Learning Objectives

Issues to Consider

Kraepelin (1856–1926) and Bleuler (1857–1939) shaped the direction of the modern approach to mental illness, where different types of mental illness are diagnosed and classified according to specific symptoms. This is where we will begin the study of phobias; we will look at the clinical characteristics or symptoms of the disorder. Diagnosis and classification raise issues such as is the diagnosis of phobia consistent (reliable) and accurate (valid)? You will be familiar with the models of abnormality from this topic at AS level, so try to recall what factors are likely to be implicated by the different models. We will also look at how the models of abnormality explain the causes of phobia. Finally, we will consider the methods of treatment of phobia.

On completion of this topic you should be familiar with the following.

*Use this list of learning objectives as a revision checklist. Cross-reference the objectives with the Specification.*

**Clinical characteristics and diagnosis of phobic disorders**

- Outline the clinical characteristics of phobias.
- Discuss issues surrounding the classification and diagnosis of phobias, including reliability and validity.

**Biological explanations of phobic disorders**

- Critically consider biological explanations of phobias.

**Psychological explanations of phobic disorders**

- Outline and evaluate psychological explanations of phobias.

**Biological therapies for phobic disorders**

- Discuss biological therapies of phobias.

**Psychological therapies for phobic disorders**

- Outline and assess psychological therapies of phobias.

**NOTE:** All exam questions will refer to one anxiety disorder rather than phobias because the Specification allows for choice as to which anxiety disorder is studied. So if you prefer to study obsessive-compulsive disorder then turn to the next chapter. You do NOT need to know both disorders.
Clinical Characteristics and Diagnosis of Phobias

For details, see Eysenck’s A2 Level Psychology (pages 472–479).

Clinical Characteristics of Phobias

Fill in the blanks.

Phobias are a form of an ________y disorder where the adaptive emotional response has become chronic and dis_______g. They consist of irrational fe______s that are out of pro____________on to the reality of the threat provided by the fear-provoking stimulus.

Physical symptoms
• The immediate physical symptoms are the body’s response to str____s.
• However, this is heightened and can result in breathlessness and tightness in the chest, hyperventilation (increased breathing), and p____________ns (increased heart rate).
• Hyperventilation increases carbon dioxide and this can lead to light headedness, “pins and needles”, and even painful muscle co____________ns. Muscle tension can lead to he____________es and aching and stiffness, particularly in the back, neck, and shoulders.

Behavioural symptoms
• Avoidance behaviour is shown as the individual usually a________s the feared object, which can greatly restrict their everyday behaviour.
• Anxiety often results in restless, “jumpy” behaviour, where the individual has difficulty relaxing and doing nothing. A startle response is often common where the individual is easily unnerved.

Emotional symptoms
• Anxiety is accompanied by a fe________g of dread. The individual is frightened and distressed and may feel he or she is about to die or lose control of their bodily functions.

Cognitive symptoms
• Anxiety can decrease c____________n and so decrease the person’s ability to perform complex tasks. Reduced cognitive capacity can inhibit workplace functioning.

Social symptoms
• Anxiety may reduce the individual’s ability to cope with so________l settings and so inhibit personal and social functioning.
Types of phobias

Fill in the blanks.
The main categories of phobia are specific phobia, social phobia, and agoraphobia. The latter usually causes more disturbances to the individual’s daily life than specific phobias, which are more easily avoided.

Specific phobia
This is the phobia of a specific object, which usually fall into four main subtypes:
1. An__________al type.
2. En______________l dangers type.
4. Sit____________al type (planes, lifts, enclosed spaces).

A fifth, “other type” is an umbrella type that covers any specific phobia that does not fall into the four main types. The prevalence is 11% of the American population (Comer, 2001). In Europe, the United States, and Canada at least twice as many females as males develop specific phobia (Comer, 2001).

Social phobia
Social phobia is a fear of social sit________s due to self-con________ss of own behaviour and fear of others’ reactions. This can be generalised, where the individual suffers social a__________y in most situations, or specific, where the individual fears a particular situation, such as public sp____________g. The prevalence is 8% of the population, 70% of which are female.

Agoraphobia
This is the fear of open or p________c places, which can include open or closed spaces, public transport, or crowds. It is very rare on its own as it is co-morbid with p________c disorder. The panic disorder usually occurs first and then the individual avoids open or public places so as not to have a panic attack, and thus the agoraphobia develops. Approximately 50% of all phobics suffer with agoraphobia with panic disorder. The prevalence is 3–4% of the population, and 75% are female.

Classification of phobias

Fill in the blanks.
DSM-IV (Diagnostic and Statistical Manual, Volume 4), which is the American classification system, and the International Classification of Diseases, the tenth edition of which (ICD-10) was published by the World Health Org__________n in 1992, are the two most common cla____________on systems.

Diagnosis of phobias
The DSM-IV diagnostic criteria are:
1. Marked and persistent fear of a specific o__________t or situation.
2. Exposure to the fear-provoking stimulus produces a rapid a_____________y response.
3. The individual recognises that the fear exp_______________d is excessive.
4. The phobic stimulus is either av__________d or responded to with great an______________y.
5. The phobic reactions interfere significantly with the individual's working or social life, or there is marked di_____________s about the phobia.

**Specific phobia**

According to DSM-IV-TR (APA, 2000; see A2 Level Psychology page 472) the diagnostic criteria for specific phobia are:

- Marked and persistent fear of a specific object or situation.
- Exposure to the phobic stimulus nearly always produces a rapid anxiety response.
- The individual recognises that his or her fear of the phobic object or situation is excessive.
- The phobic stimulus is either avoided or responded to with great anxiety.
- The phobic reactions interfere significantly with the individual's working or social life, or he or she is very distressed about the phobia.
- In individuals under the age of 18, the phobia has lasted for at least 6 months.

ICD-10 has fewer criteria and these overlap with those in DSM-IV-TR. For example, the anxiety must be restricted to the presence of the phobic object or situation and avoidance is shown.

**Social phobia**

The DSM-IV-TR (APA, 2000; see A2 Level Psychology page 473) diagnostic criteria for social phobia are as follows:

- Marked and persistent fear of social or performance situations involving exposure to unfamiliar people or possible scrutiny by others lasting at least 6 months. There is concern about humiliating or embarrassing oneself.
- Anxiety is usually produced by exposure to the social situation.
- There is a recognition that the fear is excessive and/or unreasonable.
- There is significant distress or impairment.

The ICD-10 diagnostic criteria closely resemble those in DSM-IV-TR. For example, the anxiety must be restricted to social situations, and frequent avoidance of these social situations must be shown.

**Agoraphobia**

Agoraphobia is accompanied by panic disorder when open or public spaces are experienced and so the DSM-IV-TR criteria reflect this.

The DSM-IV-TR criteria for panic disorder with agoraphobia are as follows (APA, 2000; see A2 Level Psychology page 474):

- Recurrent unexpected panic attacks.
- At least one panic attack has been followed by at least 1 month of worry about the attack, concern about having more panic attacks, or changes in behaviour resulting from the attack.
- Agoraphobia, in which there is anxiety about being in situations from which escape might be hard or embarrassing in the event of a panic attack.
- The situations are avoided, endured with marked distress, or manageable only with the presence of a companion.

The ICD-10 criteria are similar except they focus on the agoraphobia rather than the agoraphobia plus panic. One of the main criteria for agoraphobia is that anxiety is largely restricted to: crowds, public places, travelling away from home, and travelling alone. A second criterion is that there is frequent avoidance of the situations causing anxiety.

### Issues Surrounding Classification and Diagnosis

**Fill in the blanks.**

For any diagnostic system to work effectively, it must possess re__ and v___. Reliability means that there is good co__ over time and between different people's diagnosis of the same patient; known as inter-judge reliability. If diagnosis of depression is valid then patients who are diagnosed as suffering from depression must have the di___. If a diagnostic system is to be valid, it must also have high reliability. Clearly if a disorder cannot be agreed upon (so low re__) then all of the different views cannot be correct (so low v__).

In terms of classification DSM-IV and ICD-10 take a categorical approach which assumes that all mental disorders are distinct from each other, and that patients can be categorised with a disorder based on them having particular sy___. However, diagnosing abnormality is not as straightforward as this approach suggests.

**The categorical approach**

- Classification systems such as DSM-IV-TR (revised version of DSM-IV in 2000) and ICD-10 are ca__al systems.
- This is an all-or-none approach in which patients are assumed to have the dis___er or not. This seems straightforward but using the system in practice is not because many individuals may not meet all of the criteria for diagnosis but nevertheless have many of the sy___s of phobia.
- For example, many people are very frightened of snakes and/or spiders, but the fear isn’t quite strong enough to qualify as a specific phobia. The validity of DSM-IV and ICD-10 is reduced by the strict and arbitrary criteria used in the a___-or-n____ approach. Despite the weaknesses of such a classification, strict criteria are needed to achieve re__ in diagnosis.

**Comorbidity**

- Comorbidity is when a patient has two or more mental disorders at the same time.
- Approximately 50% of social phobics have one or more related dis___s, such as de___, substance abuse, agoraphobia, or generalised a____ty disorder (Rachman, 2004, see A2 Level Psychology page 477).
- Patients with agoraphobia often suffer from p____c disorder or depression.
- Comorbidity affects reliability and validity because it makes it more difficult to diagnose what exactly is wrong and so the diagnosis may be wrong (not v___d) or lack consistency (not re__e).
Diagnosis: semi-structured interviews

- Patients are generally diagnosed on the basis of one or more interviews with a therapist. Some interviews are very uns___ed and informal. This can produce good rapport between the patient and the therapist, but reliability and validity of diagnosis tend to be l____.

- Semi-structured interviews in which patients are asked a largely predetermined series of qu_____s do have good re____y and v____y. Two of the most used semi-structured interviews for phobia are the Structured Clinical Interview for DSM-IV-Patient Version (SCID-I/P) and the Anxiety Disorder Interview Schedule for DSM-IV (ADIS-IV). Both interviews involve systematic questioning about a range of sy____ms common to phobias.

- Brown et al. (2001) studied the reliability of DSM-IV. 1400 patients were interviewed twice with the second interview occurring within 2 weeks of the first one. They found inter-rater agr_____t was excellent for specific phobia, social phobia, and panic disorder with agoraphobia and reliability was hi____er than for other mental disorders such as generalised anxiety disorder and major depressive disorder.

- The high reliability of diagnosis is because phobias have clear beh____l symptoms (avoidance of the feared stimulus or situation) that make it relatively easy for therapists to diagnose them.

- The lack of reliability was mainly due to the categorical approach and what is described as the “thr____d” issue—did the patient’s symptoms cause sufficient distress or interference with his or her life to warrant a phobia diagnosis? There were inconsistencies and so lack of reliability in ju____ts on level of interference. Other issues included patients’ reports of their symptoms sometimes changed between int_____s, or interviewer errors or subjectivity in categorisation of symptoms.

Content validity

- High content validity means that the given form of assessment, such as interview or checklist, succeeds in eliciting adequate information from patients concerning all of the sy_____ms of the phobia in question.

- The semi-structured interviews such as ADIS-IV and SCID-I/P have high content validity because they have been carefully constructed to cover all symptoms of phobias contained in DSM-IV.

Criterion validity

- This involves considering various aspects of the behaviour of those diagnosed with a given phobia. High cri____n validity means that those with a diagnosis of, say, social phobia, differ in predictable ways from those not receiving that diagnosis.

- Evidence for criterion validity is that those diagnosed with agoraphobia or social phobia report significant problems of work and social ad________nt (Mataix-Cols et al., 2005).

- However, criterion validity is lower for specific phobia because impaired adjustment is usually quite low. If you imagine the specific phobia was of frogs it’s not that difficult to just av_____d them and so in every other way live a normal life! The level of impairment will depend on the co____ss of the feared object.

- There is some evidence for criterion validity for phobias, but note that poor social and work fu____ng are found in those suffering from most mental disorders and so this doesn’t distinguish patients with phobias from patients with other mental disorders.
Construct validity
- This type of validity is more theoretical in nature than the others. It involves testing hypotheses based on our understanding of the particular phobia.
- For example, we might predict that patients diagnosed with social phobia would underestimate their own social skills.
- It is sometimes hard to know what to do if a hypothesis isn’t supported. In the example, it might mean that the diagnostic assessment was inaccurate or that the hypothesis itself was at fault.
- The diagnosis of the phobias has reasonable construct validity because hypotheses are supported such as the fact that phobics have faulty cognitions.

Predictive validity
- This is concerned with the extent to which we can use the diagnosis of, say, social phobia, to predict the eventual outcomes for patients.
- Suppose, for example, that most social phobics respond well to a given form of treatment but that nevertheless it generally took a long time for recovery to occur. As we would be able to predict the eventual outcome (in this case recovery) reasonably well from the diagnosis, this would indicate high predictive validity.
- Phobias have some predictive validity because we can predict a better outcome for specific phobia than for social and agoraphobia because the latter are much more serious disorders. This is supported by the fact specific phobia is generally easier to treat than social or agoraphobia.

FIND OUT FOR YOURSELF: Research the DSM-IV and ICD-10 classifications for yourself. Identify similarities and differences in the two classifications systems.

CONCLUSIONS—SO WHAT DOES THIS MEAN?

Answer the following questions in your conclusions:
- Which types of validity are reasonably well supported?
- Which issues question the reliability and validity of diagnosis of phobias?

Using this in the exam
Outline the clinical characteristics of one anxiety disorder. (5 marks)
Discuss the issues associated with the classification and diagnosis of one anxiety disorder. (20 marks)
Biological Explanations of Phobic Disorders

For details, see Eysenck’s A2 Level Psychology (pages 479–485).

Genetic Factors

Fill in the blanks.
Mostly evidence for the genetics hypothesis for phobias is based on t____n studies, with some f____ly studies. The evidence is strongest for agoraphobia, l____t for specific phobia, and falls in the middle for s____al phobia. The concordance rates can be compared with the prevalence rates for the r____m population given above. Bienvenu et al. (2007; see A2 Level Psychology page 482) have suggested that the genetic factors underlying social phobia and agoraphobia are very similar and are linked to individual differences in extr____on and neuroticism (susceptibility to negative mood states); where genetically predisposed introverts and those high in ne____m were found to be more susceptible to social phobia and agoraphobia. However, the genetic factors underlying specific phobia differ from those underlying agoraphobia and social phobia.

RESEARCH EVIDENCE FOR GENETIC FACTORS

Summarise the research evidence below.
Ψ Specific phobias. How strong is the evidence of a genetic basis to specific phobia?
Ψ Social phobia. How strong is the evidence of a genetic basis to social phobia?
Ψ Agoraphobia. How strong is the evidence of a genetic basis to agoraphobia?
## RESEARCH EVIDENCE AGAINST GENETIC FACTORS

*Summarise the research evidence below.*

Ψ **Skre et al. (1993; see A2 Level Psychology page 481).** How does this research challenge the genetic hypothesis?

Ψ **The psychological explanations.** How do the counter-perspectives challenge the genetic hypothesis?

## EVALUATION OF RESEARCH INTO GENETIC FACTORS

*Summarise the evaluation points below.*

Ψ **Not 100% concordance.** Why is this an issue?

Ψ **Nature vs. nurture.** What conclusion can be made with reference to this debate?

Ψ **Sample size.** Assess the population validity of family, twin, and adoption studies.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td><strong>Generalisability of twin research.</strong> Why does the fact the research is on twins limit generalisability?</td>
<td></td>
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<tr>
<td><strong>Biologically deterministic.</strong> Why is the explanation deterministic?</td>
<td></td>
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<tr>
<td><strong>Methodological weaknesses of concordance studies.</strong> What are the weaknesses?</td>
<td></td>
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<tr>
<td><strong>Reliability of diagnosis.</strong> Why might diagnosis lack reliability?</td>
<td></td>
</tr>
<tr>
<td><strong>General rather than specific inheritance.</strong> What evidence is there for a general inheritance?</td>
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</tbody>
</table>
Evolutionary Explanations

Fill in the blanks.
The adaptive value of anxiety is indisputable as the ar__________al of the “fight-or-flight” response ensures that the individual is able to face en__________al threats. Also, it encourages caution and reduces risk-taking behaviour, which clearly links to s__________al and so acts as an “alarm detector”. Phobias are irrational fears that are out of proportion to the reality of the threat provided by the fear-provoking stimulus. Whilst anxiety can be adaptive, phobias can be ma____________e.

According to the “preparedness” argument (Seligman, 1970), phobias are adaptive because they are a fear of things that would have been of danger in our ev____________y past, e.g. snakes, spiders, heights (specific phobias); strangers (social phobia); strange territory (agoraphobia). The “pr__________s” explanation suggests that humans have an in____________e predisposition to acquire the fear response through conditioning. This means humans are biologically prepared to exhibit physiological and emotional responses as defence mechanisms to environmental demands.

RESEARCH EVIDENCE FOR EVOLUTIONARY EXPLANATIONS

Summarise the research evidence below.

Ψ Fear conditioning research provides evidence that we more readily associate harm with certain stimuli than others. How do Tomarken, Mineka, and Cook (1989; see A2 Level Psychology page 483) provide evidence of an innate preparedness?

Ψ Cook and Mineka (1989; see A2 Level Psychology page 484). How does this study support an innate preparedness?

Ψ Snakes and spiders vs. flowers and leaves. How does this study support an innate preparedness?
**Non-random distribution of feared objects.** How does this study support an innate preparedness?

**Fear is negatively correlated with animals’ appearance.** How does this study support an innate preparedness?

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### RESEARCH EVIDENCE AGAINST EVOLUTIONARY EXPLANATIONS

*Summarise the research evidence below.*

**Non-prepared phobias.** How do these challenge the evolutionary explanation?

**We do fear modern dangers.** How do these challenge the evolutionary explanation?

**Traditional behavioural explanations.** How do these challenge the evolutionary explanation?

**Social learning theory.** How does this theory challenge the evolutionary explanation?

**A breakdown in cognitive processing.** How does this challenge the evolutionary explanation?
### EVALUATION OF EVOLUTIONARY EXPLANATIONS

*Summarise the evaluation points below.*

**Universality of mental disorders.** How does this support the explanation?

**Face validity.** Why does the explanation have this?

**Conjecture—evolutionary stories?** Why do evolutionary explanations lack scientific validity?

**Reductionist and deterministic.** Why are evolutionary theories reductionist and deterministic?

**Psychological explanations.** What can these reveal that goes beyond the evolutionary explanations?
<table>
<thead>
<tr>
<th>Social learning theory has great explanatory power. Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature/nurture. Which one do evolutionary theories ignore?</td>
</tr>
<tr>
<td>Adaptive or maladaptive? Are evolutionary theories adaptive or maladaptive?</td>
</tr>
<tr>
<td>Alternative explanations. What are the alternatives?</td>
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</tbody>
</table>

**FIND OUT FOR YOURSELF:** Test the conclusion that non-human likeness is correlated with fear. Think about the materials you will need: a number of animals organised in order of human likeness. Which method will you use to find out how much participants fear these animals? What are the strengths and limitations of your research? How did you record the data? Which statistical test would be appropriate to analyse the data and why? Do your findings support or challenge evolutionary explanations?
CONCLUSIONS—SO WHAT DOES THIS MEAN?

*Answer the following questions in your conclusions:*

- How strongly is the genetic hypothesis supported?

- How does the diathesis–stress model best account for individual differences?

- Why do the evolutionary explanations lack scientific validity?

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**Using this in the exam**

Outline and evaluate one or more biological explanation(s) of one anxiety disorder.  

*(25 marks)*
Psychological Explanations of Phobic Disorders

For details, see Eysenck’s A2 Level Psychology (pages 485–496).

Behavioural Explanations

Fill in the blanks.
The behavioural approach uses the principles of cl_________al conditioning (learned as_________ns) and operant con____________ion (learned co__________________) to explain the development of phobias. Bandura (1986) expanded on the traditional learning theories with mo____________g, or ob__________________l learning, which offers another explanation of phobia development.

RESEARCH EVIDENCE FOR BEHAVIOURAL EXPLANATIONS

Summarise the research evidence below.

ψ The conditioning of a phobia in Albert. How was Little Albert conditioned to fear a rabbit?

ψ The behavioural principle of generalisation. What did his fear generalise to?

ψ Mowrer’s (1947) two-process theory. Which two processes account for phobias?

ψ 50% of people recalled a traumatic incident. Why does this support classical conditioning?
Hartmann, Clark, and McManus (2000, see A2 Level Psychology page 486). How does this research support classical conditioning?

Social learning theory. What evidence is there that phobias can be learnt through observation and imitation?

**RESEARCH EVIDENCE AGAINST BEHAVIOURAL EXPLANATIONS**

*Summarise the research evidence below.*

- **Classical conditioning does not explain maintenance.** Why not?
- **Replications have failed.** Why might Little Albert have been easier to condition than other participants?
- **About 50% of phobics cannot recall an unpleasant experience.** Why does this challenge classical conditioning?
- **There are only a few well-documented cases where social learning had clearly led to phobia.** Why do you think this is the case?
<table>
<thead>
<tr>
<th><strong>EVALUATION OF BEHAVIOURAL EXPLANATIONS</strong></th>
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<tbody>
<tr>
<td><strong>Summarise the evaluation points below.</strong></td>
</tr>
<tr>
<td><strong>Ψ Ethical issues.</strong> Why does the little Albert study raise ethical issues?</td>
</tr>
<tr>
<td><strong>Ψ Face validity.</strong> Why do behavioural explanations have face validity?</td>
</tr>
<tr>
<td><strong>Ψ Reliability.</strong> Why is there a lack of consistency in the research evidence?</td>
</tr>
<tr>
<td><strong>Ψ Retrospective.</strong> How might this affect validity of participants’ accounts of phobias?</td>
</tr>
<tr>
<td><strong>Ψ Reductionism.</strong> Why is the behavioural explanation too simplified?</td>
</tr>
<tr>
<td><strong>Ψ Environmental determinism.</strong> How does the theory ignore free will?</td>
</tr>
</tbody>
</table>
Psychodynamic Explanation

Fill in the blanks.
Freud proposed that anxiety results when id impulses or se________l (libidinous) desires are re____________d into the unconscious. Repressing and therefore denying wish-fu____________nt of whatever it is we know we shouldn’t do creates tension that is expressed as an________ty. Phobias develop as a consequence of c______ct and fixation at one of the ps____________al stages of development. Psychic energy becomes attached to a specific object as a way of coping with the co_______ct and so the object then comes to symbolise the conflict. For example, fi________n at the phallic stage may result in a fear of spiders because the spider may represent a fear of the sexual organs (Abraham, 1927; see A2 Level Psychology page 488).

RESEARCH EVIDENCE FOR THE PSYCHODYNAMIC EXPLANATION

Summarise the research evidence below.
Ψ Little Hans’ phobia of horses. Why was Hans frightened of horses according to Freud?

RESEARCH EVIDENCE AGAINST THE PSYCHODYNAMIC EXPLANATION

Summarise the research evidence below.
Ψ Behavioural explanations. How might these explanations better account for Hans fear?
**EVALUATION OF THE PSYCHODYNAMIC EXPLANATION**

*Summarise the evaluation points below.*

Ψ **Face validity.** Why does the psychodynamic explanation make sense?

Ψ **Lack of research evidence.** Why is this lacking?

Ψ **Researcher bias.** Why is this an issue?

Ψ **Generalisability.** Why does the research lack this?
Cognitive Explanation

Fill in the blanks.
The cognitive approach suggests that cognitive bi________s underpin phobias. Phobics employ interpretive biases, which means they are more likely to perceive ambiguous stimuli as thr_________g and harmful to themselves than others would. This has face validity as it does account for the high level of anxiety reported by phobics and it makes sense that people with an________ disorder find the world a threatening place.

Empirical support is provided by research such as Thorpe and Salkovskis (1995) who found spider phobics had a number of int________ive biases compared to non-spider phobics, when asked to imagine a spider was in the room with them. Kamieniecki, Wade, and Tsourtos (1997) presented participants with ambiguous scenarios relating to bodily s_________. Patients who had panic disorder with agoraphobia produced more anxiety-related inte________ns of these scenarios, which is consistent with the typical clinical finding that patients mistakenly believe that a panic attack means they may well have a h__________ attack and d_____. Rapee and Lim (1992) provide evidence for similar interpretive biases in social phobics as they asked social phobics to give a p__________c talk and then asked observers and the participants themselves to rate their public-speaking pe________e. Social phobics rated their performance as much worse than did the observers.

Phobics do have cognitive b__________s and so this makes the explanation highly plausible. However, a key weakness is that the cognitive explanation is descriptive rather than ex__________ry. It describes the thought patterns experienced rather than explaining how or why they developed in the first place. Hackmann et al. (2000) found that 96% of social phobics recalled a socially tr__________ event that may have helped to trigger the social phobia, which supports a be__________al origin to the phobia.

But of course behaviourism doesn’t account for cognition so the two explanations combined into a cognitive-behavioural account would provide a better understanding of phobias. Furthermore, it is not clear whether the cognitive biases precede or follow the disorder so ca__________e and e__________t is an issue.

Social Explanations

Fill in the blanks.
Parental rearing styles high in co________l and overprotection and low in af________n have been linked to social phobia and agoraphobia. However, accounts of parental styles are ret________ve and so may lack validity and research is correlational, so this cannot be inferred as a ca________e of phobias.

A high number of life ev________ts have been reported in the months preceding an anxiety disorder. Kleiner and Marshall (1987) report that 84% of agoraphobics suffered family p________s in the months prior to onset. Agoraphobia tends to be preceded by life events involving ph________al harm that are unpredictable and uncontrollable; social phobia is known to be preceded by experience of se________al assault and verbal ag____________n between parents. Research on life events is cor__________al and so cause and effect cannot be inferred. We do not know if the life event triggered the phobia or if the phobia led to the life event. For example, s________al phobia may be caused by negative social interactions or somebody in the early stages of developing a phobia may have more negative int________s as a result. It is based on retrospective self-report, and so internal validity may be reduced due to bias and distorted re________ll.
FIND OUT FOR YOURSELF: Design a survey to find out whether people with phobia-type fears (many will not have been diagnosed with phobia for the reasons discussed in the diagnosis section) have had a bad experience or not before their phobia developed. What are the strengths and limitations of your research? How did you record the data? Which statistical test would be appropriate to analyse the data and why? Do your findings support or challenge behavioural explanations?

CONCLUSIONS—SO WHAT DOES THIS MEAN?

Answer the following questions in your conclusions:

• Why do the psychological factors provide only a partial explanation?

• Why is a multi-dimensional approach needed?

Using this in the exam

Outline and evaluate one or more psychological explanation(s) of one anxiety disorder. (25 marks)
### Biological Therapies for Phobic Disorders

For details, see Eysenck’s A2 Level Psychology pages 497–500.

#### Drug Therapy

**Fill in the blank.**

Drug therapy is the main bi________________l treatment and the types of drugs used can vary slightly across the different phobias.

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### Social phobia

**Fill in the blanks.**

Anti-anxiety drugs, be________________es such as Valium and Librium, antidepressants, and monoamine oxidase inhibitors (MAOIs), have been used to treat social phobics. Benzodiazepines act on the central nervous system, i.e. the brain. Benzodiazepines increase the activity of the ne________________er GABA and GABA decreases serotonin activity. Serotonin is linked to arousal and so lowering serotonin activity reduces ar___________al and decreases anxiety. The MAOIs block monoamine oxidase and by so doing help to prevent the destruction of noradrenaline. The increased noradrenaline activity leads to a reduction in anxiety symptoms. Currently selective serotonin re-uptake inhibitors (SSRIs) are more commonly used to treat social phobia. The SSRIs include fluvoxamine, fluoxetine (Prozac), sertraline, and paroxetine, and are also used in the treatment of depression. Antidepressant drugs are often used in drug therapy for social phobia because social phobics often have high levels of de________________n (Rachman, 2004).

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### Agoraphobia with panic disorder

**Fill in the blanks.**

Benzodiazepines and SSRIs are often used. Tricyclic anti________________ts, which increase the activity of nor________________ne and serotonin, are also used to treat panic disorder with agoraphobia. The antidepressant drugs are used because patients frequently have many depressive symptoms.

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### Specific phobia

**Fill in the blanks.**

Drug therapy has seldom been used in the treatment of specific phobia. This is because with this type of phobia patients are not generally anxious and it is not as se___________s a condition as the other types of phobias. Consequently, specific phobia does not warrant the taking of mind-altering drugs, particularly when psychological treatment can be used instead; be________________al therapy is very effective with this type of phobia.
EVALUATION OF DRUG THERAPY

Summarise the evaluation points below.

Effectiveness

Ψ Moderate effectiveness for social phobia. What evidence is there for moderate effectiveness?

Ψ Moderate effectiveness for agoraphobia with panic disorder. What evidence is there for moderate effectiveness?

Ψ A multi-dimensional approach. Why might a combined approach be more effective?

Ψ No more effective than cognitive or CBT therapy. Why does this reduce the usefulness of drug therapy?

Ψ Drop-out rate. Why is this high?

Ψ Relapse rates. What evidence is there that drugs compare unfavourably to psychological treatments?
<table>
<thead>
<tr>
<th>Treats symptoms not causes. What evidence is there for this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo effect. What is this and why does it question effectiveness?</td>
</tr>
</tbody>
</table>

**Appropriateness**

<table>
<thead>
<tr>
<th>Reduces anxiety. How does effectiveness support appropriateness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fast-acting. How does this affect appropriateness?</td>
</tr>
<tr>
<td>Effects are short-lived. Why?</td>
</tr>
<tr>
<td>Palliative not curative. What does this mean and why is it a weakness?</td>
</tr>
</tbody>
</table>
**Side-effects.** What are the side-effects?

**Drop-out rate.** How does this affect appropriateness?

**Lack understanding of their effect.** How does this affect appropriateness?

**Compares unfavourably to psychological treatment.** How does this affect appropriateness?

## CONCLUSIONS—SO WHAT DOES THIS MEAN?

*Answer the following questions in your conclusions:*

- Which type of drugs seems to be more effective?

- Why does drug therapy raise issues of appropriateness?

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**Using this in the exam**

(a) Outline one or more biological therapy(ies) for one anxiety disorder.  
(b) Evaluate the therapy(ies) described in (a).
Psychological Therapies for Phobic Disorders

For details, see Eysenck’s A2 Level Psychology pages 500–510.

Behavioural Therapies

**Fill in the blanks.**

Behavioural therapies are based on the principles of learning and in particular the theory that behaviour is learned through classical conditioning. Abnormality is a result of learning maladaptive and dysfunctional behaviour and so the treatment uses counter-conditioning to replace the maladaptive (dysfunctional) behaviour with more adaptive (functional) behaviour. Of key importance is eliminating the patients’ avoidance of their phobic stimuli and situations. This is difficult because the fear reduction, which is a result of the avoidance behaviour, is rewarding.

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Systematic desensitisation

**Fill in the blanks.**

Joseph Wolpe (1958, 1969) was a behaviour therapist who devised systematic desensitisation. It involves an attempt to replace the fear response with a new response incompatible with fear. Relaxation was considered to be incompatible (can’t be experienced at the same time) with fear and so this is induced based on the logic that if the patient is relaxed then they cannot experience their usual fear response. The therapy involves four stages:

- First stage—relaxation training:
  The first stage is to provide clients with relaxation training in which they learn how to engage in deep muscle relaxation.

- Second stage—fear hierarchy:
  Second, clients construct a fear hierarchy with the assistance of their therapist. A fear hierarchy consists of a list of situations or objects that produce fear in the client, starting with those that cause only a small amount of fear and moving on to those that cause increasingly greater levels of fear. For example, the first item on the list of a snake-phobic person might be a small, harmless snake 50 feet away, with subsequent items featuring larger and more dangerous snakes closer to the client.

- Third stage—imagine feared objects:
  Third, clients learn how to use their relaxation techniques while imagining the objects or situations they fear, starting with those at the bottom of the fear hierarchy. The therapist describes the object or situation, and the client then tries to form as clear an image of it as possible.

- Fourth stage—expose to feared objects:
  An alternative approach is to present the actual object or situation itself (known as in-vivo desensitisation).
Wolpe used the term reciprocal inhibition (also known as co-ordination) to refer to this process of inhibiting anxiety by substituting some competing and incompatible response. For relaxation to inhibit the client’s anxiety, the amount of anxiety triggered by imagining the phobic stimulus must not be too great. That explains why systematic desensitisation starts with stimuli creating only a small amount of anxiety.

**Exposure therapy**

*Fill in the blanks.*

Wilson and Davison (1971) argued that the crucial process in systematic desensitisation is extinction, not reciprocal inhibition. Extinction occurs when there is repeated non-red exposure to the phobic stimulus, i.e. nothing bad happens through exposure to the feared stimulus. This led to extinction therapy, where phobic individuals are exposed to the object or situation they fear (often gradually increasing the threateningness of the object or situation) for lengthy periods of time until their anxiety level is substantially reduced. It differs from systematic desensitisation in that the latter is more gradual because it involves imaging the fear stimulus first.

Exposure therapy has now been developed into virtual reality exposure therapy, whereby a computer program produces a virtual environment simulating the phobic situation. Exposure therapy provides maximal scope for extinction to occur but doesn’t involve muscle relaxation, as this is not necessary if extinction is key rather than reciprocal inhibition.

**EVALUATION OF BEHAVIOURAL THERAPIES**

*Summarise the evaluation points below.*

**Effectiveness**

Ψ **Moderate effectiveness.** What support do Choy, Fyer, and Lipsitz (2007) provide?

Ψ **Effectiveness on avoidance lacks reliability.** Why is it not clear if systematic desensitisation affects avoidance or not?

Ψ **A pioneering treatment that paved the way for further behavioural therapies.** Which treatments followed from systematic desensitisation?
Unclear why systematic desensitisation is effective. Why do we not know how systematic desensitisation works?

Exposure therapy seems to be more effective. What evidence is there for this?

Systematic desensitisation and exposure therapy have restricted usefulness. Why is usefulness restricted?

Treat symptoms not causes. Why is this an issue?

Reductionism. Why is the therapy too simplistic?

Appropriateness

Strong theoretical and scientific basis. How do the therapies have a scientific basis?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avoidance behaviours are targeted.</strong> Why is this appropriate?</td>
<td></td>
</tr>
<tr>
<td><strong>Highly appropriate for specific phobias.</strong> Why are they very effective</td>
<td></td>
</tr>
<tr>
<td><strong>Reductionism—ignore important factors.</strong> Which factors are ignored?</td>
<td></td>
</tr>
<tr>
<td><strong>Ethical issues.</strong> Why are ethical issues raised?</td>
<td></td>
</tr>
<tr>
<td><strong>Drop-out rate.</strong> Is this high or low?</td>
<td></td>
</tr>
<tr>
<td><strong>Systematic desensitisation is less appropriate than exposure therapy.</strong></td>
<td>Which therapy is easier to use?</td>
</tr>
</tbody>
</table>
Psychological Therapy: Cognitive Therapy

**Fill in the blanks.**
According to the cognitive approach, phobias are due to interpretive biases and so treatment is designed to reduce or eliminate these biases.

### Social phobia

**Fill in the blanks.**
Cognitive therapy has been used more extensively for social phobia than for specific phobia or agoraphobia. Clark and Wells (1995) have devised a form of cognitive therapy that trains patients to focus their attention externally rather than on themselves in social situations. The training also involves watching video evidence of themselves in social situations to demonstrate that their social behaviour is more socially skilled than they believed. Patients are instructed to avoid using all their habitual safety-seeking behaviours in a social situation.

### Specific phobias

**Fill in the blanks.**
Cognitive therapy as applied to specific phobias focuses on eliminating the interpretive biases that patients have for their phobic stimuli. So patients suffering from a flying phobia would have their bias changed by statistics.

### Agoraphobia

**Fill in the blanks.**
For most patients agoraphobia arises as a consequence of already having panic disorder and so cognitive therapy first challenges the biases relating to panic disorder. For example, patients often misinterpret a fast heart rate as indicating that they are going to have a heart attack and may well die. Patients are educated about their bodily sensations so that they can more accurately interpret them in stressful situations. Patients are also trained to use distraction coping techniques so that they lose focus on their potentially anxiety-provoking bodily sensations. The symptoms of agoraphobia are generally treated by means of behaviour therapy involving exposure to panic places.

### EVALUATION OF COGNITIVE THERAPIES

**Summarise the evaluation points below.**

**Effectiveness**

Ψ Very effective in the treatment of social phobia. How do Clark et al. (2006) support effectiveness?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Moderately effective in treatment of specific phobia?</strong> What evidence is there for this?</td>
<td></td>
</tr>
<tr>
<td><strong>Very effective in treatment of panic disorder with agoraphobia.</strong> How does Comer (2001) support effectiveness?</td>
<td></td>
</tr>
<tr>
<td><strong>A combined approach is more effective.</strong> Why?</td>
<td></td>
</tr>
</tbody>
</table>

**Appropriateness**

**Challenging cognitive biases.** Why is this appropriate?  

**Effectiveness of treatment.** How does this support appropriateness?  

**Doesn’t consider the real-life context.** How does this affect appropriateness?
Patients know their fears are excessive. Why does this question the cognitive treatment?

Does not necessarily effect behavioural change. Why not?

Reductionist. Why is the cognitive approach too simplistic?

CONCLUSIONS—SO WHAT DOES THIS MEAN?

Answer the following questions in your conclusions:

• Why is it difficult to compare the effectiveness of treatments?

• Why is informed consent an issue?

• Why is the optimal approach to treatment multi-dimensional?

FIND OUT FOR YOURSELF: Try explaining the different therapies to a friend and then ask them to decide which treatment they think would be best for phobias. Teaching somebody else is an excellent way to learn the information. Make sure you present a balanced account of the treatments otherwise your friend’s answer might be extremely biased!

Using this in the exam

(a) Outline one or more psychological therapy(ies) for one anxiety disorder. (9 marks)
(b) Evaluate the therapy(ies) described in (a). (16 marks)
Example Essay Plan

(a) Outline one or more biological therapies for one anxiety disorder. (9 marks)

(b) Evaluate the therapy(ies) described in (a). (16 marks)

The marking is broken down into three sets of criteria, AO1, AO2, and AO3, but this is not how you should write your essay. The essay should include all these criteria in a holistic way—e.g. as you write about drug therapy you will then write about the research studies supporting or challenging the effectiveness of drug therapy, and then discuss the effectiveness and appropriateness of the therapy, which could include methodological (e.g. participant sample size), ethical, and reductionist issues, etc.

AO1 (9 marks)
A general but accurate description of the drug therapy is needed. Describe the different forms of drug therapy to achieve breadth but be selective as you do also want to achieve depth.

AO2 (12 marks)
Commentary and evaluation of the drug therapy is needed. This can include research studies on the effectiveness of the therapies. A good focus is to base your commentary around the effectiveness and appropriateness of the therapy.

AO3 (4 marks)
Evaluation and/or interpretation of the research could include the weaknesses of the research evidence that supports the therapy, and use reductionism to add to your evaluation.

So the essay could be structured in the following way.

Note the question is divided into AO1 in part (a) and AO2 in part (b).

(a) Outline one or more biological therapy(ies) for one anxiety disorder. (9 marks)

Introduce drug therapy as the main biological approach in the treatment of phobias. Describe the use of anti-anxiety drugs: the benzodiazepines and the antidepressants, monoamine oxidase inhibitors (MAOIs), and selective serotonin re-uptake inhibitors in the treatment of social phobia. Describe the use of benzodiazepines, SSRIs, and tricyclic antidepressants in the treatment of panic disorder with agoraphobia. You can also say that drug therapy has seldom been used in the treatment of specific phobia.

(b) Evaluate the therapy(ies) described in (a). (16 marks)

Compare the effectiveness of drugs for social phobia and panic disorder with agoraphobia. Use empirical evidence as support, such as Heimberg et al. (1998), Bandelow et al. (2007), and Mitte's (2005) research findings.

Compare biological with psychological therapies. Discuss how drug treatment does not compare as favourably as the cognitive approach in the treatment of social phobia and panic disorder with agoraphobia and that the behavioural approach has found to be highly effective for specific phobias.

Discuss whether a multi-dimensional approach is best to include drugs or not as some research suggests this reduces relapse rates, yet other research suggests that the use of drugs has a negative long-term effect.
Consider other issues that undermine the effectiveness and appropriateness of drugs as a therapy for phobias such as drop-out and relapse rates, the fact they treat symptoms not causes, and may simply show a placebo effect. The fact that the effects are short-lived, the side-effects, and our lack of understanding of how they work question appropriateness.

Consider arguments for effectiveness: they do reduce anxiety and the effect is fast-acting. Patients may find the psychological treatments too demanding in terms of effort and motivation and so drugs compare well in terms of ease of use. Furthermore, some patients may need drug therapy to calm them down to a state in which they can benefit from psychological therapy.

Consider the issues raised in comparing therapies. Discuss how comparisons of the effectiveness of different treatments should be treated with caution due to issues such as individual differences of the patient or therapist. Consider the ethical issues of therapy such as informed consent and confidentiality. Conclude why a multi-dimensional approach is optimal.