

Panic, Phobias, Obsessions & Compulsions

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Everyone gets anxious.

We all worry from time to time about our health, family, finances, and so on. We all get stressed when the demands of living ask more of us than we can give. We all have objects that make us scared. We all have situations that we would prefer to avoid. We all get panicky when there is danger. However, Clinical Psychologists would not call any of these as **disorders** of anxiety. The fact they occur to us all at some time makes them “normal.” Indeed, people with anxiety disorders experience the same worries, stresses, fears, and avoidances as everyone else.

The chief difference is that someone with an anxiety disorder will say, “I have all those experiences, but this anxiety is different.” The quality of your experience is fundamentally different from everyday anxiety. The anxiety disorder is in a category of its own. It does not feel like normal anxiety. It does not behave according to the same rules. So if anxiety disorders are different to anxiety, what are the anxiety disorders?

Specific Phobias

First of all, there are Specific Phobias. Sufferers have a crippling, extreme, and unreasonable fear of objects or situations. They have been labelled by sticking a Greek beginning onto the word *phobia*, so that arachnophobia is a fear of spiders. The alphabetical listing hides something important. Feared objects and situations can be grouped into animals (eg, spiders, dogs), aspects of the natural environment (eg, storms, heights, water), blood-injury-injections, and specific situations (eg, elevators, flying, driving, etc.).

Specific phobias are found in 10% of people and more often in females. People with phobias of blood, injury, and injections can also lose consciousness and faint.

Social Phobia

The second clustering is Social Phobia in which there is a strong and lasting fear of social situations in which embarrassment may occur. Sufferers fear others will judge them to be anxious, weak, “crazy,” or stupid. Speaking in public is feared because others may notice signs of anxiety, such as trembling. Sufferers may avoid writing in case others see their hands shake. They may avoid eating or drinking in public for fear they may choke and cause embarrassment. Social Phobia affects 3% to 20% of people. It is more common among females. Since many social demands are culture-specific, Social Phobia can look different in different cultures and at different ages.

Panic Disorder and Agoraphobia

Agoraphobia involves fear of places or situations from which escape might be difficult, embarrassing, or in which help may not be available. The usual situations include being alone outside, being in a crowd or standing in a line, being on a bridge, and travelling by bus, train, or car. People with Agoraphobia often experience attacks of panic. These are unpredictable attacks of intense fear. To the person these attacks are inexplicable and they worry they are about to die, go crazy, suffocate, or lose control.

Agoraphobia literally means fear of the market place and while sufferers do avoid supermarkets, they avoid places because they are afraid of having a panic attack. Fearing they might die, suffocate, go crazy, or lose control, they flee to situations where these events may be less likely or more easily managed.

Agoraphobia afflicts around 3% of people and begins between late adolescence and the mid-30s. It usually starts after an unexpected and unpredicted panic attack. While panic attacks afflict males and females equally, females are more likely to have agoraphobia.

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder is similar in some ways to phobias. It follows a trauma involving actual or threatened death or serious injury, during which time the person felt intensely fearful, helpless, or horrified. Afterwards they keep on re-experiencing the trauma, avoid objects or situations that remind them of the trauma, are “jumpy and on edge.” Such traumatic reactions can occur after rape, armed hold-ups, and are not uncommon among refugees who have fled to Australia to avoid war, torture, and persecution.

Generalised Anxiety Disorder

Another anxiety disorder is Generalised Anxiety Disorder. It involves uncontrollable and unstoppable worry (far out of proportion to the likelihood or impact of feared events and stops you doing everyday tasks). It also involves extreme tension (that includes restlessness, being easily fatigued, having trouble concentrating, irritability, painful muscle tension, or disturbed sleep). It is more common among women and afflicts about 5% of people. Many sufferers do not even see they have a problem, thinking, “I’ve always been this way. It’s how I am.”

Obsessive-Compulsive Disorder

The final anxiety disorder is Obsessive-Compulsive Disorder. It involves obsessions (repeated and persistent disturbing and distressing thoughts, impulses, or images) or compulsions (actions like washing, ordering, or checking, or mental acts such as counting over and over again). It affects about 2% of people.

Where Do Anxiety Disorders come from?

Broadly speaking, people who develop anxiety disorders tend to be more nervous than average. However, this is not enough to cause an anxiety disorder. Typically, something happens to start the disorder off. This could be stressful life experiences, painful and unpleasant events, hearing information, or watching another person in a threatening or dangerous situation. When something happens, nervous people react.

For instance, think about a person on a plane when the wheels drop down with a bang. The nervous person begins to worry (eg, “Oh no, we’re about to crash”) whereas the less nervous person thinks something more positive (eg, “Oh great, we must be nearly about to land”). Thus, being a nervous person, having stressful experiences, and thinking in a worrying/negative way can work together to set the stage for an anxiety disorder.

The Hard Work of Treatment

In the past thirty years, there has been a tremendous amount of research into the treatment of anxiety disorders.

As a result, we are in a privileged position of being able to know that particular treatments are effective. While new and refined treatments will emerge, at the present time we know with certainty that two effective classes of treatment are medication and a non-drug treatment called cognitive-behaviour therapy. Although you will need to discuss with one of our Clinical Psychologists the relative merits of these for each anxiety disorder and for each sufferer, it is useful to know the broad details of each.

Cognitive-Behaviour Therapy

Cognitive-behaviour therapy involves treatments that change behaviour (exposure and response prevention and anxiety management) and worry thoughts (namely, cognitive therapy).

Exposure and Response Prevention

The sufferer is encouraged to confront the feared object or situation. Since continuous exposure to a stimulus weakens the responses triggered by it, by confronting the feared stimulus, anxiety reduces. Confronting fears can be terrifying, and therefore the way exposure is conducted varies with individuals. The other aspect is **response prevention**. It counters the usual tendency to flee from feared objects and situations. Exposure triggers intense and horrible fear and panic. Fleeing causes this unpleasant state to be replaced by the pleasant experience of relief.

However, the avoidance means that the sufferer cannot learn that the feared stimulus is not truly dangerous and the relief is so rewarding that future avoidance is encouraged. To counter this, when the person is doing exposure, the usual avoidance responses are prevented.

Anxiety Management

Confronting feared places is a necessary and important step in treatment. However, it is not always the only part of treatment. Relaxation can be useful in reducing tension. People with anxiety disorders (especially Generalised Anxiety Disorder) can be so tense that their muscles hurt and they become fatigued and exhausted from the continuous muscle strain. Therefore, ***progressive muscle relaxation*** is often taught as an effective way to reduce this tension.

Anxiety, but especially panic, is made worse by overbreathing. Therefore, ***slow breathing*** is often taught so that people can stop overbreathing and in so doing, stop anxiety spiralling into panic.

Very often, people with anxiety disorders have difficulty relating to others. Many times this arises from a false belief that they are incompetent in social situations. At other times it arises because the social situations they have to deal with require more than the usual level of skill. Therefore, treatment can involve ***social skills*** and ***assertiveness training***.

It is common practice in cognitive-behaviour therapy to give homework. This is critically important because it allows the skills to be practised so the gains translate from to everyday settings.

Cognitive Therapy

During cognitive (or thought) therapy, the clinician seeks to change the anxiety-provoking, worrying, and catastrophic thoughts that the person has about the feared objects, situations, and events. The therapist will help the person spot these worrying thoughts and come to a new understanding. The sufferer will be able to replace the unhelpful thoughts

with more helpful, less anxiety-provoking, and less worrying thoughts. It is not a simple matter of reassuring the person that, “there’s nothing to worry about” or telling the sufferer what to think. Rather, it is a complex process where the therapist skilfully works with the sufferer to bring them to a new understanding and a new set of beliefs about the world. For people who worry far more than is necessary and who find that their worry is out of control, these techniques are going to be able to give them much more control over these terrifying thoughts.

Depending upon the problem, the cognitive or behavioural components are sometimes used alone or together. Either way, these treatments are the strongest and most consistently supported psychological treatment for anxiety.

Medication for Anxiety Disorders

Anxiety disorders (except for Specific Phobias) can be effectively treated with medications. Anti-anxiety medications reduce the frequency and intensity of panic and levels of general fear, anxiety, tension, and worry. They fall into three classes. The first class is the benzodiazepines (such as Valium). These work by stimulating the brain’s own anxiety control mechanisms. The chief side-effects are fatigue and drowsiness. Due to their addictive qualities, use in the long-term requires careful management. A second class of anti-anxiety medications is the tricyclic antidepressants (such as imipramine). While called “antidepressants” these medications also have anti-panic and anti-anxiety qualities. Clomipramine (Anafranil) has also been effective with Obsessive-Compulsive Disorder. While effective and not addictive, they have a number of side effects including a dry mouth, dizziness, and nausea. The most recent developments are in a class of drugs called selective serotonin re-uptake inhibitors (SSRIs), such as fluoxetine (Prozac). These drugs also have antidepressant qualities, but they act on brain systems involved in fear. They can reduce panic (eg, sertraline; Zoloft) and have fewer side-effects than the tricyclics.

USEFUL BOOKS

- Montgomery, B., & Evans, L. (1983). *You and Stress*. Ringwood: Viking O'Neil.

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