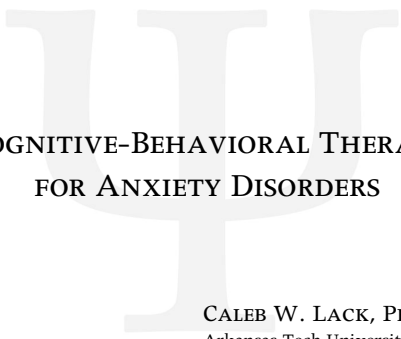


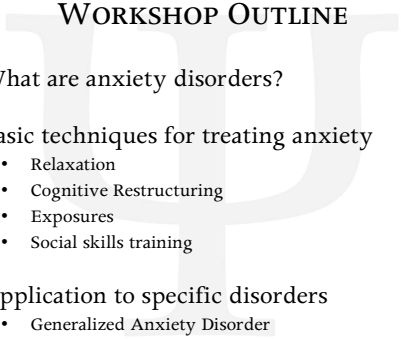
COGNITIVE-BEHAVIORAL THERAPY FOR ANXIETY DISORDERS

CALEB W. LACK, PH.D.
Arkansas Tech University
River Valley Psychological Services
| behavior therapy

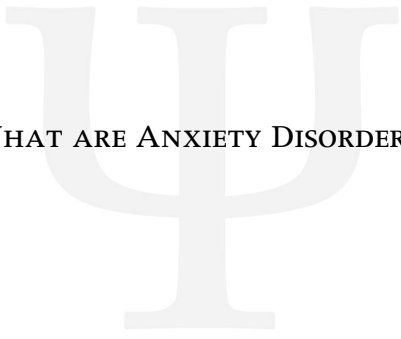


WORKSHOP OUTLINE

1. What are anxiety disorders?
2. Basic techniques for treating anxiety
 - Relaxation
 - Cognitive Restructuring
 - Exposures
 - Social skills training
3. Application to specific disorders
 - Generalized Anxiety Disorder
 - Social Phobia
 - Obsessive-Compulsive Disorder



WHAT ARE ANXIETY DISORDERS?



OPERATIONAL DEFINITIONS

Fear or **panic** is a basic emotion that involves activation of the "fight-or-flight" response in the sympathetic nervous system

When this response occurs too often, or inappropriately, it may develop into an **anxiety disorder**

OPERATIONAL DEFINITIONS

Anxiety is

A general feeling of apprehension about possible danger

More oriented to the future and more diffuse than fear

Composed of cognitive/subjective, physiological, and behavioral components

OPERATIONAL DEFINITIONS

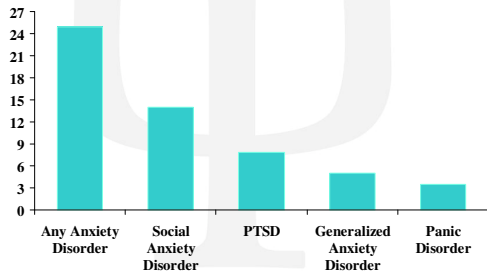
Anxiety disorders have unrealistic, irrational fears or anxieties of disabling intensity as their most obvious manifestation

The DSM-IV-TR recognizes **seven** primary types of anxiety disorders

DSM-IV-TR ANXIETY DISORDERS

- Phobic disorders of the "specific" type
- Phobic disorders of the "social" type
- Panic disorder with agoraphobia
- Panic disorder without agoraphobia
- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder

PREVALENCE OF ANXIETY DISORDERS



Kessler et al. Arch Gen Psychiatry. 1995;52:1048.
Kessler et al. Arch Gen Psychiatry. 1994;51:8.

DSM-IV-TR ANXIETY DISORDERS

There are some important similarities among

- The basic biological causes
 - The basic psychological causes
 - The effective treatments
- For all of these disorders

BIOLOGY & ANXIETY

People inherit a basic tendency to be more nervous than others, but not the tendency to develop a specific disorder

This is why anxiety disorders run in families, but specific types do not

When working with children, keep in mind that their parent(s) may also be prone to anxiety problems

PSYCHOLOGICAL CAUSES OF ANXIETY

CBT focuses on two primary psych causes:

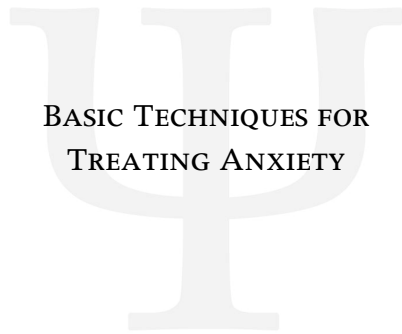
1. Reinforcement and maintenance of avoidance behaviors
2. Maladaptive cognitions regarding anxiety/fear provoking stimuli

These directly relate to the treatments employed for different disorders

ANXIETY & THREAT

Anxiety is proportional to the perception of danger; that is

$$\frac{\text{perceived likelihood it will happen} \times \text{perceived "awfulness" if it did}}{\text{perceived coping ability when it does} + \text{perceived rescue factors}}$$



BASIC TECHNIQUES FOR TREATING ANXIETY

ANXIETY TREATMENTS

There are a core set of CBT interventions designed to target different aspects of anxiety disorders:

Physiological reaction

- ➔ Relaxation

Subjective interpretation

- ➔ Cognitive restructuring

Behavioral component

- ➔ Exposures & social skills training

WHY RELAX?

Anxiety has a strong physiological component

Teaching clients relaxation skills can counter physical arousal and increase well-being

Allows people to naturally relax their muscles in various ways

To purposely cause a relaxed state, can use

Progressive muscle relaxation (PMR)

Diaphragmatic breathing (DB)

PROGRESSIVE MUSCLE RELAXATION

PMR directly targets tension that builds in muscles, and indirectly targets heart and breathing rates

Increases awareness of tension feelings and provides a way to combat that tension

Many alternate versions available, including using both stretching and tensing to relax

PROGRESSIVE MUSCLE RELAXATION

A skill learned through regular practice

First in a quiet, dim area guided by therapist or audio recording of therapist

Move to typical daytime conditions without guidance

Optimally practiced at least twice daily to master the skill

PMR STEPS

1. Therapist teaches client how to tense and then relax separate muscle groups
2. Client learns to systematically tense and relax those groups in a scripted exercise
3. Client learns to systematically relax *only* the muscle groups

PMR STEP ONE

Part 1 – Training muscle tensing and releasing

Therapist explains and demonstrates how muscles feel when relaxed

Next, therapist demonstrates how to tense and relax each specific muscle group in a developmentally appropriate fashion

This is followed by the client rating and noting his level of anxiety

PMR STEP ONE

Part 2 – Implementing the exercise

Using a script, guide the client through

- Tensing and releasing of each muscle group
- Deepening the relaxation
- Positive imagery (if desired)
- Focusing on the breath
- Ending the exercise

At the finish, ask for feedback and have client rate anxiety and tension

LET'S TRY IT OUT!

PMR STEP TWO

This step involves learning how to relax without tensing first

Identical to Step 1-2, but without the tensing

Allows for the use of PMR anywhere, without others noticing

Practice just as in tense-release PMR, but without the audio guidance outside of session

DIAPHRAGMATIC BREATHING

Gives client a very simple tool for calming the body and controlling physiological arousal

Helps to control headaches, high blood pressure, insomnia, pain, rage, and anxiety

Purpose of DB is to breath as if in a relaxed state

Eight basic steps in learning DB

DB STEPS

1. Offer basic information on breathing

Lungs have no muscles

Diaphragm controls size/frequency of breaths

Breathing is usually automatic, but can be controlled through diaphragm

When stressed, diaphragm contracts, causing shallow rapid breaths and chest and shoulders to rise and fall

When relaxed, diaphragm is loose, breathing is deep and slow, abdomen rises and falls

DB STEPS

2. Client loosens any tight clothing
3. Client places one hand on chest and another on abdomen
4. In DB, as client breathes only the hand on the abdomen should move, shoulders should stay still

DB STEPS

5. If DB is not easily achieved, have client relax ab muscles, then expand abdomen during inhalations while chest is still
6. Once client has pattern of DB mastered, have him slow to 8-10 breaths per minute
7. With this established, have clients focus on mentally saying "Re" with each inhalation and "Lax" with each exhalation

DB STEPS

8. Client should focus on "Relax" and sensations of relaxaton while letting other thoughts and images go

Practice is *essential* to master DB, and should be done multiple times a day

COMMON PROBLEMS

"I've tried relaxation before and it didn't work."

Therapist should assess if clients were doing techniques properly, and how often they were being practiced

Practice paying attention to physical sensations and not thoughts during relaxation

COMMON PROBLEMS

"My (symptoms) got worse!"

Assess what caused increase in problems
Change in bodily sensations / alertness
View of relaxation as waste of time / indulgent

Allay concerns with education and practice

COGNITIVELY FOCUSED TREATMENT

Based on knowledge that unwanted intrusive thoughts are normal

It's not the intrusion that causes the anxiety and the compulsive behavior, but the appraisal of the intrusion

Goal is to cognitively challenge appraisal and identify less threatening appraisals

SUBJECTIVE INTERPRETATIONS

Two broad types of thinking errors people make when confronted with a potentially stressful situation:

Interpretation errors, where you misread the available information

Coping errors, where you misidentify things that protect you from a negative outcome

ERRORS IN INTERPRETATION

Catastrophizing

The worst possible outcomes are predicted or imagining that basic needs (safety, self-esteem, sustenance, etc.) are threatened

“Everyone will think I’m an idiot.” or “I would die if ___ happened.”

Faulty Estimates

An inaccurately high probability of danger is estimated.

A car weaves slightly in the lane next to you and you think “That guy almost hit me!”

ERRORS IN INTERPRETATION

Gross Generalizations

The danger perceived in one event is imagined to happen everywhere

You hear that there’s an accident on the same road a friend of yours sometimes go down and you worry that it might be that person in the accident.

Polarization

Aspects of danger associated with a person or situation are seen in absolute black-or-white terms.

Seeing things as either safe or dangerous, never in-between

ERRORS IN INTERPRETATION

Minimization of safety factors

Facts that indicate protection or safety are minimized or ignored.

Even though you've studied for an exam, thinking that you don't know any of the material

ERRORS RELATED TO COPING

Minimization of Coping Capability

Expression of a lack of control or helplessness are not in line with your capabilities

"I don't know what I would do if that happened"

Unrealistic expectation for outcome

Expectation for outcome is expressed in terms of perfection, certainty, or control

"I can never make any mistakes"

THINKING ERRORS

Usually not necessary to have the client try and label what types of thinking errors they are making

Therapist can judge the client's errors and just discuss those ones they are evidencing

CHALLENGING THOUGHTS

Can I say that this statement is 100% true, without any exceptions?

What is the likelihood or probability of this happening?

Rate this twice, once emotionally and once objectively

Does this statement fit with all the available evidence?

CHALLENGING THOUGHTS

Am I ignoring any safety factors?

Does this always apply? Are there conditions under which this might not apply?

Is there a gray area to this statement (not just a black and white thing)?

Is this based on fact or feeling? Have my feelings ever turned out to be wrong?

CHALLENGING THOUGHTS

How much control do I actually have in this situation?

Am I taking responsibility for things over which I have no control?

Am I ignoring aspects of the situation that I can control?

Is my expectation for this outcome realistic or even possible?

THE THOUGHT RECORD

This is a physical manifestation of the thought challenging process

Often used early in therapy to help client generalize CR skills outside of therapy

Should be customized for the age and/or developmental level of the client

THOUGHT RECORD

Example of an adult thought record

Trigger: _____

Cognitions (images, thoughts, assumptions, and/or beliefs): _____

Strength of belief in cognitions (on a 1-7 scale): _____

Challenges to cognitions: _____

Types of thinking errors: _____

Alternative viewpoints:

- Worst outcome: _____
- Best outcome: _____
- Most realistic outcome: _____

What effect does this thought have on the way I feel? _____

Rational responses:

Even though I feel that _____ is true,
(thoughts or assumptions)
the reality is that _____
(answers to challenges and alternative viewpoints)

THOUGHT RECORD

Example of a child thought record

What happened that made OCD pop up: _____

What OCD told me or wanted me to ask: _____

How much do you believe OCD? (1 = not at all, 10 = completely) _____

How does this make me feel? _____

What did you tell OCD to fight back? _____

What would be the....

- Worst outcome?: _____
(if OCD was right)
- Best outcome?: _____
(if OCD was wrong)
- Most likely outcome: _____

Wrap It Up!

Even though I feel that _____ is true,
(what OCD says)
the reality is that _____
(your arguments against OCD)

How do you feel now? _____

How much do you believe OCD now? (1 = not at all, 10 = completely) _____

USING THE THOUGHT RECORD

When teaching clients, it is important to make sure that they are recognizing thoughts and emotions accurately

Practice in session with two-three records before clients do them on their own

Review the records they did as homework the next week and make corrections as needed

MODIFIED THOUGHT CHALLENGING

Many clients may find it inconvenient to complete a TR at certain times of the day
E.g., at work or school

Mental completion is encouraged when one cannot do the written TR

Many clients respond well to a "mini-TR"
Printed small so that it fits into a pocket and can be concealed but is easily available

MINI-THOUGHT RECORD

1. What happened that made anxiety pop up?
2. What anxiety told me or wanted me to ask?
3. How much do you believe anxiety?
4. How does this make me feel?
5. What did you tell anxiety to fight back?
6. What would be the.....
 - Worst outcome? (if anxiety was right)
 - Best outcome? (if anxiety was wrong)
 - Most likely outcome?

CHALLENGING DANGER OVERESTIMATIONS

Step	Chance	Cumulative chance
1. Not extinguish cigarette	1/10	
2. Spark falls on the floor	1/10	
3. Carpet catches on fire	1/10	
4. Carpet starts to burn and I don't notice	1/100	
5. Too late to help	1/100	1/10,000,000

WHAT ARE EXPOSURES?

Placing a client in an anxiety or fear inducing situation (exposure), and not allowing them to use avoidance or escape behaviors (response prevention)

Client stays in the presence of the fear stimulus until it no longer causes anxiety or distress

This is called habituation, and breaks the negative reinforcement cycle of the escape behaviors

GROUNDWORK FOR ERP

Conveying effectiveness and competence

Use past clinical examples as well as research data to show that the treatment works

Forming an effective therapeutic alliance

Praising client for entering therapy

Including client-specific examples when during psychoeducation

Taking a strong, nonjudgmental stance

Collaborative efforts to design exposures

GROUNDWORK FOR ERP

Selling the rationale

- Describe therapy procedures clearly
- Reassure client that it is okay to be afraid during the exposures, but that she will get better
- Using analogies to increase understanding
- Accept she may have tried something before, but emphasize the different nature of ERP

Tailor treatment to the individual

CREATING A FEAR HIERARCHY

Therapist must accurately assess the feared situations using youth and parent report, as well as behavioral observations

A dynamic process that continues throughout therapy

Generate and then sort the *specific* situations that cause anxiety, from easy to medium to challenging

ASSESSING SUDS

After generating the anxious situations, they are then rated using Subjective Units of Distress

SUDs can be adjusted to the developmental level of the client: 0-5, 0-8, 0-10, 0-100

Can also use feeling thermometers or personalized ratings to symbolize the SUDs

Used to both order the hierarchy and assess distress during exposures

TYPES OF EXPOSURES

Imaginal exposure tasks

Often used in the beginning, or when the client has abstract worries / fears

Allows for practicing coping skills before confronting the real situation

In vivo exposure tasks

Often follow imaginal exposures, use a "live and in person" version of the feared situation

BASICS OF EXPOSURE

Exposure occur both in and out of session

Often requires cooperation of parents/significant others to facilitate successful homework exposures

Should be similar to what is being done in session, using a hierarchy and SUDs ratings

Internal and external rewards for successful exposure completion should be discussed beforehand

BASICS OF EXPOSURE

Ideal exposures are prolonged, repeated, and prevent the use of distraction behaviors

SUDs decrease of *at least* 50%, with more being better

May require shaping up to the more difficult situations, in terms of both time and use of distractors

THERAPIST TASKS

Realize long-term benefits outweigh short-term distress, and communicate this effectively to the family

Work collaboratively with the client and family to plan and execute the exposures

Maintain rapport during exposures by building upon pre-established rapport

DEMONSTRATION OF ERP

THERAPIST TASKS

Do not allow avoidance or distracter behaviors during the exposure

Modeling how to conduct appropriate exposures for the parents/significant others, so that they can perform them at home

Be flexible and creative when dealing with less than optimal exposures and resistance

OBSTACLES FOR THE THERAPIST

I'm making my client *more* upset / anxious

It's difficult to see people in distress

Hearing the accounts of trauma can be emotionally draining for some people

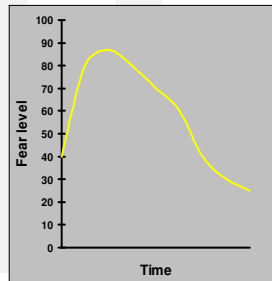
May have to do exposures that *you* are not comfortable with

THE TREATMENT OF FEAR

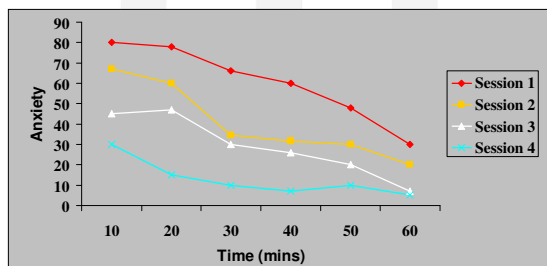
Exposure to fear-eliciting stimuli or situations

Abstinence from escape/avoidance behaviors

Anxiety increases initially, followed by habituation



WHAT HAPPENS DURING EXPOSURE THERAPY?



TREATMENT OUTCOME USING ERP

Approximately 80% of treatment completers report beneficial effects

Up to 6 years following treatment about 70% of people maintain their gains

However, ERP is not a panacea

SOCIAL SKILLS TRAINING

A psychoeducational therapy implemented when someone lacks required social skills

Follows 10 specific steps, which distinguishes it from other types of therapies

Shown to improve functioning and QoL

SOCIAL SKILLS

Refers to abilities that allow one to initiate and maintain positive social relationships with others

- Communication
- Problem-solving
- Decision making
- Self-management
- Peer relations

SOCIAL LEARNING THEORY

Developed by Bandura (1969) by building on the work of Skinner (1938, 1953)

Refers to a set of principles concerning the development and learning of social behaviors

Says social behaviors are acquired through a combination of observing others' actions and consequences of one's own actions

SLT PRINCIPLES

Each of these principles is heavily used and guides social skills training

Modeling

A person learns a new social skill by watching someone else use that skill

Therapist modeling or peer modeling in SS group

SLT PRINCIPLES

Reinforcement

Consequences following a behavior that increase the likelihood of that behavior occurring again

Positive and negative types can occur in SS training

Shaping

Reinforcing successive steps toward a desired goal

Most SS skills are too complex to teach in a single trial, but they can be broken down and shaped

SLT PRINCIPLES

Overlearning

Repeatedly practicing a skill to the point where it becomes automatic

Not just becoming familiar with a skill, but practicing until it becomes second nature

Generalization

Transferring skills acquired in one setting to a another, new setting

Can take place by using homework assignments or by *in vivo* prompting

TYPICAL SST TOPICS

Listening to others

Making requests

Expressing positive feelings

Expressing unpleasant feelings

Conversation skills

Assertiveness training

Conflict management

STEPS OF SST

1. Establish a rationale

Gives the learning of the skill meaning

Can come from the therapist or clients

Usually a mixture of the two

Should be as brief as possible, and repeated back by the clients

STEPS OF SST

2. Discuss the steps of the skill

Breaks down the skill into smaller steps, allowing for shaping of complex skills

Should be written out and displayed

Refer to display when discussing each step

STEPS OF SST

3. Modeling the skill in a role play and reviewing that role play

Therapist(s) model the skill to assist in observational learning

Translates abstract steps into concrete actions

Should be brief and to the point, with high relevance to the clients

STEPS OF SST

Start by asking clients to observe the role play and which steps the therapist uses

Afterwards, immediately review the steps and have them tell you if it was performed

Then, ask clients if therapist was effective and how s/he could improve

STEPS OF SST

4. Engaging client in a role play

After modeling, immediately engage group members in same role play, then move to a new role play

Begin with those most likely to be able to do the skill, so others have more chances for observational learning

STEPS OF SST

5. Providing positive feedback

Even for really bad role plays, give praise for something that person did well

Can be given from therapist or elicited from the other clients

No negative or corrective feedback is allowed

STEPS OF SST

6. Provide corrective feedback

Should be brief, *non-critical*, and as behaviorally specific as possible

Provided by therapist and other clients, but focus on only one or two critical pieces of the skills

STEPS OF SST

- 7. Engaging the client in another role play of same situation

Client makes changes based on corrective feedback at the instruction of the therapist

Allows client to practice skill again and improve performance

STEPS OF SST

- 8. Provide additional feedback

Should include both positive and corrective feedback

Praise improvements for Step 7's targeted components first, then praise other parts

Can repeat steps 7-8 as needed to insure adequate learning of skill

STEPS OF SST

- 9. Engaging other clients in role plays and providing feedback

Repeat steps 4-8 with each other client in the group

Try to randomize the order in which clients take turns

STEPS OF SST

10. Assign homework

Use those skills we learned in the "Homework" section to assign activities to perform

Make it concrete, doable, and easily tracked

Review it at the start of next session

IMPORTANCE OF GENERALIZATION

Without generalizing skills from in-session to the real world, therapy is not effective

Includes maintenance, situational generalization, and response generalization

These are all crucial to improvement of skills, so transfer training should be paid careful attention

TRANSFER TRAINING

Several strategies facilitate the transfer of skills from therapy to the real world

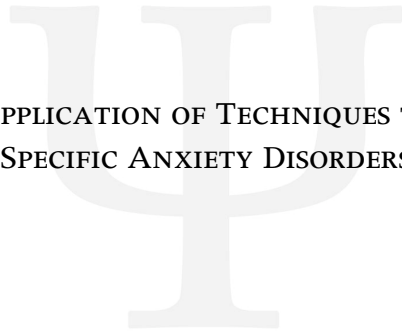
Homework

Involving other people

Maintaining effects of reinforcement

Self-management strategies

APPLICATION OF TECHNIQUES TO SPECIFIC ANXIETY DISORDERS



IMPORTANCE OF EXPOSURE

For each of these disorders, as well as all the other anxiety disorders, exposure with response prevention is the single most effective technique

ERP combined with other techniques, however, can yield even better results

ERP and CR for GAD

ERP and SST for social phobia

GENERALIZED ANXIETY DISORDER

“Newest” anxiety disorder diagnosis to be studied

Until recently (1994), little was known about the disorder or how it can be separated from other anxiety disorders

Considered “the basic anxiety disorder”

At any point in time, 1.6% of the population has GAD (lifetime prevalence of 5.1%)

Higher rates among African-American females (3.5% current and 14.5% lifetime)

GENERALIZED ANXIETY DISORDER

More common among women

Earlier age of onset than most anxiety disorders

Some studies find it to be more prevalent among older populations

Persists for a long period of time – low remission rate left on its own or following treatment

GAD IN THE DSM-IV-TR

Excessive anxiety & uncontrollable worry about a number of situations, causing interference or marked distress not focused on other Axis I issues

At least 3 of the following 6 associated symptoms

Restless, keyed up, or on edge

Easily fatigued

Difficulty concentrating

Irritability

Muscle tension

Sleep disturbance

GAD TREATMENT

Focuses on the cognitive, behavioral, and physiological components of anxiety:

Relaxation

Cognitive Restructuring

Exposure with Response Prevention

Relies on work by Borkovec, Dugas, Craske, & Barlow

GAD BEHAVIORAL DEFINITIONS

Excessive and/or unrealistic worry about a number of events or activities that is difficult to control occurring more days than not over a six month period

Motor tension

Autonomic hyperactivity

Hypervigilance

SAMPLE LONG-TERM GOALS

Reduce overall frequency, intensity, and duration of the anxiety so daily functioning is not impaired

Stabilize anxiety level while increasing ability to function on a daily basis

Enhance ability to effectively cope with the full variety of life's anxieties

SHORT-TERM OBJECTIVES

1. Describe current & past worry experiences and functional impact
2. Complete psychological tests designed to assess worry and anxiety symptoms

THERAPEUTIC INTERVENTIONS

1. Assess the focus, excessiveness, and uncontrollability of worry, and frequency, intensity, and duration of symptoms
2. Administer self-report measures to assess nature of worry

SHORT-TERM OBJECTIVES

- 3. Verbalize an understanding of the components of anxiety and its treatment

Verbalize an understanding of the rationale for treatment

THERAPEUTIC INTERVENTIONS

- 3. Discuss CBT model of anxiety and how treatment will proceed in an idiographic fashion

Assign educational materials on anxiety for client to read



CBT MODEL OF GAD

SHORT-TERM OBJECTIVES

- 4. Learn and implement calming skills to reduce overall physiological arousal and manage anxiety symptoms

THERAPEUTIC INTERVENTIONS

- 4. Teach client relaxation skills such as PMR and DB

Have them practice PMR and DB regularly

SHORT-TERM OBJECTIVES

- 5. Verbalize an understanding of the role of cognitive biases in maintaining excessive and irrational worry and anxiety

THERAPEUTIC INTERVENTIONS

- 5. Using cognitive restructuring to address both current and past anxiety-causing thoughts by challenging them and replacing them with more adaptive thoughts

SHORT-TERM OBJECTIVES

- 6. Undergo repeated imaginal or in vivo exposure to feared negative consequences predicted by worries and implement alternative reality-based predictions

THERAPEUTIC INTERVENTIONS

- 6. Construct fear hierarchy and perform exposures with response prevention to reduce learned avoidance responses to anxiety-provoking thoughts or situations

SHORT-TERM OBJECTIVES

- 7. Learn and implement relapse prevention strategies for future anxiety

THERAPEUTIC INTERVENTIONS

- 7. Discuss nature of anxiety, use booster sessions as needed

SOCIAL PHOBIA

Persistent fears of situations involving social interaction or social performance or situations in which there is the potential for scrutiny by others

More than 13% of the population meet criteria for SAD at some point in their lives

More than just "shyness"

Can be generalized (most social situations) or non-generalized (limited to specific situations)

SP IN THE DSM-IV

A marked and persistent fear of one or more social and performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others

The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing

Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or predisposed Panic Attack

The person recognizes that the fear is excessive or unreasonable

The feared social or performance situation are avoided or else are endured with intense anxiety or distress

SOCIAL PHOBIA TREATMENT

Like GAD, focuses on the cognitive, behavioral, and physiological components of anxiety

Relaxation techniques

Cognitive restructuring

Exposure with response prevention

Social skills training

Relies on work by Heimberg and Clark

SP BEHAVIORAL DEFINITIONS

Overall pattern of social anxiety or shyness that presents itself in most social situations

Hypersensitivity to criticism or disapproval of others

No close friends or confidants outside of first-degree relatives

Avoidance of situations that require a degree of interpersonal contact

SP BEHAVIORAL DEFINITIONS

Reluctant involvement in social situations out of fear of saying or doing something foolish or of becoming emotional in front of others

Debilitating performance anxiety and/or avoidance of required social performance demands

Increased physiological response in social situations

SP LONG-TERM GOALS

Interact socially without undue fear or anxiety

Participate in social performance requirements without undue fear or anxiety

Develop the essential social skills that will enhance the quality of relationships

Develop the ability to form relationships that will enhance recovery support system

Reach a balance between solitary time and interpersonal interactions with others

SHORT-TERM OBJECTIVES

1. Describe history and nature of social fears and avoidance
2. Complete psychological tests designed to assess worry and anxiety symptoms

THERAPEUTIC INTERVENTIONS

1. Assess the frequency, intensity, and duration of panic symptoms, fear, and avoidance
2. Administer self-report measures to assess nature of phobia

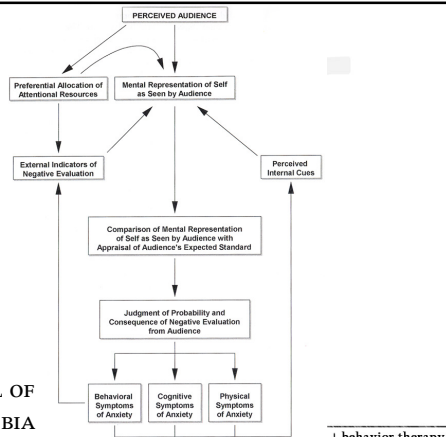
SHORT-TERM OBJECTIVES

3. Verbalize an accurate understanding of the vicious cycle of social anxiety and avoidance
- Verbalize an understanding of the rationale for treatment

THERAPEUTIC INTERVENTIONS

3. Discuss CBT model of anxiety, focusing on both negative reinforcement of avoidance and cognitive biases responsible
- Assign educational materials on anxiety for client to read

CBT MODEL OF SOCIAL PHOBIA



SHORT-TERM OBJECTIVES

- 4. Learn and implement calming and coping strategies to reduce overall physiological arousal and manage anxiety symptoms

THERAPEUTIC INTERVENTIONS

- 4. Teach client relaxation skills such as PMR and DB, as well as attentional focusing skills to manage social anxiety symptoms

SHORT-TERM OBJECTIVES

- 5. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk

THERAPEUTIC INTERVENTIONS

- 5. Using cognitive restructuring to address both current and past anxiety-causing thoughts by challenging them and replacing them with more adaptive thoughts

SHORT-TERM OBJECTIVES

- 6. Undergo gradual repeated exposure to feared social situations, first in therapy and then in daily life

THERAPEUTIC INTERVENTIONS

- 6. Construct fear hierarchy and perform exposures with response prevention to reduce learned avoidance responses to anxiety-provoking thoughts or situations

SHORT-TERM OBJECTIVES

- 7. Learn and implement social skills to reduce anxiety and build confidence in social interactions

THERAPEUTIC INTERVENTIONS

- 7. Use instruction, modeling, and role-playing to build and practice general or specific social skill deficits

Assign readings about communication or social skills

SHORT-TERM OBJECTIVES

- 8. Learn and implement relapse prevention strategies for future anxiety

THERAPEUTIC INTERVENTIONS

- 8. Discuss nature of anxiety, develop coping cards, use booster sessions as needed

OBSESSIVE-COMPULSIVE DISORDER

Characterized by intrusive thoughts that are often coupled with repetitive behaviors that are elaborate, time-consuming, and distressful.

Onset during late adolescence to early adulthood, but can be seen as early as age 4

Child onset shows a greater number of obsessions and compulsions and a greater level of clinical impairment than adult onset

OCD SUBTYPES

Contamination and doubting most common obsessions followed by somatic, need for symmetry, aggression, and sexual intrusions

Checking and washing most common compulsions followed by counting, the need to confess, ordering, and hoarding

FORMS OF OBSESSIONS

Thoughts

Ideas experienced as unacceptable or unwanted (e.g., idea of stabbing my child)

Images

Mental visualizations that are experienced as troubling or distressing (e.g., one's elderly grandparents having sex)

Impulses

Unwanted urges or notions to behave in inappropriate ways (e.g., to yell obscenities)

TYPICAL CONTENT OF OBSESSIONS

Violence

Impulse: to attack a helpless person
Image: loved ones being dismembered
Impulse to reach for a police officer's gun

Sex

Impulse: to stare at peoples' genitals
Thought: what it's like to be homosexual

Blasphemy and sacrilege

Image: Jesus with an erection on the cross
Thought: God is dead

WHAT IS NOT AN OBSESSION

- Worries about real-life issues (e.g., work)
- Depressive ruminations
- Recurrent appetitive sexual fantasies
- Jealousy
- Preoccupation with a new car, boyfriend, etc.
- Cravings to gamble, steal, drink alcohol, etc.

MENTAL RITUALS VS. OBSESSIONS

- Often confused with one another
- Obsessions are intrusive, unwanted thoughts that evoke anxiety or distress
- Mental rituals are deliberate mental acts designed to neutralize or reduce anxiety or distress

COMPULSIONS

- Overt or covert* responses to intrusions
- Designed to counteract the obsession and to decrease the anxiety the latter produces
- Sense of having 'no choice', is time-consuming, excessive and senseless
- Includes checking, washing, repeating, counting, ordering, silent praying etc.

LEARNING THEORY MODEL OF OCD

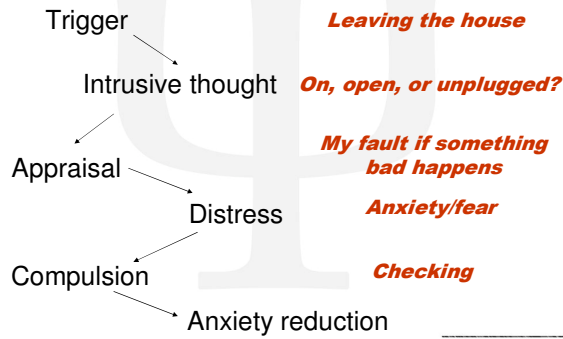
Obsessions give rise to anxiety or distress

Compulsions reduce obsessional anxiety

The performance of compulsions prevents the extinction of obsessional anxiety

Compulsions are negatively reinforced by the brief reduction of anxiety they engender

CBT MODEL FOR OCD



OCD LONG-TERM GOALS

Decreasing distress due to obsessions

Decreasing time spent engaging in rituals

Enhancing functioning
Academic, social, occupational, etc.

Rebuilding relationships and social networks

Relies on work by Kozac, Steketee, and March

SHORT-TERM OBJECTIVES

- 1. Describe current & past obsessions and compulsion and functional impact
- 2. Complete psychological tests designed to assess worry and anxiety symptoms

THERAPEUTIC INTERVENTIONS

- 1. Assess the types and anxiety level of different obsessions, as well as compulsions to ease the anxiety
- 2. Use self- and other-report measures to assess degree of impairment

SHORT-TERM OBJECTIVES

- 3. Decrease negative appraisal of intrusive thoughts
- 4. Decrease covert neutralizing behaviors
- 5. Decrease overt neutralizing behaviors

THERAPEUTIC INTERVENTIONS

- 3. Use cognitive restructuring techniques
- 4. Perform ERP using loop tapes
- 5. Generate fear hierarchy, perform *in vivo* ERP

SHORT-TERM OBJECTIVES

- 6. Provide client with skills to plan and then implement exposures on their own

THERAPEUTIC INTERVENTIONS

- 6. Practice planning of exposures in session, correct difficulties during next session
