

CHAPTER 15. ANXIETY DISORDERS

15.8 ANXIETY DISORDERS: PSYCHOLOGICAL TREATMENTS

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[Cognitive-Behavioral Therapy](#)

[Psychosocial Therapy](#)

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Since the late 1980s there has been tremendous progress in the nonpharmacological treatment of anxiety disorders. Cognitive-behavioral therapies, which reflect a recent integration of the cognitive theories and methods associated with Aaron Beck, Albert Ellis, and David Clark, and the behavioral theories and methods of B.F. Skinner and Ivan Pavlov, currently have the greatest degree of empirical validation. Panic disorder, which has been said to be the most disabling of the anxiety disorders in terms of social and occupational functioning is a case in point in that recently developed treatments contain elements based on classical or Pavlovian conditioning, behavioral techniques of exposure, and cognitive restructuring of irrational beliefs and overvalued ideas. Other anxiety disorders for which cognitive-behavioral approaches have been particularly effective include social phobia (both generalized and nongeneralized type), obsessive-compulsive disorder, specific phobia, social phobia, and generalized anxiety disorder. Further validation is needed for two recently developed treatments for posttraumatic stress disorder, one based on exposure methods, and the other based on classical conditioning (*eye movement desensitization* and *reprocessing* [EMD/R]). Psychosocial (e.g., supportive and psychodynamic) therapies have also been used in the treatment of anxiety disorders.

COGNITIVE-BEHAVIORAL THERAPY

Panic Disorder Cognitive-behavioral treatment of panic disorder or *panic control therapy* produces 80 to 90 percent panic-free status, at least within 6 months of treatment. Two-year follow-up indicates that more than 50 percent of those patients who originally responded to panic control therapy have occasional panic attacks, and more than a quarter will seek additional treatment. Nonetheless, these treatment responders do tend to have a significant decline in panic-related symptoms and most maintain many of their treatment gains. A large multi-center study comparing medication and panic control therapy treatment being carried out at the University of Pittsburgh, Yale University, State University of New York at Albany, and Columbia University should help to resolve many questions about long-term gains in panic control therapy and pharmacological treatment.

Panic control therapy is an amalgam of techniques drawn from a variety of cognitive and behavioral methods and based largely on Peter Lang's three-system model of cognitive psychophysiology, which focuses on the interactions of three systems affecting the human experience of panic and anxiety: physiological (e.g., palpitation, sweating, dizziness, nausea), cognitive (fears of losing control or going crazy), and behavioral (avoidance, pacing). Panic control therapy techniques are thus directed towards each of these systems: breathing control techniques are designed to control the physiological effects of hyperventilation and progressive muscle relaxation helps reduce the overall negative effects of muscle tension on anxiety. Cognitive restructuring techniques, which focus on catastrophic thinking errors (e.g., "I will have a heart attack and die") as well as on misinterpretation of harmless bodily associations, are directed towards problems in the cognitive system. Education about the nature of anxiety and panic, which also counters the myths of panic attacks, (i.e., that they are associated with schizophrenia or heart disease) also serves as a form of stress inoculation in the cognitive domain. Exposure to feared situations and events, such as crowded public areas, helps to reduce avoidance symptoms of the behavioral domain. A novel technique called *interoceptive exposure* involves repeated exposure to the physical sensations associated with panic. This method, which is based on a classical or Pavlovian conditioning model of panic, consists of a series of activities, such as deliberately overbreathing (to produce physical effects of hyperventilation), breathing through a straw while holding one's nose (feelings of breathlessness), spinning in a chair (dizziness), running in place (increased heart rate), staring at one's hand (feelings of unreality), and so on. These activities are rehearsed until an habituation of the anxiety response has been achieved.

In clinical practice the degree to which various techniques are emphasized may depend on particular features of the panic disorder. For example, a patient with a high degree of agoraphobic avoidance may require additional exposure to fearful situations. The house-bound person with agoraphobia may require therapist-assisted in vivo exposure therapy as opposed to less labor intensive and more instruction-oriented exposure therapy for the patient with minimal agoraphobia and panic disorder. These panic control therapy techniques may also be carried out successfully by therapists whose primary mode of treatment is pharmacological. Finally, further research is needed to identify effective components of treatment and to determine whether certain subtypes of patients may require certain components of panic control therapy over others. In clinical practice, for example, it appears that a substantial number of patients with panic disorder respond well to education and breathing control alone whereas others seem to require more extensive treatment.

José was a 27-year-old laboratory technician who began having full-blown panic attacks 8 months prior to seeking help at our research clinic. While he was unable to identify specific situations that elicited attacks, he was particularly concerned about the possibility of them occurring while he was engaged in laboratory procedures with patients. His attacks typically involved a sudden explosion of autonomic arousal and included palpitations, sweating, dizziness, feelings of unreality, and tingling in his arms and legs. He dreaded the idea that the attacks might reoccur. In the beginning of his cognitive-behavioral program, he found an educational handout that described the myths of panic attacks (e.g., that they will lead to heart attacks, losing control, or going crazy) particularly reassuring. He began practicing diaphragmatic breathing each evening, and after several weeks, became effective in challenging his negative way of thinking about the consequences of panic attacks. In the latter few weeks of his 12-week program, he practiced exposing himself to physical sensations of panic by doing a variety of interoceptive exercises at home, including hyperventilating for 1 or 2 minutes at a time (designed to help José acclimate to the physical sensations associated with overbreathing), and spinning in a chair repeatedly (designed to help acclimate him to symptoms of dizziness and feelings of unreality). At the conclusion of the treatment program José's panic attacks had disappeared, and at 6-month follow-up he had maintained his treatment gains by attending "booster sessions" with his therapist once every 2 months.

In contrast to cognitive-behavioral formulations, it has been reported that patients who develop panic symptoms in their late 20s have histories replete with relationship problems as well as other neurotic symptoms stemming from parent-child disruptions. These patterns, in turn, are said to lead to disturbances in empathy and understanding, which may ultimately elicit panic symptoms. Recently, detailed treatment protocols have been developed that are based on psychodynamic formulations of anxiety, consisting primarily of supportive-expressive psychodynamic psychotherapy. Preliminary outcome research indicates that these psychodynamically oriented protocols are useful in modifying anxiety, depression, and related interpersonal problems. Studies on hypnotherapy and hypnoanalysis, in which early childhood conflicts are identified and ultimately tied to the origins of panic and anxiety, provide some support for a more traditional analytic approach.

The importance of cultural issues in the treatment of anxiety disorders should not be overlooked. African-Americans with panic disorder appear to respond less with panic control therapy compared with whites. This may be related to the high prevalence of untreated hypertension among African-Americans, which may, in turn, exacerbate anxiety symptoms or possibly lead to higher comorbidity of emotional problems. Conversely, it has been observed that Asian Americans and Native-Americans, whose philosophical systems emphasize the control of mind over body and who have also utilized breathing control methods for centuries, are particularly receptive to the breathing and cognitive control aspects of panic control therapy. Interestingly, data from the Epidemiologic Catchment Area (ECA) study did not detect any differences in prevalence of panic disorder between African-American, Hispanic, and white groups.

Social Phobia As with panic disorder, considerable progress in the psychological treatment of social

anxiety or social phobia is linked to the application of cognitive-behavioral methods. Unlike more traditional psychotherapies, cognitive-behavioral approaches do not address the origins of social anxiety, but instead focus on the use of coping strategies that can be implemented in current fearful situations. The most thoroughly studied form of cognitive-behavioral therapy for social phobia is a group therapy consisting of several discrete entities including (1) presentation of a three-system (cognitive-behavioral-physiological) model of social anxiety; (2) training in identification and restructuring of irrational beliefs regarding social performance; (3) in-session exposure to feared social situations via group role-playing scenarios; and (4) homework assignments directing patients to utilize cognitive and exposure techniques in vivo). Groups are particularly amenable to the treatment of social phobia in that they provide natural opportunities for patients to practice feared behaviors in a supportive and informative context.

Outcome research is somewhat limited but one study showed that cognitive-behavioral group therapy was nearly twice as effective as standard educational-supportive group psychotherapy. Responders to cognitive-behavioral group therapy were also shown to maintain treatment gains to a considerable extent at 5-year follow-up. Questions remain as to the effective treatment component in these therapies that blend cognitive and exposure-based methods. For example, it is unclear whether exposure to feared situations alone, without cognitive therapy, would be just as effective as the combined treatment. Also, it is not known whether group therapies other than educational or supportive group therapy, such as interpersonal group therapy, may be effective in treating social phobia.

In terms of the differential effects of cognitive-behavioral group therapy on patients of varying subtypes (generalized versus nongeneralized social phobia), it appears that patients with more discrete or nongeneralized fears, such as of public speaking, respond best to these type of treatments. Pharmacological research has also shown differential effects based on subtype, with beta-blockers being more effective for nongeneralized fears, and antidepressant agents such as the monoamine oxidase inhibitor (MAOI) phenelzine (Nardil), being more effective for generalized social phobia. For generalized as well as more severe forms of social phobia, a combination of psychological and pharmacological therapy may be in order. Alternatively, it may be that longer-term cognitive-behavioral therapy, with or without medication, is warranted.

Despite the lack of empirical validation via controlled studies on large samples, social phobia is commonly treated with other behavioral methods. Systematic desensitization, first described in 1958, is based on a classical conditioning model of fears. It involves a pairing of previously conditioned stimuli (e.g., hierarchical presentation of images of feared social situations) with a relaxed state (promoted by means of progressive muscle relaxation). This new pairing is said to create a new set of associations that lead the patient to no longer fear previously feared stimuli. Regardless of the specific behavioral technique utilized, the key mechanism of effective treatment is related to the development of self-efficacy, or a sense of confidence that a patient experiences when confronting challenging social events or situations.

Jane was a 31-year-old marketing executive at a rapidly expanding technology company. She contacted our research clinic for help with her fear of public speaking, which had become so severe in recent months that she was at risk for losing her job, which required a considerable amount of public presentation and leading training programs. Jane was assigned to a treatment program that entailed a combination of medication (β -adrenergic receptor antagonist the beta-blocker atenolol [Tenormin]) and a 12-week group-based cognitive-behavioral treatment program for nongeneralized social phobias, such as fear of public speaking. Before beginning the group program, Jane met with her behavior therapist who helped her develop a hierarchy of the public-speaking situations she feared. Difficulty levels ranged from speaking up at meetings involving five or fewer colleagues, which caused a low level of anxiety, to leading a training program for 100 or more employees and colleagues at annual corporate gatherings, which caused a very high level of anxiety. In her group treatment, Jane began by identifying and challenging negative thoughts associated with each situation (e.g., “They won't understand what I am saying” became “I have always explained myself clearly in the past”). The other group members then assisted Jane in designing and carrying out role-plays that allowed her to practice employing her new coping responses and helped her to develop new public speaking skills. By the end of treatment, Jane still experienced occasional anxiety when making a public presentation to large numbers people, but she no longer avoided such situations.

Finally, it is important to consider cultural factors when treating social phobia. In Japan, a condition called *Taijin Kyofusho* refers to a type of social anxiety in which the sufferers become preoccupied with the idea that they are causing others to be embarrassed or humiliated. Other *Taijin* fears include fear of emitting a body odor and fear of one's facial expression becoming too stiff. In utilizing cognitive therapy with Japanese and other Asian patients, it is important to consider general cultural characteristics, such as the importance of displaying hierarchical deference (i.e., respect for those in authority) as well as an emphasis on communal versus individual expression. The emphasis on rigid moral codes and religious ritual and custom in Arab culture is said to place individuals at higher risk of social phobia, reflecting an underlying fear of betraying valued ideas and formalities. It has been reported that 13 percent of all outpatient psychiatric visits (excluding for schizophrenia) in Saudi Arabia are for treatment of social phobia.

Posttraumatic Stress Disorder Treatment of posttraumatic stress disorder is based largely on the aversive effects of a traumatic event or series of traumatic events. Specifically, fears related to this disorder are developed via classical or Pavlovian conditioning in which the unconditioned stimulus (e.g., a horrible accident or sexual assault) that automatically produces a fear response or unconditioned response is paired with other stimuli (e.g., the sounds, smells, and sights associated with the traumatic event). These conditioned stimuli then come to elicit a fear response independent of the original unconditioned stimuli. According to O. Hobart Mowrer's two-factor theory these new classically conditioned fears are subsequently maintained via operant conditioning in that escape or avoidance behaviors are reinforced by their anxiety-relieving effects. Through a process of *higher-order conditioning*, increasing numbers and types of stimuli may become elicitors of an anxiety or a posttraumatic stress disorder response. For example, if particular smells present during the original

trauma are later present in more innocuous situations, such as when walking down the street or visiting a friend or relative, the patient may eventually evidence a fear response.

It has been argued that Mowrer's two-factor theory only partially explains the cognitive, affective, and physiological response unique to posttraumatic stress disorder. Symptoms such as trauma-related nightmares and psychological numbing are believed to be best understood by cognitive network theories, which posit the development of a “fear network” of memories. These cognitive networks, which include cognitive, behavioral, and physiological information about trauma responses, are formed following a traumatic event and are activated by trauma-related stimuli. According to this model, posttraumatic stress disorder responses can change across time as the *interpretation* of original trauma events produces changes in its meaning. Thus, a delayed response in this disorder can be explained by a subsequent change in the personal meaning of the original trauma, such as when an originally asymptomatic woman who has been sexually assaulted later discovers that her assailant has been released from prison and has been stalking previous victims.

Regardless of the emphasis on cognitive or conditioning processes, empirically validated treatments of posttraumatic stress disorder employ similar components, including (1) cognitive monitoring and restructuring, (2) exposure in imagination to the original traumatic event, and (3) exposure in vivo to trauma-related stimuli. The overall goal is to reduce or eliminate the patient's anxiety reaction to trauma-related cognitive and environmental stimuli. Cognitive restructuring is based on the notion that fear networks or structures can be directly modified by identifying and modifying negative or nonproductive thinking patterns related to concerns about threat or danger. Cognitive therapy may proceed in traditional fashion, based largely on therapist-patient dialogue, or may utilize homework-based written exercises in which the patient records irrational beliefs and composes more adaptive, coping-oriented responses that are based on new interpretation of the meaning of these trauma-related events. At least one study has found this cognitive processing therapy to be more effective than a no-treatment control group in reducing the symptoms of posttraumatic stress disorder.

In vivo and imaginal exposure techniques, which involve graduated exposure either to real life or cognitive trauma-related stimuli, are clearly useful in reducing overall anxiety as well as trauma-related fears. Both imaginal and in vivo techniques may involve return to the original place where the traumatic event occurred, or may be limited to situations that produce anxiety in the present (e.g., approaching certain people or places that evoke trauma-related memories). These methods have been shown to be effective for combat veterans suffering from the disorder and for women who have been sexually assaulted. More recently, a 4-week program has been developed to prevent the symptoms of this disorder for women who have been recently raped or assaulted. This program consists of (1) education about common reactions to trauma, (2) relaxation skills, (3) exposure in imagination to the original trauma, and (4) cognitive restructuring. A preliminary study comparing 10 women participants and 10 nonparticipants showed that 70 percent of the untreated women and only 10 percent of the treated women suffered symptoms of posttraumatic stress disorder at 2 months following the original trauma.

Jennifer was a 21-year-old college student who sought treatment in the anxiety clinic after being raped repeatedly at a fraternity party. She had difficulty immediately remembering details of the rape because she had ingested an unknown recreational drug that had been slipped into the punch bowl at the party. In the days following the rape, she slowly began to remember details of the traumatic event, often in the form of flashbacks and nightmares. She also experienced increased generalized anxiety, feelings of unreality, and an intense fear reaction to stimuli associated with the attacks, such as the sight of college men wearing sweat shirts with fraternity names and logos, as well as certain odors present during the party. Her treatment program was administered one-on-one by a psychologist who specialized in posttraumatic stress disorder. In the first few sessions, Jennifer was educated about the disorder and the nature of anxiety and was provided a rationale for an exposure-based treatment program. Ensuing sessions involved extensive discussion about the details of the traumatic event, as well as in-session exposures in-imagination to the original trauma. Exposure-based homework assignments complemented these in-session activities and were designed to treat Jennifer's new tendency to avoid trauma-related situations, including campus parties and other social gatherings. Slowly, Jennifer experienced decreased reactivity to trauma-related stimuli and began to enter situations she had previously avoided. After approximately twenty-five sessions Jennifer's symptoms were almost gone and she had nearly returned to normal in terms of participating in campus-related social events and parties. Despite her gains, Jennifer remains, in her words, "more careful" about certain high-risk social events (e.g., she will rarely enter a fraternity house), and finds that her trust in men is markedly diminished. A previous supporter of fraternities on campus, Jennifer is now an ardent advocate of removing fraternities from all colleges.

Unfortunately, little has been written about cross-cultural aspects of treatment of posttraumatic stress disorder. This is surprising in light of its particular relevance for minority groups in the United States, such as African-Americans from socially disadvantaged groups who witness a great deal of violence in their communities. For example, anxious black children, compared with their non-anxious peers, were found to experience a significantly greater degree of trauma. Observers of Caribbean-American immigrants have noted an association between acculturation and symptomatology of posttraumatic stress disorder. These researchers support the use of group supportive treatments of the disorder for this ethnic group, but warn against the practice of mixing patients with those whose disorder is of differing causes (e.g., sexual assault versus acculturation).

Generalized Anxiety Disorder Recent data from the National Anxiety Disorders Screening Day (NADSD) revealed a surprisingly high 1-month prevalence (11.5 percent) of generalized anxiety disorder for those participants in an anxiety screening program who met criteria for one anxiety disorder only as compared with 5.4 percent for panic disorder, 3 percent for posttraumatic stress disorder, 3.4 percent for social phobia, and 0.7 percent for obsessive-compulsive disorder. Generalized anxiety disorder is particularly prevalent among those with multiple anxiety problems; For example, in the NADSD sample 10.2 percent met the criteria for panic disorder and generalized anxiety disorder, and 7.9 percent met criteria for panic, social phobia, and generalized anxiety disorder. The latter may therefore be considered a hidden problem in that other comorbid anxiety problems may supercede it in terms of focus of treatment.

Cognitive-behavioral formulations and treatment programs dominate this area, despite the lack of data on etiology or psychotherapy outcome. Debate continues as to whether generalized anxiety disorder should be considered a discrete anxiety disorder at all, with some arguing that high comorbidity with other anxiety and depressive disorders suggests that it is merely a basic anxiety trait that serves as a platform for the development of other related problems. Citing the inability of the Center for Epidemiologic Studies Depression Scale (CES-D) to distinguish between depression and generalized anxiety disorder, at least in a sample of mothers of handicapped children, symptoms were noted as being, in some circumstances, a natural component of more severe depression. Data from the ECA study revealed that generalized anxiety disorder was more common among people of lower socioeconomic status as well as in African-Americans, thus suggesting a sociocultural factor in etiology.

Psychological theories and treatment programs alike have tended to focus on the issue of chronic and excessive worrying among individuals who have generalized anxiety disorder. Unlike those suffering panic attacks who experience catastrophic-type cognition (e.g., “I’m going to have a heart attack and die”), those with generalized anxiety disorder exhibit less emotionally charged cognitions on an ongoing basis (e.g., “I’ll never make it through the day,” or “I’m sure something will go wrong”). Excessive worriers actually experience less physiological arousal (e.g., decreased heart rate) in response to a fearful stimuli as compared with nonworriers, and it has been speculated that generalized anxiety disorder may actually serve as a type of defense against response to more fearful events.

Treatment programs to date contain one or both of the following components: (1) *cognitive restructuring* designed to identify worry-related thoughts and replace them with more positive coping responses and (2) *relaxation training* designed to reduce excessive physiological arousal. While controlled studies have shown that these methods are superior to either nondirective therapies or no-treatment controls, identification of the most effective treatment components remains unclear as does the superiority of these methods to other types of treatments, such as interpersonal-oriented therapies or other more alternative treatments, such as biofeedback or meditation.

A large-scale study comparing cognitive restructuring, relaxation training, a combined cognitive plus relaxation program, and a no-treatment group revealed improvements in all three active treatments relative to the control condition. While responders were remarkably successful in maintaining gains at 2-year follow-up, no differences were found among the three active treatments. Additionally, study dropouts and nonresponders remained symptomatic at follow-up. In similar fashion, a study comparing relaxation training, a combined cognitive therapy with relaxation training, and a nondirective psychotherapy demonstrated the superiority of the cognitive-behavioral programs compared to a treatment consisting of Rogerian-style reflecting about worrisome thoughts. A longer-term follow-up indicated the slight superiority of the combined cognitive-behavioral treatment over the relaxation-alone condition.

Melinda's friends and family refer to her as a “worrywart.” She constantly worries about something, whether it be that the chicken she is cooking may have salmonella, that her children may not be safe while driving to school, or that her family will not have enough money to pay for expenses. As Melinda put it during her initial evaluation, “I never seem to stop worrying.” In addition to her chronic worrying, Melinda experiences ongoing physical discomfort, including headaches, nausea, sweating, and occasional shortness of breath. She does not, however, experience full-blown panic attacks. Her treatment consisted of a combination of relaxation (specifically, progressive muscle relaxation practiced on a twice-daily basis) and cognitive therapy (identifying and challenging worry-related thoughts and replacing them with more productive coping responses). For example, she applied a type of “probability analysis” to her constant fear that her children would be harmed in a car accident and produced a coping response along the lines of “It is unlikely that they will be in an accident” as well as “My son is an excellent driver.” Following completion of treatment, Melinda reported that her family saw a tremendous improvement in terms of her chronic worrying. While worry-type thoughts would still occasionally enter her consciousness, she now felt that she had effective tools for dealing with them.

PSYCHOSOCIAL THERAPY

Supportive and psychodynamic therapies have been widely used in the treatment of generalized anxiety disorder, panic disorder, and posttraumatic stress disorder, although further research is needed to establish their efficacy.

According to the 1998 American Psychiatric Association's Practical Guidelines for the Treatment of Patients with Panic Disorder, psychosocial therapies may be of use. They have some application to the other anxiety disorders discussed in this section. A summary of the relevant areas of the report follows.

Psychodynamic Psychotherapy Psychodynamic psychotherapy is based on the concept that symptoms result from mental processes that may be outside of the patient's conscious awareness and that elucidating these processes can lead to remission of symptoms. Moreover, in order to lessen the patient's vulnerability to panic, the psychodynamic therapist considers it necessary to identify and alter core conflicts. The goals of psychodynamic psychotherapy may be more ambitious and require more time to achieve than those of a more symptom-focused treatment approach. There are some case reports of brief dynamic psychotherapies that took no longer than cognitive-behavioral therapy to achieve reasonable treatment goals for patients with panic disorder.

In psychodynamic psychotherapy, the successful emotional and cognitive understanding of the various elements of psychic conflict (impulses, conscience, internal standards that are often excessively harsh, psychological defense patterns, and realistic concerns) and reintegration of these elements in a more realistic and adaptive way may result in symptom resolution and fewer relapses. To achieve this insight and acceptance, the therapist places the symptoms in the context of the patient's life history and current realities and extensively uses the therapeutic relationship to focus on unconscious symptom

determinants.

Combined Treatments Investigators have examined use of the combination of medication and cognitive behavior therapy for patients with panic disorder and agoraphobia. Several short-term treatment studies have shown that the combination of the tricyclic medication imipramine (Imipramine) with one component of cognitive behavior therapy, behavioral exposure, may be superior to either treatment alone. Another study showed that selective serotonin reuptake inhibitors, such as paroxetine (Paxil), plus cognitive therapy worked significantly better for patients with panic disorder than cognitive therapy plus placebo. There has been one study of the combination of psychodynamic psychotherapy with medication. This study suggested that psychodynamic psychotherapy may improve the long-term outcome of medication-treated patients.

Group Therapy Reports on group therapy in the treatment of panic disorder have consisted primarily of cognitive behavioral approaches; the improvements with group cognitive behavior therapy were comparable to those in studies of individually administered cognitive behavior therapy and pharmacological treatment.

Patient Support Groups Patient support groups are very helpful for some patients suffering from panic disorder. Patients have the opportunity to learn that they are not unique in experiencing panic attacks and to share ways of coping with the illness. Support groups may also have a positive effect in encouraging patients to confront phobic situations. Finally, family members of patients with panic disorder may benefit from the educational aspects of patient support groups. In deciding to refer a patient to a support group, however, it is imperative that the psychiatrist obtain information about the nature of the group and the credentials of its leader. Support groups are not a substitute for effective treatment but are complementary to it.

FUTURE DIRECTIONS

There has been significant progress in recent years in the psychological treatment of anxiety disorders. Most of this progress can be linked to research on cognitive behavioral therapies, which are symptom-directed and relatively short-term. A common feature of all these treatments is active exposure to distressing stimuli, either in vivo or in imagination. These exposures vary depending on the type of anxiety disorder (e.g., the patient with social phobia is exposed to distressing social stimuli, such as parties or public-speaking events). Psychological treatments also include various forms of cognitive therapy that target irrational ideas emblematic of a particular disorder (e.g., the catastrophic fears of a patient with panic disorder). In all cases the goal is to assist the patient to endure discomfort by regularly practicing stress-reducing techniques.

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