COGNITIVE THERAPY OF ANXIETY DISORDERS

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ANXIETY AND RELATED DISORDERS

Cognitive Therapy of Anxiety Disorders

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Cognitive Therapy of Anxiety Disorders

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The cognitive model of psychopathology and psychotherapy developed by Beck and his collaborators (e.g., Beck, Emery, & Greenberg, 1985; Beck, Freeman, & Associates, 1990; Beck, Rush, Shaw, & Emery, 1979) posits that an individual's affective state is highly influenced by the manner in which the individual perceives and structures his or her experiences. According to this model, patients who suffer from anxiety disorders tend to misperceive particular stimuli and/or life situations as being far more threatening or dangerous than they actually are. Further, such patients compound their problems by underestimating their abilities to cope with these stimuli and situations, thus causing a reduction in self-esteem.

This chapter will focus on the cognitive therapy of three main types of anxiety disorders: (1) generalized anxiety disorder (GAD), which is typified by numerous excessive worries in everyday life coupled with a wide range of physical symptoms; (2) phobic disorders (nonpanic), which are characterized by exaggerated and intense fears of discrete, innocuous stimuli or situations; and (3) panic disorder (with or without agoraphobia), in which patients

experience a sudden escalation of fear that seems to come “out of the blue,” along with extreme changes in somatic sensations (e.g., rapid heart rate, hyperventilation, dizziness) and a desire to avoid many activities that the patients associate with the onset of attacks.

There are marked similarities between the types of physical symptoms that accompany each of these three classes of anxiety disorders. The most basic similarity is that they all represent increased sympathetic nervous system activity—the “fight, flight, or freeze” reactions that humans evince in response to the perception of danger and risk. In fact, there is considerable overlap between both the symptomatology and treatment of each of these three classes of anxiety disorders, and many patients meet diagnostic criteria for more than one anxiety disorder. However, there are some important distinctions between the aforementioned anxiety disorders that have implications for case conceptualization and treatment (Clark, 1989), which will be reflected in the case studies reviewed later in this chapter.

The treatment of anxiety disorders often is complicated by collateral problems, such as depression (Barlow, 1988), personality disorders (e.g., avoidant personality disorder and dependent personality disorder) (Sanderson & Beck, 1991), abuse of drugs, alcohol, or prescription anxiolytics as a form of self-medication (Bibb & Chambless, 1986), and strained marital and family relationships (Butler, 1989). The case studies will address these

additional problems as well.

COGNITIVE THERAPY: BASIC ELEMENTS

Cognitive therapy attempts to treat anxiety disorders by teaching patients to identify, test, and modify the thoughts and beliefs that accompany their excessive alarm reactions, as well as the avoidance behaviors that perpetuate their faulty appraisals and responses. In similar fashion to cognitive therapy for depressive disorders (Beck et al., 1979; Newman & Beck, 1990), cognitive therapy for anxiety disorders is a collaborative process of investigation, reality testing, and problem solving between therapist and patient. The therapists do not forcefully exhort patients to change their views, nor do they denigrate the patients' thinking styles. Rather, the therapists show respect for their patients, try to accurately understand how the patients have come to develop their problems, and proceed to teach them a set of durable skills that will help them to think more objectively, flexibly, and constructively.

Cognitive therapy is a structured and highly active form of treatment. Anxious patients who report that they often feel "scattered" or "out of control" benefit from therapy sessions in which agendas are set, goals are defined, priorities are established, and problems are concretized. Therapists and patients share the responsibility for the work of therapy, with therapists

being willing to respond to direct questions with direct answers, but also using Socratic questioning in order to help patients gradually learn to recognize and solve problems for themselves. Further, the implementation of between-session homework assignments helps patients to translate their new hypotheses and goals into actual behaviors that increase self-esteem, reduce anxieties, fears, and avoidance, and improve the patients' quality of life.

GENERALIZED ANXIETY DISORDER—COGNITIVE CASE PROFILE

The cognitive model of GAD (Beck et al., 1985) proposes that individuals who experience chronic, compelling, and pervasive anxieties maintain beliefs that make them prone to interpret numerous situations as posing risk and threat (Clark, 1988). These beliefs (also called underlying assumptions) often center around themes of personal acceptability, personal adequacy, and control. More specifically, the generally anxious patient may believe that the failure to perform a given task perfectly means that he or she is defective and incompetent. Similarly, such a patient may assume that by making a slight social error he or she will be humiliated, vilified, and cast aside by acquaintances, friends, and loved ones. Further, these patients frequently demonstrate a fear of "what might happen?" if they neglect to take rigorous measures to guarantee favorable outcomes. By holding such beliefs, patients place themselves under excessive and continual pressure to succeed and ward off trouble. These individuals are identifiable in everyday life as people

who seem never to relax, who continually feel "keyed up" or "on edge," and who are dubbed as "worry warts" by others in their lives.

For example, Roy is a successful, 47-year-old attorney who seems to have a rather secure and rewarding life. He earns a healthy salary, is well respected by the local legal community as an expert litigator, serves as an officer on the boards of a number of civic organizations, owns a beautiful home, and has a loving wife and two daughters. Nevertheless, Roy sought therapy, as he felt that he was going to "collapse under the strain." When the therapist helped Roy to assess the breadth and depth of his professional and personal activities, it became clear that he was carrying a tremendous burden of responsibilities, the likes of which would be stressful for anyone. These factors alone did not distinguish Roy as suffering from GAD. Instead, it was his *beliefs* about needing to prove himself at every turn that fueled his anxieties and his quest to take part in more and more challenging activities.

To highlight this patient's anxiogenic cognitive style, Roy viewed each trail in which he litigated as "make or break" for his career. Although all the objective evidence suggested that his glowing reputation was secure in the minds of his colleagues and family, Roy believed that "I'm only as good as my last case." Such an outlook led to his overpreparing for his court dates to the point of exhaustion. His anxiety steadily built as each trial drew near, whereupon he would typically utilize his "nervous energy" to put on a tour de

force performance that would all but assure a favorable outcome for his clients. Thus, he came to believe that "I have to get myself worked up into a frenzy in order to succeed. If I'm relaxed, I will fail. If I fail, my career will be ruined." Such an absolutistic chain of beliefs dictated that he must never *test* this way of thinking. In Roy's mind, if he so much as attempted to take his wife's advice to "relax a bit" he was certain that the result would be professional disaster. Thus, he silently avoided allowing himself to get some rest and recreation, a tactic that supported the maintenance of his negative beliefs.

Roy's anxiety-producing beliefs didn't stop here, as he also frequently worried about maintaining his financial standing. He reported to his therapist that he often lay awake at night wondering how he would continue to make payments on his very expensive home, cars, country club memberships, daughters' college tuitions, and travel plans if his earnings were to decrease from their current level. Such financial obligations might be daunting to anyone, but Roy's belief system compounded the problem. Specifically, he felt driven to win the love and approval of as many people as possible, and he believed that only a high-profile mixture of affluence and generosity would assure this outcome. Therefore, he actually sought out new financial burdens that he thought would accomplish his goal of social popularity, including the purchasing of a boat and making huge donations to charitable organizations. His erroneous assumption that he would be valued less as a person if he cut

back on his expenses fed into his constant worries about money. By the time he sought treatment, Roy was convinced that he no longer could cope with the demands of his life.

SIMPLE AND SOCIAL PHOBIAS—COGNITIVE CASE PROFILE

Phobias are chronic, exaggerated fears of particular stimuli or situations that are in fact not dangerous (Butler, 1989). Patients who suffer from phobias are so impaired by their fears that they experience disruptions in important aspects of their everyday lives. An example is a patient who is so afraid of elevators that she turns down a very attractive job offer solely on the basis of the fact that her office would be on the 30th floor of a high-rise building, thus necessitating the daily use of an elevator.

A *simple* phobia involves a single, specific feared object or situation (e.g., bridges, snakes, sight of blood). Patients who are diagnosed with simple phobias generally do not demonstrate fearfulness as long as they can avoid coming into contact with, or thinking about, their phobic situations. A *social* phobia involves abnormally strong concerns about interpersonal interactions and evaluations. Patients with social phobias usually evidence more pervasive anxiety and fearfulness than simple phobics, as it is considerably more difficult to avoid people than to avoid discrete situations such as heights or snakes.

Social phobics may fear particular aspects of social discourse more than others, such as public speaking or dating. Regardless of the overt elements of social interactions that the patients fear, the underlying concerns are consistent across this diagnostic class of patients. These include expectations of being socially inept and/or experiencing derision and rejection from others. Many social phobics, by virtue of their social avoidance, lock themselves into self-defeating vicious cycles. They so fear botching their chances to win the support, approval, acceptance, and praise of others that they either isolate themselves (thus perpetuating their loneliness and depriving them of opportunities to gain experience in the social realm), or reveal their anxieties by acting awkwardly (thus causing embarrassment and fulfilling their negative prophecies). Some social phobics demonstrate no appreciably noticeable behaviors that would suggest ineptitude in dealing with other people, yet such patients nevertheless assume that they are coming across poorly and that others do not enjoy their company.

“Leslie,” a 22-year-old college senior, demonstrated both simple and social phobias. Her simple phobias were specific fears of going to dental and medical appointments. These fears were of such intensity that she had had no check-ups in over four years. One of the reasons for Leslie’s entering therapy was her ongoing embarrassment in postponing dental appointments.

The patient's social phobia was especially pronounced in the area of

public speaking. Although she was quite secure and adept in having one-on-one conversations with close friends, she generally remained quiet when in the presence of a group of people. Her worst fears concerned having to speak in class. Leslie, as a senior, was taking two advanced level seminars that strongly emphasized the importance of class participation, thus putting her in "peril" of having to answer questions before her professor and classmates on a moment's notice. She had attempted to circumvent this problem by privately asking her professors not to call on her in class, but both instructors agreed to this arrangement only on a temporary basis. Thus, Leslie entered therapy as a "last resort before I have to drop the classes."

Although Leslie's simple and social phobias seemed unrelated on the surface, the patient maintained two underlying beliefs that tied together the two types of fears. Specifically, Leslie believed that, "I cannot tolerate discomfort without becoming a nervous wreck," and "If I become a nervous wreck in front of others they will think I'm crazy and they will reject me." Although the kind of discomfort that Leslie presumed she would experience as a medical or dental patient was physical, while her expected classroom discomfort was psychological, Leslie anticipated that both of these types of experiences would cause her to "become a nervous wreck" in front of others. She envisioned becoming tongue-tied in class, resulting in her screaming in frustration and having to flee from the class. Similarly, she imagined that she would dissolve into tears if her physician recommended a blood test or her

dentist suggested that she would have to drill a tooth. Leslie was certain that she would “create a scene,” the likes of which would prevent her from ever showing her face to these people again.

PANIC DISORDER AND AGORAPHOBIA—COGNITIVE CASE PROFILE

The cognitive model of panic disorder (Beck & Greenberg, 1988; Clark, 1988; Ehlers, 1991; Greenberg, 1989; Salkovskis & Clark, 1991) holds that individuals produce the onset of attacks by tending to make catastrophic interpretations about a wide range of physical sensations and mental states that they may experience. Exacerbating this habit is the panic patient’s hypervigilance to (and dread of) normal changes that take place in the body and mind. The most common misinterpretations that panic patients make include the following:

1. Believing that a rapid heart rate and chest tightness are indicative of an impending coronary and sudden death

2. Viewing difficulty in breathing as leading to asphyxiation

3. Interpreting mental phenomena such as memory flashbacks, deja vu, senses of unreality and depersonalization, and disruption of attention span as precursors to insanity

4. Expecting that the discomfort associated with a number of symptoms (e.g., dizziness, cardiopulmonary distress,

> abdominal pain, feeling detached from one's surroundings) will become so intolerable as to cause the patient to "lose control," resulting in a number of dreaded consequences, such as social humiliation (e.g., screaming, fainting, losing control of one's bowels) or committing terrible acts (hurting oneself or loved ones).

Two key factors seem to perpetuate the panic patients' extreme fears: (1) a patient having a panic attack is in such a state of alarm that he or she unwittingly activates the sympathetic nervous system even further. The resultant rush of adrenaline in the bloodstream exacerbates the very symptoms that the patient fears in the first place, thus "confirming" that the symptoms are out of control. (2) Panic patients often avoid situations that the associate with the attacks (e.g., staying away from places that are deemed "unsafe," such as cars, shopping malls, theaters, and any place from which escape will be difficult in the event of emergency), and/or engage in fear-driven rituals (e.g., going to the emergency room of a nearby hospital) at the onset of attacks, thus depriving such patients of ever realizing that their symptoms are not dangerous (Salkovskis, 1988).

For example, an individual may have had a hundred panic attacks in his lifetime, each time fearing that he was having a heart attack. In spite of the fact that no heart attack ever actually occurred, the patient's fear does not extinguish because he believes that his ritualistic actions in response to the attacks (e.g., calling his wife, taking a pill, going to the hospital, escaping from

the room) save his life each time. In this way, the patient's thinking style maintains the fear, even in the repeated absence of the feared outcome.

The avoidance that is described above is a prime factor in the development of the agoraphobic component of the disorder (Chambless & Goldstein, 1982). Patients often begin to steer clear of any and all situations that they associate with the likelihood of experiencing a panic attack. Some patients accomplish this goal subtly, such as by making advance plans to obtain theater tickets that will be on an aisle or deliberately sitting in the last pew at church, so that an easy exit can be made if an attack seems imminent. In more severe cases, however, the patient may refuse to venture outside of a very restricted "safe zone" (the definition of which is entirely a product of the patient's beliefs), which sometimes entails remaining completely housebound. Common beliefs that agoraphobic patients maintain include:

1. If I venture outside of my safe zone, I will be bereft of necessary assistance should I have an attack.

2. I cannot cope with anything new and unfamiliar.

3. I need to plan easy escape routes lest I become trapped in a situation in which everyone will discover my mental illness.

4. If I go into a situation in which I previously had a panic attack, I will surely have another attack.

5. Avoiding situations that cause my panic attacks is the best way to eliminate my panic attacks.

6. If I can't avoid situations that cause my panic attacks, I can rely on a "safe person" to take care of me.

7. If I can't rely on a "safe person" to take care of me, I have no choice but to rely on my medications or alcohol.

"Penny" is a 35-year-old single woman who suffers from both panic disorder and agoraphobia. Although she successfully meets the demands of her high-level, white-collar job without suffering appreciable anxiety, she has great difficulty in coping with traveling moderate distances or staying at home alone. Thus, when her roommate got married and moved out. Penny felt compelled to ask her boyfriend to move in with her in order to make her feel safe from panic attacks, even though she had no intention of making the relationship more serious. Unfortunately, the boyfriend took the invitation to move in as a sign that Penny was looking to get married, and he began to talk about plans for their future. Penny felt trapped; on the one hand she believed that she needed her boyfriend in order to help her to cope with her anxiety, but to keep him close by meant that she would have to abandon her dreams of becoming involved with another man with whom she had fallen in love.

Further complicating Penny's dilemma was the fact that she felt very guilty for "using" her boyfriend in this way. This feeling in and of itself often

triggered panic attacks, characterized by heart palpitations and breathing difficulties that were so severe that she thought she was going to suffocate. Ironically, the boyfriend was well-schooled in coming to Penny's aid when she would experience these symptoms, thus becoming both her source of comfort and guilt at the same time.

"Tim," the man with whom Penny was in love, lived approximately 30 miles from her home. Interestingly, Penny claimed that she was unable to travel more than 25 miles from her home without suffering the onset of high anxiety and panic attacks. After two months of therapy, she was able to identify for the first time a very telling automatic thought that would cross her mind whenever she drove close to her limit of 25 miles—namely, "If I drive any further, I might be tempted to go to Tim's house." This thought was accompanied by momentary images of making love to Tim, and she would begin to feel sexually aroused. Both the feelings of guilt and physiological arousal that Penny experienced as a result of these thoughts and images brought on panic attacks, thus effectively dissuading her from considering the possibility that she could drive long distances. In essence. Penny was caught between a figurative sense of suffocation in her relationship with her boyfriend, and actual breathing difficulties brought on by thoughts of becoming involved with Tim. Although Penny could plainly see the interpersonal factors that were feeding her anxiety, panic, and agoraphobia, she continued to believe that any given panic attack could lead to her death

by asphyxiation. As a result, she continued to be hypervigilant to changes in her breathing, and avoided all situations in which she believed she might have a panic attack. She remained with her boyfriend and grew increasingly frustrated and anxious.

COGNITIVE CONCEPTUALIZATION AND THERAPY: TECHNIQUES AND STRATEGIES FOR ASSESSMENT AND TREATMENT

As noted, the assessment and treatment of GAD, simple and social phobias. and panic (with or without agoraphobia) entail some basic similarities. In each of these types of anxiety disorders, the cognitive therapist strives to do the following:

1. Assess the patients' thoughts that precede, accompany, and follow typical situations where anxieties, fears, panic, and avoidance occur.

2. Assess the patients' core beliefs that underlie their automatic thoughts about themselves (and their disorders), their lives, and their futures.

3. Review the patients' life experiences that fostered such maladaptive core beliefs.

4. Elucidate the current life factors that seem to maintain the patients' problematic thoughts, emotions, and behaviors.

Note: Taken together, these four points comprise a case conceptualization (cf.

Persons, 1989).

5. Establish a warm, collaborative, trusting therapeutic relationship as an important part of the process of change.

6. Teach patients to become more objective evaluators of themselves and their life situations. For example, describe to patients the common cognitive distortions of all-or-none thinking, overgeneralizing, fortune-telling, mind-reading, catastrophizing, and other biased processes outlined in Beck et al. (1979) and Burns (1980); then, train patients to respond with alternative, more adaptive responses.

7. Instruct patients in the skills of active problem-solving (Nezu, Nezu, & Perri, 1989) in order to build hope, increase self-efficacy, foster independence, and make meaningful, lasting changes in patients' lives.

8. Help patients to become aware of their most salient areas of vulnerability, so as to prepare for scenarios that might otherwise precipitate relapse.

This section of the chapter will focus first on the treatment of GAD, reviewing many of the strategies and techniques that are pertinent to all of the anxiety disorders. Then, as attention turns to the treatment of phobias, more emphasis will be placed on the behavioral aspects of treatment that are so important when patients habitually avoid feared situations. Finally, the case description of panic disorder with agoraphobia will review the highly

specific techniques of interoceptive exposure (panic induction), breathing control, and recognition of emotions that are so important with this population (Barlow, 1988; Salkovskis & Clark, 1991). Taken as a whole, the three case studies will explicate many of the key ingredients of cognitive assessment and cognitive therapy for the full range of anxiety disorders.

Assessment and Treatment of GAD: Roy

Roy presented himself as an assertive, gregarious, "take charge" person. He was articulate, speaking with great animation about a recent high-profile case that he won for his firm, and about an upcoming amateur golf tournament that he aspired to win. The therapist began the process of facilitating a positive therapeutic relationship with Roy by giving him appropriate positive feedback for his stories of success, while also showing some sympathy for "all the pressures that you must have to face on a regular basis."

Roy stated that, "I am where I am today [a successful person] because I always go to the limit of my endurance. People have always been able to depend on me, knowing that I can get the job done. I can't go backwards now. I've worked too hard to reach this point to start slacking off."

Over the course of a number of sessions, the therapist was able to demonstrate to Roy that his *beliefs* (e.g., those noted above) played at least as

big a role in his anxiety as his actual life demands. Roy's statements revealed that he ascribed all his success in life to his frenetic pace. He gave little credit to his natural abilities, and saw any let-up as an invitation to disaster. Further, it was clear that he highly valued others' being able to depend on him (as he believed that this made him a likable person), and he viewed any diminution in his daily demands as tantamount to "slacking off." Roy's over devotion to work at the expense of his health and personal life, along with his stubbornness, over attention to details, certainty that his points of view were correct, and need to be in control indicated an obsessive-compulsive personality disorder (OCPD) in addition to his GAD diagnosis. By recognizing this aspect of Roy's personality, the therapist was able to formulate methods that would help the patient to change, yet still allow Roy to maintain a much-valued feeling of independence and control.

In order to appeal to Roy's sense of autonomy and in order to minimize resistance (e.g., to the therapists' attempts to get Roy to relax and enjoy life at a slightly slower pace), the therapist taught Roy a number of standard cognitive therapy skills that he could apply on his own. For example, Roy was given the "challenge" (Roy could not resist a challenge!) to take mental inventory of his thoughts at times of high stress. This kind of cognitive self-monitoring is a key ingredient of cognitive therapy, as it teaches patients to recognize how their internal dialogues contribute to their emotional and behavioral reactions.

Roy also was given the task of charting his activities, in order to evaluate where he was "pushing the limit" too far, even by his standards. The therapist was able to motivate Roy to engage in this task by using Socratic questioning in the following manner:

T: Roy, you've told me that you believe that you must maintain your current level of activities in order to succeed. Is that right?

R: Basically.

T: Does your current level of demands fatigue you and place a great strain on you?

R: Yes, of course. That's what we've been talking about.

T: OK then. How *efficient* are you, as an attorney, as a golfer, as a family man, and as an active leader in the community when you're fatigued and wrung out from worrying?

R: Not as efficient as I'd like, but I still get the job done.

T: Roy, believe me, I know that you are capable of accomplishing some extraordinary things. I have a lot of respect and admiration for you, but, do you remember what you said when you entered therapy? Something about a "collapse" being imminent?

R: (Nods.) I felt like an engine about to overheat and break down.

T: That's a great analogy. You've been a super-charged, high-performance engine for a long time. What kind of engine *care* have you been doing in order to keep it from breaking down?

R: Not much. My doctor thinks I'm a candidate for a coronary.

T: And then how efficient will you be?

R: I guess I’ve got to let the engine recoup once in a while.

T: You said it.

Following this, Roy was willing to keep tabs on, and then eliminate, some of his lower priority activities.

Another important facet of his treatment was Roy’s learning how his beliefs fed into his need to over achieve. By taking a close look at Roy’s personal history as well as his current thoughts, the therapist and patient were able to ascertain how Roy actually perceived threat and danger if he *didn’t* over extend himself in everything he was doing. Earlier in life, his father had demanded perfection from Roy, and fostered an all-or-nothing mentality by ignoring him when Roy would be a “disappointment,” and praising him to the sky when he would make him “proud to be your father.” The message was clear—“You’ll be loved if you are the best. Anything less than that and you will be inadequate and a disappointment.” In the present, Roy lived out this credo by going to great lengths to be the best—not just out of a need to succeed—but as a way to avoid deprivation of love and nurturance. This realization opened the therapeutic door for Roy to attempt new ways of *thinking* (e.g., “I can turn this case over to my colleagues and still be held in high esteem by the firm. Meanwhile I’ll have a little more time to relax!” and “I can perform my job at 95% efficiency and still win the lion’s share of my cases. 100% isn’t always necessary, and it's best that I pace myself at times.")

and *acting* (e.g., clearing an entire morning off of his Wednesday schedule in order to swim or play a *leisurely* game of golf with his wife). Roy's therapeutic improvement showed itself not only in his subjective sense of well-being, but also in his decreased blood pressure.

Assessment and Treatment of Phobias: Leslie

Leslie entered therapy hoping that she could rid herself of her fears of public speaking, as well as her trepidation of seeing her physician and dentist. Unfortunately, it had not occurred to her that part of her treatment might entail directly confronting her fears. The therapist explained to the patient that exposure to the feared situations was an important part of the treatment package (cf. Butler, 1985), and assured her that he would do everything he could to teach her a set of skills that would help her to get through the “ordeals" in such a way that she would find the feared situations progressively more tolerable. In the end, a critical achievement would be Leslie’s increased self-confidence as a result of her in vivo practice.

The therapist's simply discussing this aspect of treatment brought forth a flood of tears from the patient. He asked Leslie what was going through her mind that made her so upset, whereupon Leslie replied, “I can’t do it. I just can’t do it.’’ The therapist asked Leslie why she believed so strongly that she was incapable of dealing directly with feared situations. The patient explained

that she had been a fearful person all her life. She added that most of her mother's side of the family suffered from anxieties and phobias as well. She concluded that her "cowardice was inborn," therefore it was inevitable that she would always feel incapacitated by fears. She said, "I'm just like my mother, my grandmother and my uncle . . . we can't tolerate anything uncomfortable. We're all pathetic. I'm ashamed of my family, and I'm ashamed of myself."

The therapist acknowledged that there seemed to be a hereditary component to her disorder. He also silently realized that Leslie's phobias probably were part of an avoidant personality disorder, a common diagnosis in people who have such long histories of fears and avoidance (indeed, she met diagnostic criteria for the disorder, as per the DSM-III-R, APA, 1987). However, he began to question Leslie's conclusions in an attempt to have her rethink some of her suppositions. Some of the questions that the therapist asked Leslie to ponder were:

- Do you have *all* your mother's genes? What role does your father play in your genetic make-up? How fearful is *he*?

- How much of your fearfulness and lack of self-worth was *learned*?

- What are some memorable experiences that you've had in your life where you *learned* to fear things?

- What are some *differences* between you and your mother? Did she

go to college like you? Did she get along well with friends on a one-to-one basis the way that you do?

Leslie was intrigued by these questions. She admitted that her father seemed “normal” in that he wasn’t fazed by very much. Also, she noted that, unlike herself, her mother never went to college, as the mother was afraid of dealing with all the social and scholastic demands. The therapist asked Leslie what she could conclude from this, and the patient said, “I guess I’m not as hopeless as my mother after all. It just seems that way sometimes because certain things frighten me.”

With this incremental increase in hope, Leslie was willing to start working on her self-image, as well as her exaggerated senses of risk and danger in speaking in class. An important tool to be used in this process was the Daily Thought Record (DTR) (Figure 18.1). The standard format of the DTR presents patients with five columns in which they write about:

1. Problematic situations,

2. Concomitant emotions,

3. Dysfunctional automatic thoughts,

4. Adaptive alternative thoughts, and

5. The outcome of the DTR exercise (in terms of resultant emotions and residual belief in the dysfunctional automatic thoughts).

The DTR is a powerful part of therapy if patients persevere in practicing its use on a regular basis. The most critical sections of the DTR are the third and fourth columns—"automatic thoughts," and "adaptive responses." In column three, patients ask themselves what they are thinking during their times of emotional distress. This helps to concretize the problem, to demystify the emotions that seem to arise out of nowhere, and to start the process of the patients' beginning to open their minds to more constructive ways of viewing their situations. Such adaptive (or "rational") thinking, which is recorded in column four, often leads to decreased anxiety and improved problem-solving skills and self-esteem.

Figure 18.1. Leslie's Daily Thought Record (DTR) regarding speaking in class.

In order to facilitate the process of discovering adaptive responses, the therapist instructed Leslie to ask herself the following four questions in response to her automatic thoughts:

1. What is the *evidence* that supports or refutes my automatic thoughts and beliefs?

For example, when Leslie predicted that her mind would go blank if she tried to answer a question in class, she was asked to review her scholastic history in order to judge how well she had done in similar situations in the past. Leslie noted that she was inexperienced in answering questions on the spot in class, but there had never been an episode when

her mind went blank and when she had to leave the class out of embarrassment.

2. What are some other ways that I can view this situation?

Leslie believed that her fears of social evaluation would cause her to make a fool of herself in class, and that she would be so embarrassed that she'd run out of the room screaming. However, there were many other plausible ways to view the situation. First, Leslie's anxiety might be barely noticeable to others, and though she might struggle to answer the questions, she might very well succeed in answering correctly. Second, even if she didn't know how to answer the professor's questions, the other students might be sympathetic, rather than hostile and rejecting. Third, even if the other students chuckled at Leslie's answer, they might forget about the matter in a few minutes, and still remain on friendly terms with her. Fourth, if Leslie were to try to participate more actively in class discussions, she conceivably could *improve* her performance, thus resulting in better grades and increased self-confidence.

3. Realistically, what is the worst case scenario, and how would it ultimately affect my life?

Though Leslie visualized academic and social catastrophe, the actual worst case scenario was less noxious. When the patient pondered this question, she realized that the worst that could happen would be that she would fail to answer

the question, and that she would blush and feel embarrassed. While this would make her feel uneasy, it would not portend failure and loneliness for the rest of her life.

4. What active steps can I take to solve this problem?

Since many clinically anxious patients spend more time and energy worrying about problems than trying to do something about them, this question becomes quite useful in turning their attention to the issue of problem solving. The therapist taught Leslie to recognize when she was catastrophizing, and to use this as her cue to "shift into problem-solving mode." In the present example, Leslie dealt actively with her concerns by increasing her study time, practicing answering questions in role-play exercises with both the therapist and her boyfriend, and by making a small foray into the area of speaking in class by *asking* questions. Later, she would agree to begin to *answer* questions by volunteering to comment on the topicsin which she had the most knowledge. This graded-hierarchy was a vital part of her treatment, as it helped her to tolerate increments of social discomfort a little at a time.

As Leslie began to utilize the four questions outlined above, she agreed to compose a hierarchy of feared social situations that she would tackle step by step. She practiced her use of the four questions in order to prepare mentally for the exercise, and then experimented with the new behaviors (e.g., asking questions in class). Her anxiety persisted at first, but she was

pleasantly surprised by the positive results of her attempts to confront her feared situations directly. These positive outcomes instilled a more optimistic view of herself and her abilities, and her avoidance decreased further.

At present, Leslie's social phobia has markedly diminished, and she continues to work in cognitive therapy in order to deal with her simple phobias of going to see the dentist and physician. The same principles of adaptive responding (through the use of the DTR and the four questions) and behavioral experiments are being utilized in these areas of concern as well.

Assessment and Treatment of Panic Disorder: Penny

Penny’s responses to the Panic Beliefs Questionnaire (Greenberg, 1989) indicated that she strongly believed that:

1. She was especially vulnerable to panic attacks if she were alone.
2. Intense emotions were dangerous and needed to be avoided.
3. It was important to be vigilant in monitoring her bodily sensations (see Figure 18.2).

In spite of the fact that this patient was a successful businesswoman (and therefore seemed to be quite independent), she met DSM-III-R (APA, 1987) criteria for the diagnosis of dependent personality disorder (DPD). Further complicating the clinical picture were the patient’s problematic over-

reliance on her medication, as well as her discord, ambivalence, and guilt in her relationship with her boyfriend.

Panic Belief Questionnaire

NAME: Penny DATE: October 27

Please rate how strongly you believe each statement on a scale from 1-6, as follows:

1= Totally Disagree	3= Disagree Slightly	5 = Agree Very Much
2= Disagree Very Much	4 = Agree Slightly	6 = Totally Agree

5 1. Having a bad panic attack in a situation means I will definitely have one there again.

3 2. Having panic attacks means I'm weak, defective or inferior.

5 3. If people see me having a panic attack, they'll lose respect for me.

5 4. I'll have disabling panic attacks for the rest of my life.

4 5. Exerting myself physically during a panic attack could cause me to have a heart attack and die.

4 6. If I have panic attacks, it means there's something terribly wrong with me.

4 7. I'm only safe if I can control every situation I'm in.

5 8. I'll never be able to forget about panic attacks and enjoy myself.

4 9. If I have to wait in line or sit still, there's a good chance I'll lose control, scream, faint, or start crying.

3 10. There's something wrong with me that the doctors haven't found yet.

5 11. I must be watchful or something terrible will happen.

3 12. If I lose my fear of panic attacks, I might overlook other symptoms that are dangerous.

3 13. If my children (or others close to me) see me having panic attacks, they'll become fearful and insecure.

*6 14. I have to keep checking how my body is reacting or I might have a panic attack.

2 15. Crying too much could cause a heart attack.

4 16. I have to escape the situation when I start having symptoms or something terrible could happen.

4 17. There's only so much anxiety my heart can take.

4 18. There's only so much anxiety my nervous system can take.

5 19. Anxiety can lead to loss of control and doing something awful or embarrassing.

*6 20. My emotions (anxiety, anger, sadness, or loneliness) could become so strong I wouldn't be able to tolerate them.

3 21. Panicking while driving or while stuck in traffic is likely to cause an accident.

5 22. A panic attack can give me a heart attack.

*6 23. A panic attack can kill me.

4 24. A panic attack can drive me insane.

2 25. A little anxiety means I'll be as bad as I was at my worst.

*6 26. I could experience terrible emotion that never ends.

*6 27. Expressing anger is likely to lead to losing control or provoking a fight.

5 28. I could lose control of my anxiety and become trapped in my own mind.

4 29. It could be dangerous to carry on my usual activities during a panic attack.

*6 30. I must be near my companion to be protected from panic.

Figure 18.2

Penny's panic beliefs at intake. (Note the importance of the asterisked beliefs.)

A review of the etiology of Penny's panic attacks revealed that they began approximately four years earlier, ten months after her mother died suddenly of a severe asthma attack. The patient had been extremely close to her mother, who had served as the patient's best friend, confidante, and guidance counselor. At the time of the mother's death, Penny alternated between a catatonic-like state of shock, and fits of anxiety and rage. Her

physician sedated her heavily on large doses of Xanax, which were effective in helping Penny to function socially and vocationally in the months following the tragedy.

Ten months after her mother's death, Penny decided to go off the medication all at once and, as a consequence, experienced numerous, intense panic attacks. She immediately resumed use of the anxiolytic medication, and continued to do so for four years. At the same time, she began a friendship with a man at work who seemed very nurturing. Although she didn't love him, Penny believed that she needed someone to take care of her as her mother always had.

In the years to come. Penny settled into a "comfortable" routine with the boyfriend. She believed she needed him in order to prevent her panic attacks from ruining her life, yet she was vaguely aware that the relationship had no future. This realization increased her anxiety and panic attacks to the point where even high dosages of Xanax (e.g., 4 mg/day) were insufficient treatment. At this time, she sought help at the Center for Cognitive Therapy.

It was noted that Penny's most salient catastrophic fear was that her panic attacks would make her suffocate and die. This fear clearly was tied to the fact that her mother asphyxiated as the result of a severe asthma attack. Therefore, Penny was extremely aware of any changes in her breathing

patterns, to the point that she would begin to worry if her rate of breathing changed even in reaction to natural and innocuous physical activity. The therapist initially hypothesized that this was one of the reasons that Penny had panic attacks during sexual encounters with her boyfriend. Later, both the therapist and patient would come to realize that Penny's feelings of guilt played a significant role as well.

The therapist asked Penny to keep records of her panic attacks on a panic log (see Figure 18.3). This device helps to spot patterns that pertain to the disorder, including the role of various stressful situations, catastrophic thoughts that typically occur, medications on which the patient relies, and behavioral consequences of the attacks. Penny's panic logs indicated that her attacks had a number of interesting things in common:

1. They occurred in association with extreme interpersonal situations —loneliness at one extreme and sexual feelings or activity at the other extreme.

2. Her agoraphobic symptoms were recent phenomena, and her "safe" distance was just a little shy of the distance she would have to travel in order to spend the night at the home of the man she truly loved, Tim.

3. Each panic attack involved symptoms of hyperventilation, and concomitant fears of sudden death.

4. Each attack was "cured" by the presence of another person,

including her boyfriend. The use of Xanax was the next best choice if nobody was nearby.

5. Feelings of anger and guilt also typically preceded Penny's attacks.

Name: Penny Date: November 3-9

Instructions: Please record all instances of panic over the past week. A panic attack is defined as a sudden rush of anxiety in which the symptoms build up quickly. These panic attacks are accompanied by fear or apprehension and at least four symptoms.

Weekly Panic Log

Date, Time, and Duration of Panic Attack	Situation in Which Panic Attack Occurred and Severity of the Panic Attack (1-10)	Description of Panic Attack Symptoms and Sensations Experienced	Interpretations of Sensations and Accompanying Thoughts and Images	Was This a Full-Blown Attack (Yes/No) If No, Explain Why	Your Response to Panic Attack What Did You Do? (Specify any medication taken and dosage in mgs.)
1. Monday 7:00 PM 40 minutes	Eating dinner alone at home. Feeling scared and lonely 9	Dizziness. Fainting. Rapid breathing. Heaviness in chest. Choking. Fear of dying.	Afraid I would faint and stop breathing. Nobody would be there to save me.	Yes	I called my boyfriend and asked him to leave work.
2. Friday 8:00 PM An hour	Driving to the office party at	Rapid breathing. Choking.	I can't drive anymore. I have to stop. I	Yes	I took 1 mg tablet Xanax and

	Mary's place. 10	Heart palpitations.	can't cope with seeing Tim at the party.		went to the party
3. Saturday 2:00 PM An hour	In the car with my boyfriend. I feel trapped with him. 10	Choking. Sweating. Fear of losing control.	I'm a bad person for wanting to end this relationship. He's so good to me. I feel so guilty.	Yes	I took 1 mg tablet Xanax and tried to sleep, but I was crying.
4. Sunday 10:00 PM	Watching the movie "Terms of Endearment" at home.	Fear of dying. Heart palpitations. Rapid breathing. Fainting.	Why did my mother die? I loved her so much. I'll probably die the same way.	Yes	I cried and talked it out with my boyfriend. He understands my feelings about Mom.

Figure 18.3

Penny's panic log

These data were invaluable in devising a strategy for treatment. The therapist chose a two-pronged approach that is commonly used in the treatment of panic disorder. One main strategy dealt with the phenomenology of the acute panic attack itself—examining the thoughts, beliefs, emotions, behaviors, and physiological changes that took place before, during, and after the attacks. The goal of this strategy was to modify these aspects of the patient's functioning in order to de-escalate the catastrophic

misinterpretations, fears, and physiological arousal.

The second strategy involved examining the patient's entire life situation for broader issues that needed to be addressed. As panic patients often avoid recognizing or dealing with strong emotions *other* than fear (Chambless & Goldstein, 1982), this approach attempted to focus Penny's attention on the issues that the panic attacks often disguised.

Consistent with the first strategy, the therapist taught Penny the role that hyperventilation (Clark, Salkovskis, & Chalkley, 1985; Salkovskis & Clark, 1991) and hypersensitivity to bodily sensations (Ehlers, 1991) played in her panic attacks. Specifically, by worrying about changes in her breathing (e.g., breathing too hard, or feeling constricted and asthmatic) Penny over activated her sympathetic nervous system, which exacerbated the breathing problem by pumping adrenalin into her system so that hyperventilation increased. The resultant symptoms, including dizziness and breathlessness, mimicked oxygen *debt*, thus inducing Penny to try to breath harder. The therapist explained that this reaction was in direct opposition to the body's natural tendency to return to homeostasis— in this case by *reducing* respiration in order to achieve the appropriate balance of oxygen and carbon dioxide in the bloodstream. The result was Penny's subjective sense that she was unable to breathe freely, thus spurring more of her catastrophic misinterpretations about asphyxiating as did her mother. In reality, Penny

was in no danger.

The therapist utilized many of the techniques that have been described previously in the cases of Roy and Leslie, but added an important technique that is specifically geared to the panic patient. This technique involves the deliberate induction of a panic attack in session via overbreathing (Beck & Greenberg, 1988; Salkovskis & Clark, 1989). Here, the patient is instructed to breathe deeply and quickly for up to two minutes, while the therapist provides coaching and support (Note: The therapist obtains permission from the patient's primary care physician before undertaking this procedure). In many cases, this exercise precipitates symptoms that mimic panic symptoms. When the breathing trial is over, the therapist asks the patient:

1. What are your thoughts right now?

    This question often elicits the kinds of "hot cognitions" that shed light on the reasons behind the patient's fears.

2. How similar is this experience to an actual panic attack?

    In most cases, patients rate the overbreathing exercise to be highly reminiscent of a full-blown panic attack.

3. What can you conclude about the role of hyperventilation in these panic symptoms?

    Most patients will come to see that overbreathing is a

major physiological factor in the onset and exacerbation of the attacks. Although they may argue that they do not breath in such an exaggerated fashion in everyday life, the therapist can point out that while the real-life process is a bit more prolonged and gradual than in the present exercise, the cumulative result is very similar.

4. How do you feel right now?

Most patients report feeling “recovered” from the effects of this exercise (e.g., breathlessness, dizziness, heart palpitations, nausea) within a minute after normal breathing is restored. This is usually in sharp contrast to their typical experiences with panic, when their catastrophic thinking fuels the attack for a more prolonged period. When the therapist provides distraction in the form of questions, the patients often feel better quite quickly. This serves as an important in vivo learning experience that teaches the patients that they can “turn off” the symptoms by “turning off” the concomitant worries.

5. What does this experience teach you about the degree of control that you have over your panic attacks?

After taking part in a panic induction exercise, patients come to see that their attacks are more under their control than they had realized. They can deliberately induce the attacks via overbreathing, and they can facilitate their diminution by distracting themselves from their catastrophic worries.

Penny responded very well to the panic induction, as well as the concomitant techniques of *distraction* (e.g., focus attention on a task, or a pleasant memory, or an adaptive cognitive response) and *breathing control* (learning to breathe slowly and gradually in response to anxiety and panic, so as to restore the oxygen/carbon dioxide balance in the bloodstream and therefore reduce the symptoms.)

The therapist also helped Penny to deal with her issues of unresolved grief over her mother's death, as well as her guilt and sexual frustration over her inability to end an over-dependent relationship with a man she didn't want to marry, while she was forfeiting a potential relationship with a man that she *did* want to marry.

Penny had never allowed herself to speak or think at any length or depth about her mother's death. She had used the comforting effects of Xanax and her boyfriend to avoid the issue altogether. Now, however, she wanted to terminate her relationship with her boyfriend, but reacted to these desires with extreme guilt, as well as a sense of doom in that she would have to relinquish her "safe" person. Now, Penny reasoned, if things did not work out with Tim, she would be left to deal with her grief, loneliness, and fears on her own.

Much therapeutic work was done in clarifying the patient's goals for her

future. She realized that in order to achieve her life's objectives she would have to: (1) leave her boyfriend, (2) travel more freely, (3) decrease or eliminate her Xanax use, (4) deal with her grief over her mother, and (5) take a chance on a new relationship. Topics that had long been avoided were now being discussed. These issues were very anxiety-arousing for Penny, but she no longer avoided discussing them, as she had learned some powerful tools for coping with the onset of panic attacks.

At this time, she has taken some major steps in changing her life, including: (1) ending her relationship with her boyfriend (resulting in her living alone, a situation with which she has coped beautifully); (2) spending more time with the friends whom she had previously neglected in favor of her boyfriend, (3) taking things very slowly with Tim, so as not to foster dependency once again; (4) significantly cutting back on her overuse of Xanax, to the point where she now uses the medication only on an as-needed basis; and, (5) talking more freely about her mother's death with the therapist and with her closest friends, which makes her feel melancholy, but far less anxious about her own breathing patterns.

OUTCOME STUDIES

There is a growing body of literature that collectively supports the efficacy of the methods that have been outlined in this chapter (e.g., Brown,

Beck, Greenberg, Newman, et al., 1991; Butler, Fennel, Robson, & Gelder, 1991; Clark et al., 1985; Newman, Beck, Beck, Tran, & Brown, 1990; Sanderson & Beck, 1991; Sokol, Beck, Greenberg, Wright, & Berchick, 1989).

The Butler et al. (1991) study demonstrated that patients receiving cognitive-behavioral interventions benefited from treatment in terms of diminished anxieties *as well as decreased dysphoria*, thus suggesting that the approach may be successful in treating patients who meet criteria for both an affective disorder and an anxiety disorder.

Sanderson & Beck's (1991) data stand out in that they indicate the efficacy of cognitive therapy for GAD in a natural population, *including those patients who were diagnosed as having at least one concomitant personality disorder* (although the progress of the personality disordered patients was less pronounced than the progress of the nonpersonality disorder group).

The Newman et al. (1990) findings are striking in that the patients demonstrated marked reductions in panic frequency, general anxiety, and depressed affect across the board at termination and at one-year follow-up, *including those patients who tapered off their anxiolytic medications while in cognitive therapy* (over half of the medicated sample succeeded in becoming medication-free by the end of therapy). The importance of these findings cannot be understated, as anxiety disorder patients who use medications

such as benzodiazepines often have great difficulty with physiological dependence, tolerance effects, and rebound anxiety and panic upon withdrawal (Rickels, Schweizer, Case, & Greenblatt, 1990).

The data of Brown et al. (1991) provide further support for the cognitive model of panic. The Panic Belief Questionnaire (Greenberg, 1989), having been found to be psychometrically sound, discriminated those patients who responded extremely well to cognitive therapy from those whose progress was less complete. Specifically, the patients who benefited the most endorsed fewer dysfunctional beliefs about panic (e.g., "A panic attack can give me a heart attack."). Those patients who were most successful in modifying their beliefs about panic evinced the most significant and complete recovery from the disorder.

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