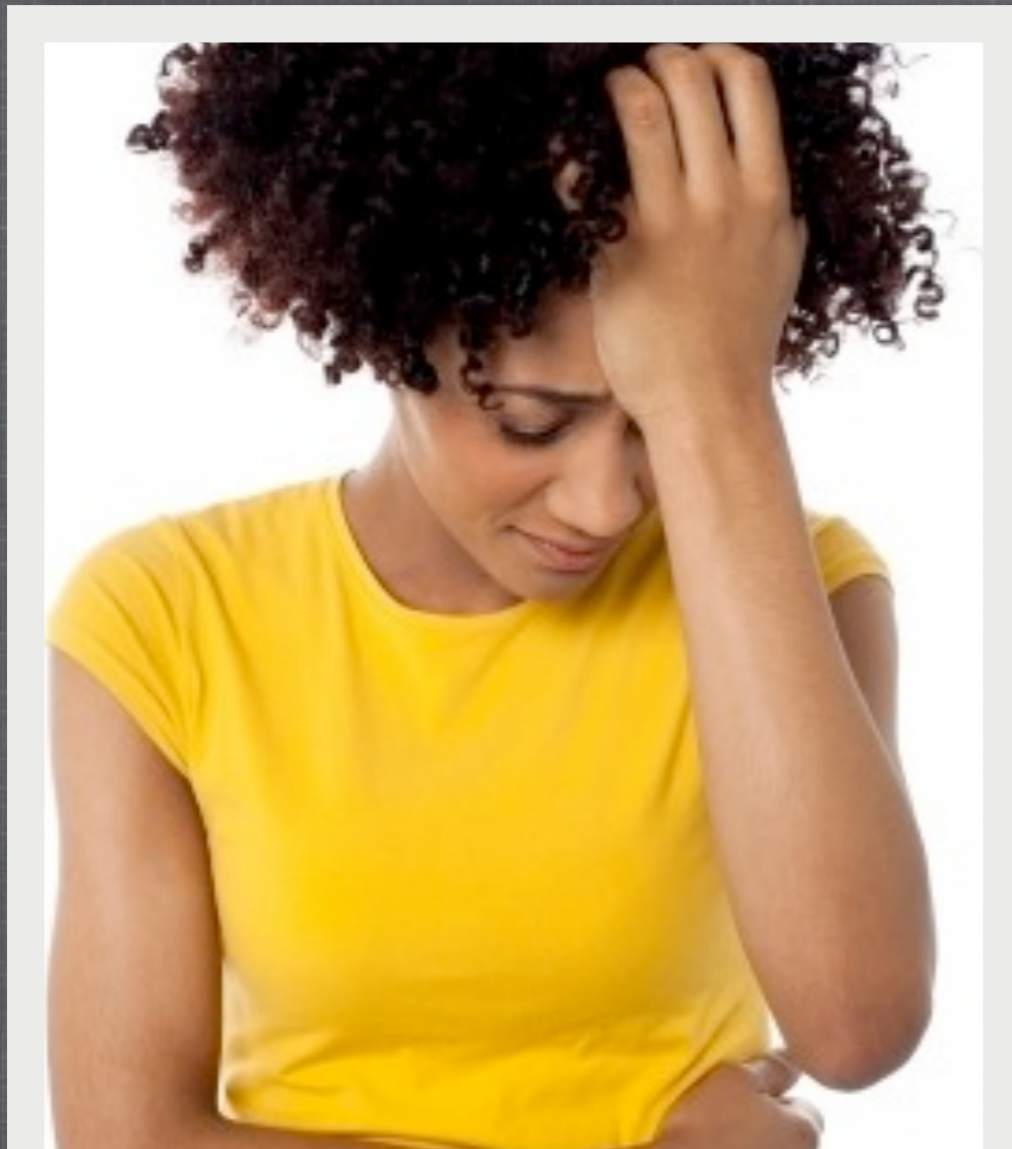


EXPOSURE TREATMENTS AND TECHNIQUES FOR ANXIETY DISORDERS



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Emotional Disorders

- Emotional disorders, known as anxiety and mood disorders, often co-occur and affect millions of Americans in a given year.
- About 29% of Americans will experience an Anxiety Disorder in their lifetime.
- About 21% will experience a mood disorder.

Kessler RC, Berglund P, Demler O, et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62(6):593–602.

Anxiety Disorders

- Anxiety disorders often precede depression
- The co-occurrence of anxiety and depression increases with age



Anxiety Defined

- A future-oriented emotion. A basic response to the perceived unpredictability of, or lack of control over, upcoming, potentially negative or dangerous events.
- Anxiety signals the need to be vigilant, reduce activity, and refocus attention on possible sources of future threat or danger.
- When we feel anxious, our bodies and minds get into a state of “preparation” so that we aren’t caught off guard if something bad happens.

Barlow DH. Anxiety and its disorders: the nature and treatment of anxiety and panic. 2nd edition. New York: Guilford Press; 2002.

Anxiety Disorders

- Experience negative affect more intensely and more frequently than healthy individuals
- View those experiences as more aversive
- Difficulty regulating emotional experiences that result from trying to dampen the emotion



Evidenced Based Treatments

- Cognitive behavioral therapy
- Components include: psychoeducation re nature and fear of anxiety; self-monitoring of symptoms; somatic exercises; cognitive restructuring; imaginal and in vivo exposure to feared stimuli while weaning from safety signals; and relapse prevention

Exposure

- Central to CBT for all anxiety disorders
- Not recommended for complicating medical conditions that make high levels of arousal potentially harmful, e.g, asthma, certain arrhythmias (Consider systematic desensitization because of the relaxation feature)

Exposure

- Require patients to be exposed to situations, thoughts or sensations that trigger their fear
- Ex: Panic attack triggered by physical sensation so client is exposed to those sensations; agoraphobia by situational cues so expose to the situation

Triggers/Cues

- Interoceptive cues-bodily sensations normally associated with fear and physical arousal--risk factor for panic attacks
- Cognitive cues--beliefs, expectations and assumptions often identified in social phobia and specific phobia.
- Situation cues -external cues-- event, object or situation that trigger anxiety

Exposure Based Treatments

- Are well established in their effectiveness
- Yet, only a small percentage of clients actually received them (less than 30%)
- Lack of well trained professionals (about 12%)
- Professionals think these procedures exacerbate symptoms, but actually exposure improves symptoms

Exposure Treatments

- Should be first line treatment for a variety of anxiety disorders (75% get better)
- Defined as any treatment that encourages systematic confrontation of the feared stimuli, which can be external (objects, situations) or internal (thoughts, sensations)
- Goal--reduce the person's fearful response to the stimuli

Biological Mechanism

- Extinction of fear mediated by N-methyl-d-aspartate receptor activity in the basolateral amygdala
- This finding is why neuroplasty compounds such as d-cycloserine are used to augment exposure.

Theories

- Average treatment is about 12 sessions; APA says 8-10
- 4 Major Theories To Explain Exposure

Habituation

- Is the natural reduction in responding with repeated exposure. Repeated exposure gradually reduces the fear response
- Think of it like going in to cold ocean water. At first, really cold, eventually you habituate to the water.

Extinction

- Extinction is overwriting previously learned fear associations
- Comes from the classical conditioning model. Stimulus (a dog bite) generalizes to other cues (other dogs) and becomes conditioned response (fear of dogs). Avoid conditioned stimuli and reinforce avoidance. Relief comes from avoidance.
- Exposure therapy weakens the conditioned response through repeated exposure to the conditioned stimuli.

Emotional Processing Theory

- Develop new interpretations and meanings for feared stimuli and feared responses
- Fear is stored in memory as a network of stimuli, response and meaning.
- Faulty meaning is assigned to stimuli and increases fear towards that stimuli.
- Exposure to feared stimuli results in a new way to process the information and corrects faulty fear structure.

Self-Efficacy

- Exposure increases perceptions that one is capable of tolerating feared stimuli and responses
- Exposure increases skills and mastery over a situation or performance.
- It builds on the success of overcoming and the resiliency of a person.
- Results in a person being more willing to face the anxiety and then a generalization of treatment effects occurs.

Methods of Delivery

- Patient Directed--usually done on a daily basis until the anxiety decreases.
- The hierarchy is developed and the person moves through the steps as he/she is able to tolerate the anxiety
- Keeps a journal, therapist gives positive feedback and deals with obstacles

Therapist-Assisted

- Therapist on location and coaches
- May challenge to push to maximum anxiety
- May also explore thoughts during it
- EX: Therapist goes to the shopping mall to do exposure aimed at decreasing anxiety re crowds.

Group Exposure

- Self exposure and practice combined with discussion of experience going through exposure
- EX: 3 hour format: 30 minutes of education; time for individual exposure and then 45 minutes for discussion
- Can do intensive--Daily for 10-14 days

Virtual Reality

- Virtual reality exposure--virtual world used to confront with a computer generated environment or scenario
- Greater sense of control because can turn device on and off
- Protects from harm or embarrassment
- Helps clients who have trouble imagining and staying with it

Table 3

Guidelines for the clinician who uses exposure therapy

Develop an exposure hierarchy

- Brainstorm external and internal stimuli that are feared and avoided
- Rate each item using the Subjective Units of Discomfort (SUD) scale

Conduct exposures in a gradual and systematic manner

- Begin with moderately fear-provoking stimuli
- Assess patient's fear during exposure using the SUD scale
- Address each exposure collaboratively, in a controlled and prolonged manner
- Progress to a higher item after the patient shows a reduced fear response to a lower item

Eliminate safety behaviors

- To the extent possible, reduce or eliminate any unnecessary behaviors that may contribute to learning conditional, rather than unconditional, safety

Challenge cognitive distortions

- Identify probability overestimation (overpredicting low-probability outcomes) and catastrophizing (inflating the magnitude of aversive outcomes)
- Ask the patient to examine the evidence for and against these beliefs
- Instruct the patient to generate and practice more adaptive ways of thinking

**Source:
Psychiatric
Times**

10 =Feels unbearably bad, beside yourself, out of control as in a nervous breakdown, overwhelmed, at the end of your rope. You may feel so upset that you don't want to talk because you can't imagine how anyone could possibly understand your agitation.

9 =Feeling desperate. What most people call a 10 is actually a 9. Feeling extremely freaked out to the point that it almost feels unbearable and you are getting scared of what you might do. Feeling very, very bad, losing control of your emotions.

8 =Freaking out. The beginning of alienation.

7 =Starting to freak out, on the edge of some definitely bad feelings. You can maintain control with difficulty.

6 =Feeling bad to the point that you begin to think something ought to be done about the way you feel.

5 =Moderately upset, uncomfortable. Unpleasant feelings are still manageable with some effort.

4 =Somewhat upset to the point that you cannot easily ignore an unpleasant thought. You can handle it OK but don't feel good.

3 =Mildly upset. Worried, bothered to the point that you notice it.

2 =A little bit upset, but not noticeable unless you took care to pay attention to your feelings and then realize, "yes" there is something bothering me.

1 =No acute distress and feeling basically good. If you took special effort you might feel something unpleasant but not much.

0 =Peace, serenity, total relief. No more anxiety of any kind about any particular issue.

Example

Source: Psychiatric Times

Table 1	Sample exposure hierarchy for a patient with specific phobia (animal type)	
Activity		Fear level (0 - 100)
Letting several large dogs lick my face		90
Petting several dogs in an enclosed space		85
Letting a large dog lick my face		80
Giving a large dog a treat		75
Petting a large dog		70
Going inside the dog park and letting dogs brush up against me		65
Going to a dog park and standing outside the park		60
Watching Animal Planet dog shows		55
Watching a real-life dog children's movie		40
Watching a cartoon dog movie		35
Looking at pictures of small and large dogs		30

Subjective Units of Distress

Fear of Contamination Example

1. Putting hand in toilet bowl water (SUDS rating: 100)
2. Touching toilet seat (SUDS rating: 95)
3. Touching floor beside toilet (SUDS rating: 90)
4. Handling raw poultry or hamburger meat (SUDS rating 85)
5. Touching wall in toilet (SUDS rating: 80)
6. Touching washroom door handle (SUDS rating: 75)
7. Shaking hands with a stranger (SUDS rating: 65)
8. Touching the bottom of your shoe (SUDS rating: 60)
9. Pressing a button on a vending machine (SUDS rating: 55)
10. Handling money (SUDS rating: 50)

Safety Behaviors

- Unnecessary actions patient takes to avert disaster or get relief (EX: Need my medication vs. panic will not harm me)
- Eliminate as much as possible because because undermines the work.

Cognitive Restructuring

- Can be used as an adjunct to exposure therapy
- During exposure can help client identify cognitive distortions, using cognitive strategies like examine the evidence, rehearsal of new thoughts, etc.

Application: Evolution of Practice

- Trained in experimental psychology with radical behaviorists in the animal labs.
- Began my practice back in the 1980s with a three step approach to clients with anxiety.
- Get them to become aware of the moment of anxiety, “I’m leaving the house and starting to feel tense.”

Teach Relaxation

- Then shift their attention to the breathing relaxation skills I had taught them and asked them to practice regularly. The focus was on the breathing and calming
- Next, they would tell themselves that they could approach or handle whatever the anxiety provoking situation was and manage the distress- “It’s OK to be anxious here. I can do this. Relax.”

Decent Results

- Clients got better. I received many referrals to do systematic desensitization. I was sent in to school systems to work with phobias, I went with clients into their cars to help with driving anxiety, worked on hierarchies to deal with social phobias, fears of contamination and more.

The Move to Exposure

- But noticed that the systematic desensitization approaches were being replaced with exposure.
- And I needed something more with my eating disorder clients who were still struggling too much with the anxiety component of eating. So I began to experiment with exposure.

EDs

- In the psychiatric hospital, I would bring in lunch to my ED patient sessions, sit with them during the meal, having them observe their thoughts, face the anxiety with gradual exposure to the food without being able to purge or restrict (response prevention), let themselves feel anxious but stay in the situation.
- After time and repeated exposure to the meal without purging, they stopped purging.

Foa and Kozak

- The theory behind this approach was that people who develop anxiety disorders hold on to distorted information about themselves or their environment and this causes them distress. The faulty information becomes associated with their distress.
- To acquire corrective information, one has to access the intense arousal associated with the specific fear. Then linger there long enough to see they are safe.

Relaxation Not Necessary

- In my desensitization work, I was spending an enormous amount of time teaching people relaxation techniques and gradually exposing them to anxiety cues as they relaxed.
- Now we know this is not necessary and may be counter indicated with panic. Relaxation exercises may accentuate the outcome, create a false safety because they need to tolerate anxiety, not avoid it.

Exposure

- I realized that clients had to experience that anxiety and stay in it long enough to see they could tolerate it.
- With my ED, they would eat, tolerate the anxiety and get through the experience without purging and build a new confidence (self-efficacy)

Collaboration

- Another difference was, in contrast to my experimental psychology training in the lab, I was now collaborating WITH the client rather than doing something TO the client
- To get better people had to be willing to do the opposite of what their disorder was compelling them to do
- And they had to tolerate the feeling as long as possible

Tackling Beliefs

- Adding the CBT piece, I taught my clients that their anxiety stemmed from an exaggerated appraisal of the threat.
- EX: A panic attack for someone in good health feels terrible, but is not a heart attack. The person with social anxiety might feel embarrassed at his awkwardness, but this doesn't mean he is humiliated and worthless.

Don't Fight

- The key was not to struggle against the anxiety sensations. The more an anxious client fought them, the more intense they become.
- Instead of calming the anxiety, I would tell my clients to feel it, induce it by putting themselves in the situation and say, “I can feel anxious here. It is OK.”
- Then challenge the catastrophic or distorted belief to something more realistic. Tolerate the panic or anxiety rather than trying to eliminate it

Confront the Fear

- Confront the fear event. Enter it and remain in it.
- The client would tell him/herself, “I can handle this.” Or “I can do all things through Christ who strengthens me.”

Another Shift in Thinking

- As I looked at Scripture, I didn't see evidence of managing anxiety or worry but of eliminating it.
- So when Barlow came along with eliminating anxiety, it made sense.

Don't Manage, Eliminate--Barlow

- Clients need to learn to tolerate feelings that feel unsafe.
- Provoke the doubt and discomfort that is feared.
- But to do so, had to make sure my clients understood what we were doing and had buy in to it. Did they agree and want to work this way? I would explain the logic, but they had to buy it.

Importance of Relationship

- So much of my behavioral and cognitive behavioral training said little about relationship, yet therapeutic alliance is a common factor that accounts for a significant amount of the variance of change.

Collaborative

- Therapeutic relationship is important and often overlooked in using exposure treatments.
- In my work with clients, I realized they have to partner, be collaborative, get the principles of what we doing and believe these would work to be effective in the long run.
- Build a trusting partnership for the work to be effective

Change the Thinking

- The goal is for the client to learn a new way to relate to their uncertainty and discomfort. How they generate distress needs changing in the big picture.
- Look at specific themes, but also the bigger picture of how the person relates to distress

Habituation

- Go towards the discomfort and trust-- biblical idea as well. “As you walk through the valley of the shadow of death, I will fear no evil. You are with me.”
- Embracing this is habituation--a habit of facing fear enough that it doesn't debilitate you now or in the future.
- Habituation requires frequent, long, exposures to the fear to reduce the threat.

The Star Trek Approach

- **Anxiety: The Final Frontier.**
“These are the voyages of (client name). To seek out new worlds and boldly go where I have gone before, but decided not to go again.”
- Go towards the fear and experience new possibilities of new responses to the feelings of intense distress and uncertainty.
- The attitude of Capt Kirk: This is difficult but bring it on.

Take the Hit

- When client says to self, “I want this. I want to overcome this and stay in it, the body calms down and secretes less adrenalin.
- “I can take the hit.” Social anxious person starts to visibly shake while speaking--I can take this. GAD makes a decision that is uncertain, “I can take this.”
- Embrace the doubt, rather than trying to avoid it.

Tolerate distress

- Distressing thoughts and feelings will come.
- Tolerate them.
- Check with client--are they getting the shift in thinking? Does this make sense? Are we good?
- Need to trust and collaborate or doesn't work.

Go Towards the Fear

- Create the protocol with them so they are engaged in the construction.
- Design the exposure--EX: School phobia, drive to the school, linger in the parking lot, go into the building, etc.
- Go towards what is frightening. Change the relationship with fear!

Example

- School phobic. Sat in the parking lot, “I can do this. I want to go back to school. I can take the hit.” Change the relationship with the fear of going to school.
- Look for opportunities in every practice to face those fears head on. In example above, client began to take away her crutches like staying close to the outer rim of the parking lot, going closer to the door.

- Thinking is, I will be anxious, but I can get through it. Feels empowering. Like the time I was convinced to go on a roller coaster. Once I faced it, felt empowered to take it on.
- Face the fear in small ways that client feels control over.
- Gradually do these longer and longer
- Do the harder things.

- Talk your way through it with confidence that you can take the hit.
- Requires strength and resiliency in clients
We often miss this.
- Requires a deep, trusting relationship--just like taking our fears to God, we have to trust him because the opposite of trust is doubt, the bedrock of worry.

- Learn to confront and experience uncomfortable emotions
- Develop ways to respond in a more adaptive fashion.
- Focus on internal process to increase emotional tolerance

Graded Exposure vs. Flooding

- Graded exposure works on a constructed hierarchy in which the mildly feared stimuli are first targeted, followed by more strong reactions.
- Usually, the work builds from mild to strong but some therapists use flooding in which the most difficult stimuli are addressed at the beginning (used to be called implosive therapy--EX: Phone solicitors)

In Vivo vs. Imaginal

- In vivo exposure--real world confrontation of feared stimuli
- Imaginary exposure--client is to vividly imagine and describe the feared stimulus, use present tense language and make it detailed with sights, sounds, smells, thoughts, emotions, etc.

Internal vs. External Cues

- Both types of cues can be targeted.
- EX of external: snake phobia--handle the snake, height phobia, go to the top of a building
- EX of internal: Panic--exposure to internal cues--heart palpitations; GAD--worried thoughts

Disorders

- Yapo: “Medication and CBT are equally effective in reducing anxiety/depression. But CBT is better at preventing relapse, and it creates greater patient satisfaction. "It's more empowering. Patients like feeling responsible for their own success."
- Further, new data suggests that the active coping CBT encourages creates new brain circuits that circumvent the dysfunctional response pathways.

Panic

- Identify specific fears within panic (e.g, sick, lose control, die)
- Expose to the situation which triggers those thoughts
- Interoceptive exposure--induce the fear sensations--spin in a chair to create dizziness, run upstairs to increase heart rate to create shortness of breath; notice symptoms and allow them; see their is no harm. Relaxation can be used before and after to manage anxiety.

Panic

- Interoceptive exposure for bodily arousal usually begins with practice sessions in the therapist office, then practice at home
- Then add physical activities that naturally produce the feared sensations
- If panic with agoraphobia, use in vivo to revisit situations the person is avoiding like leaving home, driving, etc.

Specific/Simple Phobia

- Graded exposure, in vivo most often used
- Approach feared object by degrees
- EX: Swimming in the ocean--look at pictures, then movies, go to the beach, walk along the water, get in, full swim

Social Phobia

- Exposure plus cognitive restructuring-- combination seems to prevent reoccurrence
- Difficulty is that you can't predict these as well and the social exchanges are often brief which makes prolonged practice difficult. Cognitive therapy
- Skills training component

Agoraphobia

- In vivo
- Best when spouse or friend is involved because of the support he or she can offer during practice

GAD

- CBT strategies that target uncontrollable worry and physical signs
- Cognitive restructuring used for persistent worries on a range of issues
- Address worried thoughts
- Problem-solving practice also helpful

OCD--Reclassified

- Exposure plus response prevention-- prevent compulsions
- Research--exposure to contamination leads to decrease in fears, but does not change compulsion. Response prevention decreases compulsion but not fears of contamination so do both
- Prolong and continuous is best-- 15 daily over a 3 week period (90 minute sessions)
- Gradual exposure is not more effective than flooding

PTSD Reclassified

- Imaginal treatment and cognitive treatment equally effective in some studies
- Some patients worsened with exposure or do not benefit.
- Prolonged exposure to reduce traumatic memories--flooding with systematic desensitization

Barlow: A Unified Approach and Integration

- Different behavioral disorders share a common latent structure--generalized biological vulnerability; generalized psychological vulnerability and specific psychological vulnerability

Barlow

- Noted the high comorbidity rate on many disorders associated with anxiety
- Single psychotropic medications often works for many different psychological disorders

Changes in How Exposure Works

- Research now finds that it's more effective to "expose" people to their actual emotional experience - which helps them better accept their emotional life and develop more positive ways of regulating their emotions - than merely to subject them to externally aversive conditions that may temporarily arouse those emotions without attending to how they are processing that experience.

Emotions and the Brain

- New findings that demonstrate how emotional patterns and responses affect regions of the brain.
- Brain-imaging studies show that cognitive reappraisal and other emotion-regulation techniques modulate the response of both the amygdala and prefrontal cortices in ways that reduce negative emotions, increase positive emotions, or both.

Unified Protocol

- Is a transdiagnostic (based on spectrum idea), emotion focused, cognitive-behavioral treatment
- Applied across emotional disorders (anxiety and depression)
- Developed from emotional regulation literature, cognitive neuroscience and learning theory

3 components

- Targets antecedent cognitive appraisals
- Reduces and prevents avoidance of dysregulated emotions
- Encourages actions that are inconsistent with disordered emotional states

Unified Protocol

- Focuses on modifying the processing of internal experiences rather than external cues
- Designed to help clients confront and experience uncomfortable emotions and respond to them more adaptively.
- 7 modules that target key aspects of emotional processing and regulation of emotional experience

UP Modules

- Module 1: Psychoeducation and treatment rationale (1-3 sessions)
- Module 2: Motivation enhancement for treatment engagement (collaborative)
- Module 3: Emotional awareness training (1-3)
- Module 4: Cognitive appraisal and reappraisal (1-2)

UP Modules

- Module 5: Emotion driven behaviors and emotional avoidance (1-3)
- Module 6: Interoceptive and situational exposures (4-6)
- Module 7: Relapse prevention (1)

#4 Cognitive Reappraisal

- Cognitive reappraisal--learning to think accurately about your thinking
- Thoughts produce feelings and action
- Anxiety producing thoughts are often habitual, automatic and learned

Cognitive Reappraisal

- Taught process of critical thinking:
- Identify negative and irrational thoughts
- These thoughts are treated as hypotheses, not facts
- Generate alternatives
- Evaluate the evidence for each alternative
- Select thought most supported by the evidence

Cognitive Reappraisal

- Common cognitive errors are seen across many different disorders
- Overestimation, catastrophizing, all or nothing, overgeneralization, etc.
- Identify the thinking error and substitute healthy thoughts

Emotional Regulation

- Preventing emotional avoidance--accepting emotional experience and increasing emotional literacy
- Disorders usually involve ineffective strategies to regulate emotions--suppress, avoid or deny negative emotions

Emotional Regulation

- Avoiding leads to increase in the negative one trying to avoid.
- Avoidance also hinders skill acquisition
- Can't always help how you feel, but can choose how to act on the feeling
- Taught to accept the discomfort

Changing Behavioral Habits

- Changing behavioral habits in the context of exposure treatments (facing fears and learning new habits)
- Best way to change an emotion is to change the behavior associated with it. (Act your way into a new way of feeling)

Change Behavior

- Behavioral activation often used with depression--practice behaviors known to increase mood (exercise, social activity, etc)
- Exposure therapy--which teaches clients to confront fears rather than escape or avoid them

Exposure

- Facing your fears leads to physical habituation
- As we habituate to a situation or object, our heightened nervous system activity subsides and, concurrently, our level of discomfort goes down.
- Exposure improves behavioral skills because you practice what you previously avoided.

Exposure

- Skill brings confidence, esteem and success
- Facing the fear leads to psychological empowerment--overcome the obstacle
- Increase emotional literacy--respond in ways that work

SUM

- Evidenced based treatments for anxiety disorders put exposure treatments at the top of the list
- These should be first line treatments for clinicians

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