulties encountered.

Physiological responses through activation of sympathetic nervous system. Usually it includes increased heart rate, trembling, breathing discomfort, dilated pupils, nausea etc.

On the behavioural level, there is usually a tendency to avoid the dreaded situation. However, in some cases, as in Obsessive compulsive disorder and some instances of Post traumatic Stress disorder, repetitive behaviour is also observed.

In this Unit, you would learn specifically about **Panic attacks and Phobias**.

Self Assessment Questions

1) What are the primary types of anxiety according to DSM IV TR?

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2) State *True* or *False* beside each statement

   a) Fear is imaginary; anxiety is response to a really possible event ( ).

   b) Real and pathological anxiety can be distinguished in terms of degree of dysfunction ( ).

   c) Sympathetic nervous system is activated during anxiety ( ).

1.3 PANIC ATTACK: SYMPTOMS AND CLINICAL FEATURES

Have you ever encountered any situation where a person has all on a sudden started behaving as if under severe stress? She sweats, almost faints and complains that she cannot breathe. People around may start thinking that she has a heart attack, but after some time she recovers and gradually becomes normal. While this may be an actual transient cardiac problem, it can also be a panic attack.

Panic attack is an episode of intense fear or apprehension with a sudden onset. Such symptoms develop abruptly and usually reach its peak within 10 - 15 minutes. During such attack the victim becomes completely overpowered by the symptoms, many of which are physiological in nature.

Panic attacks are characterised by their unexpectedness. The DSM IV TR mandates that a person would be diagnosed as suffering from panic disorder if she had

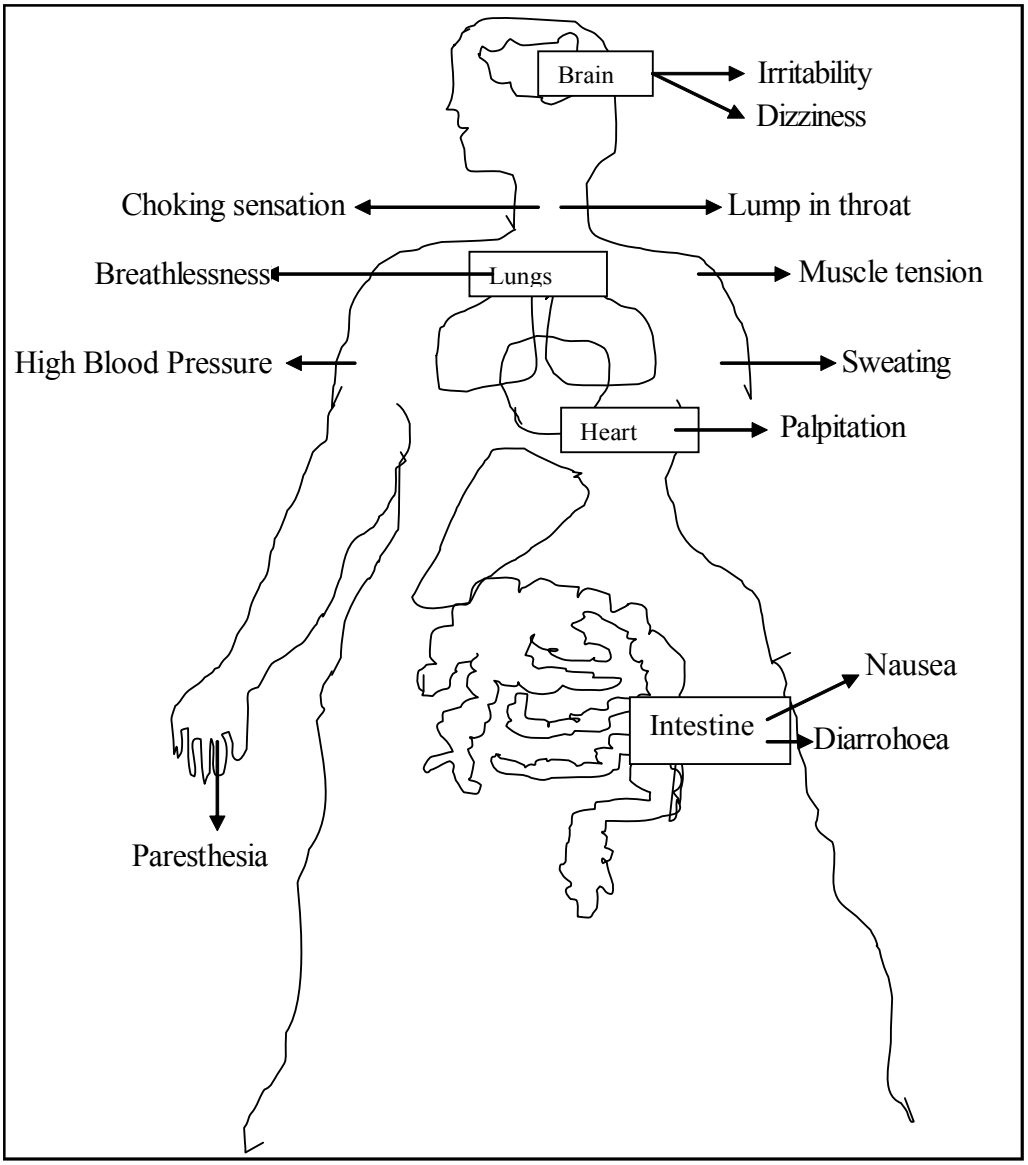
experienced recurrent unexpected attacks and is persistently concerned with having another attack. This condition must go on for at least one month. Also, the person must have at least four of the following thirteen symptoms during the attack:

- Palpitation or pounding heart
- Sweating
- Trembling or shaking
- Sensation of shortness of breath or being smothered
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, lightheaded or faint
- Derealisation or depersonalisation
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias
- Chill or hot flushes.

The typical clinical description of panic attack is featured by intense terror, at times in the form of fear of dying or going crazy. Nervousness, shaking and stress are common. The person seems to have no control on oneself. Sometimes one feels like the beginning of a heart attack, as difficulty in breathing (as if one is not getting enough air), palpitation, hyperventilation, rapid heart bits, chest pain and choking sensation along with profuse sweating predominate. Often there is a dizziness, lightheadedness, nausea and fainting. One feels dissociated from reality – one almost seems to be detached from the immediate surroundings and drawn in a whirlpool of odd sensations. Occasionally there are hot flashes or sudden chills, burning sensation in facial and neck area, tingling in fingers and toes (paresthesia). Difficulty in vision is also observed in the form of flashing vision and tunnel vision (loss of peripheral vision). The most prominent underlying characteristic is of being out of control in all respects.

The reactions are usually those associated with activation of sympathetic nervous system. You must know that panic attack is not dangerous, but it can be truly frightening. There are numerous cases when the patient has been admitted for emergency cardiac care, particularly because the symptoms are mostly physiological and mimics cardiac symptoms.

You need to be acquainted with the word ‘Agoraphobia’ in the context of panic attack. The word Agoraphobia derives from the Greek word ‘agora’ which means public places or assembly of people. Panic attacks can be with or without agoraphobia. Typically, panic attacks with agoraphobia seem to be precipitated by attending a cinema hall, a shopping mall, a cue for tickets, tunnels, trains and aircrafts or so on, where a large number of people congregate and escape in case of a panic attack may be difficult.



1.3.1 A Case Study of Panic Attack

Maya is a young lady studying at the University. She comes from a middle class family living in a suburban place. Maya is somewhat introvert, apparently cool and rational, and determined to finish her education. She regularly takes the underground Metro rail to come to the University. One day while waiting for the train, she had some kind of physical discomfort. However, she ignored it and boarded the train. The train was moderately crowded and she did not get a seat. She stood in front of the seat reserved for ladies. A few minutes later, she felt choked and nauseated, started sweating profusely and her discomfort was so strong that she asked the elderly lady sitting in front of her for help. This lady immediately offered her a seat and asked her what her problem was. By that time, Maya was trembling and had started crying. "I am going to die" – she cried. Other passengers came forward to help, gave her water to drink, and at the next station they took Maya out of the train and contacted the authority. Maya was taken to a hospital and her father was informed. By the time her father arrived, Maya had been feeling much better. The doctors had found a rapid pulse rate, but did not get anything indicating cardiac problem. Maya had retrospectively reported extreme fear of being choked to death, especially as she was in an underground train and could not jump out and run for the sunlight up on the streets.

Initially, everybody thought that this was just a stray episode. But it so happened that the experience left Maya extremely fearful of travel by underground train. She

understands that this is irrational, but cannot face traveling by underground train again. She cannot even take crowded buses. Now she takes auto rickshaws for her travel. She has to change vehicles a number of times to reach the University in time. Often she insists that her father accompany her. Her confidence has lowered considerably. She has been diagnosed of panic attack with agoraphobia.

1.4 EPIDEMIOLOGY OF PANIC ATTACKS

How prevalent is panic disorder? Estimations of prevalence of panic disorder and panic attacks at some point of life ranges between 3% to 5% of the population. It is usually more common in women, and the age of onset is usually between 15 and 24. You need to be sensitive to the fact that this gender difference may be attributed to cultural factors, as unrealistic fear is tolerated more in women, but men need to keep up a brave face. Thus, in different cultures with different gender role prescriptions, the male female ratio may change.

1.5 AETIOLOGY OF PANIC DISORDER

You must be curious to know what causes panic disorder. The aetilogy of panic disorder may be divided in biological and psychosocial factors. The biological factors include genetic factors and biochemical abnormalities in the brain. The psychosocial factors are more concerned with understanding the changes in the individual's perception which triggers panic attacks. They include learning factors and a number of cognitive variables that may trigger or maintain panic attacks. In this section you will learn about these factors in some detail.

1.5.1 Biological Factors

1) **Genetic factors:** Family and twin studies indicate that panic disorder runs in families. Identical twins seem to have greater possibilities of panic disorder, while concordance is less in fraternal twins. The specific genes responsible for panic disorder are yet to be discovered. However, there seems some evidence that panic disorder and phobia may have some genetic commonness.

2) **Brain and biochemical abnormalities:** Attempts have been made to associate panic attacks with biochemical characteristics of the brain. It has been observed that exposure to certain biochemicals generate panic attack in those who are already suffering from panic disorder, while this may not have any impact on others. Thus there has been a suggestion that there might be definite neurobiological differences between the normal persons and those with panic disorder. Some of such substances which may be considered panic provocation agents are sodium lactate, carbon dioxide, caffeine etc.

However, the brain mechanisms associated with the action of these substances are not identical and there have been suggestions that *no single neurobiological mechanism* may be held responsible for all types of panic attacks.

Some of the brain mechanisms implicated in panic attack are the increases activity in the *hippocampus and locus coeruleus*, which are responsible for monitoring external and internal stimuli and moderates brain's reactions to them. The *amygdal*a is critically important in fear reaction, and is involved in the 'fear network' of the brain. Abnormal sensitivity in this region may cause repeated anxiety attacks. Increased noradrenergic activity simulates cardiac problem by enhancing heart rate and breathing problems. It has also been suggested that people with panic disorder may have abnormalities in their benzodiazepine receptors which help in anxiety reduction. The role of GABA neurotransmitter may be important in this respect.

1.5.2 Psychological Factors

1) **Learning factor:** The learning theorists have tried to explain panic attacks as learnt phenomena – specifically as responses to conditioned stimuli. You already know how conditioning occurs and how apparently neutral stimulus may acquire a significance to elicit some response. Take the case of Maya as an instance. The panic attack happened for her for the first time in the underground train. Subsequently the situation of the train becomes the conditioned stimulus, and Maya is afraid that the next panic attack may also occur in the crowded vehicle. Thus the initial learning is reinforced and increases in vigour by reinforcements in cyclic pattern. This explanation is also known as 'fear of fear'.

   Sometimes, an internal stimulus may act as the trigger to panic attack. For example, an increased heart rate may be so associated with panic attack experiences that if heart rate increases for any reason, panic attack starts. Thus oversensitivity to internal stimuli can also be a cause of panic disorder.

2) **Cognitive factors:** The cognitive approach to panic attack focuses on the interpretation of bodily sensations and external cues that may trigger the attack. While the learning approach highlights the oversensitivity to bodily cues, the cognitive approach further affirms that a catastrophic meaning may be assigned to the bodily sensation. For example the racing of the heart may be attributed to a serious malfunctioning of the cardiac system, rather than to the medicine one has taken. If the person is not aware of this catastrophic thought, it may fall within the arena of 'automatic thoughts' that non-consciously result in the attack. You may note that the role of interpretation is crucial here. This has been highlighted by experiments where the heart rate has been increased in panic disorder patients by using drugs. If the person knows about the possible effects of the drug, panic attack does not take place or occurs to a much milder degree.

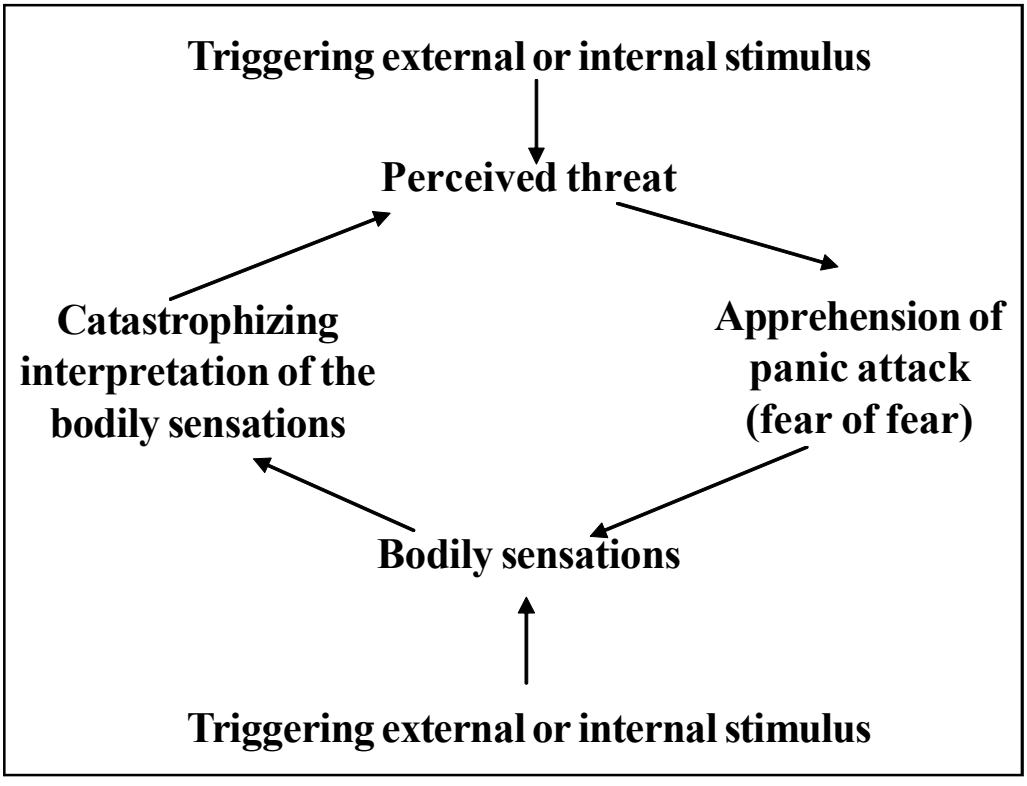


Fig.: Thevicious Panic Cycle

Panic disorder patients are also known to demonstrate cognitive bias toward certain experiences and symbols. For example they may be more prone to words like 'fainting' or 'shortness of breath'. There is however controversy as to whether these biases have been generated after repeated panic attacks or were already present before the first attack.

However, there seems to be accumulating evidence that a special kind of cognitive orientation is present in some people, which make them more amenable to consider certain stimuli as triggers of panic attack more quickly than others.

1.6 TREATMENT OF PANIC DISORDER

How would you deal with panic disorder? Panic disorder may be treated by pharmacology or psychotherapy, or a combination of both. Tranquilizers from the Benzodiazepine group of drugs (alprazolam or clonazepam) are often used to handle panic attacks. These however, have the side effect of being addictive. Antidepressants like Tricyclics and SSRIs (Selective Serotonin Reuptake Inhibitors (SSRIs) have also been used with efficacy to deal with panic attacks.

While these drugs, particularly SSRIs do not have the immediate calming effect like the Benzodiazepine group of drugs, these are relatively free from addiction and have better result in long term treatment. Although extrapyramidal effects like dryness of mouth may be occasional side effects, these are better tolerated by most people also.

Psychotherapy is also useful in dealing with panic disorder. You can teach relaxation techniques and breathing exercises to the patient for self management. These techniques include gradually relaxing the muscles of your body, progressively from one extremity to another, and also controlling breathing so that the internal cues of fear are regulated and under control.

Besides you can also employ the Cognitive technique to identify the erroneous automatic thoughts and review them in the light of reality orientation. For example, you may ask the patient to imagine the worst that can happen to her and to judge the probability of its occurrence in real life. You can also ask her to identify the triggering cues and to dissociate them by practice from the immediate physiological responses. It has been suggested that cognitive technique is more helpful than medicine for long term maintenance of the cure in case pf panic disorder.

Self Assessment Questions

1) How many of the thirteen symptoms must be there for panic attack to be diagnosed?

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2) What is 'fear of fear'?

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3) What are the relative merits and demerits of Benzodiazepine and SSRI in treating panic disorder?

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4) Write *True* (T) or *False* (F) beside the statement

a) A specific neurobiological mechanism has been specified for panic attacks ( ).

b) Panic attacks may be stimulated by internal cues ( ).

c) Panic disorder is prevalent in less than 1% of the population ( ).

1.7 PHOBIA: SYMPTOMS AND CLINICAL FEATURES

The word 'Phobia' derives from the name of the Greek god 'Phobos' who used to frighten his enemies. A phobia is an intense and irrational fear of some object, living being or situation. Do you get notably disturbed if a cockroach flies around and falls on your body? Of course nobody would love to caress a cockroach, but some people get completely panicky at the thought of touching it. Depending upon how severe it is, this may be a phobic reaction.

DSM IV – TR specifies that to be diagnosed as suffering from phobic disorder, one must have a persistent and disproportionate fear of some specific object, social situation or crowded place that actually carries little danger. Exposure to the phobic stimulus almost invariably produces intense anxiety response. The patient usually knows that the fear is unreasonable, but she has no control on the reaction. The phobic situation is usually avoided, or if forced to endured, may be tolerated with great discomfort.

When forced to encounter the phobic stimulus, the reactions may be like panic attack, or a little less severe than it. The attention of the person facing the phobic object is directed completely toward it, the affect is intense fear and the behavioural reaction is escape. As soon as the person can escape from the presence of the phobic stimulus, the negative affect and accompanying physiological reactions subside. Thus the flight reaction is reinforced as it provided relief from tension.

According to DSM IV – TR, phobias can be of three types: Specific Phobia, Social Phobia and Agoraphobia. Specific phobias are the irrational fear of specific objects, animals or situations. Some typical examples are: fear of closed space or claustrophobia, fear of heights or acrophobia, fear of blood or haemophobia, fear of snake or Ophidiophobia, fear of spider or arachnophobia, fear of fire or pyrophobia and even fear of phobias or phobophobia. You can get a list of the phobias on internet by clicking *http://en.wikipedia.org/wiki/List_of_phobias*

The specific phobias can be divided in some subtypes like

- animal type - cued by animals or insects

- natural environment type - cued by objects in the environment, such as storms, heights, or water
- blood-injection-injury type - cued by witnessing some invasive medical procedure
- situational type - cued by a specific situation, such as public transportation, tunnels, bridges, elevators, flying, driving, or enclosed spaces
- other type - cued by other stimuli than the above, such as of choking, vomiting, or contracting an illness.

Social phobias, as you may guess from its name, are persistent irrational fear associated with presence of other people. Remember how we sometimes get tongue tied at the interview boards? Social phobia is an extreme form of this kind of discomfort. Often extreme feelings of shyness and self-consciousness build into a powerful fear, so that it becomes difficult to participate in everyday social situations. People with social phobia can usually interact easily with close and familiar persons. But meeting new people, talking in a group, or speaking in public can trigger the phobic reaction. Often situations where one might be evaluated become the phobic situation. All of us may have occasional social anxieties, especially under judgmental situation. But a person with diagnosable social phobia often becomes incapable of normal social interaction.

You have already read about Agoraphobia in connection with panic disorder. You know that it refers to the fear of public spaces where many people congregate. Agoraphobia without history of panic disorder has been given a special emphasis in DSM IV – TR. It develops slowly and insidiously from early adolescence or late childhood, and gradually becomes debilitating. If it is a part of the panic attack, it should be coded within Panic disorders. If it occurs as a source of anxiety and a strong urge to avoid, but does not constitute a palpable panic attack, it should be coded within Phobia.

1.7.1 A Case Study of Specific Phobia

Kalu, now about 24, comes from a lower class family of fishermen. They earn their livelihood by fishing in shallow backwater or rivulets streaming from big rivers. He had studied up to class IV in the local school, and then left it due to poverty. As a child, he used to accompany his father to the backwaters, especially where they cultivated prawns. Very occasionally crocodiles swim in from the big river with which the backwater may be connected, and there has been tales about crocodiles killing men around the village. Everybody had heard these tales, but since the appearance of crocodiles is quite rare, everybody works in knee deep water without much anxiety. From early adolescence onward, Kalu gradually became afraid of crocodiles, which then turned into specific phobia. He was unable to work in the water, because if he sees any shadow, even of underwater plants and fish, he suffers from uncontrollable fear. Since Kalu's family has no land to cultivate, and Kalu hardly has any other skill, not being able to work in water has practically made him a non-earning member of the poor family. Kalu understands that his fear is irrational, and never in his life time has he heard of a crocodile actually attacking a man in their locality. He understands that he is becoming a burden on his family; but he cannot overcome the intense fear. While he attributes the fear to the stories he had listened to in childhood, he knows that these are not enough to provoke such strong reactions.

1.8 EPIDEMIOLOGY OF PHOBIC DISORDER

Not all phobias are of equal prevalence. Social phobias are more common than specific phobias. While specific phobias are estimated to be around 4.5%, the estimated prevalence of social phobia is around 11%. Phobias, like panic disorders, are more common in women than men.

1.9 AETIOLOGY OF PHOBIC DISORDER

Like Panic disorder, you may understand the origin of phobias in terms of biological and psychological factors.

1.9.1 Biological Factors

Biological factors are of less importance in phobias than in panic disorders. The genetic basis of phobias has been suggested by some studies, but it has not been well established.

At best the impact of genetic factors is modest. It has been suggested however, that temperament plays a significant role in developing phobia. Some children are temperamentally jumpy or easily aroused. This lability-stability dimension is a function of the predisposition of the autonomic activity. Those who are easily aroused may have greater chance of developing anxiety disorders in later life.

There have been some attempts to provide evolutionary biological explanation of phobic disorders. People are more likely to develop fear of snakes or heights than of books or cups. Thus there seems to be a 'preparedness' to consider some objects as more phobic than others. This preparedness has been retained by nature because the primates who identified these danger signals quickly had a survival advantage. However, for the normal person, the reality of the danger is judged, while for the phobic person the reaction is exaggerated.

1.9.2 Psychological Factors

You may study the psychological factors as viewed from different theoretical approaches.

1) **Psychoanalytical theory:** You already know that psychoanalytical approach emphasises the role of unconscious needs and conflicts. Freud, in his description of fear of horses in little Hans proposed that phobias are the ego's way of dealing with childhood conflict. For example, Hans could not resolve his oedipal conflict properly and his fear of father was displaced onto horses. Other psychoanalytical models attribute phobias not to id drives, but to disastrous interpersonal experiences. The mistrust and generalised fear of environment seems to be displaced on the phobic object or situation. You may note that social phobia may be particularly well explained by this latter view.

   The psychoanalytical model has been criticized by learning theorists as they state that many phobias develop as result of association with a fear eliciting object, and we need not go to the deeper id impulses for explaining them.

2) **Learning theories:** When you learnt about classical conditioning, you came across the experiments of Watson and Rayner, who conditioned little Albert to fear furry objects by associating a rat with a loud bang. The learning theory explanation of phobia takes this experiment on avoidance conditioning as the

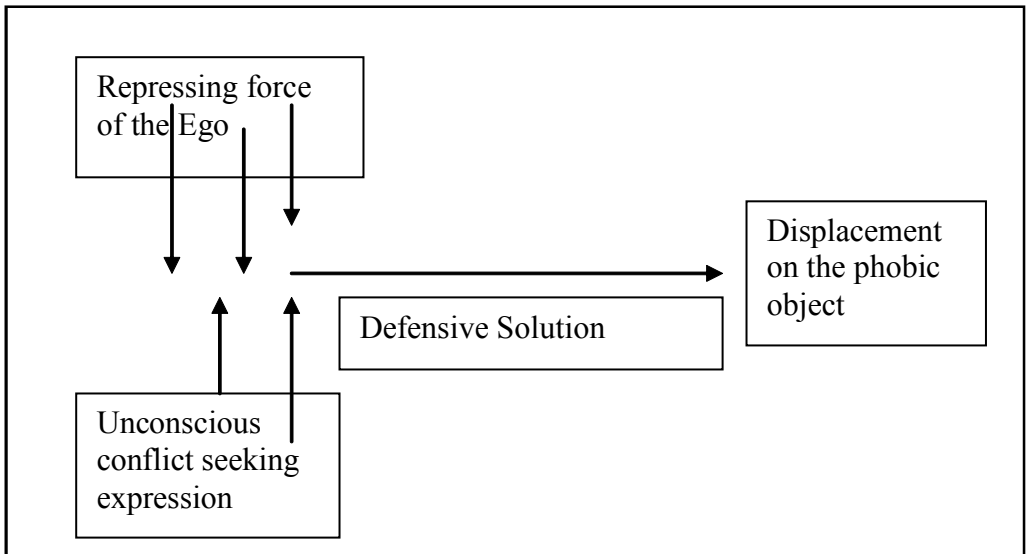
model of phobic reactions. It is believed that phobia is the end result of a process of a neutral stimulus being turned into a phobic object due to unwarranted association in time with a feared object. Initially the association creates the fear of the neutral stimulus, and then escape or avoidance of the stimulus results in relaxation. This relaxation in turn acts as a reinforcer and maintains the phobia.

Another process emphasised within the learning approach is modeling of phobias. While learning about Bandura's social learning theory, you have come across the concept of vicarious learning. It refers to the fact that a child models behaviours, but also attitudes and emotions. If a child repeatedly sees her mother being afraid of something, the same would be observed in the child also. The modeling theory proposes that phobias are learnt via observational learning processes.

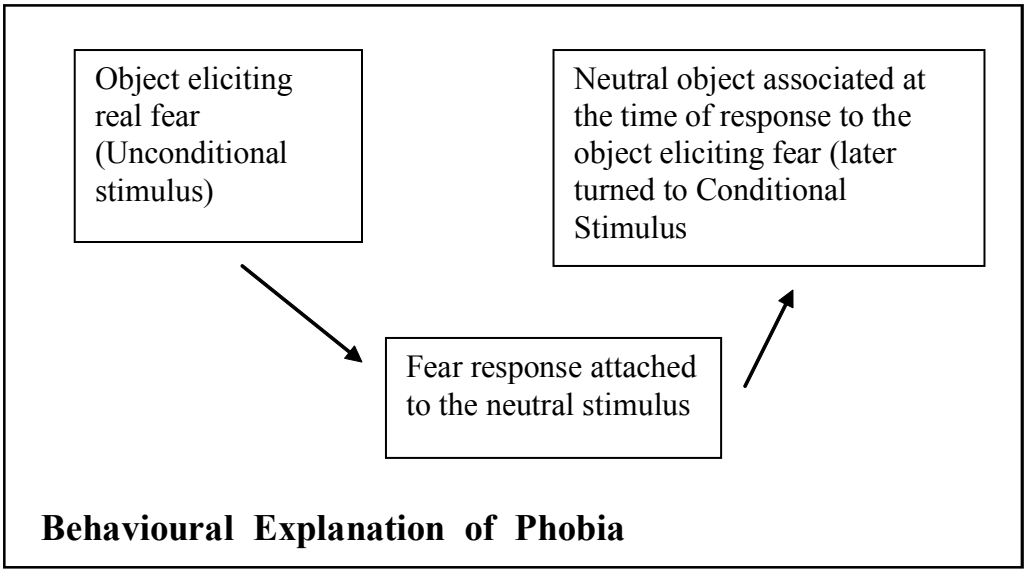
While learning theory justifies the origin of a number of phobias in some cases, not all phobias can be explained by this theory. Particularly, the role of preparedness that you have learnt earlier in connection with biological factors remains a significant issue. It may be stated that learning may play a role in phobia, but it cannot be the whole story.

3) **Cognitive theories:** Cognitive approach to phobias indicates a greater selective attention toward the phobic object. There is often an underlying core belief that negative things are going to happen. Particularly in case of social phobia, but also in other specific phobias, catastrophic outcomes are believed to be inevitable, thus distorting the reality for the person.

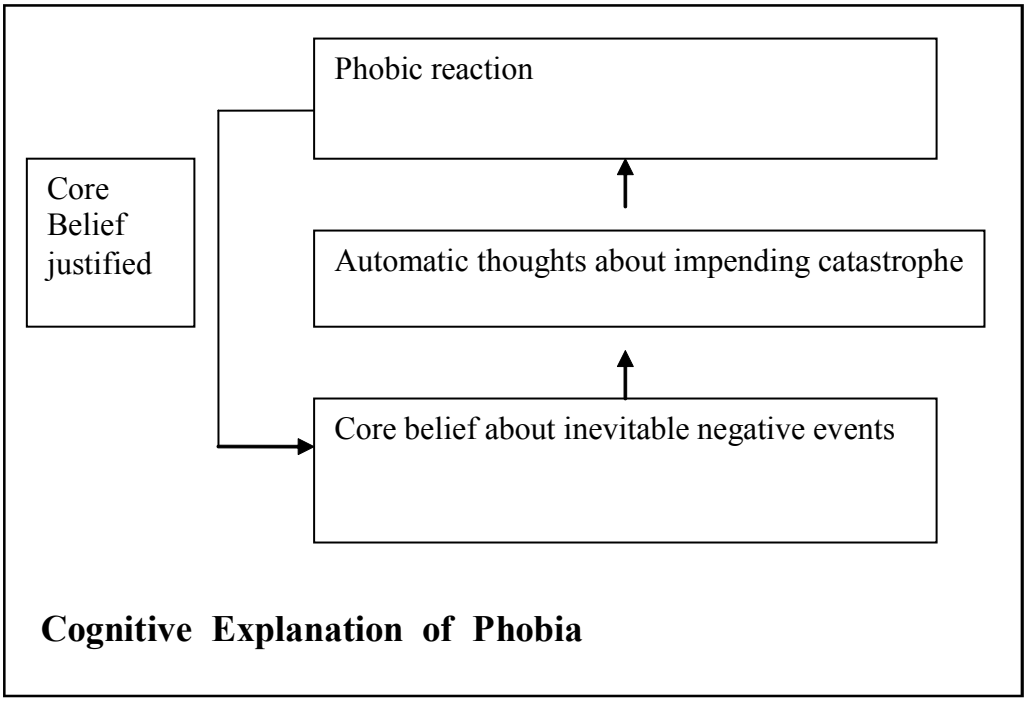
Cognitive theory also admits that the core belief may remain at a non-conscious level, thus making it difficult to modify. However, if the person is taught to look into her own erroneous assumptions and cognitive biases, the distortion in thought process may be identified. Figure Diagram explaining psychoanalytical, behavioural and cognitive explanation of phobia



Psychoanalytical Explanation of Phobia



Behavioural Explanation of Phobia



Cognitive Explanation of Phobia

1.10 TREATMENT OF PHOBIC DISORDER

As in case of panic disorder, anxiolytics and anti-depressants are used for treating phobic disorders, particularly social phobia. However, psychological treatments are of greater effectiveness. You can go for psychoanalytical, behavioural or cognitive therapies depending upon your orientation and specific case history.

Psychoanalytical therapies try to unearth repressed conflicts and deal with them at a mature level than by displacing them onto objects and situations.

Among the *behavioural approaches* to treatment, you can try systematic desensitisation, flooding and relaxation techniques.

Systematic desensitisation is a process of exposing the person to the phobic object in a graded way. Before starting systematic desensitisation, you need to teach your client the relaxation technique scientifically. Then you prepare 'hierarchies of anxiety', and design situations to expose her gradually from the lowest level of

anxiety to the highest. For example, if your client is afraid of snakes, you can first show her a cartoon picture of a snake, which would probably not elicit phobic responses in her. You ask her to relax in the presence of this picture, and she can very well do it. Next you show her a perfectly realistic photograph of a snake, and, let us say, she can relax even though she is a bit uncomfortable. Then you show her a 3D picture, and she is now disturbed. You continue working with her till she learns to relax in front of it. Then you show here a video – and so on. When finally she is ready to take her chance, you take her to a snake park and ask her to relax and enjoy.

Flooding is the opposite of graded exposure – here you expose your client straightaway to the feared situation or object and ask her to relax. This is also known as exposure therapy. Once she can mange the situation, she becomes confident of her control. Usually this is the technique rural people take for teaching swimming to young boys. They throw the protesting child in water with a cloth tightly wound around his waist. The child struggles and gasps in water, and at last through random movements float up. He may be rescued at any moment with the help of the cloth tied around his body. The same may be used with phobic people, but the risk is that some of them may be traumatized. So flooding needs to be done cautiously.

Modelling is another recommended technique. Seeing others in a group facing the situation without fear may help in trying to do the same.

The *cognitive approach* to treating specific phobic disorders has not been the best option of choice, since the person already knows the unreasonableness of her fear. Simply making her see the irrationality is of little help.

Exposure to the situation seems to be essential for reduction of specific phobia. However, cognitive behaviour therapy is useful in case of social phobia.

There are often automatic thoughts about self and others underlying social phobia.

Exploring such erroneous automatic thought and making the client approach it from a new perspective have been helpful in treating social phobia.

In fact, in real life therapeutic situation, you may go for a combination of therapies depending upon the specific need of the client.

Self Assessment Questions

1) How many types of phobias have been identified by DSM?

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2) What are the subtypes of Specific phobia?

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3) What is liability-stability dimension?

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4) Write *True* (T) or *False* (F) beside the statement

a) The psychoanalytical model attributes phobias to unconscious conflict ( ).

b) Specific phobia is more prevalent in population than social phobia ( ).

c) Systematic desensitisation is used for treating phobic disorder ( ).

1.11 LET US SUM UP

In this unit we have learnt that anxiety can be a common reaction to stress and we have to differentiate between normal and pathological anxiety. We have learnt the general nature of anxiety disorders and focussed specifically on Panic disorders and Phobias. Panic disorders can be with or without Agoraphobia. Phobias can be Specific phobia, Social phobia and Agoraphobia. We have learnt the symptoms and clinical features of the panic disorders and phobias. We have learnt about their aetiologies in terms of biological and psychological factors. We have also been acquainted with some of the treatment approaches to these disorders.

1.12 UNIT END QUESTIONS

1) Distinguish between anxiety and fear.

2) Critically discuss the difference between normal and pathological anxiety.

3) Discuss the symptoms and clinical features of different kinds of Panic disorder with case examples.

4) State the prevalence rate of Panic disorder.

5) Discuss the aetiological factors of Panic disorder.

6) Discuss the treatment options of Panic disorder.

7) Discuss the symptoms and clinical features of different kinds of Phobias with case examples.

8) State the prevalence rate of different categories of Phobias.

9) Compare the relative prevalence of Panic disorder and Phobia.

10) Discuss the aetiological factors of Phobias.

11) Discuss the treatment options of Specific Phobia.

12) Discuss the treatment options of Social Phobia.

1.13 GLOSSARY

Anxiety disorder : A group of disorders characterised by irrational fear of something or some situation. The person is usually aware of the irrationality. It includes panic disorder, phobic disorder, generalised anxiety disorder, obsessive compulsive disorder and post traumatic stress disorder.

Panic attack : Panic attack is an episode of irrational intense fear or apprehension that is of sudden onset. It is accompanied by strong autonomic arousal and numerous bodily symptoms often mimicking cardiac attack.

Agoraphobia : Irrational intense fear of crowded places from where escape might be difficult.

Specific Phobia : Irrational intense fear of specific objects, animals or situations.

Social Phobia : Irrational intense fear of being exposed to public places, specially where one has to perform and be evaluated.

Systematic desensitisation : A therapeutic technique based on behavioural approach where the client is exposed to the phobic object or its image in graded stages, starting from a point where she is fully relaxed, and then guided progressively toward staying relaxed even in situations where she experienced intense fear.

Flooding : A therapeutic technique based on behavioural approach where the client is exposed all at once to the phobic object. She is instructed to relax instead of being afraid. Once she can relax in oresence of the phobic object she may be able to master her fear.

Relaxation technique : A behavioural technique that includes any method, process, procedure, or activity that helps a person to relax and to be free from stress and anxiety. This can be done by progressive muscular relaxation, controlled breathing, meditation , biofeedback etc.

1.14 SUGGESTED READINGS

Kaplan, H. I. & Sadock, B. J. *Synopsis of Psychiatry*. Philadelphia: Lippincott Williams.

Semple, D., Smyth, R. Burns, J., DArjee, R. & McIntosh, A. (2005) Oxford *Handbook of Psychiatry*. London: OUP.