

research is that it reveals both the common and the unique features of psychological disorders by revealing the extent to which they appear to be extreme variants on three underlying dimensions of emotion.

## Specific phobias

## LO 2.2

### THE DIAGNOSIS OF SPECIFIC PHOBIAS

According to the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association [APA], 2013), the major feature of a **specific phobia** is a marked (intense), consistent (almost every time the trigger is encountered) and persistent (over a period of at least six months) fear reaction to the presence or anticipation of a specific object or situation. The individual attempts to avoid the phobic stimulus or endures it with intense anxiety. The fear must be out of proportion to the actual danger of the object or situation with respect to the person's culture. The fear and avoidance is severe to the point of causing emotional, social or occupational disruptions. Thus, although phobic-type fears are common (Agras, Sylvester, & Oliveau, 1969), they become a phobic disorder when the responses are disproportionate to the objective threat and the disruption to the person's life is excessive.

The *DSM-5* specifies four subtypes of phobias according to the primary focus of the fear: animal; natural environment (e.g., heights, storms and water); blood, injection and injury; and situational (e.g., planes, elevators and enclosed places). This subtyping can be useful for treatment. For instance, for blood, injection and injury phobias there are distinct treatment implications stemming from the unique properties of this disorder (Marks, 1988; Page, 1994a). Individuals with this disorder may experience a decrease (rather than the usual increase) in blood pressure when faced with blood and injury and are thus prone to fainting. Fainting appears to have a separate inherited predisposition (Page & Martin, 1998) and may involve emotions such as disgust in addition to fear (Page, 2003). Treatment needs to address the fainting and for this reason additional techniques such as applied tension have been developed to give individuals greater control over their physiology and make fainting less likely (Vogele, Coles, Wardle, & Steptoe, 2003). Applied tension involves the deliberate application of muscle tension to raise blood pressure and therefore prevent fainting (Öst & Sterner, 1987).

**specific phobia**  
Anxiety disorder characterised by extreme fear of a specific object or situation, which results in the individual avoiding the object or situation.



TBC

### THE EPIDEMIOLOGY OF SPECIFIC PHOBIAS

As the case study demonstrates, most specific phobias begin in childhood and early adolescence (Öst, 1987). The prevalence of phobias is greater among children than among adults, suggesting that as children mature, many phobias tend to remit without treatment. The typical age of onset varies across the different phobias. For instance, claustrophobia tends to develop after adolescence whereas animal phobias develop at about the age of seven (Öst, 1987). The estimated lifetime prevalence of specific phobias is 7–9 per cent, with a female to male ratio of 2:1 (APA, 2013). Less than 1 per cent of individuals with a specific phobia seek treatment even though, in adults, phobias tend to be chronic if untreated.

**extinction** In learning theory, elimination of a classically conditioned response by removal of the unconditioned stimulus or the elimination of an operantly conditioned response by removal of the reinforcement.

are generally maintained over the following year and can improve further if exposure continues after treatment. While the effectiveness of exposure therapy for phobias is not disputed, the mechanisms responsible for anxiety reduction during exposure are the focus of much research, with the debate focusing on whether exposure works through behavioural and/or cognitive processes. A behavioural mechanism that may account for the effectiveness of exposure therapy is **extinction**. That is, through confronting conditioned feared stimuli (e.g., a dog) in the absence of any unconditioned stimuli (e.g., being bitten by the dog), the conditioned fear response gradually decreases. Possible cognitive processes accounting for the effectiveness of exposure therapy include challenging expectations that danger will occur when confronted with the phobic stimulus, increasing **self-efficacy** (i.e., the level of confidence that the individual can cope in the phobic situation) by increasing perceptions of control over the phobic stimulus and the anxiety (Johnstone & Page, 2004).

## LO 2.3

## Panic disorder and agoraphobia

**self-efficacy** Person's belief that s/he has the ability to succeed in a specific situation.

**agoraphobia** Anxiety disorder characterised by a fear of situations in which it would be difficult to escape or in which help may not be readily available (such as enclosed places and crowds) in the event of experiencing panic symptoms.

**panic attack** Episode during which an individual experiences a rapid increase in the physiological and cognitive symptoms of intense fear and discomfort.

**panic disorder** Anxiety disorder characterised by recurrent, unexpected panic attacks.

### THE DIAGNOSIS OF PANIC DISORDER AND AGORAPHOBIA

Earlier editions of the *DSM* grouped all disorders that involved escape or avoidance of particular feared objects or situations together and distinguished the 'simple' phobias, now called specific phobias, from the 'complex' phobia called **agoraphobia**. From the Greek, meaning 'fear of the marketplace', agoraphobia is frequently misunderstood as a fear of open spaces. However, agoraphobia is anxiety about being in places where escape might be difficult or embarrassing, or in which help may not be available, in the event of having a panic attack or panic symptoms (APA, 2013). As a result of anxiety, these situations are avoided, endured with extreme distress or require the presence of a companion. Typical agoraphobic situations include being outside the home alone, travelling alone, tunnels, bridges, crowds and open spaces. Given the seemingly random clustering of feared situations, it was understandable that agoraphobia was deemed to be a 'complex phobia'. However, the apparent complexity became understandable once the unifying principle had been identified. This unifying principle was that the focus of the fear in agoraphobia was not the external environment, but rather the fear of panic and its consequences in these environments.

A **panic attack** is defined as an episode of intense fear or discomfort in which there is a rapid increase in symptoms such as a pounding or racing heart; sweating; trembling; dizziness or faintness; choking/smothering sensations or shortness of breath; chills or heat sensations; and fears of dying, going crazy or losing control (APA, 2013). **Panic disorder** is diagnosed when the sufferer is plagued by recurrent unexpected panic attacks, with at least one month of (a) persistent concern or worry about additional panic attacks or their consequences (e.g., the individual fearing that s/he is at risk of a heart attack) and/or (b) significant changes in behaviour related to the attack (e.g., avoiding any exercise because it may increase heart rate) (APA, 2013). Earlier versions of the *DSM* described diagnoses of 'panic disorder with agoraphobia' or 'panic disorder without agoraphobia', but the *DSM-5* has separated panic disorder and agoraphobia so that they can be given together or on their own. Agoraphobia is diagnosed when the sufferer experiences marked fear or anxiety in at least two of the following five situations:

1. using public transport, such as buses and trains
2. being in open spaces, such as car parks and bridges
3. being in enclosed spaces, such as theatres and cinemas
4. standing in queues or being in a crowd
5. being outside of home alone.

The agoraphobic situations almost always trigger fear and anxiety, they are actively avoided or are endured with intense fear or anxiety for at least a period of six months and the fear or anxiety is out of proportion to the situation and cultural context.

## Social anxiety disorder

## LO 2.4

### THE DIAGNOSIS OF SOCIAL ANXIETY DISORDER

Humans are social beings, with social interactions being central to human activity. Therefore, problems with social anxiety have a far-reaching impact. According to the *DSM-5* (APA, 2013), the key features of **social anxiety disorder** (also known as **social phobia**) involve marked fear or anxiety in social situations in which the person faces potential scrutiny by others, including social interactions, being observed and performing in front of others. The key fear is that the individual will act in a humiliating or embarrassing manner (e.g., their anxiety symptoms will be obvious to others), which will lead to negative evaluation and rejection. Entering situations such as initiating or maintaining conversations, being observed eating, writing, using public toilets, or public speaking provoke anxiety and panic that is excessive given the level of actual threat. As a result, social situations may be avoided entirely. The anxiety or avoidance interferes with the individual's functioning (e.g., the ability to form relationships or give presentations at work) and/or causes considerable distress. The *DSM-5* specifies 'performance only' social anxiety disorder, where the fear is restricted to speaking or performing in public. Individuals are more likely to present with this subtype when their work performance is significantly impaired, such as musicians, athletes or public speakers (APA, 2013).

Even though the symptoms of the fight or flight response are similar among people with social phobia to those with other anxiety disorders, the sensations that are most troubling to individuals are those that are visible to others (e.g., sweating, blushing, shaking) since they may elicit negative evaluation from others (Page, 1994b). Likewise, even though the situations avoided (e.g., crowded shopping malls) may be similar to other anxiety disorders, the reasons for avoidance revolve around a fear of negative evaluation from others.

**social anxiety disorder (social phobia)** Anxiety disorder characterised by an extreme fear of being judged or embarrassed in front of others, causing the individual to avoid social situations.

### THE EPIDEMIOLOGY OF SOCIAL ANXIETY DISORDER

The most recent Australian National Survey of Mental Health and Wellbeing found that social anxiety disorder afflicts over 8 per cent of Australian adults across their lifetime, which translates to over 1.3 million people (McEvoy et al., 2011). In the general population, around 1.5 as many women meet the criteria for social anxiety disorder as men (ABS, 2007) but the gender rates are approximately equal in clinical samples (APA, 2013). Apart from specific phobias, social anxiety disorder is one of the most common and earliest onset anxiety disorders, with half of sufferers reporting the onset prior to 12 years of age (McEvoy et al., 2011).

## CASE STUDY :

### SOCIAL ANXIETY DISORDER

Jason is a 28-year-old single man. He works as an accountant and lives at home with his parents. He presented to the clinic for assistance with his nervousness when meeting people. Jason reported being shy for 'as long as I can remember' and as a child he recalls hiding behind his parents when meeting strangers or visiting family friends. He was able to form a small group of friends at school but he always felt 'on the outer' because he avoided getting too involved in their conversations. He was known as the 'quiet one' and teachers would sometimes refer to him as 'Mr Chatty' as a joke. After leaving school, Jason made no effort to remain in contact with his school friends and they eventually stopped calling him after he kept making excuses for why he could not go out with them. He found it difficult to form friendships at university and, although he played soccer, he avoided attending any soccer-related

*continued*

*continued*

social events other than training and the games. When Jason could not avoid social events he would make sure he had a few alcoholic drinks before going. Although he believed this helped him to relax, he tended to feel more anxious the next day. He also started to rely heavily on alcohol and he started to worry that he would make a fool of himself by being drunk. In the lead up to social situations Jason would worry about what he would say, how anxious he would look and whether the other people would be critical of him so he felt highly anxious even before he arrived. During social situations he became very self-focused and aware that his heart was racing, he was sweating, his mouth was dry and his cheeks were blushing. He described a vivid self-image in which he imagines his cheeks glowing bright red, sweat pouring from his face, he is stammering over his words and others are looking at him with confused expressions on their faces. Jason is aware that this image is probably exaggerated but whenever he notices these physical symptoms within social situations, he expects that others will also notice them, think he is a fool and reject him. At this point, he usually looks for a way to escape the situation and heads straight home. Afterwards, Jason undergoes a 'cognitive post-mortem', where he reviews the situation in his mind, criticises himself for how he behaved and feels really down. At work, he isolates himself and, whenever possible, will email colleagues rather than speak to them. He is frustrated that he is stuck at a lower level than he is qualified for because he thinks he could not cope with a job interview. He would like to have a relationship and a family in the future but he cannot see how this is possible if he cannot even speak to women without breaking into a drenching sweat.

In the absence of effective treatment, the course of social anxiety disorder tends to be chronic, with one study finding a median duration of 25 years without treatment (DeWit, Ogborne, Offord, & MacDonald, 1999). Unfortunately, the average delay between the onset of social phobia and attendance for therapy has been found to be as long as 14 years (Dingemans, van Vliet, Couvee, & Westenberg, 2001). Part of the reluctance to seek treatment stems from the disorder itself, with individuals being embarrassed about their condition.

The delay in seeking treatment is cause for concern, given that social phobia tends to be comorbid with other anxiety disorders, depression and substance abuse. The comorbidity between social phobia and depression appears to be particularly strong (Mineka, Watson, & Clark, 1998). Those individuals with more comorbid conditions tend to be more severely afflicted, with a 'cascade of comorbidity' increasing the level of disability across various aspects of their lives (Brunello et al., 2000, p. 61). Perhaps because most people feel anxious in social situations, the severity of the disorder in terms of its impact on functioning tends to be under-acknowledged. Yet 9 out of 10 individuals with social phobia indicate that the disorder has significantly interfered with their academic, occupational and interpersonal functioning (Beidel, Turner, & Dancu, 1985). People with social phobia often perform below predicted levels of achievement in education and occupation and they are less likely to marry (reflecting their dearth of close personal relationships).

## THE AETIOLOGY OF SOCIAL ANXIETY DISORDER

A range of biological, psychological and social factors has been implicated in the aetiology of social anxiety disorder. Supporting a genetic vulnerability, there is a two- to three-fold increased risk of social phobia among the relatives of people with the disorder (Tillfors, Furmark, Ekselius, & Fredrikson, 2001). The results of twin studies are consistent with these findings, estimating that a third of the variability in the familial transmission of social phobia is due to genetic factors (Kendler, Neale, Kessler, Heath, & Eaves, 1992).

Among the psychosocial factors, excessive parental criticism may reduce the child's self-confidence. In addition, the child may learn from his/her parents to be overly concerned with the opinions of others. The social withdrawal associated with lacking self-confidence and being concerned with the opinions of others may in turn elicit dislike and rejection from others during adolescence (Neal & Edelman, 2003). Cognitive dysfunctions

**LO 2.5****Generalised anxiety disorder (GAD)**

**generalised anxiety disorder (GAD)** Anxiety disorder characterised by chronic worry in daily life accompanied by physical symptoms of tension.

**THE DIAGNOSIS OF GENERALISED ANXIETY DISORDER**

According to the *DSM-5* the main feature of **generalised anxiety disorder (GAD)** is excessive anxiety and worry (anxious expectation) about a number of events or activities such as work, health, finances, relationships or educational performance (APA, 2013). The anxiety and worry must have been present on most days for a period of at least six months. These worries must be difficult to control, meaning that the individual finds it difficult to stop and cannot easily dismiss these thoughts from his/her mind.

Unlike other anxiety disorders whose worries are contained in a few closely related themes (e.g., the fear of having a panic attack in panic disorder), the worries that characterise GAD include a more diverse range of future-focused fears. Core worries in GAD are broadly categorised into those that relate to social threat and physical threat, with sufferers typically experiencing worries that fall into both categories. Social threat fears centre on work performance (e.g., worrying about making mistakes) and interpersonal relationships (e.g., worrying about not pleasing or being liked by others). Physical threat fears typically involve health problems (e.g., worrying about developing cancer) and fears about the impact of world events (e.g., worrying about being a victim of a terrorist attack).

Irrespective of whether worry scenarios focus on perceived social or physical threat, individuals with GAD tend to engage in a catastrophising style of thinking that typically ends in imagining 'worst case scenarios' causing considerable anxiety. The process of catastrophising seems to occur automatically, such that fears of being reprimanded for arriving slightly late at work, for example, can quickly transform into a scenario of experiencing criticism from colleagues, losing one's job, becoming destitute and not being able to support one's family. This type of worry scenario, which activates significant anxiety, is not uncommon in those with GAD and may be triggered by seemingly benign events (such as when an individual with GAD is stuck in traffic on the way to work). Those with GAD also believe that if their fears were to eventuate, they would lack the necessary resources and capacity to cope. In short, individuals with GAD tend to overestimate the likelihood of catastrophic events happening while underestimating their ability to cope with negative events should they occur.

In addition, the *DSM-5* criteria specify that the individual experiences a range of associated symptoms in relation to his/her worries such as feelings of irritability, fatigue, difficulties concentrating, sleep problems, restlessness/agitation and muscle tension. The anxiety and these associated symptoms also cause the individual high levels of distress and interfere with his/her ability to function in important areas of life such as relationships and work. At a personal level, GAD interferes with the sufferer's social, work and interpersonal functioning. Some GAD sufferers become rigidly focused on over-achievement to the exclusion of other pursuits to avoid fears of inadequacy being confirmed by themselves or others. In contrast, others with GAD tend to avoid perceived challenges due to fears of failure



CALVIN AND HOBBS, BILL WATERSON/UNIVERSAL UCLICK

Avoiding the pursuit of success as a way of controlling worry about the possibility of failure and disappointing others, as illustrated here by Calvin's classroom interaction with Susie.

and poor confidence in being able to complete the task to a high standard, as satirised in the cartoon. The chronic worrying and autonomic arousal experienced by people with GAD impacts strongly on their enjoyment and quality of life and interpersonal functioning, with close relationships characterised by stress and dependence (Stein & Heimberg, 2004).

The *DSM-5* diagnostic criteria for GAD remain unchanged from the previous edition of the *DSM* (*DSM-IV-TR*, APA, 2000). This is despite the fact that several changes to the criteria had been recommended on the basis of empirical data, cognitive models and clinical expertise. The proposed changes included:

1. identifying excessive worry about two life areas and removing the criterion that worry should be difficult to control
2. suggesting that excessive worry be present for three, rather than six, months
3. retaining fewer associated symptoms
4. including the presence of behavioural symptoms such as time spent avoiding or planning for potential threat, procrastinating or seeking reassurance because of worrying (Andrews et al., 2010).

## CASE STUDY : GENERALISED ANXIETY DISORDER

The case of Lisa illustrates the *DSM-5* criteria for GAD. Lisa recently made an appointment to see a clinical psychologist. She described being a worrier for as long as she can remember, ever since childhood. Her worries became more difficult to control during adolescence and were accompanied by periods of low mood where she found it difficult to summon the energy and motivation to complete her schoolwork. Lisa sought help for depression in her teens, which was very helpful, and is now keen to address her worrying, which she feels is intensifying to the point that it places undue stress on her body and is likely to cause her some serious illness. She reported a number of stressors over the past year that have intensified her stress levels. She says she's now 'worrying all the time'.

Lisa has worked for the past 10 years as a secretary in a local school office. She is friendly and polite and always makes an effort to get on well with the other office staff and teachers. However, lately there has been tension in the workplace between senior office staff and Lisa feels that she is being forced to take sides and worries about the effect this will have on her work relationships. She is also struggling at home where she has been taking time off work to care for her mother who is undergoing treatment for cancer. Her husband has been supportive but Lisa's stress levels and increased irritability have placed pressure on their relationship. Lisa and her husband had wanted to start a family but have put these plans on hold until her mother's health improves. Lisa worries that the amount of tension and stress she is experiencing would make it difficult to conceive and worries that she will never have a normal family life like others. She had always tried to plan her future and achieve her goals but she says she is finding it difficult to cope with 'all of this uncertainty about her future'.

Lisa finds herself worrying about worst-case scenarios while she is at work and when she is trying to sleep at night. She worries that her frustration with the situation at work will result in her having a public 'outburst' in the office, jeopardising her job and relationships with her colleagues. She also worries about losing her mother and that her stress and worry will have a negative effect on her own physical and psychological wellbeing. She is terrified that her husband will not be able to cope with her stress and leave the relationship.

Whenever Lisa finds it difficult to remove these worries from her mind, she speaks with her husband or mother to seek reassurance that she has their support, that she can cope and that things will be okay. She does not want her stress and worry to affect her work performance and, as a result, she has started repeatedly checking her work (such as emails) for mistakes. At home or on lunch breaks she monitors her stress levels and scans her body for signs of stress and tension as well as for worrying thoughts. She reports feeling tense all of the time and feeling fatigued

*continued*

Orsillo, 2007; Roemer, Orsillo, & Salters-Pedneault, 2008). Moreover, mindfulness meditation programs alone result in improved outcomes compared to CBT and wait-list control groups, with patients who take part in mindfulness mediation programs being more likely to no longer meet criteria for GAD at the end of treatment (Abbott, 2007).

## Obsessive-compulsive disorder (OCD)

## LO 2.6

### THE DIAGNOSIS OF OBSESSIVE-COMPULSIVE DISORDER

Historically, both **obsessive-compulsive disorder (OCD)** and posttraumatic stress disorder (PTSD) were conceptualised as anxiety disorders; with the introduction of the *DSM-5*, (APA, 2013), OCD was included in a separate chapter (entitled ‘Obsessive-compulsive and Related Disorders’), as was PTSD (in a chapter entitled ‘Trauma- and Stressor-related Disorders’). However, the chapters on anxiety disorders, obsessive-compulsive disorders and trauma-related disorders have been placed adjacent to each other in order to reflect the close relationships between these conditions.

The *DSM-5* (APA, 2013) describes OCD according to four diagnostic criteria. The first criterion is the presence of obsessions and/or compulsions. **Obsessions** are defined as recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate or distressing. The thoughts are not simply excessive worries about real-life problems (such as mortgage interest rates or difficult interpersonal relationships). In addition, to be defined as an obsession, the person must attempt to ignore the thoughts, impulses or images or to neutralise them by engaging in some other mental routine or behaviour. Finally, in order to distinguish obsessions from some aspects of psychotic illness, the person must recognise that the obsessional thoughts are the product of his/her own mind.

**Compulsions** are defined as repetitive behaviours (including mental routines) that the person feels compelled to perform in response to an obsession or according to strict rules. To be termed a compulsion, the behaviours must be aimed at reducing anxiety (usually triggered by an obsession) or preventing a threatening outcome.

As in many other disorders, the second criterion of the *DSM-5* states that the disorder must cause marked distress, be time-consuming (i.e., take more than one hour a day) or significantly interfere with the sufferer’s occupational or social functioning. The third criterion states that the symptoms are not attributable to a substance (i.e., a drug of abuse or medication) or another medical condition. Finally, in a related fourth criterion, the *DSM-5* emphasises that the content of obsessions or compulsions cannot be restricted to another disorder that is present. For example, excessive concern about appearance in an individual with body dysmorphic disorder would not warrant the additional diagnosis of OCD.

In addition to meeting these criteria, the *DSM-5* (APA, 2013) requires that the individual’s level of insight is specified in each case. ‘Good or fair insight’ is defined as the individual recognising that his/her OCD beliefs are probably not true. ‘Poor insight’ is noted in cases where the sufferer argues that his/her OCD beliefs are probably true. ‘Absent insight’ (or ‘delusional beliefs’) refers to individuals who appear to be completely convinced that their OCD beliefs are true. It should be noted that the inclusion of an ‘absent insight’ specifier is somewhat controversial as it makes the distinction between OCD and psychotic conditions more difficult. Finally, given the frequent experience of tic-related problems in OCD, a current or past history of tic disorder (e.g., Tourette’s disorder in which sufferers experience motor tics such as repeated eye blinking and vocal tics such as repeating one’s own words) should also be specified in a complete *DSM-5* assessment of OCD.

As mentioned, the most notable change from the *DSM-IV-TR* (2000) to *DSM-5* (2013) is the removal of OCD from the anxiety disorders. Instead, it has been grouped in the new category of ‘obsessive-compulsive and related disorders’ along with other conditions such as body dysmorphic disorder, hoarding disorder,

**obsessive-compulsive disorder (OCD)**  
Anxiety disorder characterised by obsessions and/or compulsions.

**obsessions**  
Uncontrollable, persistent thoughts, images, ideas or impulses that an individual feels intrude upon his/her consciousness and that cause significant anxiety or distress.

**compulsions**  
Repetitive behaviours or mental acts that an individual feels s/he must perform.

trichotillomania (hair-pulling) and excoriation (skin-picking) disorder. The American Psychiatric Association (2013) states that this regrouping reflects ‘increasing evidence of these disorders’ relatedness to one another in terms of a range of diagnostic validators as well as the clinical utility of grouping these disorders in the same chapter’ (p. 235). However, separating OCD from the anxiety disorders is a controversial decision, given substantial commonalities between cognitive models of OCD and other anxiety disorders.

While the *DSM-5* does a good job of describing the limits of the condition, it does little to indicate the breadth of possible presentations of the disorder. Perhaps more than any other psychiatric condition, OCD varies considerably from case to case. A seemingly endless list of possible topics can become the source of an obsession. Among these are fears of contamination and germs; fire, robbery, rape and assault; losing one’s mind or becoming insane; insulting others; impulsive swearing; harming others by acting on a sudden impulse (e.g., stabbing a friend); doing something embarrassing; engaging in a homosexual act; engaging in a paedophilic act; offending a higher power through blasphemy; or driving into an individual without knowing (Einstein & Menzies, 2003).

Further, almost any behaviour can become a compulsion, even when there is no obvious or logical link between the behaviour and the prevention of harm. For example, in order to prevent fire a sufferer may repeatedly engage in any of the following: checking power points and electrical appliances; touching the knobs on the gas stove; blinking one’s eyes a set amount of times; counting objects; saying a mantra in one’s head or out loud; tapping a surface; touching an object; hopping; climbing onto a chair; getting into and out of a chair; re-entering a room; or arranging objects on a desk. Thus, given the possible combinations of obsessions and compulsions, an almost infinite variety of presentations of the disorder are possible.

The following case describes a less common manifestation of OCD, namely, the occurrence of aggressive obsessions:

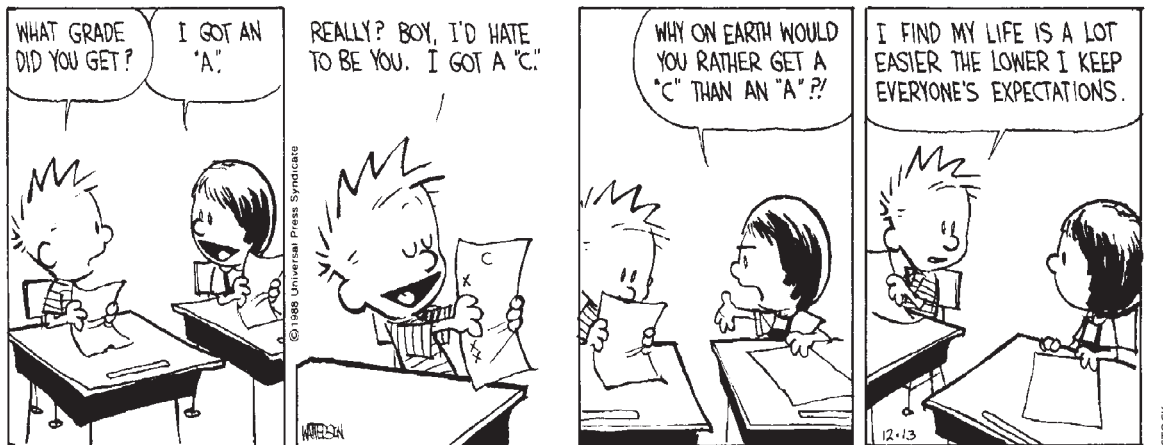
*One day, I’m sure I’ll end up in gaol. I think I’ve just been lucky so far. Sometimes I feel such a strong urge to strike or stab someone—one day I’m sure it will happen. I worry when I have to walk down the street. I’m sure I’m going to strike a young child or baby in a pram. Dinner parties, and cooking in general, are even harder. If I have to do anything in the kitchen when other people are near me, I get strong urges to pick up a knife and stab them. It’s worse if I really care for the person. I can’t have my husband help me cook and I keep all the largest knives in the highest cupboard in the kitchen, out of easy reach. Part of me knows the thoughts are just my OCD, but another part is petrified that I really will carry out the thoughts.*

While there are diverse manifestations of OCD, some types of the disorder are more common than others. For example, it has been suggested that the majority of individuals with OCD have performed excessive, compulsive washing at some point (Jones & Krochmalik, 2003; Rapoport, 1989). Summerfeldt, Antony, Downie, Richter, and Swinson (1997) reported that of nearly 200 patients with OCD, 63.7 per cent had current washing compulsions. Compulsive washing typically entails excessive handwashing, showering or toilet routines, although cleaning of kitchen and bathroom surfaces is not uncommon. The following case illustrates one individual’s experience of compulsive washing:

*It takes me at least two hours to shower properly, so I avoid it whenever I can. I’d rather stay in my pyjamas and not leave the house than have to shower and dress. First I have to strip off my pyjamas and lay out my new clothes. If my clean clothes touch my pyjamas, or anything I think is dirty, I have to put them in the wash. Then I have to clean the bathroom. I use bleach on all the taps in the bathroom before I shower, and I also clean the shower door. When I’m in the shower I work on one body part at a time. I use an antibacterial soap and wash each part of my body until I count to 50 in my head. I do this five times and then I move to a different body part. Before I start, I also mix up a bottle of face cleanser, bleach and water—I use this mix on my genitals. Sometimes it makes my skin go red, but it’s the only way I can be sure I’m clean.*



We have not fixed this page correction, since the markup given in pencil



Compulsive washing is a common symptom of obsessive-compulsive disorder (OCD). Compulsive washing typically entails excessive handwashing, showering or toilet routines.

In addition to washing/cleaning, compulsive checking is another common feature of OCD. Checking behaviours can include a seemingly endless range of objects and activities, although the most common involve the checking of taps, power points, stoves, electrical appliances and door and window locks. Rachman (2003a) argues that compulsive checking is the most common and prominent feature of OCD and some research supports this claim. For instance, Antony, Downie, and Swinson (1998) found the ratio of checkers to washers to be about 4:3. Certainly, together with washing, compulsive checking accounts for much of the behaviour seen in OCD clinics around the world. The following case describes an individual's compulsive checking ritual:

*I check so many things—I really don't know where to start. Stuff around the house is the worst. Before I leave the house I have to check that every tap and power point is turned off, all the downstairs windows are locked and all the knobs on the gas stove are off. The taps and the stove are the most difficult. I find it very hard to trust my eyes. I look at the bottom of each tap and stare, sometimes for 5 or 10 minutes, looking for water. Often I have to put my hands under each tap repeatedly to see if they get wet, even though I see that no water is coming out. With the stove, I'm terrified that I will knock a gas knob on while I do my checks. To help me, I've marked the 'off' symbol in bright red paint so I can do a final check from the other side of the room. That way I know I can't have accidentally knocked the knobs on, because I'm too far away to touch them.*

Another form of OCD is 'primary obsessional slowness'. This form of OCD refers to a compulsive disorder in which the sufferer carries out everyday activities, like washing and dressing, in an exceedingly precise, slow and unvarying sequence. The term 'primary' is used to indicate that the slowness is not secondary to other checking behaviours. That is, the slowness is not occurring because of the repeated need to check a part of the sequence over and over again. Rachman (2003b) describes the case of a 38-year-old man with primary obsessional slowness who took nearly an hour to brush his teeth each evening. The sufferer demonstrated his teeth cleaning to the therapist and it became apparent that the time was taken because of the need to brush each small group of teeth in turn, in a repetitive and unchanging manner. Rachman (2003b) reports that the same slowness was apparent in virtually all of the individual's grooming behaviours. Given the severe impact of primary obsessional slowness on the individual's capacity to function, and the fact that it tends to follow a chronic course over years or decades, it is fortunate that it is a rare disorder. In a survey of 665 patients seen at the Maudsley Hospital in London over a 15-year period, only 21 cases of the condition were identified (Rachman, 2003b).

Closely related to OCD is hoarding disorder. The *DSM-5* defines this condition as a persistent difficulty in discarding possessions (even those of useless or limited value), with a high level of distress associated with discarding the items. This accumulation of possessions results in significant congestion of living areas, which are only cleared through the actions of others. Frost, Steketee, and Williams (2000) reported that hoarding is associated with substantial risk to health and safety. In a five-year study of complaints made about hoarding to local health departments in the State of Massachusetts, several deaths were directly attributed to hoarding (e.g., house fires stemming from hoarded newspapers). Frost and Hartl (2003) provide several anecdotes that point to the severity and impact of compulsive hoarding, including a description of an 80-year-old hoarder who could not walk anywhere in her house, but instead had to ‘swim’ through the waist-high debris. The following illustrates a case of compulsive hoarding:

*I simply can't throw out sections of newspapers that could be useful in the future. At last count I had over 125 cardboard boxes of newspaper clippings and other papers. I have them stacked in the hall of my home and in two bedrooms. I have most trouble with the travel sections, and with food and restaurant reviews. I could miss out on something important if I simply throw them out—when I do travel, I want to know that I have collected everything that could guide me. It would be a disaster to miss something, and it would be all my own fault.*

#### body dysmorphic disorder

Disorder involving obsessive concern regarding a part of the body the individual believes is defective.

#### clinical

**significance** This disorder causes substantial impairment in social, occupational or other areas of functioning.

Also included within the chapter ‘Obsessive-compulsive and Related Disorders’ is **body dysmorphic disorder**, which entails a preoccupation with an imagined defect of appearance. The individual believes that a part of his/her body is deformed or of the wrong size (too big or too small). Even if there is a slight defect in appearance, the individual’s level of concern is markedly excessive. Women with the disorder tend to worry about their nose, breasts, hips and weight; men about their genitals, body hair, baldness and general body build. The preoccupation causes almost compulsive mirror checking, excessive grooming or need for reassurance from others. To be considered a disorder it must be associated with **clinically significant** distress or impairment in social, occupational or other important areas of functioning (e.g., avoidance of public situations) and is not better accounted for by another psychological disorder (e.g., dissatisfaction with body shape and weight in anorexia nervosa). Those with the disorder may seek cosmetic surgery but unfortunately this is not always successful in eliminating the individual’s concerns. Evidence suggests that up to 15 per cent of people seeking cosmetic surgery meet criteria for body dysmorphic disorder (Crerand, Franklin & Sarwer, 2006). Although surgery may have only limited success in reducing the patient’s concerns, psychological therapies can be of benefit (Cororve & Gleaves, 2001).

## CASE STUDY :

### OBSESSIVE-COMPULSIVE DISORDER

Peter is a 32-year-old man who has suffered with OCD since early childhood. His anxiety began at age 8 when his uncle died suddenly of a heart attack. Peter became obsessed with the idea that his mother would suddenly die and he began a counting ritual each night to prevent any harm from occurring. At first, this simply involved counting backwards by 3s from 90. However, over time the ritual became more elaborate, involving a series of movements and mantras that had to be performed in order to prevent his mother’s death. These behaviours were kept secret from his family for several years because he feared that his parents would stop him from completing the rituals if they were discovered.

**LO 2.7****Posttraumatic stress disorder (PTSD)**

**posttraumatic stress disorder (PTSD)** Anxiety disorder that may develop after a traumatic experience that is characterised by: (a) repeated re-experiencing of the traumatic event; (b) avoidance of stimuli associated with the trauma or emotional numbing; (c) negative changes in cognitions and mood; and (d) increased arousal.

**THE DIAGNOSIS OF POSTTRAUMATIC STRESS DISORDER**

**Posttraumatic stress disorder (PTSD)** is classified among ‘Trauma- and stressor-related disorders’ in the *DSM-5* (APA, 2013) and is defined as a disorder that entails extreme stress reactions after exposure to a traumatic event. The event must include threatened or actual harm to the self or others. Although PTSD can develop in response to a wide range of traumatic events, there is strong evidence of a relationship between the greater likelihood of PTSD development as the severity of trauma increases. Common examples of traumatic events associated with PTSD include war, natural disasters, rape, assault, car accidents and terrorism (March, 1993).

**SYMPTOMS**

PTSD comprises four major clusters of symptoms: re-experiencing symptoms, avoidance symptoms, negative changes in cognitions and mood, and marked alterations in arousal. The first symptom cluster involves re-experiencing symptoms that include intrusive memories, flashbacks and nightmares related to the traumatic event and distress when exposed to reminders of the trauma. The second cluster involves active avoidance symptoms, including avoidance of thoughts and reminders of the trauma. The third symptom grouping entails negative alterations in cognition and mood, which includes emotional numbing, being unable to recall an important aspect of the trauma, exaggerated negative expectations about oneself or the world, excessive blaming of the self or others and pervasive negative affective states (e.g., fear, anger, guilt and shame). The final cluster involves arousal symptoms, including an exaggerated startle response (i.e., being very jumpy or reactive to stimuli), hypervigilance (i.e., being on the lookout for possible sources of threat), sleeping and concentration difficulties, reckless or self-destructive behaviour and anger outbursts. To qualify for a diagnosis of PTSD, these symptoms must have been present for at least one month.

Some changes were introduced in the *DSM-5* that altered the operational and conceptual definitions of PTSD (Friedman, Resick, Bryant, & Brewin, 2011). The individual’s subjective response at the time of the traumatic event (i.e., one of intense fear, helplessness or horror) was a requirement in the *DSM-IV-TR* (APA, 2000) but has been deleted in the *DSM-5* as it does not add to the accuracy of identifying people with PTSD. In addition, the *DSM-IV-TR* defined avoidance as the *active* avoidance of thoughts and situations in recognition that these symptoms are distinct from more passive forms of avoidance, such as disinterest and withdrawal from usual activities. The *DSM-5* now classifies these latter symptoms in the new cluster that involves negative alterations in cognitions and mood (e.g., feelings of detachment from others or inability to experience positive emotions). The rationale for adding this new cluster of alterations in cognitions and mood was the overwhelming evidence that PTSD can be characterised by catastrophic cognitive interpretations of the event (Ehlers & Clark, 2000) and by a range of emotional responses beyond fear and anxiety (Brewin, Andrews, & Valentine, 2000).

**THE EPIDEMIOLOGY OF POSTTRAUMATIC STRESS DISORDER**

Population studies have shown that many people in the community have been exposed to traumatic stressors. For instance, the National Comorbidity Survey conducted in the United States indicated that 61 per cent of randomly sampled adults reported exposure to a traumatic stressor (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Even higher, a study of adults living in Detroit found that 90 per cent reported exposure to a traumatic stressor (Breslau, Davis, Andreski, & Peterson, 1991). Yet despite the frequency of exposure to potentially traumatising events, relatively few people actually develop PTSD. For example, the National

Comorbidity Survey found that only 20.4 per cent of the women and 8.2 per cent of the men who had experienced a traumatic event ever developed PTSD (Kessler et al., 1995). Similarly, the Detroit study found that only 13 per cent of the women and 6.2 per cent of the men had developed PTSD (Breslau, Davis, Andreski, & Peterson, 1991). These studies indicate that the normative response following trauma exposure is to adapt to the experience and not to develop PTSD. Although men are more likely to be exposed to trauma than women, women have at least a two-fold risk of developing PTSD compared to men (Breslau, Davis, Andreski, Peterson, & Schultz, 1997). More severe traumas tend to result in more severe PTSD. There is evidence that interpersonal violence leads to more PTSD than impersonal trauma. For example, whereas 55 per cent of rape victims develop PTSD, only 7.5 per cent of accident victims develop PTSD.

Interesting patterns have been observed in the prevalence of PTSD among Australian adults. In the Australian National Survey of Mental Health and Wellbeing, conducted in 1997 by the Australian Bureau of Statistics, it was found that although the rates of trauma exposure were similar to those found in the US studies, the Australian study found lower rates of PTSD (Creamer, Burgess, & McFarlane, 2001). Specifically, whereas the 12-month prevalence rate for PTSD was 3.9 per cent in the United States (Kessler et al., 1999), the Australian study reported 1.3 per cent (Creamer et al., 2001). This study also highlighted the comorbidity that exists among people with PTSD. Table 2.6 presents a summary of the comorbid psychiatric disorders that were reported in this study, and highlights that developing PTSD is strongly associated with a range of other psychiatric disorders. However, when the national survey was repeated in 2007, a higher prevalence rate of 4.4 per cent was observed, which is more consistent with rates noted overseas (Australian Bureau of Statistics, 2007).

**TABLE 2.6** The prevalence of psychological disorders in individuals with and without posttraumatic stress disorder

	WITH PTSD	WITHOUT PTSD
Major depression	59%	6%
Dysthymia	5%	1%
Bipolar disorder	2%	0%
Generalised anxiety disorder	31%	2%
Panic disorder	16%	1%
Social phobia	18%	1%
Obsessive-compulsive disorder	11%	1%
Alcohol use disorder	25%	6%
Drug use disorder	18%	3%

Source: From Creamer, M., Burgess, P., & McFarlane, A. C. (2001). Posttraumatic stress disorder: Findings from the Australian National Survey of Mental Health and Wellbeing. *Psychological Medicine*, 31, 1237–1247.

## PREVALENCE IN CHILDREN

The prevalence of PTSD in children is generally similar to that reported in studies of trauma-exposed adults (Fletcher, 1996). Despite the overall comparability between children's and adults' reactions, there are suggestions that PTSD can be manifested differently across different stages of childhood (Salmon & Bryant, 2002). That is, preschool children can display fewer cognitive symptoms (e.g., fewer re-experiencing symptoms such as reliving, daydreaming or talking about the event) and little avoidance (e.g., inability to recall an aspect of the trauma and avoidance of thoughts, feelings or conversations about the event) compared to older children.

## RISK FACTORS

It is common for individuals to experience a broad array of PTSD-type symptoms in the initial weeks after trauma exposure (Harvey & Bryant, 2002). Despite the prevalence of acute stress reactions, the majority of