Managing Anxiety Disorders with Cognitive Behavior Therapy

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Paradox of Anxiety

- Why should nervous system that functions exquisitely under ordinary circumstances starts to work against us in very instances when we most want it to work effectively?
- Evolution favors anxious gene.
- It is better to have "false positives" (false alarms) than "false negatives" (which miss the danger) in an ambiguous situation.
- The cost of survival of the lineage may be a lifetime of discomfort.

Changing Concepts of Anxiety

- Turning anxiety on its head
- A patient's complaints generally center around feelings in the peripheral areas – sweaty palms, trembling of the hands, heart palpitations; and most research on anxiety has focused on systematically measuring these symptoms.
- Although patients generally do not volunteer much data about their thinking, particularly when they are in the throes of acute anxiety, we find, when we question a patient specifically, that his consciousness is saturated with thoughts and images of a threatening nature.

Definitions

- Anxiety: "tense emotional state", "often marked by such physical symptoms as tension, tremor, sweating, palpitation and increased pulse rate"
- Fear: "sudden calamity or danger", "an agitated foreboding often or some real or specific peril", "the possibility that something dreaded or unwanted may occur"
- Fear refers to the appraisal that there is actual or potential danger in a given situation. It is a cognitive process as opposed to an emotional reaction.

Definition

- Phobia: "an exaggerated and often disabling fear", "intense desire to avoid the feared situation, and evokes anxiety when one is exposed to that situation. – Phobos -
- Panic: "sudden overpowering fright... accompanied by increasing or frantic attempts to secure safety" – Panikos -

The function of Anxiety

- Adaptational aspects

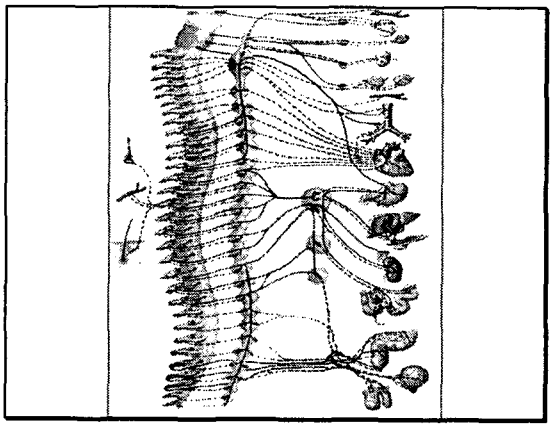
  - terms such as teleonomic and adaptational are used to refer to a behaviors that have had survival value in an any evolutionary sense (Lorenz 1980)

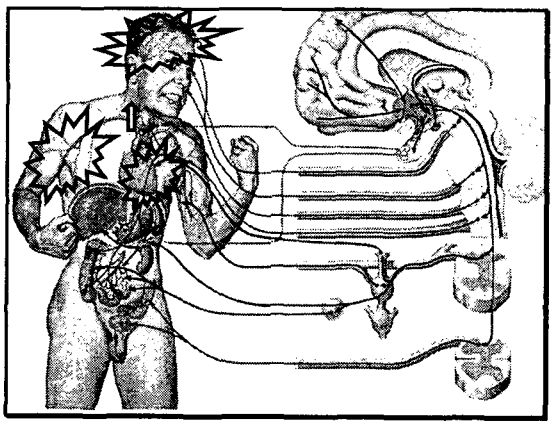
- Anxiety as a strategy in response to threat

  - the main problem in the anxiety disorders is not in the generation of anxiety but in the overactive cognitive patterns (schemas) relevant to danger that are continually structuring external and/or internal experiences as a sign of danger (Beck, 1971)

Survival Mechanisms

- The phenomenon of anxiety represents but one of many separate but interrelated "strategies" for dealing with threat and thus should be analyzed within the total framework of an organism's responses to danger.
- In the broadest sense, these responses include not only with anxiety, but also with anger.
- W. B. Cannon (1929) formulated the well-known paradigm of the "fight-flight reaction" to designated the characteristic physiological patterns of response to threat.
- Reflexes and Defensive patterns





Free-Floating Anxiety – Fact or Artifact?

- Behavior therapists (J. Wolpe (1969)) postulate that a patient will react to a neutral stimulus with acute anxiety if that stimulus has once been paired with an aversive or threatening stimulus.
- Freud (1915-17) initially proposed that free-floating anxiety results from the accumulation of sexual tension. His later view (1926) regarded anxiety as a reaction to the threat of unconscious impulses breaking into consciousness.
- A number of biochemical explanations also assume the validity of the "free-floating" concepts. (E. Kraepelin, 1907; F. N. Pitts, Jr., 1969; D. Klein, 1981)

Normal versus Pathological anxiety

- Anxiety is generally considered a normal reaction if it is aroused by a "realistic" danger and if it dissipates when the danger is no longer present.
- If the degree of anxiety is greatly disproportionate to the risk and the severity of possible danger, and if it continues even though no objective danger exists, then the reaction is considered abnormal.
- Another way of making the judgment is by assessing the impact of the reaction on the individual's functioning.
- Drawing a precise line between normal and abnormal anxiety is difficult and is governed to some degree by social norms.

Thinking Disorders in Clinical Anxiety

- Attention, Concentration, and Vigilance
- "Alarm System" and "Automatic Thoughts"
- Loss of Objectivity and of Voluntary Control
- Stimulus Generalization
- Catastrophizing
- Selective Abstraction and Loss of Perspective
- Dichotomous thinking
- Lack of habituation

Anxiety disorders

- Phobias
  - Specific Phobias
  - Social Phobias
  - *Panic disorder w/o Agoraphobia*
  - *Panic disorder w/ Agoraphobia*
  - *Agoraphobia w/o panic*
- Generalized Anxiety Disorder
- PTSD, *Acute Stress Disorder*
- OCD
- Anxiety secondary to GMC/ Substance induced
- *Anxiety disorder NOS*
- *Adjustment disorder with anxiety features*

Cognitive Behavior Therapy

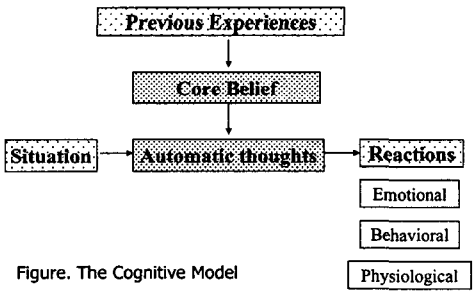


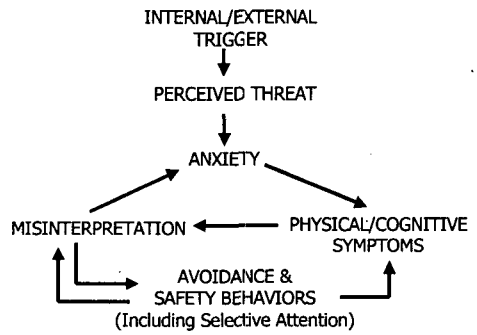
Figure. The Cognitive Model

Panic Disorder

Current Theories of Panic Disorder

- **Cognitive Theory**
- **Anxiety sensitivity Theory**
- **Conditioning Theory**

Clark's cognitive model of panic with maintenance cycles added



8 Components of group CBT for Panic Disorder with or without Agoraphobia

- Psychoeducation & cognitive restructuring
- Body Regulation Training
  - Breathing retraining and Muscle Relaxation Training
- Interoceptive exposure
- In vivo exposure
- Therapeutic testimonial and Panic Master
- Graduation ceremony and farewell party
- Follow up booster sessions
- Self-help group: Miso Moim 微笑 會合 (smile meeting)

GAD

Wells and Butler's Model

- Metacognitive model of GAD emphasizing the central role of worrying in this disorder.
- GAD patients overestimate the likelihood of negative events, rate the cost of threatening events as very high, and interpret ambiguous events as more threatening than persons without GAD would interpret them.
- GAD patients have both positive and negative beliefs about worrying.
- That is they worry about worrying, but they also believe that giving up worrying may expose them to unforeseen threat or danger.

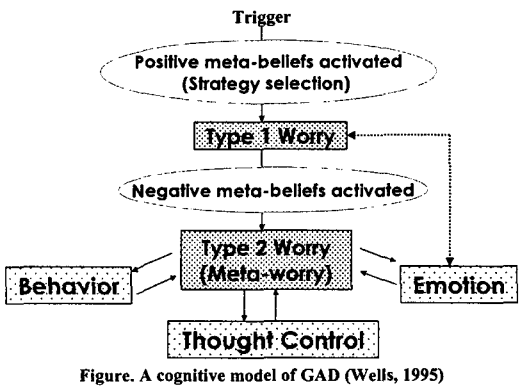
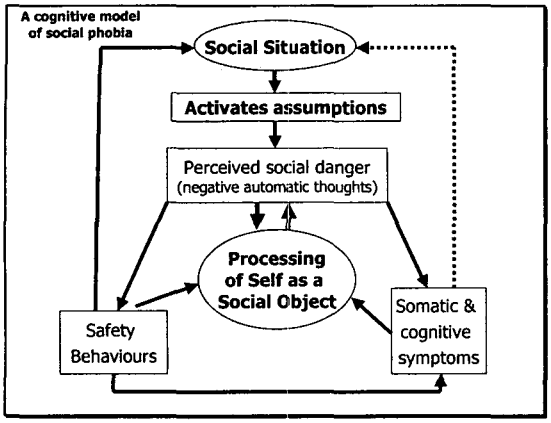


Figure. A cognitive model of GAD (Wells, 1995)

Wells and Butler's Model

- The therapeutic model derived from this theory involves identification of the patient's beliefs about the costs and benefits of worrying, the recognition of productive worrying, experiments in "letting go" of worry or postponing worry, challenging avoidance of activities or thoughts about which the patient worries, and constructing positive outcomes in imagery (Wells & Butler, 1997)

Social Phobia



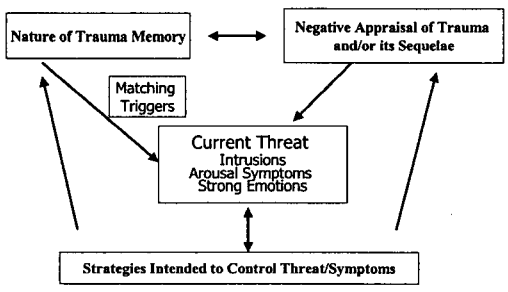
TREATMENT PROGRAM

- EDUCATION AND INSIGHT
- REALISTIC THINKING
- ATTENTION TRAINING
- EXPOSURE
- PERFORMANCE TRAINING
- INDIVIDUAL NEEDS
  - ASSERTIVENESS
  - PERFECTIONISM
  - TRUST

PTSD

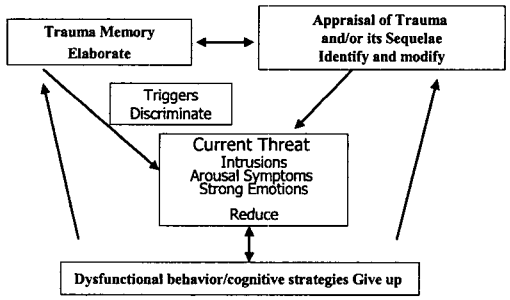
Persistent PTSD

(Ehlers & Clark, 2000)



Treatment Goals

(Ehlers & Clark, 2000)



TREATMENT COMPONENTS

- **Goal 1: Reduce re-experiencing by elaboration of trauma memory and discrimination of triggers**
  Imaginal reliving, writing out narrative, stimulus discrimination, revisit the site
- **Goal 2: Modify excessively negative appraisals**
  Appraisals of trauma: Identify : "hot spots", cognitive therapy, integrate new appraisals into reliving
  Appraisals of sequelae: Cognitive therapy, behavioural experiments, reclaiming your life
- **Goal 3: Drop maintaining behaviors and cognitive strategies**

OCD

Cognitive Behavioral Treatment for OCD (EX/RP) includes:

Exposure in vivo: Prolonged confrontation with anxiety evoking stimuli (e.g., contact with contamination)

Imaginal Exposure: Prolonged confrontation with feared disasters (e.g., hitting a pedestrian while driving)

Ritual prevention: The blocking of compulsions (e.g., leaving the kitchen without checking the stove)

Cognitive Interventions: Correcting erroneous cognitions (e.g., anxiety decreases without ritualizing)

Principles of Cognitive Therapy

1. Cognitive therapy is based on the cognitive model of emotional disorders.
2. Cognitive therapy is brief and time-limited.
3. A sound therapeutic relationship is a necessary condition for effective cognitive therapy.
4. Therapy is a collaborative effort between therapist and patient.
5. Cognitive therapy uses primarily the Socratic method.
6. Cognitive therapy is structured and directive.
7. Cognitive therapy is problem-oriented.
8. Cognitive therapy is based on an educational model.
9. The theory and techniques of cognitive therapy rely on the inductive method.
10. Homework is a central feature of cognitive therapy.