Anxiety and phobic disorders are among the most prevalent, distressing, and disabling of psychosocial problems. They are problems that have long fascinated psychological theorists, and were the first phenomena to which self-efficacy theory was applied (Bandura, 1977; Bandura & Adams, 1977; Bandura, Adams, & Beyer, 1977). Since that initial work, considerable additional research has addressed how people's views of their own coping abilities bear on diverse adjustment problems (Maddux, 1991). This chapter reviews the status of self-efficacy perceptions as causes of anxiety and phobia, and whether self-efficacy theory is heuristic in developing improved treatments. The focus is on current causation rather than historical etiology. The aim is not to systematically address every constellation of responses that might be labeled an anxiety disorder*, but to examine the

*The term anxiety disorders is used in an informal and nonmedical sense. Social cognitive theory does not consider psychological problems as "mental illnesses," since that would be a pointless and misleading medicalization of human experience (Bandura, 1969, 1978a). Nor does social cognitive theory accept that human problems can be neatly arrayed in a catalog that dictates how they shall be characterized for all occasions and circumstances. Human problems can and must be viewed in different ways for different purposes. Enshrining a few arbitrary combinations of problematic phenomena as fixed "mental disorders" in diagnostic
influence of self-efficacy perceptions on the functional impairment, scary thoughts and feelings, and physiological arousal that characterize anxiety-related problems.

THE MEANING OF ANXIETY

Anxiety, an aversive experience of distress, is a major psychological problem not only in so-called anxiety disorders, but in life generally. What exactly is anxiety? The term has come to denote a diverse array of emotional, attitudinal, cognitive, perceptual, physiological, and behavioral responses. This expansive scope has been sustained partly because it could not be shown that any particular index of anxiety strongly predicts problem behavior (Williams, 1987, 1988). The result has been a frequent confusion between anxiety per se and numerous other responses that are merely correlated with anxiety.

Being anxious means primarily feeling anxious. The essence and sine qua non of anxiety is the subjective feeling of fear* (Williams, 1987). Operationally, feeling anxious means a self-judgment of fear intensity, as on a rating scale from Not Afraid to Extremely Afraid. Some have argued that because subjective fear is not public, it cannot by itself be proper data for the scientific study of fear (Lang, 1978). But nature presents anxiety to people primarily as an aversive feeling, and that is a good way to study it. This feeling is not merely operant “verbal behavior” or “language responding,” but a personal reality of indisputable importance in its own right.

Nor is fear largely physiological arousal, since such arousal does not much correlate with feeling afraid (Lang, 1978; Morrow & Labrum, 1978; Williams, 1987). If physiology enters into it, it is mainly as subjectively felt by the client, which tends to be only weakly related with actual physiological arousal (e.g., Ehlers & Breuer, 1992; Mandler, 1962; Whitehead, Drescher, Heiman, & Blackwell, 1977). Physiological arousal without fear is commonplace, as when people exercise, feel exhilaration, or eat spicy food. And fear without physiological arousal is also common; even people having panic attacks do not always show autonomic increases (Barlow & Craske, 1988; Lang, 1978; Margraf, Taylor, Ehlers, Roth, & Agras, 1987; Taylor et al., 1986). Across a broad range of emotions, peripheral physiol-

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manuals hampers more than it helps our ability to understand and alleviate psychological suffering (cf. Detre, 1985; Persons, 1986; Williams, 1985).

*This paper considers the terms anxiety and fear synonymous.