The Anxiety & Phobia WORKBOOK

FIFTH EDITION

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Contents

1

Anxiety Disorders

Susan awakens suddenly almost every night, a couple of hours after going to sleep, with a tightness in her throat, a racing heart, dizziness, and a fear that she's going to die. Although she's shaking all over, she hasn't a clue why. After many nights of getting up and pacing her living room floor in an attempt to get a grip on herself, she decides to go see her doctor to find out whether something is wrong with her heart.

Cindy, a medical secretary, has been having attacks like Susan's whenever she's in a confined public situation. Not only does she fear losing control over herself, but she dreads what others might think of her if this were to happen. Recently she has been avoiding going into any kind of store other than the local 7-Eleven unless her boyfriend is with her. She has also needed to leave restaurants and movie theaters during dates. Now she is beginning to wonder whether she can cope with her job. She has been forcing herself to go into work, yet after a few minutes among her office mates, she starts to fear that she's losing control of herself. Suddenly she feels as though she *has* to leave.

Steve has a responsible position as a software engineer but feels he is unable to advance because of his inability to contribute in group meetings. It's almost more than he can bear just to sit in on meetings, let alone offer his opinions. Yesterday his boss asked him whether he would be available to make a presentation on his segment of a large project. At that point, Steve became extremely nervous and tongue-tied. He walked out of the room, stammering that he would let his boss know by the next day about the presentation. Privately, he thought about resigning.

Mike is so embarrassed about a peculiar fear he's had over the past few months that he can't tell anyone, not even his wife. While driving he is frequently gripped by the fear that he has run over someone or perhaps an animal. Even though there is no "thud" suggesting that anything like this has happened, he feels compelled to make a U-turn and retrace the route he's just driven to make absolutely sure. In fact, recently, his paranoia about having hit someone has grown so strong that he has to retrace his route three or four times to assure himself that nothing has happened. Mike is a bright, successful professional and feels utterly humiliated about his compulsion to check. He's beginning to wonder if he's going crazy.

Susan, Cindy, Steve, and Mike are all confronted by anxiety. Yet it is not ordinary anxiety. Their experiences differ in two fundamental respects from the "normal" anxiety people experience in response to everyday life. First, their anxiety has gone out of control. In each case, the individual feels powerless to direct what's happening. This sense of powerlessness in turn creates even more anxiety. Second, the anxiety is interfering with the normal functioning of

their lives. Susan's sleep is disrupted. Cindy and Steve may lose their jobs. And Mike has lost the ability to drive in an efficient and timely manner.

The examples of Susan, Cindy, Steve, and Mike illustrate four types of anxiety disorder: panic disorder, agoraphobia, social phobia, and obsessive-compulsive disorder. Later in this chapter, you can find detailed descriptions of the characteristics of each specific anxiety disorder. But I would first like you to consider the common theme that runs through them all. What is the nature of anxiety itself?

What Is Anxiety?

You can better understand the nature of anxiety by looking at both what it is and what it is not. For example, anxiety can be distinguished from fear in several ways. When you are afraid, your fear is usually directed toward some concrete external object or situation. The event that you fear usually is within the bounds of possibility. You might fear not meeting a deadline, failing an exam, being unable to pay your bills, or being rejected by someone you want to please. When you experience anxiety, on the other hand, you often can't specify what it is you're anxious about. The focus of anxiety is more internal than external. It seems to be a response to a vague, distant, or even unrecognized danger. You might be anxious about "losing control" of yourself or some situation. Or you might feel a vague anxiety about "something bad happening."

Anxiety affects your whole being. It is a physiological, behavioral, and psychological reaction all at once. On a physiological level, anxiety may include bodily reactions such as rapid heartbeat, muscle tension, queasiness, dry mouth, or sweating. On a behavioral level, it can sabotage your ability to act, express yourself, or deal with certain everyday situations.

Psychologically, anxiety is a subjective state of apprehension and uneasiness. In its most extreme form, it can cause you to feel detached from yourself and even fearful of dying or going crazy.

The fact that anxiety can affect you on a physiological, behavioral, and psychological level has important implications for your attempts to recover. A complete program of recovery from an anxiety disorder must intervene at all three levels to

1. Reduce physiological reactivity
2. Eliminate avoidance behavior
3. Change subjective interpretations (or "self-talk") which perpetuate a state of apprehension and worry

Anxiety can appear in different forms and at different levels of intensity. It can range in severity from a mere twinge of uneasiness to a full-blown panic attack marked by heart palpitations, disorientation, and terror. Anxiety that is not connected with any particular situation, that comes "out of the blue," is called free-floating anxiety or, in more severe instances, a *spontaneous panic attack*. The difference between an episode of free-floating anxiety and a spontaneous panic attack can be defined by whether you experience four or more of the following symptoms at the same time (the occurrence of four or more symptoms defines a panic attack):

- Shortness of breath
- Heart palpitations (rapid or irregular heartbeat)
- Trembling or shaking
- Sweating
- Choking
- Nausea or abdominal distress
- Numbness
- Dizziness or unsteadiness
- Feeling of detachment or being out of touch with yourself
- Hot flashes or chills
- Fear of dying
- Fear of going crazy or out of control

If your anxiety arises *only* in response to a specific situation, it is called *situational anxiety* or *phobic anxiety.* Situational anxiety is different from everyday fear in that it tends to be out of proportion or unrealistic. If you have a disproportionate apprehension about driving on freeways, going to the doctor, or confronting your spouse, this may qualify as situational anxiety. Situational anxiety becomes *phobic* when you actually start to *avoid* the situation: if you give up driving on freeways, going to doctors, or confronting your spouse altogether. In other words, phobic anxiety is situational anxiety that includes persistent avoidance of the situation.

Often anxiety can be brought on merely by thinking about a particular situation. When you feel distressed about what might happen when or if you have to face one of your phobic situations, you are experiencing what is called *anticipatory anxiety.* In its milder forms, anticipatory anxiety is indistinguishable from ordinary "worrying." But sometimes anticipatory anxiety becomes intense enough to be called *anticipatory panic.*

There is an important difference between spontaneous anxiety (or panic) and anticipatory anxiety (or panic). Spontaneous anxiety tends to come out of the blue, peaks to a high level very rapidly, and then subsides gradually. The peak is usually reached within five minutes, followed by a gradual tapering-off period of an hour or more. Anticipatory anxiety, on the other hand, tends to build up more gradually in response to encountering—or simply thinking about—a threatening situation and then usually falls off quickly. You may "worry yourself into a frenzy" about something for an hour or more and then let go of the worry as you find something else to occupy your mind.

Anxiety vs. Anxiety Disorders

Anxiety is an inevitable part of life in contemporary society. It's important to realize that there are many situations that come up in everyday life in which it is *appropriate* and *reasonable* to react with some anxiety. If you didn't feel *any* anxiety in response to everyday challenges involving potential loss or failure, something would be wrong. This workbook can be of use to anyone experiencing normal, ordinary anxiety reactions (everyone, in other words). It is also intended for those of you who are dealing with specific anxiety disorders. Incorporating exercise, breathing skills, relaxation, and good nutritional habits into your daily life—as well as paying attention to self-talk, mistaken beliefs, feelings, assertiveness, and self-esteem—can all contribute to making your life more balanced and less anxious, regardless of the nature and extent of the anxiety you happen to be dealing with.

Anxiety disorders are distinguished from everyday, normal anxiety in that they involve anxiety that 1) *is more intense* (for example, panic attacks), 2) *lasts longer* (anxiety that may persist for months instead of going away after a stressful situation has passed), or 3) *leads to phobias* that interfere with your life.

Criteria for diagnosing specific anxiety disorders have been established by the American Psychiatric Association and are listed in a well-known diagnostic manual used by mental health professionals. This manual is called the *DSM–IV* (*Diagnostic and Statistical Manual of Mental Disorders*—fourth edition). The following descriptions of various anxiety disorders are based on the criteria in the *DSM–IV*, as is the self-diagnosis questionnaire at the end of this chapter. This workbook can help you even if your specific anxiety disorder or reaction doesn't fit any of the *DSM–IV*'s diagnostic categories. On the other hand, don't be unduly concerned if your reaction is perfectly described by one of the diagnostic categories. Approximately 15 percent of the people in the United States would find themselves in your company.

Panic Disorder

Panic disorder is characterized by sudden episodes of acute apprehension or intense fear that occur "out of the blue," without any apparent cause. Intense panic usually lasts no more than a few minutes, but, in rare instances, can return in "waves" for a period of up to two hours. During the panic itself, any of the following symptoms can occur:

- Shortness of breath or a feeling of being smothered
- Heart palpitations—pounding heart or accelerated heart rate
- Dizziness, unsteadiness, or faintness
- Trembling or shaking
- A feeling of choking
- Sweating
- Nausea or abdominal distress

- A feeling of unreality—as if you're "not all there" (*depersonalization*)
- Numbness or tingling in hands and feet
- Hot and cold flashes
- Chest pain or discomfort
- Fears of going crazy or losing control
- Fears of dying

At least four of these symptoms are present in a full-blown panic attack, while having two or three of them is referred to as a *limited-symptom attack.*

Your symptoms would be diagnosed as panic disorder if 1) you have had two or more panic attacks and 2) at least one of these attacks has been followed by one month (or more) of persistent concern about having another panic attack, or worry about the possible implications of having another panic attack. It's important to recognize that panic disorder, by itself, does not involve any phobias. The panic doesn't occur because you are thinking about, approaching, or actually entering a phobic situation. Instead, it occurs spontaneously, unexpectedly, and for no apparent reason. Also, the panic attacks are not due to the physiological effects of a drug (prescription or recreational) or a medical condition.

You may have two or three panic attacks without ever having another one again or without having another one for years. Or you may have several panic attacks followed by a panic-free period, only to have the panic return a month or two later. Sometimes an initial panic attack may be followed by recurring attacks three or more times per week unremittingly until you seek treatment. In all of these cases, there is a tendency to develop *anticipatory anxiety* or apprehension between panic attacks focusing on fear of having another one. This apprehension about having another panic attack is one of the hallmarks of panic disorder.

If you are suffering from panic disorder, you may be very frightened by your symptoms and consult with doctors to find a medical cause. Heart palpitations and an irregular heartbeat may lead to EKG and other cardiac tests, which, in most cases, turn out normal. (Sometimes mitral valve prolapse, a benign arrhythmia of the heart, may coexist with panic disorder.) Fortunately, an increasing number of physicians have some knowledge of panic disorder and are able to distinguish it from purely physical complaints.

A diagnosis of panic disorder is made only after possible medical causes—including hypoglycemia, hyperthyroidism, reaction to excess caffeine, or withdrawal from alcohol, tranquilizers, or sedatives—have been ruled out. The causes of panic disorder involve a combination of heredity, chemical imbalances in the brain, and personal stress. Sudden losses or major life changes may trigger the onset of panic attacks.

People tend to develop panic disorder during late adolescence or in their twenties. About half of the people who have panic disorder develop it before the age of twenty-four. In about a third of cases, panic is complicated by the development of agoraphobia (as described in the following section). Between 1 and 2 percent of the population have "pure" panic disorder, while about 5 percent, or one in every twenty people, suffer from panic attacks complicated by agoraphobia. Women are about twice as likely as men to develop panic disorder.

Cigarette smoking increases the risk of panic disorder (Isensee et al. 2003). About 30 percent of people with panic disorder use alcohol to self-medicate (Mental Health America 2007), which often worsens their symptoms when the effects of alcohol wear off. Cannabis often precipitates panic in some people.

Panic disorder is in part influenced by excessive activity in parts of the brain known as the amygdala and the hypothalamus. See chapter 2 for more detailed information on the neurobiology of panic disorder.

Current Treatment

All of the following strategies are considered state-of-the-art treatments for panic disorder.

Relaxation Training. Practicing abdominal breathing and some form of deep muscle relaxation (such as progressive muscle relaxation) on a daily basis. This helps to reduce the *physical* symptoms of panic as well as anticipatory anxiety you might experience about having a panic attack. A physical exercise program may also be recommended to reduce anxiety. (See chapters 4 and 5.)

Panic-Control Therapy. Identifying and eliminating catastrophic thoughts (such as "I'm trapped!" "I'm going to go crazy!" or "I'm going to have a heart attack!") that tend to trigger panic attacks. (See chapter 6.)

Interoceptive Desensitization. Practicing voluntary habituation to the *bodily symptoms* of panic, such as rapid heartbeat, sweaty hands, shortness of breath, or dizziness. Such symptoms are created deliberately, usually in the therapist's office. For example, dizziness might be induced by spinning in a chair or rapid heartbeat by running up and down stairs. Repeated exposure to unpleasant bodily symptoms promotes *desensitization*, which basically means getting used to them to the point that they no longer frighten you. (See chapter 7.)

Medication. SSRI antidepressant medications such as Zoloft, Lexapro, Celexa, or Cymbalta—or benzodiazepine medications such as Xanax, Ativan, or Klonopin—may be used to reduce severity of panic symptoms. Such medications are best used in conjunction with the first three strategies above. (See chapter 17.)

Lifestyle and Personality Changes. Some of the lifestyle changes that can reduce your tendency to have panic attacks include stress management, regular exercise, eliminating stimulants and sugar from your diet, slowing down and creating "downtime," and altering your attitudes about perfectionism, the excessive need to please, and the excessive need to control. (Chapters 4, 5, 10, and 15 address these issues.)

Agoraphobia

The word *agoraphobia* means fear of open spaces; however, the essence of agoraphobia is a fear of panic attacks. If you suffer from agoraphobia, you are afraid of being in situations from which escape might be difficult—or in which help might be unavailable—if you suddenly had a panic attack. You may avoid grocery stores or freeways, for example, not so much because of their inherent characteristics but because these are situations from which escape might be difficult or embarrassing in the event of panic. Fear of embarrassment plays a key role. Most agoraphobics fear not only having panic attacks but *what other people will think* should they be seen having a panic attack.

It is common for the agoraphobic to avoid a variety of situations. Some of the more common ones include

- Crowded public places such as grocery stores, department stores, or restaurants
- Enclosed or confined places such as tunnels, bridges, or the hairdresser's chair
- Public transportation such as trains, buses, subways, or planes
- Being at home alone

Perhaps the most common feature of agoraphobia is anxiety about being far away from home or far from a "safe person" (usually your spouse, partner, a parent, or anyone to whom you have a primary attachment). You may completely avoid driving alone or may be afraid of driving alone beyond a certain short distance from home. In more severe cases, you might be able to walk alone only a few yards from home or you might be housebound altogether. I know of one agoraphobic who was unable to leave her bedroom without being accompanied.

If you have agoraphobia, you are not only phobic about a variety of situations but tend to be anxious much of the time. This anxiety arises from *anticipating* that you *might* be stuck in a situation in which you would panic. What would happen, for example, if you were asked to go somewhere you ordinarily avoid and have to explain your way out of it? Or what would happen if you suddenly were left alone? Because of the severe restrictions in your activities and life, you may also be depressed. Depression arises from feeling in the grip of a condition over which you have no control or that you are powerless to change.

Agoraphobia, in most cases, appears to be engendered by panic disorder. At first you simply have panic attacks that occur for no apparent reason (panic disorder). After a while, though, you become aware that your attacks occur more frequently in confined situations away from home or when you are by yourself. You begin to be afraid of these situations. At the point where you actually start to avoid these situations for fear of panicking, you've started to develop agoraphobia. From that point you might go on to develop a mild, moderate, or severe problem. In a mild case, you might feel uncomfortable in confined situations but not actually avoid them. You continue to work or shop on your own but do not want to go far from home otherwise. In a moderate case, you might start to avoid some situations, such as public transportation, elevators, driving far from home, or being in restaurants. However, your restriction is only partial, and there are certain situations away from home or your safe

person that you can handle on your own, even with some discomfort. Severe agoraphobia is marked by an all-inclusive restriction of activities to the point where you are unable to leave your house without being accompanied.

Just why some people with panic attacks develop agoraphobia and others do not is unknown at this time. (There are a few people who develop only agoraphobia without any panic attacks.) Nor is it understood why some people develop much more severe cases than others. What is known is that agoraphobia is caused by a combination of heredity and environment. Agoraphobics may have a parent, sibling, or other relative who also has the problem. When one identical twin is agoraphobic, the other has a high likelihood of being agoraphobic, too. On the environmental side, there are certain types of childhood circumstances that predispose a child to agoraphobia. These include growing up with parents who are 1) perfectionist and overcritical, 2) overprotective, and/or 3) overly anxious to the point of communicating to their child that the world is a "dangerous place." The hereditary and environmental origins of agoraphobia and other anxiety disorders will be explored in greater depth in the following chapter.

Agoraphobia affects people in all walks of life and at all levels of the socioeconomic scale. Approximately 80 percent of agoraphobics are women, although this percentage has been dropping recently. It is possible to speculate that as women are increasingly expected to hold down full-time jobs (making a housebound lifestyle less socially acceptable), the percentage of women and men with agoraphobia may tend to equalize.

Current Treatment

Relaxation Training, Panic Control Therapy, and Interoceptive Desensitization. Since agoraphobia is usually based on a fear of panic attacks, the same treatments as were described for panic disorder are utilized. (See chapters 4 and 6.)

Exposure. Exposure therapy means you face, or expose, yourself to a feared situation. Situations that you have avoided are gradually confronted through a process of small incremental steps. Such exposures are conducted first in imagination and then in real life (see chapter 7). For example, if you were fearful of driving far from home, you would gradually increase the distance you drive in small increments. A support person might accompany you in the same car at first, then drive in a second car behind you, and then, finally, you would practice driving alone. Or, if you were fearful of being home alone, the person who usually stays with you would leave for only a few minutes at first and then gradually increase the time away. Over time you learn to confront and enter into all of the situations you have been avoiding.

Cognitive Therapy. The aim of cognitive therapy is to help you replace exaggerated, fearful thinking about panic and phobias with more realistic and supportive mental habits. You learn to identify, challenge, and replace counterproductive thoughts with constructive ones. (See chapters 8 and 9.)

Medication. Current treatment for agoraphobia often utilizes medication. SSRIs such as Zoloft, Lexapro, Celexa, or Cymbalta are especially likely to be used for more severe cases where a

person is housebound or highly restricted in what they are able to do. Low doses of tranquilizers such as Xanax or Klonopin may also be used to help people negotiate the early stages of exposure. (See chapter 17.)

Assertiveness Training. Since agoraphobics often have difficulty standing up for themselves and their rights, assertiveness training is frequently part of the treatment. (See chapter 13.)

Group Therapy. Treatment for agoraphobia can be done very effectively in a group setting. There is much support available in a group, both for realizing that you are not alone and for completing week-to-week homework assignments.

Social Anxiety Disorder

Social anxiety disorder (also known as social phobia) is one of the more common anxiety disorders. It involves fear of embarrassment or humiliation in situations where you are exposed to the scrutiny of others or you must perform. This fear is much stronger than the normal anxiety most nonphobic people experience in social or performance situations. Usually it's so strong that it causes you to avoid the situation altogether, although some people with social phobia endure social situations, albeit with considerable anxiety. Typically, your concern is that you will say or do something that will cause others to judge you as being anxious, weak, "crazy," or stupid. Your concern is generally out of proportion with the situation, and you recognize that it's excessive (children with social phobia, however, do not recognize the excessiveness of their fear).

The most common social phobia is fear of public speaking. In fact, this is the most common of all phobias and affects performers, speakers, people whose jobs require them to make presentations, and students who have to speak before their class. Public-speaking phobia affects a large percentage of the population and is equally prevalent among men and women.

Other common social phobias include

- Fear of blushing in public
- Fear of choking on or spilling food while eating in public
- Fear of being watched at work
- Fear of using public toilets
- Fear of writing or signing documents in the presence of others
- Fear of crowds
- Fear of taking examinations

Sometimes social phobia is less specific and involves a generalized fear of *any* social or group situation where you feel that you might be watched or evaluated. When your fear is of a wide range of social situations (for example, initiating conversations, participating in small

groups, speaking to authority figures, dating, attending parties, and so on), the condition is referred to as *generalized social phobia.*

Common symptoms of social anxiety disorder include blushing, sweating, trembling, heart palpitations, and nausea. Many people who are unaware that they are socially phobic use alcohol to reduce these symptoms, which, in some cases, can lead to alcoholism.

While social anxieties are common, you would be given a formal diagnosis of social phobia only if your avoidance interferes with work, social activities, or important relationships, and/or if it causes you considerable distress. As with agoraphobia, panic attacks can accompany social phobia, although your panic is related more to being embarrassed or humiliated than to being confined or trapped. Also, the panic arises only in connection with a specific type of social situation.

Social phobias tend to develop earlier than agoraphobia and can begin in late childhood or adolescence, often between ages eleven and nineteen. They often develop in shy children around the time they are faced with increased peer pressure at school. Typically these phobias persist (without treatment) through adolescence and young adulthood but have a tendency to decrease in severity later in life. Recent studies suggest that social phobia affects between 3 to 7 percent of the U.S. population and may be more prevalent among men than women. Up to 14 percent of adults experience social phobia at some time in their lives. Social anxiety disorder occurs almost twice as often in women, but men are more likely to seek treatment for it (U.S. Department of Health and Human Services 1999).

A significant percentage of people with social anxiety disorder are clinically depressed, have another anxiety disorder such as panic disorder or generalized anxiety disorder, or are dealing with substance abuse.

As with other anxiety disorders, there are both genetic and environmental components in the causes of social anxiety disorder. If one identical twin has the problem, the other twin is 30 to 50 percent more likely to have the problem. At the same time, social anxiety in adoptive parents is significantly correlated with social anxiety in their children (Kendler, Karkowski, and Prescott 1999).

Current Treatment

All of the following interventions are part of the current treatment for social phobia:

Relaxation Training. Abdominal breathing and deep relaxation techniques are practiced on a regular basis to assuage physical symptoms of anxiety. (See chapter 4.)

Cognitive Therapy. Fearful thoughts that tend to perpetuate social phobias are identified, challenged, and replaced with more realistic thoughts. For example, the thought "I'll make a fool of myself if I speak up" would be replaced with the idea "It's okay if I'm a bit awkward at first when I speak up—most people won't be bothered."

Cognitive therapists tend to focus on three specific types of cognitive distortions: an excessive focus on anxiety symptoms and how they might appear to others, distortions in self-concept about your social attractiveness, and the tendency to overestimate the likelihood of a negative evaluation.

Exposure. Exposure involves gradually and incrementally facing the social situation or situations you're phobic about. You might do this first in imagery and then in real life. For example, if you're phobic of public speaking, you might start out giving a one-minute talk to a friend and then *gradually* increase, through many steps, both the duration of your talk and the number of people you speak to. Or, if you have difficulty speaking up in groups, you'd gradually increase both the length and degree of self-disclosure of remarks made in a group setting. (See chapter 7.) After each exposure, you'd review and challenge any unrealistic thinking that caused anxiety. While the treatment for social phobia can be done on an individual basis, group therapy is the ideal treatment format. This allows *direct* exposure to the situation and stimuli that evoke anxiety in the first place.

Staying on Task. People with social phobia tend to focus a lot on how they are doing or try to gauge other people's reactions while speaking in a social situation. Treatment includes training yourself to focus only on the task at hand, whether conversing with a boss, speaking up in class, or presenting information to a group.

Medication. SSRI medications such as Zoloft, Luvox, Cymbalta, or Lexapro, or low doses of benzodiazepine tranquilizers such as Xanax or Klonopin, may be used as an adjunct to the cognitive and exposure-based treatments described above. Sometimes MAO-inhibitor medications such as Nardil or Parnate are used to treat social phobia with success. (See chapter 17.)

Social Skills Training. In some cases, learning basic social skills such as smiling and making eye contact, maintaining a conversation, self-disclosure, and active listening are part of the treatment for social phobia.

Assertiveness Training. Training in assertiveness, the ability to ask directly for what you want or to say no to what you don't want, is often included in the treatment. (See chapter 13.)

Specific Phobia

A specific phobia typically involves a strong fear and avoidance of *one particular* type of object or situation. There are no spontaneous panic attacks, and there is no fear of panic attacks, as in agoraphobia. There is also no fear of humiliation or embarrassment in social situations, as in social phobia. Direct exposure to the feared object or situation may elicit a panic reaction, however. The fear and avoidance are strong enough to interfere with your normal routines, work, or relationships and to cause you significant distress. Even though you recognize its irrationalities, a specific phobia can cause you considerable anxiety.

Among the most common specific phobias are the following:

Animal Phobias. These can include fear and avoidance of snakes, bats, rats, spiders, bees, dogs, and other creatures. Often these phobias begin in childhood, when they are considered normal fears. Only when they persist into adulthood and disrupt your life or cause significant distress do they come to be classified as specific phobias.

Acrophobia (fear of heights). With acrophobia, you tend to be afraid of high floors of buildings or of finding yourself atop mountains, hills, or high-level bridges. In such situations you may experience 1) vertigo (dizziness) or 2) an urge to jump, usually experienced as some external force drawing you to the edge.

Elevator Phobia. This phobia may involve a fear that the cables will break and the elevator will crash *or* a fear that the elevator will get stuck and you will be trapped inside. You may have panic reactions, but you have no history of panic disorder or agoraphobia.

Airplane Phobia. This most often involves a fear that the plane will crash. Alternatively, it can involve a fear that the cabin will depressurize, causing you to asphyxiate. More recently, phobias about planes being hijacked or bombed have become common. When flying, you may have a panic attack. Otherwise you have no history of panic disorder or agoraphobia. Fear of flying is a very common phobia. Approximately 10 percent of the population will not fly at all, while an additional 20 percent experience considerable anxiety while flying.

Doctor or Dentist Phobias. This can begin as a fear of painful procedures (injections, having teeth filled) conducted in a doctor's or dentist's office. Later it can generalize to anything having to do with doctors or dentists. The danger is that you may avoid needed medical treatment.

Phobias of Thunder and/or Lightning. Almost invariably, phobias of thunder and lightning begin in childhood. When they persist beyond adolescence, they are classified as specific phobias.

Blood-Injury Phobia. This is a unique phobia in that you have a tendency to faint (rather than panic) if exposed to blood or your own pain through injections or inadvertent injury. People with blood-injury phobia tend to be both physically and psychologically healthy in other regards.

Disease Phobia (Hypochondria). Usually this phobia involves a fear of contracting and/or ultimately succumbing to a specific illness, such as a heart attack or cancer. With disease phobias, you tend to seek constant reassurance from doctors and will avoid any situation that reminds you of the dreaded disease.

Specific phobias are common and affect approximately 10 percent of the population. However, since they do not always result in severe impairment, only a minority of people with specific phobias actually seek treatment. These types of phobias occur in men and women about equally. Animal phobias tend to be more common in women, while disease phobias are more common in men. In general, women are twice as likely to report specific phobias as men, but this may reflect a difference in who seeks treatment (Cameron 2004).

As previously mentioned, specific phobias are often childhood fears that were never outgrown. In other instances, they may develop after a traumatic event, such as an accident, a natural disaster, an illness, or a visit to the dentist—in other words, as a result of conditioning. A final cause is childhood *modeling*. Repeated observation of a parent with a specific phobia can lead a child to develop it as well.

Current Treatment

Since specific phobias generally do not involve spontaneous panic attacks, some of the treatments for panic, such as panic-control therapy, interoceptive desensitization, and medication, are usually not included.

Relaxation Training. Abdominal breathing and deep muscle relaxation are practiced on a regular basis to reduce symptoms of anxiety that occur both when facing the specific phobia and when experiencing worry (anticipatory anxiety) about having to deal with the phobic situation. (See chapter 4.)

Cognitive Therapy. Fearful thoughts that tend to perpetuate the specific phobia are challenged and replaced. For example, "What if I panic because I feel trapped aboard an airplane?" would be replaced with more realistic and supportive thoughts, such as "While I may not be able to leave the airplane for two hours, I *can* move around, such as leaving my seat to go to the bathroom several times if needed. If I start to feel panicky, I have many strategies for coping that I can use, including abdominal breathing, talking to my companion, listening to a relaxing tape, or taking medication, if necessary." Coping statements, such as "I've handled this before and I can handle it again" or "This is just a thought; it has no validity," are also useful. These supportive coping statements are rehearsed until they are internalized. (See chapter 8.)

Exposure. This involves gradually facing the phobic situation through a series of incremental steps. For example, fear of flying would be faced first in imagination only (imagery desensitization), then by watching planes land and take off, then by boarding a grounded plane, then by taking a short flight, and, finally, by taking a longer flight. A support person would accompany you first through all the steps, then you'd try them on your own.

For some phobias, it's difficult to do real-life exposure. For example, if you're afraid of earthquakes, treatment would emphasize cognitive therapy and then exposure to imagined scenes of earthquakes (or watching movies about earthquakes). Imagery and real-life exposure are described in chapter 7.

To sum up, specific phobia is usually a benign disorder, particularly if it begins as a common childhood fear. Though it may last for years, it rarely gets worse and it often diminishes over time. Typically it is not associated with other psychiatric disturbances. People with specific phobias are usually functioning at a high level in all other respects.

Generalized Anxiety Disorder

Generalized anxiety disorder is characterized by chronic anxiety that persists for at least six months *but is unaccompanied by panic attacks, phobias, or obsessions.* You simply experience persistent anxiety and worry without the complicating features of other anxiety disorders. To be given a diagnosis of generalized anxiety disorder, your anxiety and worry must focus on two or more stressful life circumstances (such as finances, relationships, health, work problems, or school performance) a majority of days during a six-month period. It's common, if you're

dealing with generalized anxiety disorder, to have a large number of worries and to spend a lot of your time worrying. Yet you find it difficult to exercise much control over your worrying. Moreover, the intensity and frequency of the worry are always out of proportion to the actual likelihood of the feared events happening.

In addition to frequent, hard-to-control worry, generalized anxiety disorder involves having at least three of the following six symptoms (with some symptoms present more days than not over the past six months):

- Tense—feeling keyed up
- Being easily fatigued
- Difficulty concentrating
- Irritability
- Muscle tightness
- Difficulties with sleep

Generalized anxiety disorder is frequently associated with physical symptoms such as tension headaches, irritable bowel syndrome, high blood pressure, insomnia, and even osteoporosis. However, the presence of any or all of these physical problems does not necessarily imply a diagnosis of generalized anxiety disorder, which is based primarily on the presence of ongoing worry.

You are likely to receive a diagnosis of generalized anxiety disorder if your worry and associated symptoms cause you significant distress and/or interfere with your ability to function occupationally, socially, or in other important areas.

If a doctor tells you that you suffer from generalized anxiety disorder, he or she has probably ruled out possible medical causes of chronic anxiety, such as hyperventilation, thyroid problems, or drug-induced anxiety (alcohol or benzodiazepine withdrawal). Generalized anxiety disorder often occurs together with depression, a condition sometimes referred to as "mixed anxiety-depressive disorder." In such instances, a careful history will usually reveal which disorder—the generalized anxiety or the depression—came first.

Generalized anxiety disorder can develop at any age. In children and adolescents, the focus of worry often tends to be on performance in school or sports events. In adults, the focus can vary. This disorder affects approximately 5 percent of the American population and may be slightly more common in females than males (55 to 60 percent of those diagnosed with the disorder are female).

Although there are no specific phobias associated with generalized anxiety disorder, one view propounded by Aaron Beck and Gary Emery suggests that the disorder is sustained by "basic fears" of a broader nature than specific phobias, such as

- Fear of losing control
- Fear of not being able to cope
- Fear of failure
- Fear of rejection or abandonment

- Fear of death and disease

Generalized anxiety disorder can be aggravated by any stressful situation that elicits these fears, such as increased demands for performance, intensified marital conflict, physical illness, or *any situation that heightens your perception of danger or threat.*

The underlying causes of generalized anxiety disorder are unknown. It is likely to involve a combination of heredity, neurobiology, and predisposing childhood experiences, such as excessive parental expectations or parental abandonment and rejection, or parents modeling worry behavior.

Current Treatment

Relaxation Training. Abdominal breathing and deep relaxation techniques are practiced on a regular basis to directly reduce anxiety. A physical exercise program may also be included in the treatment. (See chapters 4 and 5.)

Cognitive Therapy. Fearful self-talk underlying specific worry themes is identified, challenged, and replaced with more realistic thinking. When you worry, you overestimate the odds of something negative happening and underestimate your ability to cope if something bad did, in fact, happen. Cognitive therapy aims to correct both types of distorted thinking. You would also work on changing negative beliefs, or "metabeliefs," about worry itself. These include both beliefs that worry will help you avoid something negative, such as "If I worry about it, it won't happen," as well as fearful beliefs about worry itself, such as "My worries are uncontrollable" or "I'll go crazy from worrying." Realistic self-statements are consistently practiced and internalized over time. Guided imagery may also be used to help redirect your mind from preoccupation with worry to more optimistic themes.

Worry Exposure. In worry exposure, you do repeated and prolonged exposure to fearful images (your worst-case scenarios) of what you're worried about. In these images you include strategies you would use to reduce anxiety and cope with the situation.

Reducing Worry Behaviors. You identify overly cautious "safety behaviors" that tend to reinforce worrying. For example, if you tend to call your spouse or child several times a day to check on them, you would reduce the frequency of this behavior.

Problem Solving. This means taking systematic action to solve the problem you're worried about. In short, you focus on solutions to the problem that worries you instead of the worry itself. If there is no practical solution, you work on changing your attitude toward the situation—that is, learning to accept what you can't change.

Distraction. A variety of distraction techniques can be helpful for worries that do not lend themselves easily to cognitive therapy or problem solving. Common diversionary activities include talking to a friend, journaling, listening to music, gardening, exercise, puzzle solving, arts and crafts, cooking, and using the Internet.

Medication. For moderate to severe cases of generalized anxiety disorder, SSRI medications

such as Zoloft, Luvox, Lexapro, or Celexa may be used. The SNRI medication Effexor has also been found to be effective in treating generalized anxiety disorder. Another medication, BuSpar, has been used for fifteen years to treat worry and generalized anxiety. It is no longer considered a first-line medication, however, as the SSRIs appear to be slightly more effective. BuSpar may sometimes be combined with an SSRI to enhance the SSRI's effectiveness. Benzodiazepines such as Xanax, Ativan, and Klonopin are often used in primary care but are not considered a first-line treatment by psychiatrists because of their potential for tolerance, dependence, and abuse.

Mindfulness Practice. Mindfulness is an attitude of simply witnessing the ongoing stream of your thoughts and feelings in the present moment without judgment. It originated in Buddhist meditation practice but is now being used as a common treatment for stress, depression, and generalized anxiety. For further information about mindfulness practice, see chapter 18.

Lifestyle and Personality Changes. Such changes are basically similar to the methods described for panic disorder: stress management, increased downtime, regular exercise, eliminating stimulants/sweets from your diet, resolving interpersonal conflicts, and changing attitudes toward perfectionism, an excessive need to please others, or the excessive need to control.

Obsessive-Compulsive Disorder

Some people naturally tend to be more neat, tidy, and orderly than others. These traits can be useful in many situations, both at work and at home. In obsessive-compulsive disorder, however, they are carried to an extreme and disruptive degree. Obsessive-compulsive people can spend many hours cleaning, tidying, checking, or ordering, to the point that these activities interfere with the rest of the business of their lives.

Obsessions are recurring ideas, thoughts, images, or impulses that seem senseless but nonetheless continue to intrude into your mind. Examples include images of violence, thoughts of doing violence to someone else, or fears of leaving on lights or the stove or leaving your door unlocked. You recognize that these thoughts or fears are irrational and you try to suppress them, but they continue to intrude into your mind for hours, days, weeks, or longer. These thoughts or images are not merely excessive worries about real-life problems and are usually unrelated to a real-life problem.

Compulsions are behaviors or rituals that you perform to dispel the anxiety brought up by obsessions. For example, you may wash your hands numerous times to dispel a fear of being contaminated, check the stove again and again to see if it is turned off, or look continually in your rearview mirror while driving to assuage anxiety about having hit somebody. You realize that these rituals are unreasonable, yet you feel compelled to perform them to ward off the anxiety associated with your particular obsession. The conflict between your wish to be free of the compulsive ritual and the irresistible desire to perform it is a source of anxiety, shame, and even despair. Eventually you may cease struggling with your compulsions and give over to them entirely.

Obsessions may occur by themselves, without necessarily being accompanied by compulsions. In fact, about 20 percent of the people who suffer from obsessive-compulsive disor-

der only have obsessions, and these often center around fears of causing harm to a loved one or having disquieting sexual thoughts.

The most common compulsions include washing, checking, and counting. If you are a washer, you are constantly concerned about avoiding contamination. You avoid touching doorknobs, shaking hands, or coming into contact with any object you associate with germs, filth, or a toxic substance. You can spend literally hours washing hands or showering to reduce anxiety about being contaminated. Women more often have this compulsion than men. Men outnumber women as checkers, however. Doors have to be repeatedly checked to dispel obsessions about being robbed; stoves are repeatedly checked to dispel obsessions about starting a fire; or roads repeatedly checked to dispel obsessions about having hit someone. In the counting compulsion, you must count up to a certain number or repeat a word a certain number of times to dispel anxiety about harm befalling you or someone else.

Obsessive-compulsive disorder is often accompanied by depression. Preoccupation with obsessions, in fact, tends to wax and wane with depression. This disorder is also typically accompanied by phobic avoidance—such as when a person with an obsession about dirt avoids public restrooms or touching doorknobs. Sometimes avoidance interferes with the person's social or occupational functioning.

It is very important to realize that as bizarre as obsessive-compulsive behavior may sound, it has nothing to do with "being crazy." You always recognize the irrationality and senselessness of your thoughts and behavior, and you are very frustrated (as well as depressed) about your inability to control them.

Obsessive-compulsive disorder is different from compulsive behavior disorders such as gambling and overeating. People with compulsive behavior disorders derive some pleasure from their compulsive activities, whereas people with OCD neither want to perform their compulsions (except to reduce fear) nor derive any pleasure from doing so.

Obsessive-compulsive disorder used to be considered a rare behavior disturbance. However, recent studies have shown that about *2 to 3 percent of the general population* may suffer, to varying degrees, from obsessive-compulsive disorder. The reason prevalence rates have been underestimated up to now is that most sufferers have been very reluctant to tell anyone about their problem. This disorder appears to affect men and women in equal numbers. Although many cases of obsessive-compulsive disorder begin in adolescence and young adulthood, about half begin in childhood. The age of onset tends to be earlier in males than females.

The causes of obsessive-compulsive disorder are unclear. There is some evidence that a deficiency of a neurotransmitter substance in the brain known as serotonin, or a disturbance in serotonin metabolism, is associated with the disorder. This is borne out by the fact that many sufferers improve when they take medications that increase brain serotonin levels, such as clomipramine (Anafranil) or specific serotonin-enhancing antidepressants such as fluoxetine (Prozac), fluvoxamine (Luvox), sertraline (Zoloft), or escitalopram (Lexapro). It also appears that persons with OCD have excessive activity in certain parts of the brain, such as the prefrontal cortex and the caudate nucleus. See chapter 2 for a more detailed description of the latest research on the neurobiology of obsessive-compulsive disorder.

Current Treatment

Relaxation Training. As with all of the anxiety disorders, abdominal breathing and deep relaxation skills are practiced on a daily basis to help reduce anxiety symptoms. (See chapter 4.)

Cognitive Therapy. Fearful, superstitious, or guilty thoughts associated with obsessions are identified, challenged, and replaced. For example, the idea "If I have a thought of doing harm to my child, I might act on it" is replaced with "The thought of doing harm is just 'random noise' caused by the OCD. It has no significance. Just having the thought doesn't mean I'll do it." (See chapter 8.)

Exposure and Response Prevention (ERP). This technique consists of exposure to situations that aggravate obsessions, followed by enforced prevention from performing rituals or compulsions. For example, if you've been washing your hands every time you touch a doorknob, you'd be instructed to touch doorknobs and either reduce the number of times you wash your hands or refrain from washing at all. Similarly, if you check the door five times whenever you leave your house, you would be required to gradually reduce the number of checks to one.

You and your therapist devise a variety of situations, preferably in your home setting. Then you continually practice exposing yourself to these situations and desist from performing the compulsions (response prevention). Usually your therapist or a support person accompanies you to monitor your compliance in not performing compulsions.

When your problem involves obsessions only, without compulsions, any neutralizing thoughts or covert rituals you use to reduce anxiety caused by your obsessions need to be stopped. You would also work on accepting your obsessions without trying to make them go away. (For further information on exposure and response prevention in treating OCD, see the book *Stop Obsessing: How to Overcome Your Obsessions and Compulsions* by Edna Foa and Reid Wilson, or *The OCD Workbook* by Bruce Hyman and Cherry Pedrick.)

Medication. Medications such as Anafranil and the SSRI medications, including Prozac, Luvox, Lexapro, Cymbalta, and Zoloft, help about 60 to 70 percent of those with OCD. Long-term use of medication is fairly common with OCD, although in some cases the cognitive and exposure/response prevention strategies described above may suffice. Effective doses of SSRI medications are usually higher for OCD than for other anxiety disorders, and benefits from these medications tend to appear only after two to three months at higher doses. Low doses of antipsychotic medications such as Zyprexa and Resperdal have been found to be useful adjuncts in the treatment of OCD for some people, which indicates that part of the brain mechanisms underlying OCD involve the role of dopamine receptors.

Lifestyle and Personality Changes. Essentially, the same lifestyle and personality changes described for panic disorder and generalized anxiety disorder apply to OCD.

The strategies presented in this workbook will be helpful if you are affected by obsessive-compulsive disorder. Yet the primary mode of treatment I would suggest is to consult a professional who is well versed in the use of behavioral methods, such as exposure and response prevention, as well as in the use of appropriate medications. This workbook can complement behavioral and pharmacological treatment approaches.

Post-Traumatic Stress Disorder

The essential feature of post-traumatic stress disorder (PTSD) is the development of disabling psychological symptoms following a traumatic event. It was first identified during World War I, when soldiers were observed to suffer chronic anxiety, nightmares, and flashbacks for weeks, months, or even years following combat. This condition came to be known as shell shock.

Post-traumatic stress disorder can occur in anyone in the wake of a severe trauma outside the normal range of human experience. These are traumas that would produce intense fear, terror, and feelings of helplessness in anyone and include natural disasters, such as earthquakes or tornadoes; car or plane crashes; and rape, assault, or other violent crimes against you or your immediate family. It appears that the symptoms are more intense and longer lasting when the trauma is personal, as in rape or other violent crimes. Observation of someone else suffering a severe trauma can be sufficient to induce post-traumatic stress disorder.

Among the variety of symptoms that can occur with post-traumatic stress disorder, the following nine are particularly common:

- Repetitive, distressing thoughts about the event
- Nightmares related to the event
- Flashbacks so intense that you feel or act as though the trauma were occurring all over again
- An attempt to avoid thoughts or feelings associated with the trauma
- An attempt to avoid activities or external situations associated with the trauma—such as developing a phobia about driving after you have been in an auto accident
- Emotional numbness—being out of touch with your feelings
- Feelings of detachment or estrangement from others
- Losing interest in activities that used to give you pleasure
- Persistent symptoms of increased anxiety, such as difficulty falling or staying asleep, difficulty concentrating, startling easily, or irritability and outbursts of anger

For you to receive a diagnosis of post-traumatic stress disorder, these symptoms need to have persisted for at least one month (with less than one month's duration, the appropriate diagnosis is acute stress disorder—see below). In addition, the disturbance must be causing you significant distress, interfering with social, vocational, or other important areas of your life.

If you suffer from post-traumatic stress disorder, you tend to be anxious and depressed. Sometimes you will find yourself acting impulsively, suddenly changing residence or going on a trip with hardly any plans. If you have been through a trauma where others around you died, you may suffer from guilt about having survived.

Post-traumatic stress disorder can occur at any age and affects about 8 percent of the population. Children with the disorder tend not to relive the trauma consciously but continually reenact it in their play or in distressing dreams.

There is some evidence that susceptibility to post-traumatic stress disorder is hereditary. For identical twins exposed to combat in Vietnam, if one identical twin developed the disorder, the odds were higher that the other identical twin would, as compared with fraternal twins (True, Rice, and Eisen 1993).

Current Treatment

Treatment for post-traumatic stress disorder is complex and multifaceted. Many of the strategies described above for other anxiety disorders are helpful, but additional techniques may be used as well.

Relaxation Training. Abdominal breathing and progressive muscle relaxation techniques are practiced to better control anxiety symptoms. (See chapter 4.)

Cognitive Therapy. Fearful or depressed thinking is identified, challenged, and replaced with more productive thinking. For example, guilt about having been responsible for the trauma—or having survived when someone you loved did not—would be challenged. You would reinforce yourself with supportive, constructive thoughts, such as "What happened was horrible, and I accept that there is nothing I could have done to prevent it. I'm learning now that I can go on." (See chapters 8 and 9.)

Exposure Therapy. A therapist or support person helps you confront fearful situations that you want to avoid because they trigger strong anxiety. In imaginal exposure, you would repeatedly go back over fearful memories of events, objects, and persons associated with the original trauma. In real-life exposure, you would return to the actual situation where the trauma occurred. For example, if you were assaulted in an elevator, you would return to the elevator several times. Repeated exposure helps you to understand that the fearful situation is no longer dangerous. (See chapter 7.)

Medication. SSRI medications such as Zoloft, Luvox, Prozac, or Celexa are often helpful in alleviating PTSD symptoms. Especially when these symptoms are severe and long-lasting, a course of medication lasting one or two years might be utilized. Tranquilizers such as Xanax or Klonopin might be used on a short-term basis. (See chapter 17.)

Support Groups. Support groups are particularly helpful in enabling PTSD victims to realize that they are not alone. Support groups for rape or crime survivors are often available in larger metropolitan areas. Considerable research indicates that social support offers protective effects in both avoiding and recovering from the disorder.

EMDR or Hypnotherapy. Eye-movement desensitization and reprocessing (EMDR) or hypnotherapy are often helpful in enabling PTSD victims to retrieve and work through memories of the original traumatic incident. These techniques may be used to accelerate the course of therapy and/or overcome resistance to exposure. Studies have found these techniques to be

equally effective as cognitive behavioral therapy and exposure (Seidler and Wagner 2006).

It's important to add that the treatment for any anxiety disorder may include marital or family therapy. Interpersonal problems with spouses and/or family may serve to perpetuate anxiety and undermine the success of treatment until these issues are addressed. Family therapy is also useful in educating family members about how to understand, support, and, in some cases, set limits with the family member suffering with the anxiety disorder.

Additional Anxiety Disorders in the *DSM–IV*

The anxiety disorders described above have been recognized by professionals in the field for over twenty years. When the fourth edition of *The Diagnostic and Statistical Manual of Mental Disorders* was published in 1994, the following four disorders were added.

Acute Stress Disorder

Like post-traumatic stress disorder, acute stress disorder involves developing anxiety and other disabling symptoms after exposure to a traumatic event. The principal distinction is that the symptoms subside in less than one month; if the symptoms last beyond one month, the diagnosis is changed from acute stress disorder to post-traumatic stress disorder. As with post-traumatic stress disorder, the initial trauma involves exposure to an event that carries the threat of death or serious injury (for example, military combat, violent personal assault, sexual assault, a natural or man-made disaster, a car accident, or being diagnosed with a life-threatening illness). Either during or after the traumatic incident, you have symptoms such as numbness, detachment, or feelings of unreality or depersonalization. Later you tend to avoid anything that reminds you of the incident and have persistent symptoms of anxiety (difficulty sleeping, irritability, poor concentration, exaggerated startle response, restlessness). This disturbance typically interferes with your work and your significant relationships but, as indicated, lasts no longer than four weeks following the traumatic event.

Agoraphobia Without a History of Panic Disorder

This particular anxiety disorder has all of the same features as agoraphobia—such as avoidance of a variety of situations—but there is no history of having had full-blown panic attacks. Instead, the focus of your fear is on only *one or two* symptoms among all those listed for panic disorder. For example, you might be afraid *only* of having heart palpitations if you venture too far from home or go to a crowded public place. Sometimes the fear is of an incapacitating symptom not on the list of panic attack symptoms. For example, you might be afraid to drive long distances and/or to be far from a town because of a fear of losing bladder control or having a bout of diarrhea.

Only a small percentage of people with agoraphobia do not have a history of panic disorder (estimates range from 5 to 15 percent). Treatment emphasizes relaxation, cognitive therapy, and *in vivo* exposure.

Anxiety Disorder Due to a General Medical Condition

This diagnostic category is reserved for situations in which significant anxiety (in the form of either panic attacks or generalized anxiety) is a direct physiological effect of a specific medical condition. Numerous types of medical conditions can cause anxiety, including endocrine conditions (hyper- and hypothyroidism, pheochromocytoma, hypoglycemia), cardiovascular conditions (congestive heart failure, pulmonary embolism), metabolic conditions (vitamin B_{12} deficiency, porphyria), and neurological conditions (vestibular problems, encephalitis). For a more complete listing, see the section in chapter 2 entitled "Medical Conditions That Can Cause Panic Attacks or Anxiety."

Substance-Induced Anxiety Disorder

This category is used when generalized anxiety or panic attacks are determined to be the direct physiological effect of a substance, whether a drug of abuse, a medication, or toxin exposure. The anxiety may be a result either of exposure to the substance or of withdrawal from it. For example, if you had no previous history of an anxiety disorder, then suddenly developed panic attacks as a result of withdrawing too quickly from a medication, you would receive this diagnosis.

Self-Diagnosis Questionnaire

The following questionnaire is designed to help you identify which particular anxiety disorder you may be dealing with. It is based on the official classification of anxiety disorders used by mental health professionals and known as the *DSM–IV (Diagnostic and Statistical Manual of Mental Disorders*—fourth edition).

1. Do you have spontaneous anxiety attacks that come out of the blue? (Only answer "yes" if you do *not* have any phobias.) Yes ____ No ____
2. Have you had at least one such attack in the last month? Yes ____ No ____
3. If you had an anxiety attack in the last month, did you worry about having another one? Or did you worry about the implications of your attack for your physical or mental health? Yes ____ No ____
4. In your worst experience with anxiety, did you have more than three of the following symptoms?

   □ Shortness of breath or a smothering sensation

- □ Dizziness or an unsteady feeling
- □ Heart palpitations or rapid heartbeat
- □ Trembling or shaking
- □ Sweating
- □ Choking
- □ Nausea or abdominal distress
- □ Feelings of being detached or out of touch with your body
- □ Numbness or tingling sensations
- □ Flushes or chills
- □ Chest pain or discomfort
- □ Fear of dying
- □ Fear of going crazy or doing something out of control

If your answers to 1, 2, 3, and 4 were yes, stop. You've met the conditions for **panic disorder**.

If your answer to 1 was yes, but your anxiety reaction involved three or fewer of the symptoms listed under 4, you're experiencing what are called *limited-symptom attacks*, but do not have full-blown panic disorder.

If you have panic attacks *and* phobias, go on.

5. Does fear of having panic attacks cause you to avoid going into certain situations? Yes ____ No ____

If your answer to 5 was yes, stop. It is likely that you are dealing with **agoraphobia**. See question 6 to determine the extent of your agoraphobia.

6. Which of the following situations do you avoid because you are afraid of panicking?

- □ Going far away from home
- □ Shopping in a grocery store
- □ Standing in a grocery store line
- □ Going to department stores
- □ Going to shopping malls
- □ Driving on freeways
- □ Driving on surface streets far from home
- □ Driving anywhere by yourself
- □ Using public transportation (buses, trains, etc.)

- ☐ Going over bridges (whether you're the driver or the passenger)
- ☐ Going through tunnels (as driver or passenger)
- ☐ Flying in planes
- ☐ Riding in elevators
- ☐ Being in high places
- ☐ Going to a dentist's or doctor's office
- ☐ Sitting in a barber's or beautician's chair
- ☐ Eating in restaurants
- ☐ Going to work
- ☐ Being too far from a safe person or safe place
- ☐ Being alone
- ☐ Going outside your house
- ☐ Other _____

The number of situations you checked above indicates the extent of your agoraphobia and the degree to which it limits your activity.

If your answer to 5 was no, but you do have phobias, go on.

7. Do you avoid certain situations *not* primarily because you are afraid of panicking but because you're afraid of being embarrassed or negatively evaluated by other people (which could subsequently lead you to panic)? Yes ____ No ____

If your answer to 7 was yes, stop. It's likely that you are dealing with **social phobia**. See question 8 to determine the extent of your social phobia.

8. Which of the following situations do you avoid because of a fear of embarrassing or humiliating yourself?

- ☐ Sitting in any kind of group (for example, at work, in school classrooms, in social organizations, or in self-help groups)
- ☐ Giving a talk or presentation before a small group of people
- ☐ Giving a talk or presentation before a large group of people
- ☐ Parties and social functions
- ☐ Using public restrooms
- ☐ Eating in front of others
- ☐ Writing or signing your name in the presence of others
- ☐ Dating
- ☐ Any situation in which you might say something foolish

- ☐ Other _____

The number of situations you checked indicates the extent to which social phobia limits your activities.

If your answers to questions 5 and 7 were no, but you have other phobias, continue.

9. Do you fear and avoid any one (or more than one) of the following?
   - ☐ Insects or animals, such as spiders, bees, snakes, rats, bats, or dogs
   - ☐ Heights (high floors in buildings, tops of hills or mountains, high-level bridges)
   - ☐ Driving
   - ☐ Tunnels
   - ☐ Bridges
   - ☐ Elevators
   - ☐ Airplanes (flying)
   - ☐ Doctors or dentists
   - ☐ Thunder or lightning
   - ☐ Water
   - ☐ Blood
   - ☐ Injections or medical procedures
   - ☐ Illness such as heart attacks or cancer
   - ☐ Darkness
   - ☐ Other _____
10. Do you have high degrees of anxiety usually *only* when you have to face one of these situations? Yes ____ No ____

If you checked one or more items in 9 and answered yes to 10, stop. It's likely that you're dealing with a **specific phobia**. If not, proceed.

11. Do you feel quite anxious much of the time but do *not* have distinct panic attacks, do *not* have phobias, and do *not* have specific obsessions or compulsions? Yes ____ No
12. Have you been prone to excessive worry for at least the last six months? Yes ____ No ____
13. Has your anxiety and worry been associated with at least three of the following six symptoms?
    - ☐ Tense—feeling keyed up
    - ☐ Being easily fatigued

- ☐ Difficulty concentrating or mind going blank
- ☐ Irritability
- ☐ Muscle tension
- ☐ Sleep disturbance (difficulty falling or staying asleep, or restless and unsatisfying sleep)

If your answers to 11, 12, and 13 were yes, stop. It's likely that you're dealing with **generalized anxiety disorder.** If you answered yes to 11 but no to 12 or 13, you're dealing with an anxiety condition that is not severe enough to qualify as generalized anxiety disorder.

14. Do you have recurring intrusive thoughts such as about hurting or harming a close relative, about being contaminated with dirt or a toxic substance, fearing you forgot to lock your door or turn off an appliance, or an unpleasant fantasy of catastrophe? (You recognize that these thoughts are irrational but you can't keep them from coming into your mind.) Yes ____ No ____

15. Do you perform ritualistic actions such as washing your hands, checking, or counting to relieve anxiety over irrational fears that enter your mind? Yes ____ No ____

If you answered yes to 14 but no to 15, you are probably dealing with **obsessive-compulsive disorder**, but have obsessions only.

If you answered yes to 14 and 15, you're probably dealing with **obsessive-compulsive disorder**, with both obsessions and compulsions.

If you answered no to 14 and 15 and most or all of the preceding questions, but you still have anxiety or anxiety-related symptoms, you may be dealing with **post-traumatic stress disorder** or a nonspecific anxiety condition. Use the section in this chapter on post-traumatic stress disorder to determine whether your symptoms fit this category.

Co-Occurrence of Anxiety Disorders

In the years that have passed since the first edition of *The Anxiety & Phobia Workbook* was published, it has become increasingly apparent that many people are dealing with more than one anxiety disorder. For example, one survey of people with panic disorder found that 15 to 30 percent also have social phobia, 10 to 20 percent have a specific phobia, 25 percent have generalized anxiety disorder, and 8 to 10 percent have obsessive-compulsive disorder. People with agoraphobia quite often have social phobias and/or obsessive-compulsive difficulties. If you find that your particular condition fits the description for more than one anxiety disorder, you are not alone.