CAROL LINDEMANN PHD

PHOBIAS

ANXIETY AND RELATED DISORDERS

Phobias

CAROL LINDEMANN, PhD

e-Book 2015 International Psychotherapy Institute

From *Anxiety and Related Disorders* edited by Benjamin Wolman & George Stricker

Orig. Publisher: John Wiley & Sons

Created in the United States of America

Table of Contents

Contributors

Carol Lindemann, PhD
Private Practice
New York. NY

Phobias

CAROL LINDEMANN, PhD

Phobias are the most common emotional disorders known and have been recorded since the earliest writings, from the Old Testament and Hippocrates through the 17th-century diagnostician, Robert Burton, and continuing into current times.

Anxiety disorder is the most prevalent of all the major groups of mental disorders and within this group, phobias are the most common disorder. For phobias, one-month incidence (the likelihood of occurrence in a single individual during one month) is 6.2% and prevalence (the occurrence over the population at any given time) is 12.5%. Anxiety disorders are twice as common in women (9.7%) as in men (4.7%) (Regier et al., 1988). The median age of onset for phobias is 13 years of age (Burke, Burke, Regier, & Roe, 1990). Weissman and Merikangas (1986) found that over 9% of the population has had a least one panic attack, and 3% to 4% have had recurrent panic attacks.

The clinical definition of phobias includes:

1. An intense experience of fear occurring in a situation that is harmless.

2. Recognition that the fear is excessive for the actual threat; that it is irrational.

3. The reaction is automatic and pervasive; the person cannot voluntarily control the fear reaction.

4. The fear reaction includes symptoms such as rapid heart beat, shortness of breath, trembling, and an overwhelming desire to flee the situation.

5. The object or situation is actually avoided.

Not all of these features need be present to diagnose a phobia. For example, while avoidance of the phobic situation or object is a hallmark of phobias, a fearful flier who will still ride in an airplane when necessary, despite severe anxiety, might be classified as phobic. Conversely, a person who always avoids an airplane despite never actually experiencing panic in the phobic situation, or one who is not experiencing panic at the time of diagnosis, might still be phobic because of the prominence of avoidance.

Phobias are so common that often they are trivialized and may become a source of humor. Far from being trivial, this disorder causes significant disability in the population it afflicts. There is often a significant decrease in the quality of life, including an increase in emergency room visits, depression, suicide, and financial difficulties (Weissman & Merikangas, 1986). The risk for drug abuse disorder doubles in young adults who have had an earlier anxiety

disorder, and alcoholism similarly increases (Christie et al., 1988; Regier et al., 1990).

The panic attack is often described by patients as "the most horrible feeling I have ever experienced." Unlike the memory of pain, people vividly recall every instant of the feeling of panic and can often reproduce the symptoms of anxiety merely by thinking about it. The intense unpleasantness of the experience is a strong deterrent to putting oneself in the same situation again, and if the likelihood is deemed high that future panics cannot be avoided, the person may become preoccupied with worry and fear. The content of the preoccupations may vary according to the individual's experience of panic; this includes such common examples as concerns about the disintegration of the physical self (dying, having a heart attack), the psychological self (going crazy, losing control), or the social self (humiliation).

The American Psychiatric Association Diagnostic and Statistical Manual (DSM-III-R, 1987) divides the phobias into three categories: agoraphobia, social phobia, and simple phobia. The phobias are categorized according to what triggers the fear, how the person reacts, and the thing feared. In agoraphobia, the panic attack may occur when the person is not in a phobic situation, whereas in social and simple phobias, the panic is specific to the situation. In agoraphobia, the person fears being in a situation in which he or she cannot escape to safety in the event of a panic attack. The agoraphobic

thus typically either restricts travel far from home or travels only with a trusted companion. The social phobic fears and avoids situations in which he or she might be exposed to the scrutiny of others, such as public speaking. The simple phobias are specific discrete fears; often more than one fear is present. Common types include animal phobias, acrophobia, and claustrophobia. Despite the variety of triggers, all share the traits of panic or anxiety in the phobic situation; avoidance of the situation; and being unable to control the reaction despite awareness that the fear is excessive, unreasonable, or irrational. Although the validity of separating the phobias into these categories is controversial, the varieties of phobias will be discussed under these headings for convenience.

CLASSIFICATION OF PHOBIAS

Agoraphobia

Westphal is credited with coining the term, agoraphobia, describing in 1871 a symptom syndrome of feelings of impending doom, fear of dying, and anticipatory anxiety when walking in open spaces (Westphal, 1871). The greek word, *agora*, means marketplace, yet this term is misleading since an agoraphobic may be as fearful of a claustrophobic space as of a wide open space. Agoraphobia is, in fact, usually a syndrome of multiple phobias (Marks, 1987).

The concept of panic attack and spontaneous panic attack is crucial to the understanding of this diagnostic category. The panic attack, fully described elsewhere in this volume, is "hardwired" into all people as a survival tactic, and shared by all mammals as well. In phobias, the normal mechanism of panic is triggered at inappropriate times or to inappropriate objects. When the panic is triggered by a specific situation such as being in a high place, or seeing a snake, it is called "situational." In agoraphobia, however, the experience is of panics occurring while not in the presence of a phobic object, "spontaneous" panics. The phrase "spontaneous panic attack" alludes to the lack of an immediate environmental cause; the cause is sought rather in the person's physical and psychological internal environment. It does not mean that there is no cause, but, rather, implies an agnostic position as to the cause of the panic attack. Breier, Charney, and Heninger (1986) found that in 78% of agoraphobics, the first panic was a spontaneous panic attack and in only 22% was it situational. The defining feature of spontaneous panic attack in agoraphobia explains the multiple phobia picture so often seen. The disorder often begins with a single attack. While in other phobias, the attack occurs with an obvious environmental object that can then be avoided, for the agoraphobic, the attack may be unpredictable. Sufferers may then avoid any situation that is not familiar and protected, so that when the panic occurs, they will not be endangered or humiliated. In addition to the terror of the panic attack proper, the dread of future panic, called anticipatory

anxiety, can be crippling, thus further inhibiting the person's activity. Since avoidance of phobic objects is insufficient to insure that panic will not occur, a state of generalized anxiety might follow.

Although agoraphobia is not the most common of phobias, it is the phobia for which people most frequently seek treatment. Agras, Sylvester, and Oliveau (1969) report that over half of people seeking treatment for anxiety disorders are agoraphobic. The extreme forms of limitation connected with agoraphobia can develop even if the person is no longer experiencing panic attacks because of the anticipatory dread, therefore a diagnostic distinction is made between agoraphobia with and without panic attacks. Thyer, Nesse, Cameron, and Curtis (1985) found a ratio of 83% agoraphobia with panic attacks and 17% agoraphobia without panic. Unlike social and simple phobias which are equally likely to occur in men as in women, Thorpe and Burns (1983) found that the ratio of women to men with agoraphobia is approximately 4 to 1.

Agoraphobics seem sicker than the general phobic population. Mavissakalian and Hamann (1986) found a personality disorder in over a quarter of agoraphobics, especially the dependent, avoidant, and histrionic personalities, just as might be expected. There is a high co-morbidity rate between the phobias, especially agoraphobia, and the affective disorders (Breier et al., 1986; Weissman & Merikangas, 1986). The relationship

between depression and agoraphobia is a complex one since in some cases it seems to be a consequence of the panic attacks, while in some cases, the anxiety seems to be caused by the onset of the depression. Furthermore, some patients reported that they became depressed or "demoralized," only after the phobic restrictions began to curtail their activities. Most outcome studies have found an improvement in depression coinciding with improvement on agoraphobia (Michelson, Mavissakalian, & Marchione, 1985).

> Mrs. A. sought treatment at 22 for agoraphobia with symptoms of panic attacks several times a day and an inability to leave home without her parents. She was an exceptionally pretty young woman who paid great attention to details of personal grooming and, due to her considerable charm, she prided herself on being liked by everyone. The content of the sessions was often about clothes and fashion, gossip about her friends, and talk of boyfriends, usually presented in a humorous fashion.
>
> She first started having panic attacks at age 13, at the time of menarche. She avoided going to school, complaining of dizziness and stomachaches. Her family doctor gave her tranquilizers and suggested that she could stay home from school. In retrospect she sees this as a mistake and did not start to feel better until she went to summer camp and was engaged with friends and activities. Although she continued to have occasional panic attacks over the next few years, she was able to attend college, but upon returning home after graduation began to have massive and frequent panic attacks. She refused to leave the house unless accompanied by one of her parents. At this point, she sought treatment. Therapy consisted of behavioral and supportive psychotherapy once a week for a year and a half. After a few months of treatment and despite considerable anxiety, she found a job in the fashion industry. She felt relatively anxiety-free at home with her parents, and at work with her friends and, on a "good day," could walk around within a circumscribed area downtown. She soon met a

young man whom she dated and was able to travel everywhere in his company. Although she continued to have occasional panic attacks, she also continued to achieve good symptom remission and we mutually agreed to terminate treatment.

Four years later, soon after her marriage, she returned to treatment for a recurrence of panic attacks and increasing difficulty leaving the house. She was terrified that she was having another "nervous breakdown." She dreaded the social ostracism she imagined if people knew she was "weird." She cried frequently, felt confused and depressed. She decided to try medication, the tricyclic antidepressant, imipramine. The panic attacks abated within a month with the help of medication and psychotherapy. She attributed the relapse to the life change that marriage entailed and fears about the expectation to be both an adult and a woman. Within a year, she started a new career in which she was very successful. Her mood improved as did her self-esteem.

Some 6 years later, she returned to therapy. She had a series of medical problems that required surgery and multiple hospitalizations and she had learned that she would not be able to bear children. Panic attacks had recurred and she had re-instituted a course of the same tricyclic antidepressant with which she had been treated successfully earlier. This time, however, the phobic restriction did not recur. She felt she had learned to control her anxiety experience, understood why it recurred at this point in her life, and would not give in to avoidance. Rather than fearing that she was "having a nervous breakdown," she felt she had a biological disorder that she would have to learn to cope with, if necessary, for life. At the same time, she felt she was psychologically fragile and continued in psychotherapy once weekly for two and a half more years. The psychodynamic issues dealt with were ambivalence concerning her femininity, excessive narcissistic need for admiration and love, and difficulties in expressing aggression.

This case illustrates several features of the course of agoraphobia in therapy. The disorder often begins with a single spontaneous panic attack,

then there is a tendency for multiple attacks. During this period, there are increasing restrictions in activities that usually persist well after panic is no longer present. The course is fluctuating, with relative remission and resurgence. The occurrence of panic and possibly a series of multiple panic attacks may recur throughout the person's lifetime, especially at times of crisis, life change, or other sources of fragility (Marks, 1969). With proper treatment, however, the person can learn to handle the recurrent panic without again becoming agoraphobic.

Social Phobia

Social phobics fear being judged or evaluated. This may vary from avoidance of even being seen by others, to anxiety only about performing complicated tasks. Common social phobias are fear of public speaking, performance anxiety, and test anxiety. Other manifestations may include fear of eating or signing one's name in public and difficulty in urinating in a public bathroom.

The experience is of intense self-consciousness and embarrassment about oneself. The paradox facing many social phobics is that because of their intense social anxiety, they often bring upon themselves the kind of humiliation they fear most. The anxious performer is more likely to blush, or forget lines, and the person trembling with anticipatory anxiety is more likely

to have shaking hands when he or she lifts a spoon or signs a check (Beck & Emery, 1985).

Although may social phobias are mild, they also can be very disabling, sometimes carrying with them an increased risk of depression, suicide, alcohol or drug abuse, and impaired physical health (Davidson, 1991).

> Mr. B. was a 34-year-old, unmarried Italian-American photographer. He gave the impression of a mild-mannered, unassertive man who was ill at ease with himself and his surroundings. A big grin covered his face regardless of its appropriateness to what was being said. He came to treatment because of a fear of choking that occurred primarily when he tried to swallow food, but which might also occur during anxiety attacks. The fear had started about 10 years before, when he had an anxiety attack accompanied by a tightening of the throat, and the fear that he could not swallow. He became increasingly frightened and ended up in the emergency room. He remembers this incident and the period in which it occurred as the nadir of his life. He had recently returned from living in California and was rejected both in his hunt to find employment and his fiancee. After this anxiety attack, he became increasingly dysfunctional and symptomatic. He rarely ate in restaurants or in front of others for fear of embarrassing himself with a choking attack. This concern led to painful social limitations, and the fear that he would never be able to marry.

The cognitive component of social phobias involves worry both over the public embarrassment and the private shame of not meeting the demands of the situation. Beck and Emery (1985) find cognitive distortions in the global judgments made: First any misstep, regardless of how slight, proves to them that their entire performance is to be evaluated negatively; and second, a negative evaluation of a performance is generalized to the entire personhood.

Turner and Beidel (1985) found that negative thoughts about the self and the performance were the hallmark of the socially anxious, regardless of whether there was a significant physiological arousal, such as trembling hands. As might be expected, those with social anxiety set unrealistically high standards (Alden & Cappe, 1981).

There is considerable overlap between social phobias and agoraphobia: Most agoraphobics have social phobia. However, the autonomic symptoms experienced by social phobic tend to be those that can be observed by others, such as blushing or trembling. Also, the situations feared by the social phobic tend to be interpersonal and the concern is being scrutinized by others. The agoraphobic is more concerned with situations of being alone or in which the retreat to safety is impeded (Amies, Gelder, & Shaw, 1983). The distinction drawn by Beck and Emery (1985) is that agoraphobics fear the internal disaster of a panic attack and social phobics fear embarrassment and shame.

Simple or Single Phobia

Simple phobias are by far the most common form of phobia. They are simple in the sense that they may consist of only a single, discrete feared object or situation, such as a specific animal or fear of flying, although several of such may co-exist. The defining features of a simple phobia are a reaction of anxiety and sometimes panic in the presence of the phobic stimulus, and an

attempt to avoid it. The person recognizes that the fear is irrational, but cannot change the distressing reaction. Anticipatory anxiety is usually present, that is, the person becomes extremely anxious, and possibly panicky in anticipation of being unable to avoid the feared object. It is generally the case that the anticipatory anxiety is worse than the anxiety in the phobic situation itself. The diagnosis of simple phobia is made only if the person is not an agoraphobic or social phobic and, in that sense, it is the residual category of all other phobias.

Because the phobia is circumscribed, however, the simple phobic, unlike the agoraphobic, does not usually become preoccupied with the "fear of fear." When not in the presence of the feared object, or actively anticipating it, the simple phobic would not seem more anxious, depressed, or show higher neuroticism than a nonphobic (Agras et al., 1969).

Although the prevalence of simple phobias is 8% in the general population, only a small percentage seek treatment (Agras et al., 1969). The degree of impairment may be mild, especially if the feared situation is not encountered often, such as the form associated with open heights, or can be easily avoided, as is the case with most animal phobias. Very often the simple phobic learns to live with the specific restriction, but on occasion, they do constitute a significant disability and treatment is sought. This most often occurs when there is a change in life style that causes the restriction to

become intolerable. For example, a young woman sought treatment for a lifelong fear of cats only after her marriage. She had married a man born on an island in Greece renowned for hundreds of freely roaming cats. A visit to her new husband's homeland was inconceivable to her, causing considerable friction in the relationship, until she had overcome the phobia.

Another common precipitant for seeking treatment is a particularly bad panic attack. For example, a man in his 50s who had a fear of thunderstorms dating back to age 7, sought treatment after he had a severe panic in his home during a thunderstorm.. He felt terrified, was crying and trembling, and tried to seek shelter under a couch. Afterwards, his reaction of humiliation and self-disgust at his performance led him to decide to deal with the phobia. In this case, he had recently suffered the death of a parent which may have precipitated a reaction more severe than usual. As with other forms of phobia, a separation or other stress can initiate or intensify an existing anxiety disorder (Roy-Bryne, Geraci, & Uhde, 1986).

In simple phobias, there is a strong component of maladaptive cognitions that maintain the phobic reaction. Forecasting disastrous consequence when one is in the phobic situation can increase the psychophysiological arousal. This physiological component of fear is a primary source of subjective discomfort, and in turn often causes the person to avoid or flee the phobic situation, even in the absence of panic.

In vivo exposure therapy seems to be the most effective treatment for the simple phobias. Gradual exposure to the feared object reduces the fear reaction.

ETIOLOGY

Despite the distinctions drawn between agoraphobia, social phobia, and simple phobia, the causes and treatment of the phobias can be discussed together.

The origin of phobias is multiply determined. There is considerable evidence of a familial trend in anxiety disorders, indicating both a genetic component and the role of early training (Turner, Beidel, & Costello, 1987). Some physiological disorders may predispose people to panic attacks, such as mitral valve prolapse and thyroid disorders (Lindemann, Zitrin, & Klein, 1984). Marks (1969) proposes a "preparedness theory," that the object or situation feared is one that is in nature dangerous and we are predisposed to a fear reaction, for example, to open places, heights, or snakes, and so on. Learning theory posits that phobias are learned through the highly negative experience of intense anxiety in confrontation with the object or situation. Cognitive theory holds that we are told in childhood that certain things are dangerous and learn to fear them, and further, we develop our own interior fearful dialogue. Traumatic origin (for example, a plane crash) can

occasionally account for a phobia. Some of these major theories of origin and causes of phobias will be discussed in depth in other chapters of this volume.

Freud's initial theory of phobias was psychobiological, a result of thwarted libidinal discharge, however, it must be remembered that Freud revised his central theory of anxiety several times. In his 1909 case of Little Hans, he reformulated his position on phobias, and this case serves as a model for the psychoanalytic understanding and treatment of phobias. Little Hans had a fear of horses, and in his effort to avoid them he resisted going out on the street where horses and carriages were encountered. Freud helped Hans' father understand Hans' unconscious Oedipal fears and his defenses of denial of his forbidden wish and projection of the feared retribution for this wish onto the horse. The phobia is thus a symptom of an unconscious conflict. The anxiety of the conflict is experienced, but the source is shifted or displaced onto some harmless object that becomes its symbol. This displacement helps to keep the real source of anxiety from conscious awareness. The treatment implications of this position are that the symptoms of the phobia indicate that there are unresolved unconscious conflicts and the phobia will be given up after the real source of the anxiety is successfully addressed by the analyst and the patient.

The learning theories follow the conditioning model of the origin of phobias. Pavlov's (1927) classical conditioning model is: the dog is given food

and salivates, the sound of the bell is presented a few seconds before the food, and the dog therefore becomes conditioned to salivate at the sound of the bell. The application of the classical conditioning model to phobias runs as follows: a panic attack occurs, for reasons unspecified, in the elevator. The person, on the basis of a "one-trial learning," becomes conditioned to have a fear response when in the elevator. Mowrer's (1939) two-factor theory of anxiety adds that leaving the situation is reinforced by the anxiety reduction experienced and thus the tendency to escape the phobic object is perpetuated. Although learning theory is not totally satisfactory in explaining the variety of theoretical issues in the development of phobias (Rachman & Seligman, 1976), nevertheless, the treatment of the disorder based on learning theory is generally rapid and effective.

The cognitive model of the origin of phobias makes significant contributions to the understanding of the catastrophic thoughts and irrational beliefs that occur in phobias. The catastrophic thoughts, for example, "I would die if I were stuck in a crowded elevator," serve to maintain the avoidance (Beck & Emery, 1985). Misattribution of common anxiety symptoms of physiological arousal, such as sweaty palms or increased heartbeat, can become erroneously conceived as of warnings of an incipient panic. The person might then avoid the phobic object, retreat from the object, or become so anxiously preoccupied with the physiological arousal that there is a rapid escalation to an actual panic attack (Goldstein & Chambless, 1978). Such

patients may seek to avoid any arousal, including even intense pleasurable emotions. They may also develop an obsessional focus on the symptoms of anxiety, constantly checking on their current psychophysiological state for distress. Cognitive theorists also point out a deficit in problem-solving skills, as a result of phobic worry, the common experience of being so anxious you "can't think straight."

TREATMENT

With proper treatment, over 70% of phobia patients improve significantly or completely overcome their fears. Moreover, once a phobia is successfully overcome, over 66% of the patients will be free of symptoms for years if not for life (Zitrin et al., 1975). Conversely, left untreated, 42% of phobics do not improve over a four-year period, and under 10% will be symptom free (Marks, 1971). In 1964 before the new treatment techniques were developed, Roberts found that with standard psychotherapy interventions only 24% recovered.

Psychoanalytic Treatment and Related Schools

The psychoanalytically oriented treatment of phobias is derived from the theory of the origin of phobias just described. The purpose of psychoanalysis and psychoanalytic psychotherapy is not so much symptom

relief as it is understanding unconscious meaning and increasing the patient's awareness. Thus, it is not the phobia itself that is directly treated, but the symptom that is seen as a symbol of underlying conflict. Further, the symptoms and anxiety are seen as a motivation for the patient to work in his treatment, and in this sense rapid symptom reduction would be counterproductive. Symptom change is a byproduct rather than a goal.

The current popular direct symptom reduction treatments of phobias differ from previous psychodynamic psychotherapies in several characteristics: The focus is on a particular diagnostic category rather than on a theory or technique, specific empirically developed techniques are used, and the goal is symptom relief rather than broader psychosocial goals.

There are several components to phobic anxiety, all of which must be addressed for effective and stable symptom remission: the avoidance of the phobic object, the panic attack itself, the fear of the symptoms of intense anxiety and their consequences ("fear of fear"), the anticipatory anxiety, and the generalized anxiety or hypervigilence.

Techniques currently accepted as the most effective for rapid symptom relief include exposure therapy, cognitive restructuring, medication, education, and breathe retraining and supportive psychotherapy, all of which will be briefly described.

Exposure Therapy

Current research indicates that the most crucial issue for change in phobias is exposure to the phobic situation, such as an elevator, until the anxiety that might be experienced subsides to tolerable levels. A panic attack is self-limiting, lasting only a few minutes at peak. The anxiety will gradually diminish over time, therefore, if the person stays in the situation long enough.

Exposure therapy is often preceded by *imaginal desensitization*. In this technique introduced by Wolpe (1958), the patient is first given a progressive muscle relaxation exercise (see Wilson, 1989, for a sample relaxation exercise). When the patient is relaxed, images of the things he fears are presented to him on a hierarchial scale, from the least fearsome to the most. If the patient can remain relaxed while contemplating the feared event, the next step of the hierarchy is presented. For maximum effectiveness, this hierarchy is then repeated in the situation itself (*in vivo*) where feasible.

Much of the behavioral research literature is concerned with discovering what elements of exposure are the most important for rapid and complete eradication of the anxiety response. Exposure *in vivo* is more effective than in *imagination*, and exposure with the therapist present is more effective than self-exposure, (although good results can often be obtained with self-exposure). Long periods of exposure are better than shorter ones, but it is of primary importance that the anxiety be allowed to subside before

the patient leaves the situation. Returning to the situation several times is better than only one exposure. Periodic re-exposure is necessary; for example, someone who has overcome a fear of flying must continue to fly.

As mentioned, learning theory is not perfect in explaining why exposure therapy works. One unexplained paradox is that if the phobia began with a traumatic exposure to the phobic object, why would repeated exposure be ameliorative. Obviously, some new element must intervene as a corrective experience, and this is the contribution of the cognitive therapists.

Cognitive Restructuring

Cognitive therapy is an *anxiety coping skill*, that is, it helps the patient to control anxiety in the phobic situation. Like relaxation therapy, it can have a direct impact in lowering physiological arousal and thus it facilitates the person's facing the phobic object with reduced anxiety.

The cognitive aspects of the panic attacks are a set of automatic negative thoughts, such as "what if I panic," "I can't do that," "I have to get out of here," "I'm having a heart attack." Taking the example of the elevator phobic, to say, "I will surely panic if I am stuck in an elevator" is more likely to induce anxiety in a person than to say, "I can cope with whatever emerges." The anxiety-provoking thoughts predict catastrophes that are extremely unlikely, and seriously overestimate the probability of panic. The therapist discusses

the irrational nature of these thoughts and points out that they actually increase the anxiety rather than protecting the patient from the eventualities they fear.

Psychodynamic therapists see cognitive therapy as the behaviorists way out of the "black box"; it allows behaviorists to deal with mental content as well as observable behavior. The role of irrational thoughts in the development and maintenance of phobias is crucial to psychoanalytic theory as well, since the point of bringing unconscious fantasy to awareness is so that the fantasy can be evaluated as irrational or irrelevant to the current reality. However, the more direct approach of the cognitive therapists is considerably faster. Further, the cognitive therapists have developed a variety of techniques to deter these thoughts, once the patient is convinced they are maladaptive (See for example, Beck & Emery, 1985; Meichenbaum, 1977).

Psychotropic Medication

Panic attacks are a measurable psychophysiological event and the treatment of anxiety disorders is firmly grounded in psychobiology and the use of psychotropic medication. The first major breakthrough in the psychopharmacological treatment of phobias was the effective use of the tricyclic antidepressant imipramine (Tofranil) (Klein & Fink, 1962). Imipramine was found to block panic attacks, facilitating the phobic's

confrontation of the phobic object. However, many phobics continue avoidance because of high levels of anticipatory anxiety. The medication most frequently found to be useful for anticipatory anxiety is the benzodiazepine group. A common treatment protocol is to treat the panic attacks with antidepressant medication and to treat any residual avoidance with minor tranquilizers and desensitization (Klein, 1964). The antidepressants (tricyclics, mao inhibitors, tetracyclics, and serotonin reuptake blockers) are more effective in blocking nonsituational panic attacks, than in those panics of the simple phobics, and thus are more commonly used with panic disorder and agoraphobic patients. For social phobics, beta blockers are frequently employed to block the symptoms of tremor, rapid heartbeat, weakness in the knees, and so on, that may cause the social phobic embarrassment and avoidance of the situation.

Alcohol is the most common self-medication, for example, having a drink to ease anxiety in social situations. Thus, it is not surprising that co-morbidity of alcoholism and phobias is high (Regier et al., 1990).

Psychoeducation

Most programs begin with some instructional material. The value is especially great for the confused and frightened patient, who may fear that the phobia is far more serious a disorder than it is ("I am losing my mind"). It

is explained to the patient that anxiety and panic are a natural reaction to threat; they are of survival value. They are not inherently dangerous or harmful. It is emphasized that phobias are extremely common and that the prognosis is excellent. Space does not allow a thorough discussion of the subject, but excellent sources are found in Rapee, Craske, and Barlow (1989) for the therapist, and Weekes (1968) for the patient.

Breathe Retraining

It is very common for anxiety disorder patients to hyperventilate when they become anxious, thus exacerbating the problem. If hyperventilation continues, sufficient carbon dioxide may be blown off to bring on alkalosis which in turn can lead to tingling or numbness in the fingers and other extremities, lightheadness, dizziness, and feelings of unreality. These highly unpleasant sensations in turn increase the patient's experience of anxiety and the interaction continues to spiral toward a panic attack. Readily detectable signs of hyperventilation in the office might be sighing, periodic deep breaths, rapid speech with gasping, and so forth.

Several cases had significant symptom remission attributable solely to changing the breathing pattern, for example:

> Ms. A. came to treatment for performance anxiety which was impairing her ability to work. She was an opera singer, but her primary income was derived from teaching voice. Recently, she started to have anxiety attacks

> while teaching. She was considering giving up her job which would mean not only a loss of income, but also a loss of considerable satisfaction in her life. As she described her work, and the excitement she experienced in teaching, I could easily discern that she took gasps of breath before running on in long-phrased sentences. I pointed this out to her. She was unaware of the breathing pattern, despite teaching breathing techniques herself in voice class. I suggested to her that she merely pay attention to her breathing while teaching. This led to immediate improvement. I further suggested that when she started to feel dizzy, and the symptoms of impending panic, she try to notice if she was overbreathing, and if so, she take a few deep breaths. This further helped to re-enforce the change in the breathing pattern, and was sufficient for her to continue teaching without further experiences of dizziness, lightheadedness, and anxiety.

This very elementary intervention can be as simple as suggesting the patient take three deep breathes (preferred to breathing into a paper bag), to more extensive retraining techniques (Weiss, 1989).

Supportive Therapy

With the exception of exposure, all of the techniques mentioned above, cognitive therapy, medication, training in anxiety coping skills, and so on, are supportive techniques. Support is needed to bolster ego strength while the patient is exposing himself or herself to phobic objects. Simultaneous focus on painful psychodynamic material, unconscious conflict, and separation from important objects may be counterproductive during this phase, although research to study this effect has not yet been designed. However, after symptom remission, without the debilitating effect of the phobia, a decrease in dysphoria associated with the disorder and an increase in pleasure in

everyday activity, in self-confidence and self-esteem, are often seen. The shift may also lead to increase in productive activity, both in terms of fulfilling everyday obligations and in pursuing plans and goals that were impossible to carry out during the period of symptomatic restrictions. The most propitious time to deal with psychodynamic issues and character change may thus be after symptom change rather than at the beginning of treatment. (Lindemann, 1992). Not only is the patient then feeling more confident in his or her own ability to cope and to change, but also more confident in the therapist's ability to be an effective facilitator for change.

SUMMARY

Phobias are a common disorder that can vary from a mild annoyance to a severe disability. They are defined by a severe anxiety reaction that is disproportionate to the actual threat. The phobic avoids the phobic object despite awareness that the reaction is irrational. Phobias are divided into three categories: agoraphobia, social phobia, and simple phobia, according to the situation feared and to the anxiety reaction experienced. The theoretical understanding of the origin and development of the phobia results in treatment techniques that can be effective in over 70% of patients suffering from phobic disorder.

REFERENCES

Agras, W. S., Sylvester, D., & Oliveau, D. C. (1969). The epidemiology of common fears and phobias. *Comprehensive Psychiatry, 10,* 151-156.

Alden, L., & Cappe, R. (1981). Nonassertiveness: Skill deficit or self-evaluation? *Behavior Therapy, 12,* 107-114.

American Psychiatric Association, Committee on Nomenclature and Statistics (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. rev.). Washington, DC: Author.

Amies, P. L. Gelder, M. G., & Shaw, P. M. (1983). Social phobia: A comparative clinical study. *British Journal of Psychiatry, 142,* 174-179.

Beck, A. T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective.* New York: Basic Books.

Breier, A., Charney, D. S., & Heninger, G. R. (1986). Agoraphobia with panic attacks: Development, diagnostic stability and course of illness. *Archives of General Psychiatry, 43,* 1029-1036.

Burke, Kimberly C., Burke, Jack D., Regier, Darrel A., & Roe, Donald S. (1990). Age of onset of selected mental disorders in five community populations. *Archives of General Psychiatry, 47,* 511-518.

Christie, Kimberly A., Burke, Jack D., Regier, Darrel A., Rae. Donald S., Boyd, Jeffrey H., & Locke, Ben Z. (1988). Epidemiologic evidence for early onset of mental disorders and higher risk of drug abuse in young adults. *American Journal of Psychiatry, 145,* 971-975.

Davidson, Jonathan R. T. (1991). Introduction: Social phobia in review. *Journal of Clinical Psychiatry, 52* (Suppl.), 3-4.

Freud, S. (1909). Analysis of a phobia in a five-year-old boy. In *The standard edition.* Vol. 10 (pp. 5-149). London: Hogarth Press.

Goldstein, Alan J., & Chambless, Dianne L. (1978). A reanalysis of agoraphobia. *Behavior Therapy, 9,* 47-59.

Klein, Donald F. (1964). Delineation of two drug-responsive anxiety syndromes. *Psychoparmacologia, 53.* 397-408.

Klein, D. F., & Fink, M. (1962). Psychiatric reaction patterns to imipramine. *American Journal of Psychiatry, 119,* 432-438.

Lindemann, Carol (1992). Change in the expression of aggression following symptom reduction in phobias. Paper presented at the Anxiety Disorder Association of America National Conference. Houston, Texas.

Lindemann, Carol, Zitrin, C. M., & Klein, D. F. (1984). Thyroid dysfunction in phobia patients. *Psychosomatics, 25,* 603-606.

Marks, I. M. (1969). *Fears and phobias.* New York: Academic Press.

Marks, I. M. (1971). Phobic disorders four years after treatment: A prospective follow-up. *British Journal of Psychiatry, 11X,* 683-686.

Marks, I. M. (1987). Fears, phobias and rituals: Panic anxiety and their disorders. New York: Oxford University Press, Inc.

Mavissakalian, M., and Hamann, M. S. (1986). DSM-III personality disorder in agoraphobia. *Comprehensive Psychiatry, 27,* 471-479.

Meichenbaum, D. T. (1977). *Cognitive behavior modification.* New York: Plenum Press.

Michelson, L., Mavissakalian, M., & Marchione, K. (1985). Cognitive-behavioral treatments of agoraphobia. Clinical, behavioral and psychophysiological outcome. *Journal of Consulting and Clinical Psychology, 53,* 913-925.

Mowrer, O. H. (1939). Stimulus response theory of anxiety. *Psychological Review, 46,* 553-565.

Pavlov, I. P. (1927). *Conditioned reflexes.* London: Oxford University Press.

Rachman, S., & Seligman, M. (1976). Unprepared phobias: Be prepared. *Behaviour Research and Therapy, 14,* 333-338.

Rapee, Ronald M., Craske, Michelle, & Barlow, David H. (1989). Psychoeducation (pp. 225-236). In C. Lindemann (Ed.), *Handbook of phobia therapy: Rapid symptom relief in anxiety disorders.* Northvale. NJ: Jason Aronson.

Regier, Darrel A., Boyd, Jeffrey H., Burke, Jack D., Rae, Donald S., Myers, Jerome K., Kramer, Morton, Robins. Lee N., George, Linda K., Karno, Marvin, & Locke, Ben, Z. (1988). One month prevalence of mental disorders in the United States: Based on five edidemiologic catchment area sites. *Archives of General Psychiatry, 45,* 977-986.

Regier, Darrel A., Farmer, Mary E., Rae, Donald S., Locke, Ben Z. Keith, Samuel J., Judd, Lewis L., & Goodwin, Fredrick K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the epidemiologic catchment area (ECA) study. *JAMA, 264,* 2511-2518.

Roberts, A. H. (1964). Housebound housewives: A follow-up study of phobic anxiety states. *British Journal of Psychiatry, 110,* 191-197.

Roy-Byrne, P. P., Geraci, M., & Uhde, T. W. (1986). Life events and the onset of panic disorder. *American Journal of Psychiatry, 143,* 1424-1427.

Thorpe, G. K., & Burns, L. E. (1983). *The Agoraphobia Syndrome.* New York: Wiley.

Thyer, B. A., Nesse, R. M., Cameron, O. G., & Curtis, G. C. (1985). Agoraphobia: A test of the separation anxiety hypothesis. *Behaviour Research and Therapy, 23,* 75-78.

Turner, S. M., & Beidel, D. C. (1985). Empirically derived subtypes of social anxiety. *Behavior Therapy, 16,* 384-392.

Turner, S. M., Beidel, D. C., & Costello, A. (1987). Psychopathology in the offspring of anxiety disorder patients. *Journal of Consulting and Clinical Psychology, 55,* 229-235.

Weekes, Claire (1968). *Hope and help for your nerves.* New York: Hawthorne.

Weiss, J. H. (1989). Breathing control. In C. Lindemann (Ed.), *Handbook of phobia therapy: Rapid symptom relief in anxiety disorders.* Northvale, NJ: Jason Aronson.

Weissman, Myrna M., & Merikangas, Kathleen R. (1986). The epidemiology of anxiety and panic disorders: An update. *Journal of Clinical Psychiatry, 47,* (Suppl.), 11-17.

Westphal, C. (1871). Agraphobia: A Neuropathological description. *Archives of Psychiatry and Neurology, 3,* 384-412.

Wilson, Reid, (1989). Imaginal Desensitization (pp. 271-296). In C. Lindemann (Ed.) *Handbook of phobia therapy: Rapid symptom relief in anxiety disorders.* Northvale, NJ: Jason Aronson.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition.* Stanford: Stanford University Press.

Zitrin, C. M., Klein, D. F., Lindemann, C., Rock, M., Tobak, P., Kaplan, J. H., & Ganz, V. H. (1975). Comparison of short-term treatment regimens in phobic patients: A preliminary report. In R. L. Spitzer & D. F. Klein (Eds.), *Evaluation of Psychological Therapies.* Baltimore: The Johns Hopkins Press.