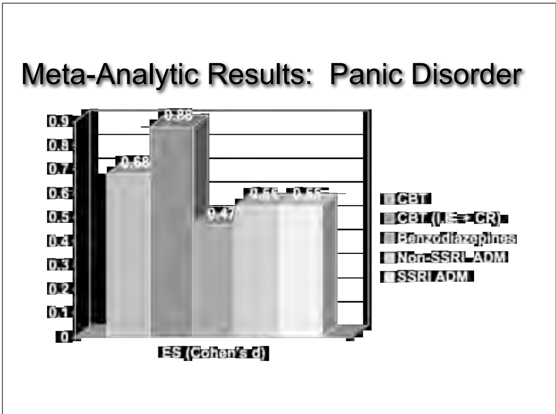
CBT for Anxiety Disorders

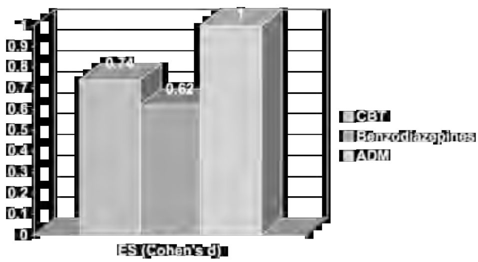
Application of CBT

- An effective first-line treatment
- A replacement strategy for medication treatment (medication discontinuation)
- In combination with medication
- treatment
  - Treatment resistance
  - Standard strategy

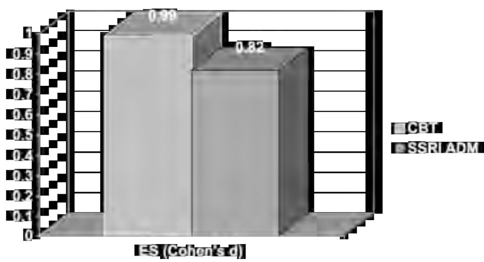
Meta-Analytic Results: Panic Disorder



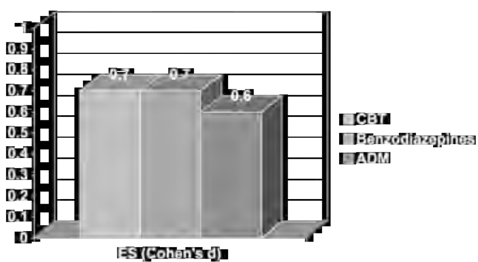
Meta-Analytic Results: Social Phobia



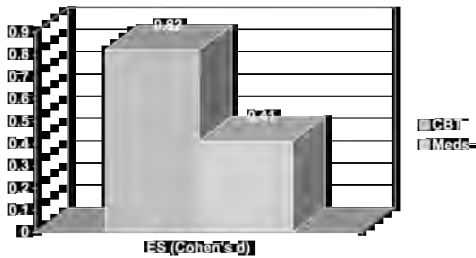
Meta-Analytic Results: OCD



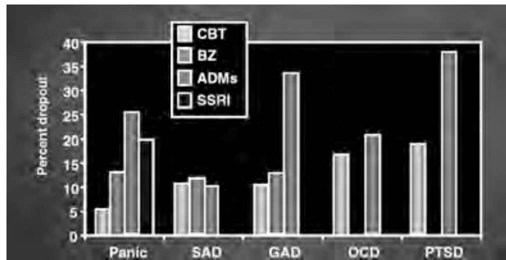
Meta-Analytic Results: GAD



Meta-Analytic Results: PTSD



Treatment Acceptability
(Dropout Rates)



The Core of Treatment

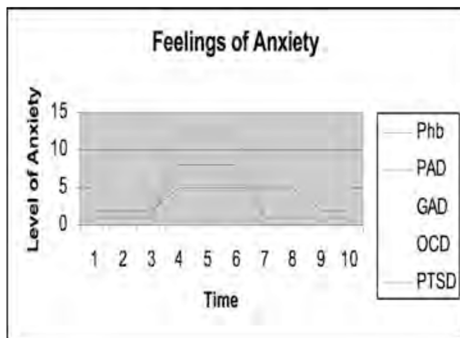
- Provide patients with a way to "unlearn" their fears (re-establish safety around fear cues)
  - Use information
  - Use logical evaluation
  - Use experience
  - Direct their attention to what is learned (use of objective evaluation standards)

Specialized Treatment of Anxiety Disorders: Targeting the Core Fear

Panic Disorder	Fears of anxiety sensations
Social Phobia	Fears of negative evaluation
OCD	Fears of perceived catastrophes
PTSD	Fears of trauma memories
GAD	Chronic worry problems

Exposure Interventions

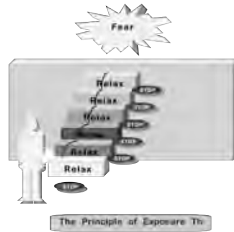
- Provide rationale for confronting feared situations
- Establish a hierarchy of feared situations
- Provide accurate expectations
- Repeat exposure until fear diminishes
- Attend to the disconfirmation of fears
- Do not use PRN medications



Behavioral Strategies

Exposure therapy for anxiety

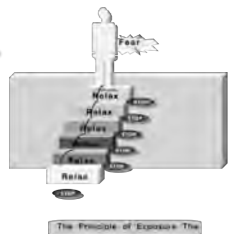
- Used in OCD, PTSD, PD+A, Specific and Social Phobia
- Exposure to anxiety in graded fashion.
- Identify specific goals and break them into smaller, manageable steps



Behavioral Strategies

Exposure therapy for anxiety

- Learn to master situations that cause mild, then gradually greater, anxiety.
- Teach & test a relaxation strategy before to reduce distress/panic during exposure
- Aim is to achieve relative relaxation before next step



Behavioral Strategies

- Principle: best way to overcome fear is to face it, but in ways research says are more likely to succeed
- Emphasize habituation to anxiety in each exposure session.
- Biggest trap is to flee a step at height of fear
  - Re-forges association of situation & fear
- Confront fears regularly and frequently

Behavioral Strategies

Example of exposure hierarchy for Agoraphobia

Goal: To travel alone by bus to the city and back

1. Travelling one stop, quiet time of day (SUDS = 40)
2. Travelling two stops, quiet time of day (SUDS = 50)
3. Travelling two stops, rush hour (SUDS = 60)
4. Travelling five stops, quiet time of day (SUDS = 70)
5. Travelling five stops, rush hour (SUDS = 80)
6. Travelling all the way, quiet time of day (SUDS = 90)
7. Travelling all the way, rush hour (SUDS = 100)

Learning Safety in Panic

Interoceptive Exposure

- Feared sensations become safe sensations
- In the office with the therapist
- At home
- Independent of the treatment context

Panic Disorder: Interoceptive exposure

- Straw breathing
- Headrolling/spinning
- Stair running
- Hyperventilation
- Hand staring
- Throat constriction

Panic Disorder: Naturalistic exposure

- Caffeine
- Alcohol
- Exercise
- Sex
- Sauna/whirlpool
- Suspense/scary movies
- Getting overheated
- Showering with the door closed
- Amusement park rides
- Eating certain foods
- Sugar
- Allowing self to become hungry

Panic Disorder: In-vivo exposure

- Common situations include bridges, malls, theatres
- Use Mobility Inventory to assist in hierarchy construction
- Watch for use of safety signals

What About Relaxation?

- Now used infrequently in the treatment of panic disorder, PTSD, social phobia and OCD
  - Appears to reduce efficacy of panic treatment
- Applied relaxation in GAD

Coping vs. Acceptance

I've got to relax

Emotional tolerance, emotional acceptance (e.g "talking to the limbic system")

Cognitive Restructuring
Major Players

- Aaron Beck
  - Cognitive Therapy
  - "dysfunctional thoughts"
- Albert Ellis
  - Rational Emotive Therapy (RET)
  - "irrational thoughts"

"Cognitive therapy relies on helping individuals switch to a controlled, effortful mode of processing that is metacognitive in nature and focuses on depression-related cognition" and that "the long term effectiveness of cognitive therapy may lie in teaching patients to initiate this process in the face of future stress."

Ingram and Hollon (1986, p. 272)

Cognitive Restructuring

- Identify truth about thoughts: They do not have to be true to affect emotions
- Learn about common biases in thoughts
- Treat thoughts as “guesses” or “hypotheses” about the world

Cognitive Restructuring

Monitor and evaluate thought accuracy

- Substitute more useful thoughts

Attention to:

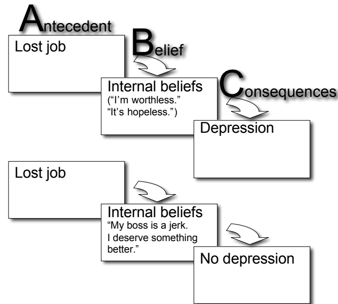
- Overestimations of the probability of negative events
- Overestimates of the degree of catastrophe should events occur

Context for these interventions…

Common College Stressor
(midterms as an example…)

Physical Reactions	Emotions	Thoughts	Behaviors
shallow breathing	fear	*I will fail this test…*	bite nails?
HR up	anxious	*my parents will be upset…*	drink more?
BP up	worried		study more?
sweat…			positive self-talk?

Key Concepts: ABCs



Cognitive Restructuring
as an intervention…

- teaching a client this as a skill
- how to put a new "frame" around a thought
  - different frames can draw out different aspects of a picture
  - still the same picture
- trying to view a situation differently
- shouldn't deny the reality of the situation
- should help improve ability to cope
- should decrease negative affect (depression)
- practice, practice, practice…

Cognitive Restructuring
same situation, different perspectives…

Situation	***What you think***	***How you feel***	***What you do***
Friend is late for dinner	"She might have been hurt on the way here."	Worried or anxious	Call hospital ERs to find out if she's there
	"She didn't bother to let me know she was delayed."	Annoyed or angry	Chew her out, or act chilly, when she does show up
	"It doesn't matter to me whether people are on time."	Indifferent	Nothing in particular
	"I needed the time to fix the house up anyway."	Relieved	Relax and enjoy yourself

Useful questions to challenge thoughts

- What is the evidence? Is is feelings and self-image?
- Is there any other explanation? Did my safety behaviors make it difficult for others?
- Am I mind reading?
- How would I think if I was the other person?

Useful questions for socially anxious client

For identifying negative thoughts

- What went through your mind before/as you entered the situation or as you noticed yourself becoming anxious?
- What was the worst you thought could happen?
- What did you think others would notice/think?
- What would that mean?

Useful questions for client with social anxiety

For identifying safety behaviors

- When you thought the feared event was/might happen, did you do anything to try to prevent it from happening or prevent others from noticing?
- Is there anything that you do to ensure that you come across well?
- What do you do to avoid drawing attention to yourself?
- Do you do anything to try to control the symptoms?

Useful questions for client with social anxiety

For identifying self as a social object

- What happens to your attention when you are afraid that the feared event will happen?
- Do you become more self-conscious?
- Do you have difficulty following what other people are saying/doing?
- Are you less aware of others?

Useful questions for client with social anxiety

For identifying self as a social object (Cont'd)

- As you focus your attention on yourself, what do you notice?
- Do you have an image of how you think you appear?
- Do you have an impression of how you feel you are coming across?
- When you try to conceal your symptoms, how do you feel you look to others?

Interrogating the environment

- Behave in an "unacceptable" fashion and observe others' response (e.g., pause in speech, damp armpits, shake/spill drink, disagree/express opinion, ignore acquaintance)
- Manipulate felt sense and observe others' response
- Conduct surveys (e.g., why do people stutter? What would you think about someone who stutters. Would you think less of someone for stuttering)
- Articulate and discount imaginary critic

Anticipatory anxiety

- Often involves imagining the worst which in turn produces anxious feelings and self-awareness which are taken as evidence the worst will happen.
- Rehearsal of coping responses may be a safety behaviour and may lead to rigid rules about how to behave.

Dealing with post-mortem

- Identify content of post-mortem (feelings not events)
- Review what actually happens and keeping a positive log of what happened
- Review advantages and disadvantages of post-mortem and ban it

Safety Signals/Safety Behaviors

Panic Disorder: Safety signals

- Medication
- Cell phone
- Vomit bag
- Paper bag for re-breathing
- Alcohol
- Water
- Comfort person

Remembering Safety (Bouton, 2002)

- Memories of extinction (safety) are more dependent on context for retrieval than conditioning (fear) memories
- Changes in context can decrease retrieval of extinction (safety) memories, leaving fear memories dominant

External Context Effects

Animal Research

- Environmental & Background Stimuli
  - e.g., Bouton 1993; Smith 1988.

Human Research

- Treatment of 65 Spider Phobics
- (Rodriguez et al. 2003.)
- Extinction, then retesting in new context
  - New room & furnishings
- Some evidence of greater return of fear with context shift

Maximizing the Learning of Safety

- Target the relevant fear cues
- Provide strong training in unambiguous safety
- Practice in multiple contexts
- Go beyond conditional safety (e.g., On this day, wearing my lucky shirt, I am OK)

Safety Behaviors Reduce Exposure Efficacy

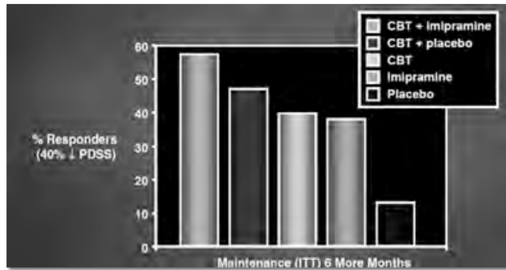
- Programmed use of safety behaviors impairs anxiety reduction in patients with social phobia
- Impairs disconfirmation of fears
- Provides safety conditional on the use of safety behaviors "if not for__________, then Disaster!"

Wells et al. (1995)

The Bad News About Context Effects: Combination Treatment

- Medication treatment appears to be a powerful context
- What is learned on medication does not necessarily extend to the non-medication period

Example from Panic Disorder Treatment



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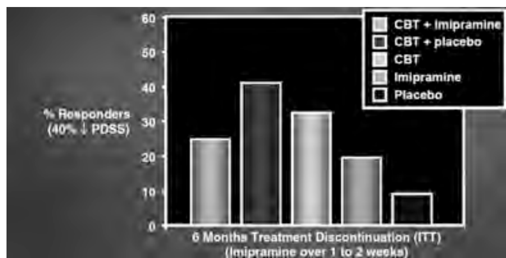

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Solution for context effects

- Apply (re-apply) CBT at the time of medication taper and thereafter
- Works for medication discontinuation with expansion of treatment gains
- Treatment with benzodiazepines
  - Otto et al. 1992; Spiegel et al. 1994.
- Treatment with SSRIs
  - Schmidt et al. 2002; Whittal et al. 2001.
- Relevant for MDD too