## Chapter 2

# *ANXIETY*

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Anxiety disorders are the most common, frequently occurring, so-called mental disorders in the United States (we say "so-called" because there are compelling reasons to doubt the notion that these conditions have their etiology in the "mind" of individuals). Differing from everyday stress and anxiousness caused by stimuli such as examinations, new jobs, and morning traffic, anxiety disorders are pervasive and chronic and may need professional care to alleviate or cure them. Over 19 million Americans between the ages of 18 and 54 are estimated to meet the formal diagnostic criteria for one or more anxiety disorders (National Institute of Mental Health [NIMH], 1999). Anxiety disorders can be the result of life stressors and events, learning, parental upbringing, illness-induced stress, genetic endowment and other biological conditions, and the inability to cope with and manage all of those factors at once. Mental health problems such as anxiety present particular problems during adulthood, including contributing to high rates of suicide, relationship problems, and difficulty functioning in society. Some specific events during adulthood (having children, divorcing, and expectations about success) can contribute to the development of an anxiety disorder.

Some anxiety is helpful, keeping persons alert and aware of their environment; too much anxiety, however, fatigues a person and can lead to diminished functioning. Anxiety disorders are linked by extreme or pathological anxiousness as the principal disturbance. The term *anxiety disorder* is formally given to pathological disturbances of affect, thinking, behavior, and physiological activity (U.S. Surgeon General, 1999). This subsumes emotional responses such as intense fear and feelings of dread and physical symptoms of shortness of breath, cold hands and feet, perspiration, lightheadedness or dizziness, rapid heart rate,

trembling, restlessness, and muscle tension (U.S. Surgeon General, 1999). Anxiety disorders are characterized by an excessive or inappropriate state of fear, apprehension, and uncertainty (NIMH, 1999).

## TYPES OF ANXIETY DISORDERS

There are several specific types of anxiety disorders, including the following.

### Phobias

The underlying element in all phobias is an *irrational fear* of something. They can range in intensity from mild to traumatic, but "in all cases there is a sense of predictability which accompanies them" (Clark & Wardman, 1985, p. 13). The following are general definitions of several common phobias.

#### *Specific Phobia*

Formerly known as "simple phobia," specific phobia is persistent fear of an object or situation. According to the *Diagnostic and Statistical Manual of Mental Disorders* text revision (*DSM;* American Psychological Association, 2000), there are five subtypes of specific phobia: animal type (generally with childhood onset; examples include fear of snakes, dogs, or insects), natural environment type (fear of storms, heights, weather), blood-injection injury type (fear cued by seeing blood), situational type (fear cued by a situation such as crossing a bridge, driving, being in enclosed places), and other (e.g., fear of clowns, claustrophobia, fear of choking). Exposure to the stimulus causes intense fear and stimulates avoidance behavior by the individual. The fears are excessive and unreasonable. Most specific phobias begin during childhood and eventually disappear. They are more common in women than in men.

#### *Social Phobia*

Also called "social anxiety disorder," social phobia is diagnosed when a person's shyness and social avoidance becomes so severe and intense that it causes impairment or dysfunction. The anxiety-evoking stimulus involves being observed, judged, or evaluated by others. Social phobia is one of the most common anxiety disorders and can become worse over time if not treated (Thyer, 2002; Thyer, Tomlin, Curtis, Cameron, & Nesse, 1985). Social phobia is defined by the *DSM* as "marked or persistent fear of social or performance situations in which embarrassment may occur" (American Psychiatric Association, 2000, p. 450). Situations that are often feared by people with social phobia are speaking in public,

participating in sports, being in public places, meeting new people, talking to an authority figure, using public lavatories when others are present, and musical or other performances. Clinical presentations may be different across cultures. By some criteria, social phobia is the third most prevalent mental health care problem in the world.

*Agoraphobia*

The word *agoraphobia* literally translates as "fear of the marketplace" (Clark & Wardman, 1985, p. 8) and refers to a generalized fear of being in public places. More specifically, agoraphobia is "anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a panic attack or panic-like symptoms" (American Psychiatric Association, 2000, p. 432). This anxiety usually leads to the individual avoiding situations in which the anxiety may arise. In severe cases, individuals are unable to leave their comfort zone and often self-isolate to the point of being housebound.

## General Anxiety Disorder

This disorder is characterized by excessive anxiety or worry accompanied by at least three of the following: restlessness, fatigue, lack of concentration, muscle tension, irritability, and lack of sleep. General Anxiety Disorder can manifest in physical symptoms such as trembling, twitching, muscle aches, and soreness as well as diarrhea and vomiting. The intensity and worry individuals report is grossly out of proportion to the real risk. This disorder frequently occurs with mood disorders and other anxiety disorders and is more common in women than in men.

## Panic Disorder

Panic Disorder is characterized by panic attacks, which are described as a "rush of fear or discomfort that reaches a peak in less than 10 minutes" (Antony & Swinson, 2000, p. 12). These attacks are accompanied by physical symptoms such as a racing heart, shortness of breath, sweating, shaking, chest pain, faintness, and hot flashes or chills. Panic attacks often occur in the absence of any specific stimuli but can be brought on by stressful events such as an exam or a public speaking event. According to the *DSM* (American Psychiatric Association, 2000), there are three subtypes of Panic Disorder: unexpected (occur without warning or a precipitating event), situationally bound (occur in a particular situation, e.g., with phobia exposure), and situationally predisposed (these fall somewhere in between the

two previous). Panic attacks are often disabling. Panic Disorder is estimated to impact more than 4% of Americans (Datilio, 2001).

### Obsessive Compulsive Disorder

The *DSM* defines Obsessive Compulsive Disorder (OCD) as "recurrent obsessions or compulsions that are severe enough to be time consuming (more than 1 hour a day) or cause marked distress or significant impairment" (American Psychiatric Association, 2000, p. 458). OCD usually presents with both obsessive thoughts and compulsive behaviors, although individuals may suffer from only one. The obsessions are characterized by persistent thoughts, images, or impulses that cause marked anxiety or stress; for example, the thought of germs contaminating one's hands, ruminating over whether one locked the door, or the urge to blurt out an obscenity. The compulsive behaviors are often associated with the obsessions: with the thought of germs comes excessive hand washing, even to the point where the skin is extremely chafed. Adults with OCD usually realize that these actions are inappropriate, unreasonable, and excessive. If they do not come to this realization, the illness is referred to as OCD with poor insight.

### Posttraumatic Stress Disorder

In Posttraumatic Stress Disorder (PTSD), a person who has experienced a traumatic situation that involved actual or threatened death or serious bodily harm responds with trauma-related symptoms of intense fear, helplessness, or horror. Events can include, but are not limited to, crime victimization, wartime events, or serious accident. Symptoms can include distressing dreams about the event, feeling as if the event is recurring, stress surrounding the anniversary of the event, flashbacks, or avoiding activities associated with the event. In addition, the individual may have difficulty concentrating, may have insomnia, may display outbursts of anger, may be unable to recall the traumatic event, and may display a lack of interest in activities. PTSD is common among victims of rape and personal assault and those who serve in active combat. Sometimes the victim is unable to make the connection between the traumatic event and current struggles.

## PREVENTION

There has been much research on the diagnosis and treatment of adult anxiety disorders but little attention paid to prevention. Anxiety disorders can be prevented provided the person has access to treatment or prevention information in

the early stages of the disorder (Leighton, 1987). Delay in treatment and a lack of information about anxiety disorders and management contribute to the development of a diagnosable anxiety disorder.

The primary problem with attempting to prevent anxiety disorders is that individuals often try to camouflage their disorder instead of getting treatment. They may hide their symptoms from friends, family members, and coworkers, leading to a delay in professional treatment and intervention for perhaps many years, or until they are so uncomfortable and the symptoms so overwhelming that they are functionally impaired (Craske & Zucker, 2001).

Anxiety prevention programs have slowly grown in numbers, but few have been empirically supported. Three types of prevention programs are discussed in this chapter: universal, selective, and targeted. Programs aimed toward preventing the entire population or a community from feeling stressed or anxious about life events are monumental undertakings. This type of program is called a *universal* preventive intervention. *Selective* interventions are aimed at a population known to be at risk for anxiety problems or at higher risk than the average person, such as adults who have been exposed to violence at home or in the community. Preventive interventions aimed at adults who are already showing signs and symptoms of anxiety disorders are called *targeted.*

## TRENDS AND INCIDENCE

The cost of anxiety disorders to the United States is more than $42 billion a year, with more than $22 billion attributed to repeat medical care costs in a search for relief from symptoms that look like physical illness (Greenberg, Sisitsky, & Kessler, 1999). People with anxiety disorders are three to five times more likely to go to the doctor and six times more likely to be hospitalized for psychiatric disorders. About one in seven adults in the United States and Britain are affected by anxiety disorders each year (Brown, 2003; see Table 2.1 on page 18).

## RISK FACTORS

The predictors and risk factors for anxiety disorders have been well studied. A combination of biological, psychological-behavioral, and social-environmental factors determines if an individual will develop an anxiety disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2003). The Anxiety Disorders Association of America suggests that anxiety disorders develop from a complex combination of risk factors, including genetics, brain chemistry, personality, and life events.

**Table 2.1 Disorder Distribution among U.S. Adults**

| Disorder | Total U.S. Population Affected | | |
|---|---|---|---|
| | Number (in Millions) | Percentage | Gender |
| Generalized Anxiety Disorder | 4 | 2.8 | Women are twice as likely as men to be afflicted. |
| Obsessive Compulsive Disorder | 3.3 | 2.3 | Equally afflicts men and women. |
| Panic Disorder | 2.4 | 1.7 | Women are twice as likely as men to be afflicted. |
| Posttraumatic Stress Disorder | 5.2 | 3.6 | Women are more likely than men to be afflicted. |
| Social phobia | 5.3 | 3.7 | Equally afflicts men and women. |
| Specific phobia | 6.3 | 4.4 | Women are twice as likely as men to be afflicted. |
| Total all/any phobia | 14.8 | 10.3 | |

*Source:* Retrieved February 15, 2004, from www.adaa.org/mediaroom/index.cfm.

Life stressors and events may include severe or life-threatening trauma either during adulthood or childhood that contributes to the stress level of an individual (see Thyer, 1993). Stressors may include maltreatment during childhood, exposure to violence in or external to the home, violent relationships during adulthood, and being exposed to violence or trauma in personal or work environments. Some events can result in distress and dysfunction that, if not treated or managed, manifests as a mental illness, such as an anxiety disorder (U.S. Surgeon General, 1999).

For a substantial proportion of individuals who meet the criteria for an anxiety disorder, a clear biological or psychosocial etiology cannot be established. *Women* are at twice the risk for anxiety disorders compared to men, with the exception of OCD and possibly social anxiety. Possible explanations for this discrepancy include hormonal differences, cultural pressures, and a higher rate of reporting anxiety. Anxiety disorders appear to have a genetic factor and run in families. Many other factors influence an individual, including social, home, and peer relationships, but genetics plays a strong role.

## EFFECTIVE UNIVERSAL PREVENTIVE INTERVENTIONS

The following interventions group all anxiety disorders together and attempt to prevent them for the entire population or community.

## National Institute of Mental Health Anxiety Disorders Education Program

This program was developed by the NIMH Communications and Public Liaison Office. The purpose of the program was to educate and increase awareness among the public and health care providers about anxiety disorders and their "realness," and to convey the message that these conditions can be effectively diagnosed and treated. The primary goal of the program was to improve the lives of people with anxiety disorders. A six-pronged approach was used to disseminate information:

- A toll-free information line (800-ANXIETY) to receive free printed materials.
- A web site about anxiety disorders (www.nimh.nih.gov/anxiety).
- Radio and television public service announcements.
- Printed and audiovisual materials discussing diagnosis, treatment, and referral information about anxiety disorders.
- Print media outreach.
- Partnerships with community mental health, health, and civic organizations that provide public and professional education and research at the local level.

## National Anxiety Disorders Screening Day: May 1

The purpose of this day is to destigmatize anxiety disorders, educate the public, and help people with anxiety disorders connect with service providers to obtain treatment. This has been a federal education and prevention program since 1994.

## National Campaign on Anxiety and Depression Awareness 2004

This program is a year-long campaign to educate the public about the signs and symptoms of anxiety and depressive illnesses and guide affected individuals to treatment networks. The campaign includes public service announcements, print media releases, promotion of films about mental health issues, visits to communities, colleges, and universities, and a web site and toll-free number. Individuals found to have signs and symptoms of anxiety and depressive illness will be referred to a registered mental health provider to receive a free telephone or in-person mental health screening.

### Anxiety Web Sites

A number of web sites that describe anxiety disorders, their features and symptoms, resources for more education and diagnosis, and methods of prevention are available with simple searches on the Internet. The following is a list of prevention-specific sites:

- www.panicanxietydisorder.org.au/4_Prevention.htm
- eMedicine.com: www.emedicine.com/aaem/topic26.htm
- Anxiety Disorders Association of America: www.adaa.org
- The Anxiety Panic Internet Resource: www.algy.com/anxiety/index.html
- Obsessive-Compulsive Foundation: www.ocfoundation.org/indright.htm

## EFFECTIVE SELECTIVE PREVENTIVE INTERVENTIONS

The following interventions attempt to prevent all types of anxiety disorders for individuals identified as at risk.

### Exercise Training Studies

The purpose of exercise programs were examined and found to be more beneficial for those with stressful lifestyles regarding anxiety reduction and management. Low to moderate stress management was achieved by participating in aerobic exercise including walking and jogging from a minimum of 5 weeks to 1 year.

### Stress Management Training Program

Timmerman, Emmelkamp, and Sanderman (1998) developed a training protocol addressing issues that may cause increased stress in an individual's life: changing an unhealthy lifestyle, relaxation training, problem-solving training, and social skill training. Individuals randomly selected from a single community were chosen to participate after a screening to determine that they did not have serious mental health complaints but had an increased chance of developing one if exposed to stress. Participants were assigned to either a treatment or a control group. The treatment group, which followed the training protocol, reported more assertiveness, more satisfaction with social support, fewer daily hassles, less trait anxiety, and less distress.

### Stress Inoculation Training for Step-Couples

Fausel (1995) designed this program to assist step-couples dealing with the stress of mourning the loss of their first families as well as learning how to cope and negotiate new relationships. The technique used Stress Inoculation Training in a three-phase program of behavioral and imaginal rehearsal, self-monitoring and instruction, cognitive restructuring, problem solving, didactic teaching, Socratic discussion, relaxation training, self-reinforcement, and environmental manipulation. Results of the program found that 62% of the 51 step-couples participating had reduced their stress scores.

### Stress Management Exploratory Cognitive-Behavioral College Course

College students elected to take this course due to their interest in stress management and anxiety (Schiraldi & Brown, 2001). The course was based on the components of Stress Inoculation Training. The students were taught skills to reduce anger, prevent anxiety and depression, and improve self-esteem. The course lasted 15 weeks and pre- and posttests showed significant reductions in anxiety and depression and improvement in self-esteem.

### Toastmasters International

This organization offers basic public speaking and communication skills along with methods to diminish fear and anxiety related to public speaking and leadership roles. The meetings feature learning how to develop presentations, lead teams and conduct meetings, give and receive constructive evaluations, and improve listening skills. The program is self-paced and meetings are offered around the world at many locations and times. There is a nominal fee for membership. See www.toastmasters.org for more information.

## EFFECTIVE INDICATED PREVENTIVE INTERVENTIONS

Prevention Program for Panic Disorders, Brief Prevention Program for Recent Assault Victims, Video Intervention Program for Rape Survivors, Critical Incident Stress Debriefing, and Agoraphobics in Motion Self-Help Group are programs supported by empirical research studies.

## Prevention Program for Panic Disorders

This program involved attending a 1-day prevention workshop group and monthly contact for 6 months (Gardenswartz & Craske, 2001). The workshop was based on cognitive-behavioral treatment techniques and focused on education about panic, strategies to control panic, information about agoraphobia, and exposure to overcome physical sensations and fears. Participants were selected to attend the workshop or to go on a wait-list (comparison group) if they reported they had at least one panic attack in the previous year and had at least moderate anxiety sensitivity but did not have diagnosed Panic Disorder. Outcomes showed that workshop participants were less likely to develop Panic Disorder in comparison to those wait-listed.

## Prevention Workshop for College Students

First-year college students ($n = 231$) identified to be at risk for depression and anxiety were assigned to treatment or control groups over a 3-year period (Seligman, Schulman, & DeRubeis, 1999). The intervention was done three times over the 3-year period. The treatment group participated in 16 hours of meetings over 8 weeks as well as completing homework assignments led by a trainer and a cotrainer. The content of the treatment was based on cognitive-behavioral techniques; specific topics included:

> the cognitive theory of change, identifying automatic negative thoughts and underlying beliefs, marshaling evidence to question and dispute automatic negative thoughts and irrational beliefs, replacing automatic negative thoughts with more constructive interpretations, beliefs, and behaviors, behavioral activation strategies, interpersonal skills, stress management, and generalizing these skills to new and relevant situations. (para. 20)

The workshop participants showed fewer episodes of Generalized Anxiety Disorder and fewer anxiety symptoms than the control group.

## Brief Prevention Program for Recent Assault Victims

This program targeted recent female victims of sexual and nonsexual assault (Foa, Hearst-Ikeda, & Perry, 1995). The treatment group ($n = 10$) received four sessions of cognitive-behavioral interventions, while a control group received repeated assessments only. Education about common reactions to assaults was provided along with a mixture of cognitive-behavioral techniques, including video narration, relaxation techniques, cognitive distortion recognition and

discussion, imaginal exposure, and cognitive restructuring. Two months after the assault, the treatment group demonstrated significantly fewer PTSD symptoms. After five and a half months, the treatment group participants were significantly less depressed and had significantly fewer severe symptoms of re-experiencing the event compared to those in the assessment-only group.

## Video Intervention Program for Rape Survivors

The purpose of this prevention program was to decrease the anxiety of recent sexual assault victims during the forensic exam and prevent PTSD (Resnick, Acierno, Holmes, Kilpatrick, & Jager, 1999). Recent sexual assault victims who had been forcibly penetrated orally, anally, or vaginally within the previous 72 hours were randomly assigned to a treatment ($n = 13$) or a control group ($n = 33$). The treatment group watched a 17-minute video prior to the sexual assault forensic exam. The video was created to reduce distress during the exam as well as provide education about preventing PTSD, substance abuse, depression, and Panic Disorder. The video described the forensic exam and instructed viewers on how to recognize and implement techniques to reduce avoidance. Mood control and controlling anxiety levels were also discussed and modeled along with exposure exercises. Results indicated that distress during the forensic exam was reduced for the treatment group.

## Critical Incident Stress Debriefing

Critical incident stress debriefings (CISDs) are single-session group debriefings designed to be used with primary and secondary victims of crisis and trauma (victims of crime or terrorism, emergency service workers, police officers; Mitchell, 1983, 1988). Sessions incorporate a seven-step structured group discussion: introduction of team members, process, and expectations from group; group members describing their role in the incident (without identifying their related feelings); discussion of each member's thoughts and reactions; discussion of emotional reactions; reframing the event; teaching about normal reactions and basic stress management; and summary of the discussions.

CISDs have been used worldwide in response to the psychological needs of victims and service providers. Twenty years after the debriefings were introduced, few studies have found evidence that the method produces positive outcomes (decreasing PTSD symptoms and diagnoses), with some studies showing negative outcomes (Rose, Bisson, & Wessely, 2003). Caution should be used when considering this intervention to address posttraumatic stress symptoms due to the potential to cause harm (see Lewis, 2003, for a

comprehensive review of the evidence). At present, CISD is not recommended as a preventive program.

### Agoraphobics in Motion Self-Help Group

Agoraphobics in motion (AIM) was founded over 20 years ago by an individual suffering from agoraphobia and Panic Disorder as an educational, supportive, and therapeutic (nonprofessional) program. Usually at each meeting (held in community-based locations), guest speakers make a presentation about some aspect of an anxiety disorder. Field trips facilitate gradual reentry into feared situations. The organization has a web site, an Internet message board, a newsletter, and a pen pal program (for the housebound). Its message is that recovery is possible. AIM is but one example of numerous consumer-based self-help groups available for individuals who suffer from crippling anxiety, regardless of whether they have been formally diagnosed or whether they receive professional care. See www.aim-hq.org.

## PRACTICE AND POLICY IMPLICATIONS

The anxiety literature has focused on assessment and treatment but has neglected the development and validation of prevention models for adult anxiety disorders. A limited number of studies have empirically tested prevention programs for individuals at risk for the development of an anxiety disorder, as well as for the general public. However, none of these programs can be said to rise to the level of an evidence-based preventive intervention. This renders direct practice and policy implications more speculative than empirical.

It does seem clear that the widespread failure to effectively educate the public about anxiety disorders tends to promote ignorance and stigma around this significant mental health problem. The social and financial costs associated with the anxiety disorders are considerable and rising, justifying some additional efforts at prevention. Their prevalence justifies an increased focus as well on the provision of specialized training for health care providers, ideally at the level of graduate education, and less optimally through evidence-based continuing education programs. Attention must be given to the cost-effectiveness of prevention programs, especially those involved in primary prevention aimed at the general public and funded by taxpayers' dollars. Compelling evidence is required regarding the numbers needed to be reached through such programs and the associated reduction in the development of anxiety disorders and their psychosocial sequelae (including functional impairments) relative to the costs

incurred. Is a billion-dollar prevention program that effectively prevents five persons from developing OCD worth it? How about 500, or even 5,000 cases? For prevention programs in the anxiety disorders (as well as in all other fields) to be seen as justifiable, relatively unambiguous data are required to show that the public receives value for money, in addition to being helpful to small numbers of individuals. As yet, no compelling theory exists for either the etiology of the anxiety disorders or the possible efficacy of prevention programs. While these lacunae do not prohibit the development of effective prevention efforts, they do tend to inhibit advances in the field. We have a long way to go.

## REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Antony, M., & Swinson, R. (2000). *Phobic disorders and panic in adults: A guide to assessment and treatment.* Washington, DC: American Psychological Association.

Brown, P. (2003, September 6). In the shadow of fear. *New Scientist,* p. 30.

Clark, J., & Wardman, W. (1985). *Agoraphobia: A clinical and personal account.* Oxford, England: Pergamon Press.

Craske, M. G., & Zucker, B. G. (2001). Prevention of anxiety disorders: A model for intervention. *Applied and Preventive Psychology, 10,* 155–175.

Datilio, F. M. (2001). Crisis intervention techniques for panic disorders. *American Journal of Psychotherapy, 55,* 388–405.

Fausel, D. F. (1995). Stress inoculation training for step couples. *Marriage and Family Review, 21,* 137–155.

Foa, E. B., Hearst-Ikeda, D., & Perry, K. J. (1995). Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology, 6,* 948–955.

Gardenswartz, C. A., & Craske, M. G. (2001). Prevention of panic disorders. *Behavior Therapy, 32,* 725–737.

Greenberg, P. E., Sisitsky, T., & Kessler, R. C. (1999). The economic burden of anxiety disorders in the 1990s. *Journal of Clinical Psychiatry, 60,* 427–435.

Leighton, A. H. (1987). Primary prevention of psychiatric disorders. *Acta Psychiatrica Scandinavica, 76,* 7–13.

Lewis, S. J. (2003). Do one-shot preventive interventions for PTSD work: A systematic research synthesis of psychological debriefings. *Aggression and Violent Behavior, 8,* 329–343.

Long, C., & Van Stavel, R. (1995). Effects of exercise training on anxiety: A meta-analysis. *Journal of Applied Sport Psychology, 7,* 167–189.

Mitchell, J. T. (1983). When disaster strikes: The critical incident stress debriefing process. *Journal of Emergency Medical Services, 8,* 36–39.

Mitchell, J. T. (1988). Development and functions of a critical incident stress debriefing team. *Journal of Emergency Medical Services, 13,* 43–46.

National Institute of Mental Health. (1999). *Anxiety disorder research: Fact sheet.* Bethesda, MD: Department of Health and Human Services, National Institute of Health.

Resnick, H., Acierno, R., Holmes, M., Kilpatrick, D. G., & Jager, N. (1999). Prevention of post-rape psychopathology: Preliminary findings of a controlled acute rape treatment study. *Journal of Anxiety Disorders, 13,* 359–370.

Rose, S., Bisson, J., & Wessely, S. (2003). A systematic review of single-session psychological interventions (debriefing) following trauma. *Psychotherapy and Psychosomatics, 72,* 176–184.

Schiraldi, G. R., & Brown, S. L. (2001). Primary prevention for mental health: Results of an exploratory cognitive-behavioral college course. *Journal of Primary Prevention, 22,* 55–67.

Seligman, M. E. P., Schulman, P., & DeRubeis, R. J. (1999). The prevention of depression and anxiety. *Prevention and Treatment, 2.* Retrieved January 22, 2004, from http://journals.apa.org/prevention/volume2/pre0020008a.html.

Substance Abuse and Mental Health Services Administration. (2003). *Science-based prevention programs and principles.* Rockville, MD: Department of Health and Human Services.

Thyer, B. A. (1993). Childhood separation anxiety disorder and adult-onset agoraphobia: Review of evidence. In C. G. Last (Ed.), *Anxiety across the lifespan: A development perspective on anxiety and the anxiety disorders* (pp. 128–147). New York: Springer.

Thyer, B. A. (2002). Treatment plans for clients with social phobia. In A. R. Roberts & G. I. Greene (Eds.), *Social workers' desk reference* (pp. 346–352). New York: Oxford University Press.

Thyer, B. A., Tomlin, P., Curtis, G. C., Cameron, O. G., & Nesse, R. (1995). Diagnostic and gender differences in the expressed fears of anxious patients. *Journal of Behavior Therapy and Experimental Psychiatry, 16,* 111–115.

Timmerman, I. G. H., Emmelkamp, P. M. G., & Sanderman, R. (1998). The effects of a stress-management training program in individuals at risk in the community at large. *Behaviour Research and Therapy, 36,* 863–875.

U.S. Surgeon General's Report on Mental Health. (1999). *Mental health: A report of the Surgeon General: Executive summary.* Rockville, MD: U.S. Department of Health and Human Services.