

**Impulse control therapy** is outlined by Miller (2010). Based on his theory of feeling-states, he believes that both cognitive *and* behaviour change is necessary to control the disorder. Miller proposed the **impulse-control disorder protocol** (ICDP) developed from EMDR. EMDR is eye-movement desensitisation and reprocessing, which was originally devised by Shapiro (1998) to treat post-traumatic stress disorder (PTSD). EMDR treatment involves identifying the traumatic image, identifying the negative feelings and beliefs associated with the image, and then using eye movements to process the image and feelings and install positive beliefs and feelings.

Miller outlines a 12-step process summarised as:

- identifying the specific aspect of the compulsive behaviour that has the most emotional intensity
- identifying the specific positive feeling (and physical sensations) associated with this behaviour and calculating its PFS\* rating
- forming an image linking the behaviour, feelings and sensations
- performing eye movements (EMDR)
- setting homework and conducting follow-up sessions

\* Baseline and progress can be assessed using the **positive feelings scale** (PFS) with 10 being the most positive feelings.

Miller cites the case study of 'John', a 35-year-old male with a gambling problem who had lost more than \$1,000,000 playing poker. John's 'feeling-states' were identified, e.g. a time when he won \$16,000 and felt excitement. His PFS was rated as 10. John followed the 12-step process and in his follow-up interview 3 months later he reported that his poker compulsion had not returned.

### Evaluation

- The biological treatments are **reductionist** (*strengths and weaknesses*) but so are the cognitive-behavioural treatments.
- Biochemical treatments are based on the **physiological and biochemical approaches** (*strengths and weaknesses*) and the nature side of the **nature–nurture** debate.
- Biological treatments are **biological determinism** and **individual** rather than **situational**. The two **case studies** reported here have many strengths and weaknesses.

### Cross check

Reductionism, page 89  
 Nature–nurture debate, page 75  
 Determinism, page 90  
 Individual–situational debate, page 74  
 Case studies, page 51

### Expert tip

Prepare an exam-style essay on impulse control and non-addictive substance disorders. For part (a), the 'describe' part, decide what you need to include (and exclude). In the exam, you should spend no more than 12 minutes on this part. For part (b), the 'evaluate' part, choose a range of issues to include (three is a range). Choose two issues in addition to the named issue. You should spend no more than 18 minutes on part (b).

## Anxiety disorders

Revised

### Characteristics

#### Definitions and types

Some people have **generalised anxiety disorder**, meaning they might have a 'panic attack' but do not know its cause. The characteristics of generalised anxiety disorder are as follows:

- Excessive, uncontrollable and often irrational worry, which interferes with daily functioning.
- Physical symptoms of headaches, nausea, numbness in hands and feet, muscle tension, difficulty swallowing and/or breathing, trembling, twitching and sweating.

**Anxiety** is a general feeling of dread or apprehensiveness accompanied by various physiological reactions such as increased heart rate, sweating, muscle tension, and rapid and shallow breathing.

- Feeling anxious most days and struggling to remember the last time they felt relaxed; as soon as one anxious thought is resolved, another may appear about a different issue.
- It is a long-term condition that causes feelings of anxiety about a wide range of situations and issues, rather than one specific event.

A **phobia** is a persistent fear of an object or situation in which the sufferer does anything possible to avoid the feared object.

On the other hand, some people know the actual cause and this is called a **phobia**. In everyday life people say 'I have a phobia of...' when they don't like something. To be diagnosed formally as phobic there must be anxiety 'attacks' and the person must have 'difficulty in social and occupational functioning' because of it. For example, a person with agoraphobia may not have left their home for 6 months or more, they will have closed curtains and never go to a door because of their fear of the outside world.

There are many different phobias, some very common and some quite rare. Acrophobia (heights) and agoraphobia (the 'outside') are common, while claustrophobia (buttons) is rare. Blood-injection phobia (a blood phobia is hemophobia) often results in the person fainting (see below and page 107).

There are two classic case studies about phobias in psychological literature: the case of Little Albert (based on classical conditioning – see page 29) and the case of Little Hans (based on the psychodynamic approach of Freud – see page 93).

McGrath et al. (1990) report a case study about Lucy, a 9-year-old girl with a phobia of specific loud bangs such as fireworks and popping balloons. She was treated successfully with systematic desensitisation (see treatments of phobias, page 107).

Saavedra and Silverman (2002) report on a 9-year-old with a fear of buttons. A large bowl of buttons fell on him while at school and from that point he would not wear clothes with buttons. Small, plastic buttons caused him most distress. Slow exposure with associated positive reinforcement led to improvements, but it was then discovered that he found buttons disgusting when they touched his body.

### Cross check

Case studies, page 51

Saavedra and Silverman, page 29

### Measures of anxiety disorders

**Blood injection phobia** can be assessed using the **blood-injection phobia inventory** (BIPI) devised by Mas et al. (2010). The BIPI is a self-administered questionnaire of three parts:

- 50 items about diverse situations related to blood, injections, and the dentist. Items include:
  13. *When I feel the needle go into the vein of my arm to extract blood.*
  26. *When I get local anaesthesia.*
  29. *When I see a bloody wound or cut.*
- It measures the frequency of a patient's different types of response (cognitive, physiological and behavioural) to the situations on a 4-point scale ranging from 0 (never), 1 (sometimes), 2 (almost always) to 3 (always).
- It appraises both 'situational anxiety' and 'anticipatory anxiety' responses.

**Generalised anxiety disorder** can be measured using **GAD-7** (Spitzer et al., 2006). The 'GAD score' is calculated by assigning scores of 0 (not at all), 1 (several days), 2 (more than half the days), and 3 (nearly every day), respectively. A GAD-7 total score for the seven items ranges from 0 to 21. Scores represent: 0–5 mild anxiety, 6–10 moderate anxiety, 11–15 moderately severe anxiety and 15–21 severe anxiety.

Typical items include:

'Over the last 2 weeks, how often have you been bothered by the following problems?'

Q1: Feeling nervous, anxious or on edge (0, 1, 2, 3)

Q3: Worrying too much about different things (0, 1, 2, 3)

Q4: Trouble relaxing (0, 1, 2, 3)

### Evaluation

- BIPI and GAD-7 anxiety questionnaires gather **quantitative data**. Both questionnaires claim that they are **reliable** and **valid** because they are **psychometric**. [*Strengths and weaknesses for all.*]
- These tests may have **cultural bias** (*weakness*). The **case study** of 'button boy' has strengths and weaknesses.

### Cross check

Quantitative data, page 60  
Reliability, page 66  
Validity, page 67  
Cultural bias, page 88  
Case studies, page 51

## Explanations of phobias

**Behavioural explanations:** classical conditioning assumes that fears are acquired by a process of association. A previously neutral object (e.g. white rat) is associated with a potentially threatening negative event (e.g. loud noise) so that in the future the person is fearful because of the expectation of what will happen when coming into contact with the object (in Albert's case, the white rat).

**Watson and Raynor** (1920) classically conditioned Little Albert. Initially, Albert was not afraid of animals, and his favourite was a white rat. But then, every time the rat was presented to Albert, a loud noise, made by banging two metal bars together, made him jump and frightened him. Albert associated the fear with the rat, and this fear of the rat generalised to other animals too. This demonstrated that fears and phobias can be learned.

**Psychoanalytic explanations:** the Freudian psychoanalytic theory suggests that phobias are a defence mechanism against the anxiety created by the unresolved conflicts between the id and the superego. The ego attempts to resolve these conflicts by using the coping mechanisms of repression and displacement. In *repression*, the ego attempts to 'forget' that the conflict exists. In *displacement* the ego re-channels the anxiety, which is displaced from the feared impulse (such as hatred towards one's father) and moved towards an object or situation that is symbolically connected to it (such as Little Hans's father resembling a horse).

**Freud** (1909) writes about the case of Little Hans, who apparently had a phobia of horses. Freud's interpretation was that Hans was really afraid of his father but displaced this onto horses.

**Biomedical (genetic) explanations:** genes may predispose some people to anxiety (and phobic) disorders. Kendler et al. (1992) argue that the genetic factor common to all phobias strongly predisposes a person to specific phobias such as blood phobia.

**Ost** (1992) sampled 81 blood phobics and 59 injection phobics. Ost discovered that 61% of those with a specific phobia for blood injuries had 61% of first-degree relatives (parent or sibling) who had the same phobia. Ost et al. concluded that 'The high percentage of blood phobics with the same fear could mean that a heredity component is of importance.'

**Cognitive explanations:** DiNardo et al. (1988) suggested a cognitive explanation for phobias. They found that only half of people who had a traumatic experience with an animal, even when pain was inflicted, developed a phobia of animals. Why? DiNardo et al. believed that people who have *any* traumatic experience (e.g. with animals) but do not develop a phobia must *interpret* the event differently from those who do develop a phobia. This means that it is the way people think about their experience that makes the difference. It is an exaggerated expectation of harm in some people that leads to the development of a phobia.

### Now test yourself

- 13 Describe **one** study supporting the cognitive explanation for phobias.

**Answer on p. 198**

Tested

**Evaluation**

- All the approaches here are **reductionist** (*strengths and weaknesses*).
- The **nature–nurture debate** (*strengths and weaknesses*) applies because genetic and psychoanalytic explanations are nature, and behavioural explanations are nurture.
- Behavioural approaches emphasise **environmental determinism** whereas biochemical approaches emphasise **biological determinism**.

**Treating and managing anxiety disorders**

**Systematic desensitisation**, based on classical conditioning, was developed by **Wolpe** in 1958, specifically for the counter-conditioning of fears, phobias and anxieties. The aim is to replace the conditioned fear, which is maladaptive, with relaxation, which is adaptive and desirable. It involves three phases:

- An **anxiety hierarchy** is constructed – a range of situations or events with which the fear is associated. These are arranged in order from the least fearful (e.g. *imagining* exposure) to the most fearful (e.g. *in vivo*).
- The person is trained in **deep muscle relaxation and deep breathing techniques**. This counteracts the effects of anxiety-related hormones such as adrenaline.
- The person then thinks about, or is brought into contact with, the least fearful item and applies relaxation techniques. When relaxed, the next item in the hierarchy is presented. This continues systematically until all the items in the hierarchy have been removed and the person is desensitised.

**Applied tension** (**Ost et al.**, 1989) is specifically for people with blood and injection phobias. At the sight of blood, blood pressure drops sharply (called vasovagal response), often leading the person to fainting (passing out). Applied tension involves tensing the muscles in the arms, legs and body for about 10–15 seconds, relaxing for 20–30 seconds and then repeating both these five times to raise blood pressure. Ost et al. found that 73% of patients were improved (i.e. no fainting) at the end of the treatment and 77% were improved at follow-up.

Cognitive therapy is based on the principle that certain ways of thinking can trigger, or 'fuel', various disorders. The aim is to change ways of thinking to avoid these ideas. Behaviour therapy aims to change any behaviours that are harmful or not helpful. **Cognitive–behaviour therapy** (CBT) is a mixture of cognitive and behaviour therapies combined because behaviour often reflects thoughts about certain things or situations.

**Ost and Westling** (1995) compared CBT with applied relaxation in the treatment of panic disorder. Over 12 weekly sessions those in the applied relaxation group received training in deep muscle relaxation only. The CBT group also received training in restructuring the thoughts associated with the panic attacks. Results: the CBT group had a significant reduction in the number of panic attacks after treatment (74%), and 89% at follow-up.

**Evaluation**

- The **learning approach** underlies systematic desensitisation and CBT. Applied tension is a **biological approach**. (*Strengths and weaknesses for both.*)
- The learning approach is the nurture side of the **nature–nurture debate** (*strengths and weaknesses*), whereas the biological approach is nature.

**Expert tip**

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**Cross check**

Reductionism, page 89  
 Nature–nurture debate, page 75  
 The learning approach, page 71  
 The cognitive approach, page 71  
 The behaviourist approach, page 93  
 The biomedical approach, page 92  
 The psychodynamic approach, page 93  
 Determinism, page 90

**Now test yourself**

- 14 Describe the applied tension technique for treating blood and injection phobias.

**Answer on p. 198**

Tested

**Cross check**

The learning approach, page 71  
 The biological approach, page 70  
 Nature–nurture debate, page 75