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Three Essential Pieces for Solving the Anxiety Puzzle

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Agenda

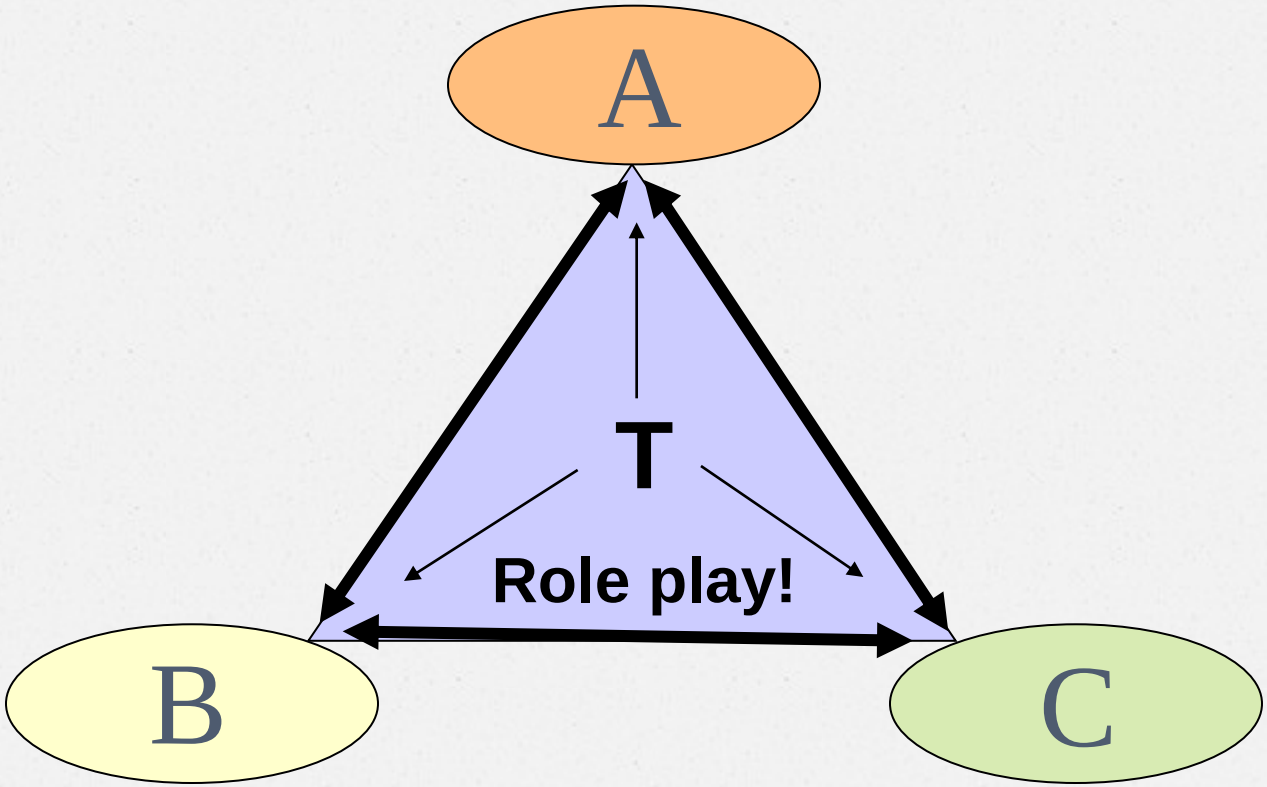
- Cognitive-behavioral theory: A quick review
- Where's the beef? A summary of the literature
- My cherry pie: 3 essential ingredients
- Bonuses:
  - A quick note on:
    1) Combining CBT w/ medications
    2) "Third Wave" therapies

In Brief, CBT:

- Is based on a model of the emotional disorders which emphasizes the integration of thoughts, feelings, and behaviors.
- Utilizes the *bi-directional relationship* between thoughts, feelings, and behaviors to help patients decrease negative affective states and attain a better quality of life.

The CBT Triangle

Feelings of anxiety



Escape, avoid or cope

“This is threatening!”

Principles of CBT

- Brief and time-limited

Principles of CBT

- **Focus is on the "here and now"**

"It's got to come out, of course, but that doesn't address the deeper problem."

Principles of CBT

- Relies on "active collaboration" b/w the patient & therapist ("collaborative empiricism")

Principles of CBT

- Sessions are structured
- Treatment is skills-based
- Therapists are directive
- Homework is a key element
- Relapse prevention is built into the treatment
- The end goal is to have the patient become his/her own "therapist"

Where's the Beef? A Summary of the Literature

- CBT "works" for the anxiety disorders!!!
- A Guide to Treatments That Work (Nathan & Gorman, 2007)
- Effective Treatments for PTSD: Practice Guidelines from the ISTSS, 2nd Edition (Foa, Keane, Friedman, & Cohen, 2008)
- A Meta-Analytic Review of Adult Cognitive-Behavioral Treatment Outcome Across the Anxiety Disorders (Norton & Price, 2007)
- The Empirical Status of Cognitive-Behavioral Therapy: A Review of Meta-analyses (Butler, Chapman, Foreman, & Beck, 2006)

Generalized Anxiety Disorder

- "The most successful psychosocial treatments combine **relaxation** exercises and **cognitive behavior therapy** in an effort to bring the worry process under the patient's control."
- Treatments integrating emotion regulation & mindfulness components also show effectiveness

Obsessive-compulsive Disorder

- "**Cognitive behavioral therapy** involving exposure and ritual prevention methods, which reduce or eliminate the obsessions and…rituals of this disorder, is the (other) *first-line treatment* for OCD."

Panic Disorder

- "**Cognitive behavioral treatments** that focused on **education** about the nature of anxiety and panic, and provided some form of **exposure** and **coping skills** acquisition have proven efficacious." (in PD)
- "Situational **in vivo exposure** substantially reduced symptoms." (in PDA)

Social Anxiety Disorder

- "**Exposure-based procedures** and… **cognitive behavioral treatments** most effectively reduced or eliminated the symptoms of social phobia."
- "**Social skills training** and **relaxation techniques** have also been used with some success."

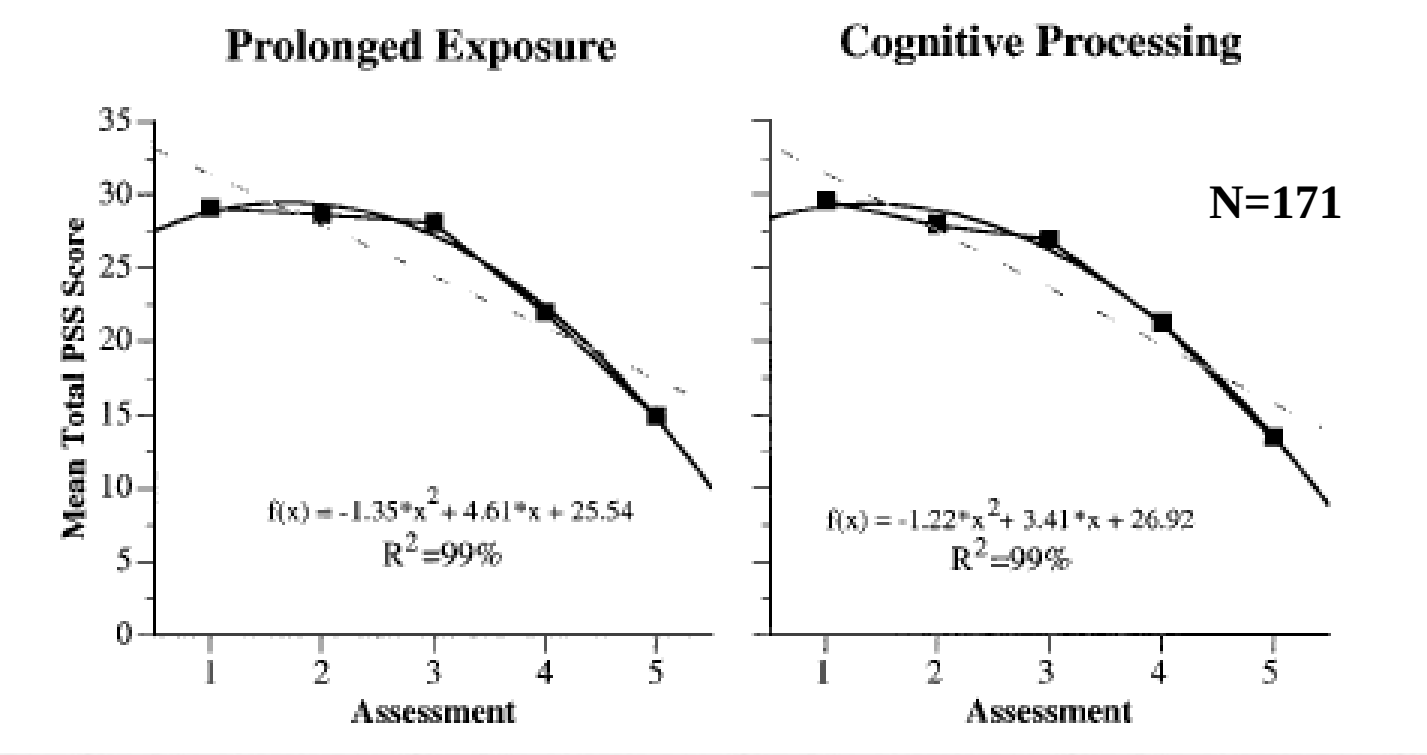
Specific Phobias

- "**Exposure-based procedures**, especially in vivo exposure, reduce or eliminate most or all components of specific phobic disorders"
- "*No* pharmacological intervention has been shown to be effective for specific phobias"

Posttraumatic Stress Disorder

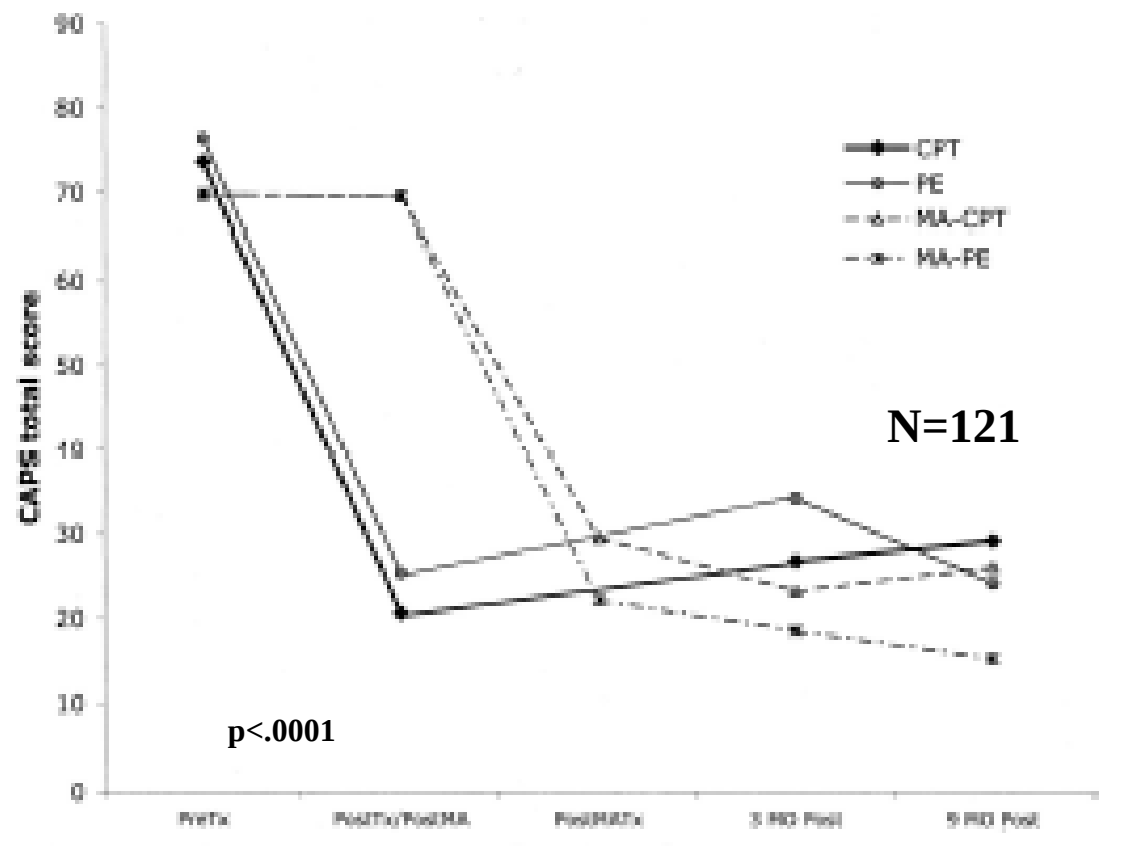
- "Evidence from many well controlled trials with a variety of trauma survivors indicates that **exposure** is efficacious."
- Cognitive processing of traumatic event shown to be important component of treatment

Intent-to-treat Sample: the Lines of Best Fit, Mathematical Functions, and Explained Variances for the Mean *Total PSS Scores* for Prolonged Exposure and Cognitive-processing Therapy.



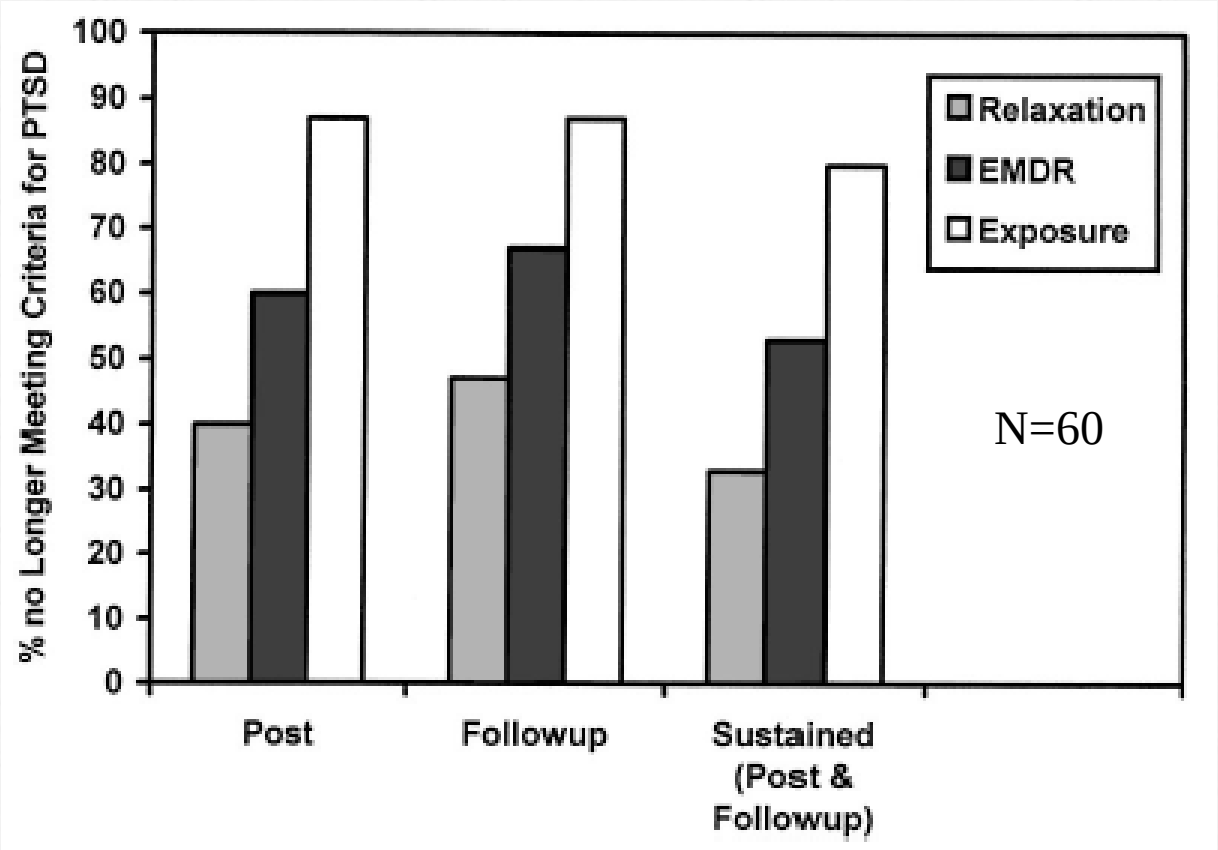
Nishith et al., (2002). Pattern of change in PE and CPT for female rape victims with PTSD. *JCCP, 70(4),* 880-886

Total CAPS Scores in CPT, PE and MA-CPT and MA-PE Conditions: Treatment Completers



Resick et al., (2002). A comparison of CPT with PE and a Waiting Condition for the treatment of chronic PTSD in female rape victims. *JCCP, 70(4),* 867-879.

Percentage of Participants No Longer Meeting DSM-IV-TR Criteria for PTSD After Treatment



Taylor et al., (2003). Comparative Efficacy, Speed, and Adverse Effects of Three PTSD Treatments: Exposure Therapy, EMDR, and Relaxation Training. *JCCP, 71(2)*, 330–338

My Cherry Pie: 3 Essential Ingredients in CBT for Anxiety

- Exposure to anxiety-provoking triggers *while blocking/eliminating "safety behaviors"*
- Enhance anxiety management skills
- Restructure faulty and/or maladaptive cognitive processes

Strategy 1a: Exposure to Anxiety-provoking Triggers

- Goal: diminish or extinguish anxiety associated with patient's trigger stimuli
- How: via systematic, hierarchical, and prolonged exposure to anxiety provoking stimuli *without employing any anxiety-reduction methods*
- Why: a decrease in anxiety leads to decreased urges to escape/avoid, development of more adaptive behavioral responses, and restructures faulty beliefs.

Exposure: Three Main Types

- In vivo
- Interoceptive
- Imaginal

Exposure: How Do You Do It?

- Provide subjects with a rationale
- Develop a "SUDS" scale
  - May also utilize Avoidance Scale
- Create a hierarchy

Exposure Should Always Be:

- Graded
- Gradual
- Prolonged
- Structured
- Repeated
- Assigned for homework

Strategy 1b: Block or Eliminate "Safety Behaviors"

- SBs: "actions that may fall short of outright avoidance but still perpetuate the anxiety reaction"
- Goal: design interventions that help the patient understand these behaviors are maladaptive
- How: via safety behavior experiments, self-monitoring, psychoeducation, etc.

Strategy 2: Enhance Anxiety Management Skills*

- Provide psychoeducation on the role of anxiety
- Identify current anxiety triggers
- Assess current coping strategies
- Teach somatic/relaxation skills
  - Progressive muscle relaxation
  - Passive muscle relaxation
  - Diaphragmatic breathing
- Transport to increasingly difficult situations
- Enhance with imagery, mindfulness, etc.

Strategy 3: Restructure Faulty Cognitive Processes

- Provide psychoeducation
  - Information about the disorder!
  - Provide rationale for the maintenance of the symptoms
  - Develop an idiosyncratic model
  - Provide rationale for treatment interventions
  - Discuss relapse prevention

Strategy 3: Restructure Faulty Cognitive Processes

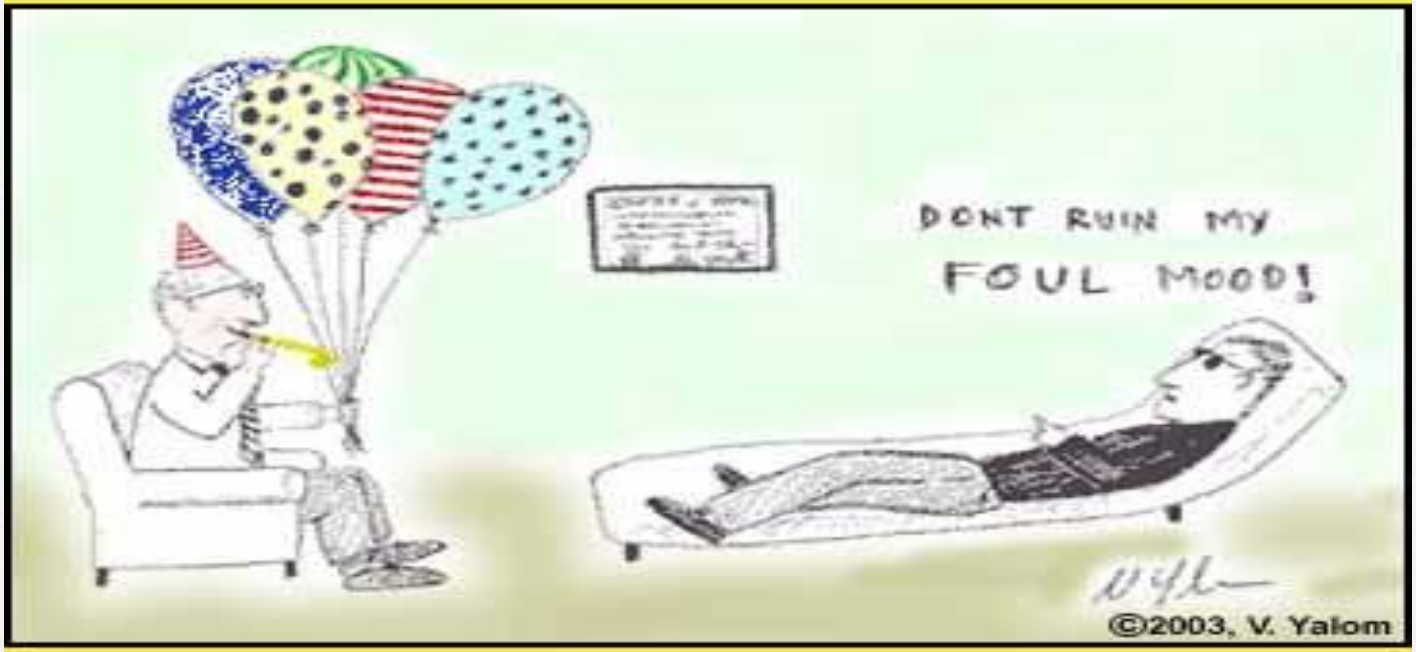
- Include Self-monitoring & Self-Report Assessments
  - Self-monitoring:
    - Allows patients to take an active role in treatment
    - Increases awareness
    - Establishes baselines
    - Decreases maladaptive behaviors
  - Self-report assessments
    - Allows for objective, structured measurement of symptoms
    - Normalizes symptoms
    - Allows comparisons to be made with established norms

Strategy 3: Restructure Faulty Cognitive Processes

- Engage in Formal Cognitive Restructuring
- Train patients to:
  - Think flexibly
  - Be a "scientist" with their symptoms
    - Consider their thoughts and beliefs as *hypotheses* rather than facts
    - Pay attention to *all* available information
    - Revise hypotheses according to incoming information

Cognitive Restructuring

- Is *not* simply telling patients to think positively!



Cognitive Restructuring: Basics

- Identify distortions
- Examine evidence for and against belief
- Conduct experiments to test belief
- Encourage thinking in "shades of gray"
- Conduct a survey
- Define negative terms and substitute less emotionally loaded words
- Re-attribution theory
- Conduct a "cost-benefit" analysis of maintaining belief

Common Distortion in Patients w/ Anxiety: "Catastrophizing"

- See potential (social) consequences as catastrophic and/or intolerable
- Challenge by:
  - Imaging the worst
  - Critically evaluating it
    - How bad is it? Would you be able to cope anyway?
    - Is it a horror or a hassle?
    - Have you experienced something like that before?

Common Distortion in Patients w/ Anxiety: "Overestimating"

- Thinking an improbable event is likely to happen in the near future
- Challenge by:
  - Evaluate evidence for and against
    - How many times have I had that thought?
    - How many times has _____ happened?
    - How many times has _____ *not* happened?
    - How likely is it to happen the next time I think of it?
  - Generate alternatives

Combining CBT & Medications

Proponents ("it seems logical…")

- ✓ Adding medication to CBT will enhance the outcome by reducing the patient's anxiety, thereby promoting his or her ability to tolerate longer exposure(s) to feared situations
- ✓ Evidence suggests that longer exposure is more effective

Combining CBT & Medications

Opponents:

- The reduction of anxiety caused by medication will block the fear activation that is a necessary condition for cognitive changes that mediate treatment success
- There now appears to be a negative indication in combining CBT and medications in patients with panic disorder

A Closer Look at the Literature

- Number of RCTs comparing CBT to medications or examining the combination of these approaches for treating *anxiety disorders*?
- **26!!!**

CBT With & Without Meds in Anxiety Disorders

- Foa, Franklin, & Moser (2002) conducted a comprehensive literature search of published randomized trials comparing treatment with CBT or medications
- Reviewed in detail 10 studies meeting their inclusion criteria (e.g., established diagnosis, at least 2 treatment groups, adequate methodology, etc.)

Foa, Franklin, & Moser (2002): Results

- For OCD, SAD, and GAD: at post-treatment and follow-up, there was no demonstrable advantage or disadvantage of combined treatment over **CBT alone**
- In the few studies that allowed for such a direct comparison, there appears to be some advantage of combined treatment over **medications alone,** suggesting that a course of CBT should be considered for patients receiving medications alone – especially partial responders

Foa, Franklin, & Moser (2002): Results (Cont.)

- In contrast to results for OCD, SAD, and GAD, combined treatment for PD seems to provide an advantage over CBT alone *at post-treatment*
- However, adding medications to CBT in PD appears to be associated with a greater *relapse rate* after treatment discontinuation

Conclusions

- "The hope that combined treatments will be a panacea for patients with anxiety disorders has not been fulfilled"
- On the other hand, the worry that combining treatments will negatively impact treatment has not been realized (except maybe for PD)

Acceptance and Mindfulness-Based Behavior Therapies (The "Third Wave")

- Acceptance and mindfulness-based therapies
  - To name a few:
    - Acceptance and Commitment Therapy (ACT)
    - Mindfulness-based Cognitive Therapy (MBCT)
    - Dialectical Behavior Therapy (DBT)
    - Behavioral Activation (BA)

Acceptance and Mindfulness-Based Behavior Therapies

- Focuses on strategies for changing the *process & function* of cognitions rather than the content
  - Ex: cognitive diffusion vs cognitive restructuring
- Targets experiential avoidance and encourages experiential acceptance
  - Ex: mindfulness increases present-focus, and decreases over-engagement (e.g., rumination) and under-engagement (e.g., avoidance)
- Focuses on value-directed goals and improvement in quality, meaningfulness of life

Acceptance and Mindfulness-Based Behavior Therapies

- Although well-controlled studies on acceptance and mindfulness-based interventions for anxiety disorders are limited, they are gaining empirical support (Block, 2002; Forman et al., 2007; Hayes et al. 2006; Roemer & Orsillo, 2008; Twohig et al., 2007)
- It is unclear if these interventions have an additive effect on outcome when included in enriched CBT approaches for anxiety, although the research look promising!

"TBL"

- CBT "works" for anxiety disorders!
- CBT capitalizes on a "bi-directional" relationship between thoughts, feelings, and behaviors
- Include 3 main ingredients and the treatment should go well!

"THM"

- 3 Essential Ingredients in CBT for Anxiety
  - Exposure to anxiety-provoking triggers *while blocking/eliminating "safety behaviors"*
  - Enhance anxiety management skills
  - Restructure faulty and/or maladaptive cognitive processes

Questions???

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