

Treatment Plans and Interventions for Depression and Anxiety Disorders

SECOND EDITION

Robert L. Leahy, Stephen J. F. Holland, and Lata K. McGinn

“Written by highly experienced clinicians and scholars, this volume (together with the included CD-ROM) has filled a crucial need since its original publication. The second edition provides up-to-date, hands-on recommendations and concrete guidelines for treating the most common anxiety and mood disorders using well-supported cognitive and behavioral strategies.” —Stefan G. Hofmann, PhD, Department of Psychology, Boston University

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for Depression and Anxiety Disorders

SECOND
EDITION

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Treatment Plans and Interventions for Evidence-Based Psychotherapy

Robert L. Leahy, Series Editor

Treatment Plans and Interventions for Depression and Anxiety Disorders

SECOND EDITION



Robert L. Leahy,
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TREATMENT PLANS AND INTERVENTIONS
FOR DEPRESSION AND ANXIETY DISORDERS

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TREATMENT PLANS AND INTERVENTIONS FOR BULIMIA AND BINGE-EATING DISORDER

Rene D. Zweig and Robert L. Leahy

Treatment Plans and Interventions for Depression and Anxiety Disorders

SECOND EDITION

Robert L. Leahy
Stephen J. F. Holland
Lata K. McGinn



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For Helen

—R. L. L.

For Mia

—S. J. F. H.

To my husband, Tom, and my children, Ariana and Emma

—L. K. M.

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TREATMENT PLANS AND INTERVENTIONS
FOR DEPRESSION AND ANXIETY DISORDERS

Introduction

The first edition of *Treatment Plans and Interventions for Depression and Anxiety Disorders* was written with practicing clinicians in mind. Our goal was to provide a hands-on guide to the best research-based cognitive-behavioral treatments for anxiety and depression, and to do so in a form that would allow busy clinicians to adopt these treatments readily in their own practices. The book was well received and has been used worldwide by clinicians interested in implementing the best practices of cognitive-behavioral therapy. Indeed, 2 years after the publication of the first edition, one of us (Robert L. Leahy) was attending the conference of the British Association of Behavioral and Cognitive Psychotherapies when a participant in his workshop told him, “This book has structured my practice. I use it every day.”

This is exactly what we had in mind. We wanted to write a book that would serve as a daily set of tools—forms, treatment plans, examples of dialogues, and lists of techniques and interventions. Our own students and staff over the years have been using *Treatment Plans* in their classes, internships, postdoctoral training, and clinical practices. When we wrote the original book, we asked ourselves, “If I were learning cognitive-behavioral therapy, what would I want from a book?” We decided to write the book we would have wanted.

Cognitive-behavioral treatment protocols now exist for all of the major anxiety disorders and depression. These protocols have been shown in empirical studies to be effective in reducing the symptoms of most patients. Over the last decade, numerous advances have been made in the treatment of depression and anxiety. In this updated, highly revised, and expanded new edition, we provide the reader with brief reviews of the relevant research on etiology, life course, processes of change, models of intervention, and clinical strategies. We also have updated the discussions of medication to reflect advances in the uses and combinations of psychotropics.

Too often, clinicians are not aware of the important and exciting research in the field; instead, they often rely on anecdotes and clinical lore. This is unfortunate, since research and theory help us understand the processes underlying the maintenance and exacerbation of psychological disorders, and this knowledge can help us understand the relevance of techniques and interventions. A case in point is the use of “thought stopping,” which is no longer a recommended treatment for intrusive or unwanted thoughts. However, some clinicians still use this outmoded technique. The research on thought suppression (or emotional suppression) indicates that these self-control strategies actually make things worse. Thus research has informed clinical practice. Similarly, advances in our understanding of the role of experiential avoidance, affect tolerance,

and metacognitive evaluations of thoughts and emotions can inform clinical practice. It is essential for clinicians to understand the theory and know the research behind these processes and models. Otherwise, therapy becomes a simplistic application of uninformed techniques.

Conversely, we believe that researchers can benefit from the insights and experiences of clinicians. Each of us maintains a private practice, seeing patients every week. (In order to preserve their confidentiality, all patients' identities in case examples have been disguised.) Consequently, we understand that all of the best research and theory will fall on deaf ears if clinicians lack the means to make use of it. Thus we have included in each treatment plan chapter a discussion translating clinical research into specific interventions, as well as specific guidelines for using these interventions with clients. We have also included descriptions of problems that may arise. These impediments to treatment may not be directly obvious from the research models that inform the treatment, but practicing clinicians recognize the real problems in the use of cognitive-behavioral therapy in everyday practice. Therefore, we have tried to provide some examples of the art of therapy—or, perhaps more modestly, the *experience* of therapy.

The results are treatment packages for the major anxiety disorders and for depression. Each package includes a description of the disorder; instructions for assessing patients; assessment forms; detailed descriptions of the therapeutic interventions used to treat the disorder; a session-by-session treatment plan; sample symptoms; goals and interventions to be used in writing reports for managed care companies; and information and homework forms that can be given to patients. Therapy works well when therapists approach each session with some idea of what to do, and when they can provide patients with handy forms to use both in sessions and between sessions (for self-help homework). We have expanded the number and detail level of many forms in this edition, so that clinicians can give their patients materials with specific guidelines for understanding the habitual negative patterns of thinking and behavior, as well as specific self-help forms to facilitate changing these patterns.

We have tried to make this book useful for clinicians of various theoretical backgrounds and levels of experience. For therapists already trained in cognitive and behavioral approaches, the book can offer a handy reference to the most recent treatments for specific disorders, as well as providing a variety of forms that can be used with patients. For therapists trained in other orientations, the book can provide an introduction to the kinds of short-term treatments now expected by many patients and third-party payers. It is our belief that the treatment techniques described in the book need not be incompatible with other theoretical orientations. Finally, graduate students may find in this book a useful introduction to cognitive-behavioral therapies.

Chapter 1 introduces some of the basic assumptions of cognitive-behavioral therapy and offers suggestions for obtaining treatment authorization from managed care companies. Following that discussion are chapters for each of the following disorders: depression; panic disorder and agoraphobia; generalized anxiety disorder; social anxiety (social phobia); posttraumatic stress disorder; specific phobia; and obsessive-compulsive disorder. We have also included two chapters that cover basic principles and techniques in behavior therapy and cognitive therapy.

The CD-ROM that accompanies the book is designed to provide quick and convenient access to key elements of the treatment packages—including session-by-session guidelines; lists of interventions for each disorder; and sample symptoms, goals, and interventions for use in writing treatment reports. The CD also allows users to print the handouts and assessment forms for use with their patients, and it includes listings of behavior and cognitive therapy techniques

and of common psychotropic medications. Clinicians may wish to consult the most up-to-date information on the newest medications when they become available; updated information on a wide range of medications can be found at two websites (www.nlm.nih.gov/medlineplus/druginformation.html and www.pdrhealth.com/home/home.aspx).

THE TREATMENT PACKAGE APPROACH: ADVANTAGES AND CAUTIONS

Using structured, research-based treatment packages has a number of advantages. The packages are empirically based, so clinicians can know they are offering treatment that is likely to work. In addition, the gains made by patients using these treatments have been found to be durable. For some disorders, the evidence suggests that patients actually continue to improve after treatment has terminated.

The packages are practical: Treatments are laid out step by step. They are also short-term: Dramatic changes in symptoms can be achieved in a relatively brief period. They are compatible with managed care and with the resources available to many patients. In addition, treatment is specific for each disorder, while drawing on a limited number of basic techniques. Patients with multiple Axis I diagnoses may be served by combining elements from each of the appropriate treatment packages.

Despite all these advantages of using these treatment packages, some cautions must be noted. First, these treatments cannot be handled like cookie cutters. For most patients, following the steps of the treatment plan will yield good results. Other patients will present problems that hinder treatment, ranging from life crises to characterologically based resistance. In each case, the therapist will need to use clinical judgment to adapt the package to the needs of the patient, while staying mindful of the techniques that are essential to successful treatment of the specific disorder. Second, treatment plans should include case conceptualizations that take into account the developmental origins of problems, possible genetic links, evolutionary adaptiveness (for many anxiety disorders), underlying assumptions, personal schemas, emotion regulation strategies, safety behaviors, interpersonal context, cultural factors, automatic thoughts, behavioral excesses and deficits, skills, problem-solving strategies, implicit theories of emotion and thinking, and other factors. Some of the treatment plans review some of these factors, but a clinician may need to develop a case conceptualization prior to implementing treatment. Indeed, this case conceptualization may help anticipate where roadblocks in treatment will arise.

One last caution: These treatments can appear simple, and, conceptually, they are. However, applying them to real patients is a skill that requires time to master. Clinicians who have not had training and experience in cognitive-behavioral therapy should seek consultation when first attempting to use these treatment packages. An advantage of working with a group of professional colleagues is that clinical training need never end. We highly recommend this approach for continued professional development. Training does not end when a degree or license is conferred.

The techniques presented in this book are essential tools for any therapist. We have sought to present them in a form that will be helpful to busy clinicians struggling with the demands of outpatient practice in a managed care world. It is our belief that these treatment packages,

skillfully applied, will provide effective treatment for most patients with depression and anxiety disorders. However, the packages must be used with sensitivity and good clinical judgment.

Writing this book has been a rewarding experience. The process of preparing it has helped us to provide more effective treatment to our own patients. Moreover, we continue to realize that our patients teach us and that our students keep us honest. This has been a useful personal and professional experience for each of us. We hope that others find it useful as well.

Treatment in a Changing Health Care Environment

The primary purpose of this book is to help mental health professionals in typical outpatient settings provide the best empirically supported treatments for the major anxiety disorders and depression. We wrote the first edition of this book during the height of the managed care movement. It was a time of anxiety for many clinicians, as they found themselves for the first time having to seek approval for treatment from their patients' insurance companies. A secondary goal of the first edition was to help therapists navigate the managed care system by providing guidance in how to write treatments plans that managed care reviewers would approve.

Much has changed in the health care environment since that time. Over the last decade, many managed care companies have become less stringent in their requirements for clinical review and preapproval (Horgan, Garnick, Merrick, & Hodgkin, 2007). Recent developments, however, may reverse that trend. The Mental Health Parity and Addiction Equity Act, passed in 2008, requires insurers to provide the same coverage for mental disorders that they do for other medical conditions. This includes provisions that the degree of clinical review required be the same. However, as regulations related to the 2008 act have gone into effect, there is already indication that some insurers are again tightening their requirements for managed care review (Clemens, 2010). In addition, the future effects of health care reforms enacted under the Affordable Care Act of 2010 are, at this writing, uncertain.

Whatever further changes occur, it is clear that there will continue to be competing pressures to provide high-quality care while containing costs. Across all branches of the health care field, the use of empirically supported best practices is seen as crucial in attempting to meet these goals. Therapists can expect to have to continue justifying the treatments they provide to patients.

One of the advantages of using the cognitive-behavioral treatments described in this book is that, because they have been shown in studies using real patients to provide relief for depression and anxiety disorders, therapists can know and represent to insurers that they are providing high-quality care to their patients. In addition, because these treatments are designed to be relatively short-term, there are likely to be viewed favorably by managed care companies and other entities in the health care system whose role it is to control costs.

The managed care industry has adopted several of the basic assumptions that underlie

cognitive-behavioral approaches to mental disorders. Understanding these assumptions (even if you don't necessarily agree with them) will help both in dealing with managed care reviewers and in applying these treatments to patients.

Three key assumptions shared by managed care and cognitive-behavioral approaches are as follows:

1. **Symptoms are the problem.** Rather than viewing symptoms as signs of “deeper” issues that must become the target of treatment, cognitive-behavioral approaches focus on patients' symptoms as the problems to be solved. Therefore, the disorders to be treated are defined by patients' symptoms and the impairments in daily functioning they cause.
2. **Symptom relief is the goal.** Because symptoms are viewed as the problem, the goal of therapy is the reduction or elimination of those symptoms. In order to show that treatment has been effective, there must be some means of measuring changes in symptom severity and improvements in functioning.
3. **Treatment interventions must have scientific evidence of effectiveness in reducing symptoms.** Cognitive-behavioral researchers develop treatment techniques based on their theoretical understanding of the disorder being addressed. However, these techniques are not considered valid until they have been shown in clinical studies to reduce symptoms effectively. Often researchers will compare the effectiveness of different cognitive-behavioral techniques to determine which technique or combination of techniques is most effective.

In summary, cognitive-behavioral researchers (and most managed care reviewers) assume that patients' symptoms dictate the goals, which in turn dictate the empirically validated treatment techniques to be used.

The assumptions outlined above influence who gets approved for treatment by managed care companies (patients who meet criteria for a mental disorder; see “Medical Necessity,” below), what types and lengths of treatment are approved (brief, empirically supported treatments such as cognitive-behavioral therapy are preferred), and even what questions are asked on treatment reports (evidence of symptoms and impairments consistent with a diagnosis; what techniques that will be used to target specific symptoms; measurable goals and outcomes). The rest of this chapter provides suggestions on how to use an understanding of these assumptions to increase the likelihood of getting treatment approved.

Chapters 2–8 of this book describe cognitive-behavioral treatment packages for specific disorders. These chapters follow the basic logic of symptoms leading to goals leading to interventions; as such, they guide therapists through the process of working with patients, from assessment to theoretical formulation to implementation of treatment. Topics covered in each chapter include the following:

- A description of the disorder and related features
- A cognitive-behavioral conceptualization of the disorder
- A brief review of the outcome literature supporting the use of specific interventions
- Detailed instructions for assessing and treating patients, including patient handouts and homework forms

- Hints for troubleshooting common problems in therapy
- Sample symptoms, goals, and interventions to be used in writing treatment reports
- A detailed plan of treatment options
- A case example

GETTING APPROVAL FOR TREATMENTS: GENERAL CRITERIA

Getting approval from managed care companies—particularly for the kinds of treatments described in this book—need not be a nerve-racking experience, provided you understand what reviewers are looking for. Although you may still encounter restrictions on treatment, following the recommendations in this chapter should increase the likelihood of getting a favorable response.

Virtually all companies require that two basic criteria be met before a treatment plan will be approved: (1) medical necessity and (2) appropriate treatment. Let us look more closely at what these entail.

Medical Necessity

“Medical necessity” is determined by the patient’s symptoms. In order for treatment to be considered medically necessary, the patient must meet criteria for a mental disorder as defined by the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (at this writing, DSM-IV-TR; American Psychiatric Association, 2000), which include evidence of distress or impairment in social, occupational, or educational functioning. Reviewers check whether the specific symptoms and mental status described on a treatment report are consistent with the diagnosis shown, and whether there is evidence of sufficient impairment to justify treatment.

Appropriate Treatment

“Appropriate treatment” involves both the goals of treatment and the interventions used to reach those goals. Goals must relate to the reduction of the patient’s symptoms or to amelioration of impairments, and they should be specified in terms that can be measured.

When evaluating interventions, reviewers typically consider two questions: (1) Does the level of care match the severity of the patient’s symptoms? (2) Is the treatment approach appropriate for the symptoms? “Level of care” has to do with the intensity of treatment—that is, whether the patient should be hospitalized, placed in a partial hospitalization or day treatment program, or seen in an outpatient setting. If the patient is seen on an outpatient basis, level of care also involves how often the patient is seen. Many companies will not approve sessions more than once a week unless the patient is clearly in crisis and/or unable to carry out routine daily functions, such as work or child care. Meeting more than twice a week is unlikely to be approved unless the patient is actively suicidal or homicidal and an argument can be made that intense outpatient treatment will prevent hospitalization.

The treatment approach must also be judged appropriate for the patient’s symptoms. For example, a treatment plan for a patient with a bipolar disorder that includes intensive psycho-

therapy but no medication is likely to be questioned. The treatment techniques described in this book, because they are empirically validated and specific to each disorder, will almost always be considered appropriate treatment.

THE INITIAL TREATMENT REPORT

Each managed care company has its own form for filing treatment reports. However, the key elements are the same for all reports and cover the three key areas discussed above: symptoms, goals, and interventions. Symptoms are assessed in most treatment reports by questions related to the patient's DSM diagnosis, presenting problem, mental status, and level of impairment. Many reports request specific goals. Interventions are assessed by questions related to frequency of visits, type of therapy provided, and medication. Some reports request the specific types of interventions to be used for each goal listed. Outlined below are guidelines for completing the sections found in a typical treatment report.

Please note that before completing any managed care reports, you should familiarize yourself with the laws governing patient records in your state or jurisdiction. Some states have laws that are more restrictive than the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). When state law is more restrictive, it prevails, and you may not be able to release all of the information requested on the report or described below.

Symptoms

Diagnosis

Be sure that the diagnosis is accurate and complete. Underdiagnosing a patient may result in fewer sessions' being approved or in questions' being raised when additional sessions are requested. However, you also cannot give a patient a more severe diagnosis for which he or she does not meet criteria. Giving a patient an inaccurate diagnosis in order to obtain services is unethical and constitutes insurance fraud.

List all DSM disorders for which the patient meets criteria. The presence of comorbid conditions may complicate treatment, and the reviewer should be aware of this from the start. Be aware that some companies will not cover treatment of certain disorders—for example, sexual dysfunctions or personality disorders. Some companies require that any patient with a primary or secondary diagnosis of substance abuse or dependence be evaluated and treated by a clinician with special certification in substance abuse treatment (e.g., a certified alcoholism counselor). In general, "V-code" diagnoses will not be covered. Marital/couple therapy is also not covered by most companies. However, if one of the partners meets criteria for an Axis I mental disorder, some companies will cover conjoint therapy with the spouse participating, as long as the treatment goals relate to the symptoms of the partner who is the identified patient.

Presenting Problem

The section on the presenting problem should cover three areas: (1) precipitating events or stressors, (2) specific symptoms, and (3) impairments in life functioning.

1. **Precipitating events.** Briefly list the events that have resulted in the patient's seeking treatment at this time. Protect the patient's confidentiality by giving only enough detail to indicate the level of stress. Any known history of physical or sexual abuse or other trauma should be noted here.
2. **Specific symptoms.** This is not a place for creative writing. Get out the DSM, or the tables listing sample symptoms in this book, and simply list the criteria that the patient meets for each disorder. Remember, reviewers are going to check off these symptoms to make sure the patient meets the diagnosis. You might as well make their job easy.
3. **Impairments.** Indicate how the specific symptoms interfere with the patient's functioning. Be sure to note any impairments in work, school, parenting, marital/couple, or social functioning.

Mental Status

Some treatment reports provide a checkoff list for evaluating mental status. Others request a brief written mental status report. The key elements of a mental status report are as follows (see also Sadock, Sadock, & Ruiz, 2009):

- **Appearance.** Describe the patient and note anything unusual in his or her appearance (e.g., marked obesity, poor grooming, unusual clothing or makeup).
- **Attitude.** Describe the patient's attitude toward you as the therapist (e.g., cooperative, guarded, belligerent, seductive, etc.).
- **Consciousness.** Is the patient alert, or is there some impairment in consciousness (e.g., drowsy, clouded, unconscious)?
- **Orientation.** Is the patient aware of (1) person (who he or she is, who other people present are); (2) place (where he or she is); and (3) time (date, day of week)? If the patient is oriented in all three areas, this is often abbreviated as "oriented times three" or "oriented × 3."
- **Memory.** Note any deficit in immediate, short-term, or long-term memory.
- **Psychomotor activity.** Describe any abnormalities in the patient's movement (e.g., agitation, retardation, nervous tics, etc.).
- **Speech.** Note anything unusual in the rate, tone, or volume of speech (e.g., slow and halting, rapid, pressured, barely audible, high-pitched).
- **Mood.** Briefly describe the patient's mood, either as the patient reports it or by observation (e.g., anxious, depressed, calm, angry).
- **Affect.** "Affect" refers to the manner in which the patient's mood is expressed. Normal affective response is described as "full range," indicating that the patient is able to express a variety of emotions. Common variations in affect include "restricted" (ability to express only one or a few emotions); "blunted" (emotions are present, but their expression is muted); "flat" (lack of emotion); "labile" (rapid swings between emotions); and "inappropriate" (emotion does not match the situation or content of what is being discussed).
- **Perception.** Indicate any abnormalities of perception, such as visual or auditory hallucinations, depersonalization, or derealization.
- **Thought content.** Indicate any abnormalities of expressed ideas, such as delusions, persecutory ideation, or ideas of reference. Also note any suicidal or homicidal ideation.

- **Thought process.** The thinking of patients who can stay on topic is described as “goal-directed.” Variations in thought include “circumstantial thought” (excessive detail), “tangential thought” (going off topic), “loose associations” (jumping from one topic to another with no apparent logic), and “perseveration” (returning to the same topic repeatedly).
- **Judgment.** “Judgment” refers to the patient’s ability to make sound decisions in social situations and to understand the likely consequences of behavior. Judgment is typically described as “poor,” “fair,” or “good.”
- **Insight.** “Insight” refers to the degree to which the patient is aware that he or she has a problem or is ill.

The mental status report should support the diagnosis. For example, a patient who is depressed may be expected to have depressed mood. In addition, such a patient may or may not have psychomotor retardation, halting speech, constricted affect, and suicidal ideation.

Goals

Whenever possible, treatment goals should be stated in terms that are observable and measurable (e.g., specific countable behaviors, scores on assessment instruments, client reports). Goals may cover the following areas:

1. **Completion of tasks required as part of treatment.** Examples: (a) completing exposure to all avoided situations; (b) engaging in one pleasurable/rewarding activity daily; (c) acquiring assertion skills.
2. **Relief of specific symptoms.** Examples: (a) eliminating intrusive memories of trauma; (b) reducing self-critical ideation; (c) reporting anxiety below 2 on a scale from 0 to 10 in business meetings.
3. **Reduced impairment.** Examples: (a) bringing grades up to prior level (A’s and B’s); (b) resuming all household activities; (c) beginning to date; (d) finding appropriate employment.
4. **Cognitive change.** Examples: (a) stating less than a 10% belief in assumption of need for perfection; (b) modifying schema of worthlessness.
5. **End-state goals.** These are goals that will indicate that treatment has been successfully completed. Examples: (a) eliminating all depressive symptoms (Beck Depression Inventory–II score under 10 for 1 month); (b) engaging in all previously avoided activities; (c) eliminating panic attacks.

Interventions

Treatment Frequency and Type; Specific Techniques

Some treatment forms request only basic information about the treatment: frequency and length of sessions, type of therapy (e.g., cognitive-behavioral, psychodynamic, systems), and format (individual, conjoint, family). Others request more specific information about the types of interventions to be used to meet each goal. In such cases, the specific techniques described in the treatment packages in this book can be listed. Sample goals and corresponding interventions can be found in Chapters 2–8, as well as on the CD-ROM.

Medication

Most treatment forms request information regarding what medication, if any, the patient is receiving. If the patient is not taking medication, it can be helpful to indicate that the patient has been educated regarding the advantages and disadvantages of medication (which should always be done). It may also be helpful to give a rationale for why medication has not been chosen as an option. Symptoms in the mild to moderate range, lack of suicidal or homicidal ideation, and good initial response to psychotherapy are generally acceptable reasons to proceed without medication. However, expect that if the patient does not show improvement, reviewers may request that the patient receive a medication evaluation.

Sample Treatment Report

Figure 1.1 shows a sample treatment report.

REQUESTS FOR ADDITIONAL SESSIONS

Few managed care companies will authorize more than 10–12 sessions on the basis of an initial treatment report. This means that you will often need to file subsequent treatment reports requesting additional sessions. In evaluating such a report, reviewers generally look for two things: (1) evidence that the patient is making progress, and (2) the continued presence of symptomatology that makes additional treatment necessary. If the patient has not progressed, reviewers are likely to question the efficacy of the treatment and may suggest alternative treatment or disallow further sessions. If the patient no longer has symptoms, the reviewers will obviously consider treatment no longer medically necessary. Outlined below are things to consider when you are writing requests for additional sessions.

Progress Made in Treatment

Most treatment forms ask for some accounting of the progress the patient has made since the prior report. Progress should be described in relation to the symptoms (including impairments), goals, and interventions included on the initial treatment report (see below for specific suggestions regarding each of these). Remember, if you cannot document that your patient is making some progress, you may have trouble getting additional sessions authorized.

You should also note any conditions that have interfered with progress in treatment. If the patient has been subjected to a new stressor that has exacerbated his or her condition, this should be noted. For example, a depressed patient who has been laid off from his or her job since the last treatment report may reasonably be expected to have a temporary increase in symptoms. Most managed care companies will make allowances for such occurrences. In addition, if the patient is resistant to treatment in some way, this should be noted, along with the steps that are being taken to address the resistance.

Changes in Symptoms

Diagnosis

If any additional diagnoses have become apparent during your work with the patient, be sure to add the appropriate diagnostic codes. Comorbid conditions may slow progress, and the reviewer

Symptoms

Diagnosis

Axis I	300.23 Social phobia (social anxiety disorder) 296.21 Major depressive disorder, single episode, mild
Axis II	None
Axis III	None
Axis IV	New job
Axis V	Current: 55 Highest: 80

Presenting Problem

Patient recently took a new job that requires public speaking. Patient has long-standing fear of public speaking and has avoided it in the past. He has responded by becoming very anxious and depressed in last month. Specific symptoms: Intense fear of anticipated speech, avoidance of public speaking, stomach cramps, muscle tension, insomnia, fatigue, impaired concentration, depressed and anxious mood, loss of appetite, weight loss, and feelings of worthlessness and guilt. These symptoms interfere with work functioning.

Mental Status

Patient is a 26-year-old white male. Appears stated age. Well groomed. Cooperative. Alert and oriented × 3. Memory intact. Movement normal. Speech soft. Mood depressed and anxious. Affect constricted. Thoughts goal-directed. No psychotic symptoms. Denies suicidal or homicidal ideation. Insight and judgment good.

Goals and Interventions

Treatment goals

Reducing physical anxiety symptoms
 Reducing fear of public speaking
 Engaging in three public speaking activities
 Completing speaking assignment with anxiety level of 2 or less on a scale of 1–10
 Eliminating ideation of worthlessness and guilt
 Engaging in one rewarding non-work-related activity/day
 Stating reduced belief (10%) in assumption of need for perfection
 Returning to previous level of work functioning
 Eliminating anxiety and depressive symptoms (BDI-II score 10; Millon Clinical Multiaxial Inventory score in normal range).

Interventions

Exposure
 Cognitive restructuring, exposure
 Public speaking group
 All of the above
 Cognitive restructuring
 Activity scheduling
 Developmental analysis, cognitive restructuring
 Cognitive restructuring, exposure
 All of the above

Medication

None. Patient has been educated regarding costs and benefits of medication. Does not wish to consider medication at this time. Symptoms are mild and of brief duration.

Frequency of Sessions/Expected Duration of Treatment

One 45-minute session per week; 12–16 sessions.

FIGURE 1.1. Sample treatment report (BDI-II: Beck Depression Inventory–II).

should be made aware of this fact. Conversely, if the patient no longer meets criteria for one of the original diagnoses, or if the level of severity has changed (e.g., on a diagnosis of major depression), this should be noted. Also note any change in functional impairment.

Presenting Problem

List all specific symptoms and impairments that the patient continues to have. If some symptoms or impairments remain but have lessened in intensity or frequency, note that. As before, these should correspond to DSM criteria for the patient's diagnoses. Even if some symptoms have remitted, additional treatment is likely to be approved if other symptoms are still present and there continues to be some impairment in functioning. Be sure to list symptoms and impairments for any additional diagnoses that are included.

Mental Status

Note any changes in mental status. As before, the mental status report should support the current diagnosis or diagnoses and the progress made in treatment. For example, if a depressed patient no longer has suicidal thinking, psychomotor retardation, or constricted affect, these changes should all be reflected in the mental status.

Changes in Goals

Note which goals from the original treatment report have been fully or partially met. Add goals related to any new diagnoses, specific symptoms or impairments, or life stressors. If it was not included in the first treatment report, it may be advisable to add the acquisition of relapse prevention skills as a goal.

Changes in Interventions

Treatment Frequency and Type; Specific Techniques

Note any changes that have been made in treatment frequency or type, as well as in specific treatment techniques employed. Be sure to give the rationale for these changes and to describe the patient's response to them.

Medication

Note any changes in the patient's medication or dosage, along with the rationale for the change and the patient's response.

Justification for Continued Treatment

Some forms request reasons for continued treatment. The explanation should be brief and summarize what has been included on the rest of the form. Progress that the patient has made should

be noted, along with any new stressors, followed by a description of remaining symptoms and impairments. If a change in the patient's condition or life circumstances has necessitated new treatment goals, these should be highlighted. The need for continued treatment should be based on the continued presence of symptoms and on the need to prevent relapse.

TELEPHONE APPROVALS

Some insurance plans require that approval be obtained by phone rather than by written treatment report. For some clinicians, this can be especially anxiety-provoking (after all, rejection in person is harder to take than rejection by letter). However, the same principles apply in obtaining approvals via telephone as in submitting written reports. Reviewers want evidence that the treatment is medically necessary and appropriate, and, on subsequent approvals, that the patient is making reasonable progress while continuing to require treatment.

Two key principles to keep in mind when talking to reviewers by phone are these: (1) Be courteous; and (2) be professional. Taking an adversarial stance is not likely to help. What will help is being prepared. Before calling, you should have thought through (and possibly written out) all of the information that would be required on a written treatment report. This will enable you to answer the reviewer's questions clearly and succinctly. It has been our experience that describing a cognitive-behavioral treatment plan with specific techniques and an expectable short-term course makes approval more likely.

REQUESTS FOR EXTENDED TREATMENT

Managed care companies vary in the degree to which they are willing to approve sessions beyond a typical course of 16–20 sessions. For those companies that will consider longer treatment, we have found that the following indications make approval more likely:

1. More severe symptoms and impairments.
2. Suicidal or homicidal ideation.
3. A life crisis that has arisen during the course of treatment.
4. Clearly specified goals for continued treatment.
5. Evidence of progress between treatment reports.
6. Utilization of adjunctive treatments, such as medication or support groups.

This information must, of course, be accurate and must be supported by session notes.

Session Notes

Some managed care companies will request copies of session notes. Depending on state law, insurers may have the right to review a patient's complete record. This raises a dilemma for clinicians, who, in addition to needing to document their treatment adequately for clinical purposes, must be concerned with protecting patients' privacy while at the same time being mindful of the

need to justify treatment to managed care reviewers. In trying to strike the best balance of too little versus too much information, it can be helpful to consider exactly what reviewers will be looking for in session notes. In short, for the purposes of managed care approval, treatment notes should include data that support the diagnosis and treatment plan consistent with the guidelines outlined above. Therefore, each session note should include a description of the patient's status, including the nature and severity of symptoms and distress that day, and any change in the presence or severity of symptoms; a description of interventions used in the session; and any progress made on patient goals.

Depression

DESCRIPTION AND DIAGNOSIS

Depression is one of the most devastating of all psychiatric disorders. It is the leading cause of disability in the United States and the world for people between ages 15 and 44 (Kessler, Chiu, Demler, & Walters, 2005; World Health Organization, 2004). Of all diseases, depression is only exceeded by perinatal conditions, lower respiratory infections, ischemic heart disease, cerebrovascular disease, HIV/AIDS, and diarrheal diseases in terms of disability during a person's lifetime (World Health Organization, 2004). This is partly because of the chronicity and recurrence of depression. Tragically, 76% of people with moderate depression and 61% of people with severe depression never get help (Pratt & Brody, 2008).

In addition, 80% of depressed people are impaired in their daily functioning, particularly at work; they lose (on average) 5.6 hours of productive work per week (Pratt & Brody, 2008; Stewart, Ricci, Chee, Hahn, & Morganstein, 2003). The cost of depression in the United States is \$83 billion per year (Greenberg et al., 2003). Half of the loss of work productivity is due to absenteeism and short-term disability (Kessler et al., 1999). In any 30-day period, depressed workers have 1.5–3.2 more short-term disability days than other workers do (Druss, Schlesinger, & Allen, 2001). People with symptoms of depression are 2.17 times more likely than others to take sick days (Adler et al., 2006; Greener & Guest, 2007). And even when they are at work, their productivity is impaired by inability to concentrate, low efficiency, and inability to organize work. Unsurprisingly, depressed people are seven times more likely than nondepressed people to be unemployed (Lerner et al., 2004). Furthermore, absenteeism and work performance are directly related to how severe the depression is: The more severe the depression, the worse the outcome. In one study, the costs of absenteeism were directly related to taking versus not taking antidepressant medication (Birnbaum et al., 2010; Dewa, Hoch, Lin, Paterson, & Goering, 2003); those who took the prescribed medication had a 20% lower cost of absenteeism.

In one of the largest studies of its nature, children were followed for 40 years to determine the effects of illness and psychological problems on their life chances (Smith & Smith, 2010). Children or adults who suffered from depression earlier were found to have lower incomes, lower educational attainment, and fewer days working each year. In fact, their psychological problems led to 7 fewer weeks of work per year, a loss of 20% in potential income, and a lifetime loss for each family that had a depressed family member of \$300,000 (Smith & Smith, 2010). People who

suffered from depression also ended up with 0.6. year less schooling, an 11% decrease in the probability of getting married, and a loss (on average) of \$10,400 per year in income by age 50 (Smith & Smith, 2010). In fact, there was a 35% decrease in lifetime income due to depression. The cost for the total group over a person's lifetime was estimated at \$2.1 trillion (Smith & Smith, 2010).

In this chapter, we identify the characteristics of major depression and describe a treatment package for it. Although depression may be devastating for some, it is highly treatable; combining treatments, and the possibilities of switching medication classes and including cognitive-behavioral therapy in particular, can substantially increase the likelihood of recovery. For the treatment of bipolar disorders, we refer the reader to other publications (Basco, 2000; Miklowitz, 2008; Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002). Although the interventions that are useful for unipolar depression are also useful for bipolar depression (Miklowitz et al., 2007), a treatment package for bipolar depression needs to include the use of mood-stabilizing medication, as well as socialization of the patient (and family) into the biomedical model of bipolar disorders.

The differential diagnosis of bipolar and unipolar depression is essential to competent treatment. Hypomania or mania, with the accompanying sense of grandiosity, sexual excitement, and risk taking, is seldom a cause for self-referral in clinical practice. Indeed, a patient with a bipolar disorder may initially present with depression (or, in a mixed state, with agitation and depression), which often obscures the diagnosis. This is why all patients presenting with depression should also be evaluated for a history of hypomania or mania. Obtaining such a history will sometimes require the corroborating input of family members, who may be better historians of the patient's past behavior than the patient is. We discuss this differential diagnosis in more detail shortly, but it is important to bear in mind the differences in medication treatment entailed in these disorders. In the remainder of this chapter, we focus on the treatment of unipolar depression.

Symptoms

Patients suffering from major depressive disorder (MDD) must first be determined to be experiencing a major depressive episode. The two key symptoms of a major depressive episode are depressed mood or sadness, and greatly lessened pleasure or interest in most activities. Other symptoms may include insomnia or hypersomnia, significant weight loss or gain, feelings of guilt or worthlessness, fatigue, impaired concentration, indecision, psychomotor retardation or agitation, and recurrent thoughts of death or suicide. A patient must be experiencing at least five of these symptoms, one of which *must* be either depressed mood or a loss of pleasure or interest in regular activities. The symptoms must be present nearly every day for 2 weeks and must hamper the patient's functioning, as evidenced by difficulty at work, in relationships, or in general enjoyment of life. A major depressive episode is also not considered to be present if the symptoms can be attributed to a general medical condition or to a substance (e.g., alcohol or drugs).

Besides the presence of a major depressive episode, a formal diagnosis of MDD requires several "rule-outs." There must never have been a hypomanic, manic, or mixed episode, and the symptoms must also be distinguished from those of several psychotic disorders. Once MDD has been diagnosed, it can be classified in several ways to indicate its clinical status and course.

For a detailed description of the current diagnostic criteria for MDD, refer to DSM-IV-TR (American Psychiatric Association, 2000, pp. 349–356 and 369–376).

Prevalence and Life Course

The lifetime prevalence of MDD is estimated at 16.9% (Kessler et al., 2003). A 12-year prospective study indicated that for any given year of assessment the prevalence rates were 4–5%, but that over the whole 12-year period rates were 24.2% of women and 14.2% of men, which were twice as high as previous estimates (Patten, 2009). MDD may be a chronic diathesis for many: 80% of individuals who have one major depressive episode will have another episode—and, in fact, such a person will have an average of seven episodes across his or her lifetime (Kessler et al., 2003).

Relationship conflict is associated with increased risk for MDD: Women experiencing conflict in their marriages are 25 times more likely to become depressed (Hammen, 2004; Weissman, 1987). In addition, approximately 8–12% of women experience postpartum depression (Heneghan, Silver, Bauman, & Stein, 2000). The greatest risk for MDD occurs for individuals between 18 and 44 years of age, and the lowest risk is for those age 60 and over. Over a 6-month period, 50% of children and adolescents and 20% of adults report *some* symptoms of depression (Kessler, Avenevoli, & Ries Merikangas, 2001). The age cohorts born after World War II are at greater risk for MDD as well as other disorders (e.g., substance abuse).

The lifetime prevalence rates of MDD for females are twice those of males. Rates for attempted suicide are higher for females, but completed attempts are higher for males, who prefer more lethal methods of suicide (e.g., guns and hanging as compared to medication overdose or wrist cutting). The highest suicide risk is for the separated, divorced, and recently widowed, and the lowest risk is for single and married individuals. Living alone and urban environment confer greater risk than cohabiting or rural residence. Those individuals whose families show a history of suicide, alcoholism, and depression, or who perceive that they do not have good social support, are at greater risk. Greater risk is also found for individuals with a personal history of self-harm or injury, with less social connectedness, and with perceptions of themselves as a burden to others (Joiner, Van Orden, Witte, & Rudd, 2009).

Genetic/Biological Factors

Estimates of the heritability for depression range between 37% and 66%, with early-onset depression marked by greater heritability (Sullivan, Neale, & Kendler, 2000). The concordance for monozygotic twins for MDD is about 50%, whereas the concordance for dizygotic twins is about 35% (Kaeler, Moul, & Farmer, 1995). Kendler, Neale, Kessler, Heath, and Eaves (1992) estimate heritability for MDD at 39%, indicating some biological predisposition, but reflecting that other factors (such as life events, developmental history, and coping skills) are more prominent. Early-onset depression is associated with a family history of depression, implicating genetic factors in early onset (Nierenberg et al., 2007). Genetics interacts with socialization, so that individuals at higher genetic risk are more likely to become depressed after experiencing stressful events during childhood; this interaction supports the stress–diathesis model of depression (Kendler, Kessler, et al., 1995; Kendler, Walters, et al., 1995).

Socialization

Depression is higher among individuals whose parents divorced, separated, or died during the individuals' childhood (Blatt & Homann, 1992). Although loss of a parent is associated with

greater risk for later depression, the way in which the loss was handled may be more important: Decreased warmth, care, and attention following the loss are associated with increased risk of depression (Harris, Brown, & Bifulco, 1986). Sexual abuse—or any abuse—is also associated with increased risk for depression (Bifulco, Brown, & Adler, 1991; Ingram, 2003).

There is evidence that a combination of parental cognitive styles (negative attributional style), negative inferential feedback, and emotional maltreatment confer greater risk for depression later in life. All these factors mediate the effects of stressful life events in leading to depression (Alloy et al., 2004; Alloy, Abramson, Smith, Gibb, & Neeren, 2006; Gibb, Abramson, & Alloy, 2004; Gibb et al., 2001; Panzarella, Alloy, & Whitehouse, 2006). In particular, socialization experiences that affect cognitive styles may lead to greater vulnerability to depression.

Coexisting Conditions

MDD has high comorbidity with other disorders, including panic disorder, agoraphobia, social anxiety disorder (social phobia), generalized anxiety disorder, posttraumatic stress disorder, and substance abuse. As indicated, marital conflict (for both males and females) is an excellent predictor of depression; indeed, some clinicians recommend marital/couple therapy as the treatment of choice for patients presenting with depression associated with relationship discord (Beach, Dreifuss, Franklin, Kamen, & Gabriel, 2008). Physical illness, especially in the elderly, is correlated with depression. For individuals with chronic depression or a history of MDD, there is increased risk of Alzheimer's disease, stroke, and poor outcome of HIV disease (Andersen, Lolk, Kragh-Sørensen, Petersen, & Green, 2005; Bos et al., 2008; Leserman, 2003). Elderly people who are depressed are more likely to die earlier (Janzing, Bouwens, Teunisse, Vant' Hof, & Zitman, 1999). Several physical conditions are associated with depression; these may be pharmacological (steroid use, amphetamine/cocaine/alcohol/sedative withdrawal), endocrine (hypothyroidism and hyperthyroidism, diabetes, Cushing's disease), infectious (general paresis, influenza, hepatitis, AIDS), or neurological (multiple sclerosis, Parkinson's disease, head trauma, cerebrovascular disorder). (See Akiskal, 1995, for a more complete list.) In addition, MDD is highly correlated with personality disorders, although the diagnosis of a personality disorder may be uncertain until the depression is alleviated.

Differential Diagnosis

In addition to the diagnosis of MDD, there are several DSM disorders of related interest. Dysthymic disorder is a milder form of depression, with symptoms for most days over at least a 2-year period. MDD may be superimposed on dysthymia, resulting in a diagnosis of so-called "double depression." Bipolar I disorder refers to the presence of at least one manic episode in the past, and usually also to the presence of one or more depressive episodes. (The past or present existence of a manic episode is necessary for the diagnosis of bipolar I disorder. A manic episode is characterized by grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, irritability, increase in goal-directed activity or psychomotor agitation, and/or excessive engagement in pleasurable but risky behaviors.) Bipolar II disorder is similar to bipolar I disorder, except that a past or present hypomanic episode (a milder form of a manic episode) is required. Finally, cyclothymic disorder consists of frequent (but not severe) episodes

of hypomania and depression. The lifetime prevalence of bipolar (I and II) disorders is 4.4% (Kessler, Berglund, et al., 2005).

Figure 2.1 is a diagnostic flow chart for MDD.

UNDERSTANDING DEPRESSION IN COGNITIVE-BEHAVIORAL TERMS

Behavioral Factors

Behavioral models of depression can be traced to Ferster's (1973) operant model, according to which depression is a consequence of a loss, decrease, or absence of rewards, or the inability to obtain rewards. In behavioral models, depression is understood in terms of the *relationship* between the individual and environment, such that depression is characterized by the difficulty in obtaining reinforcements or by the noncontingency of reinforcement and behavior. According to this view, depression is not something "inside" the person (such as "cognition"), but rather part of the *context* or *relationship* between the person and the environment (Zettle, 2007).

A Model of Behavioral Activation

This conceptualization has been expanded to a model of behavioral activation, which stresses a functional analysis of behavior to determine what maintains or reinforces depressive functioning or behavior. A functional analysis examines the antecedents and consequences of depressive behavior. For example, consider Ted, a patient who sits in front of a television for hours (arguably a depressive-type behavior). What is the antecedent? Perhaps it is thinking of going out and meeting someone, which activates anxious feelings. The passive and isolated behavior of watching television is reinforced by the reduction of anxiety—escape from the immediate anxiety and avoidance of further anxiety (negative reinforcement). Therapy emphasizes activation of more rewarding and predictable patterns of response, increasing the contingency of behavior and reward (Martell, Addis, & Jacobson, 2001).

The behavioral activation model emphasizes predictability and control of outcomes related to behavior. For example, Ted may find that he cannot sufficiently control or predict social outcomes, since he anticipates rejection. Consequently, he turns to the one source of behavior that is controllable—staying at home. The behavioral approach stresses taking a tally of the behaviors that characterize Ted's depression (e.g., passively watching television, complaining, ruminating), examining these behaviors through functional analysis, developing a menu of behaviors that Ted views as rewarding, and setting up behavioral assignments to increase rewarding behaviors. Depression is often the result of passive, repetitious, unrewarding behavior; for example, staying home and watching television removes Ted from opportunities for other rewards. The goal of behavior therapy is gradually to increase the frequency and intensity of rewarding behavior by the use of techniques such as "activity schedules" and "reward menus"—the latter are lists of behaviors that were previously rewarding or could become rewarding in the future (Lewinsohn, Antonuccio, Steinmetz, & Teri, 1984; Lewinsohn, Munoz, Youngren, & Zeiss, 1986). The emphasis is on *acting better before feeling better*.

A related behavioral factor contributing to depression is that behavior that was once rewarding is no longer rewarding. This may be due to greater demands or standards in the environ-

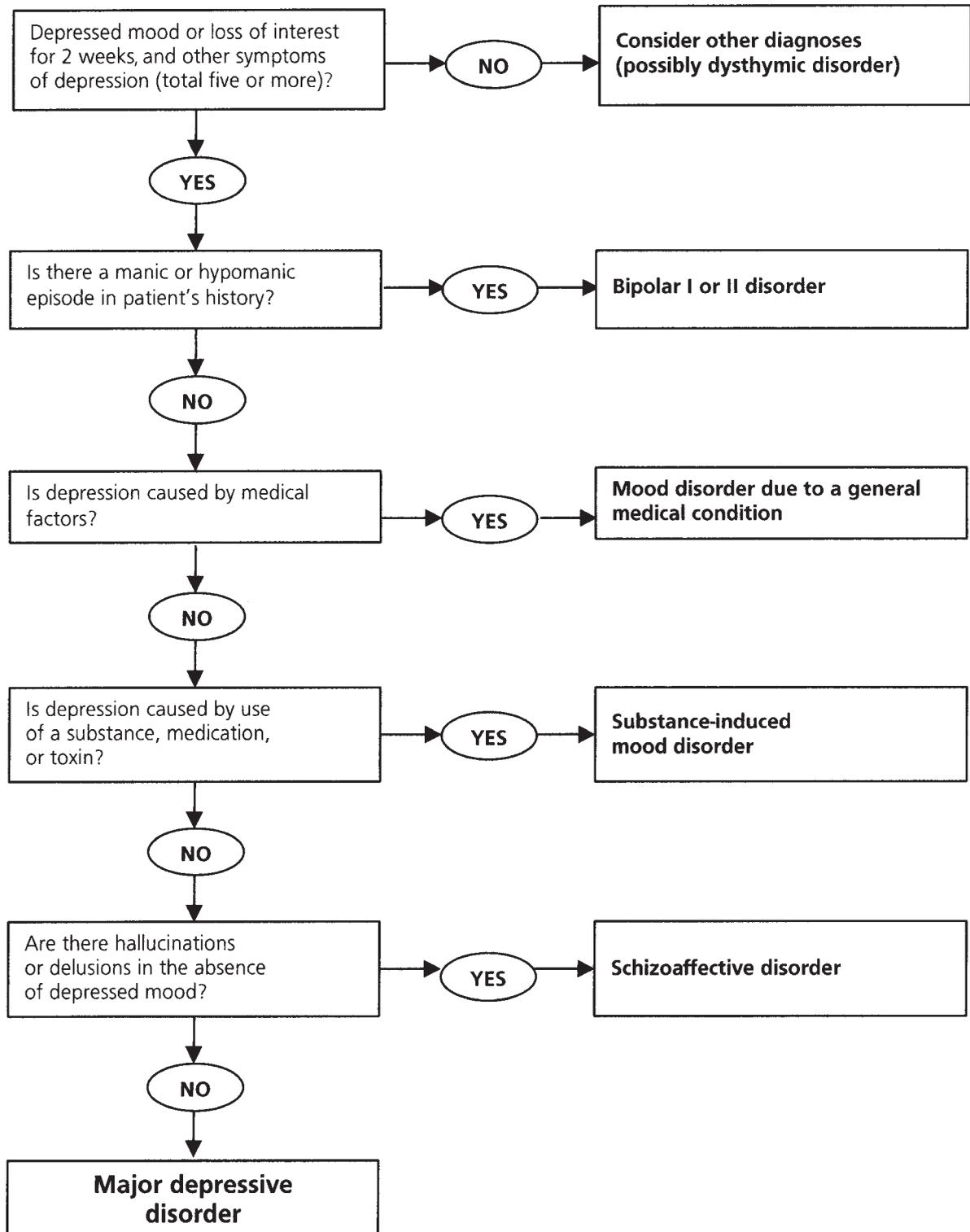


FIGURE 2.1. Diagnostic flow chart for major depression.

ment (i.e., it takes more of the same behavior to get the same level of reward). Consequently, an individual may need to increase the intensity of previously rewarded behavior. Furthermore, if rewarding agents in the environment are no longer available or no longer providing rewards, a therapist may need to assist a patient in identifying alternative sources of rewards. Moreover, depression may be the result of a reduction of positive behavior, lack of self-reward, use of self-punishment (e.g., self-criticism) or focus on skill deficits, lack of assertion, poor problem-solving skills (see below), exposure to aversive situations, sleep deprivation, and/or noncontingency of behavior and outcomes (D’Zurilla & Nezu, 1990; Nezu, 2004; Rehm, 1990).

Similarly, stressful life events or aversive consequences for an individual are predictive of depressive episodes, and individuals who experienced childhood adversity are at greater risk of becoming depressed after stressful life events as adults (Kendler, Kuhn, & Prescott, 2004a, 2004b). Stressful life events can include divorce/separation, loss of job, increased conflicts, moving, and/or change in financial status—although daily hassles that accumulate can also be predictive of depression.

The behavioral activation model has been modified by Hayes, Strosahl, and Wilson (1999) to stress clarification of values (e.g., being a good mother or father) that can help motivate the individual to carry out difficult or unpleasant behaviors. Hayes et al.’s acceptance and commitment therapy (ACT) stresses acceptance of the situation as “the given,” recognition of “creative hopelessness” (i.e., that prior attempts to *feel better* have failed); flexibility in response, depending on context; and willingness to change. In addition, ACT emphasizes eliminating tendencies to avoid or escape from unpleasant emotions and an emphasis on tolerating unpleasant feelings. Similar to Ferster’s (1973) original formulation in its emphasis on context, contingency, avoidance, and activity, ACT has made significant contributions to appreciating the role of “a life worth living” as part of the motivational repertoire in therapy.

Problem-Solving Skills

Lack of social skills and lack of appropriate assertion skills are also useful behavioral targets for therapy. Many depressed patients need to learn appropriate social behaviors (e.g., in some cases, fundamentals of hygiene and appearance are important goals). Poor assertion skills may result in the inability to obtain rewards, greater feelings of helplessness and (in some cases) more aggressive and nonrewarding behavior directed toward others. Consequently, the behavior therapist will often include assertion training as part of their treatment plan.

D’Zurilla and his colleagues have argued that depression may stem from a lack of problem-solving skills or behaviors, which results in the persistence of mundane problems that contribute to feelings of helplessness (Bell & D’Zurilla, 2009; D’Zurilla, Chang, Nottingham, & Faccini, 1998). Behavior therapists assist patients in developing problem-solving skills by helping the patients identify their frustrations as “problems to be solved,” rather than issues about which they will ventilate. A therapist may programmatically train a patient in problem definition (“What is the problem you are trying to solve?”), collecting information (“What resources do you have?”, “How have others solved similar problems?”), brainstorming possible solutions (“How many different ways could this problem be solved?”), rank-ordering possible solutions, setting up an experiment to implement a possible solution, executing the plan, evaluating the outcome, and revising the plan if necessary.

To summarize, the behavioral approach (and, to some extent, the interpersonal approach; see below) suggests that various behavioral deficits and excesses characterize depression, and that depression has distinctive behavioral precursors. All these factors are listed in Table 2.1. Behavioral interventions for depression target the characteristic deficits and excesses of behavior. In Table 2.2, we identify some of the major behavioral techniques. For fuller descriptions, refer to Chapter 9 and Appendix A of this volume or to Leahy's (2003) *Cognitive Therapy Techniques: A Practitioner's Guide*.

Cognitive Factors

The Three Levels of Cognitive Distortions

The cognitive models of depression (there are several) propose that the cognitive, motivational, and vegetative symptoms of depression are either caused by, increased, or maintained by biases, distortions, or styles in thinking. According to Aaron T. Beck and his colleagues, the depressed individual suffers from negative views of self, experience, and future—in other words, the beliefs that “I am a failure,” “Nothing in this experience is worthwhile,” and “The future will be filled with failure” (Beck & Alford, 2008; Beck, Rush, Shaw, & Emery, 1979). The content is negative because it is supported by biases or distortions in thinking—that is, distorted “automatic thoughts.” These types of thoughts include labeling, fortunetelling, personalizing, all-or-nothing thinking, discounting the positive, catastrophizing, and mind reading (see Chapter 10 and Appendix B of this book, as well as the CD-ROM). Thus, when an event occurs—for example, a conflict at work—it is processed through distorted automatic thoughts in an excessively nega-

TABLE 2.1. Behavioral Deficits and Excesses in, and Precursors of, Depression

Deficits	Excesses	Precursors
Social skills	Complaining	Marital or relationship conflicts
Assertiveness	Negative or punitive behavior toward others	Arguments
Self-reward	Self-criticism	Relationship exits
Rewards from others	Punishments from others	Daily hassles
Sleep deprivation	Hypersomnia	Negative life events (e.g., loss of job, divorce, death of close relative)
Problem-solving skills		Early loss of parent
Rewarding and pleasurable experiences		Parents with negative attributional style
Self-control and self-direction		Lack of nurturance from parents
Ability to reward others		Noncontingency of behavior and rewards

TABLE 2.2. Summary of Behavioral Techniques for Depression

Technique	Description
Listing examples of depressive behaviors	Typical examples: Isolation, passivity, complaining, rumination, avoidance
Examining triggers for depressed mood or behavior	Help the patient to determine what stimuli precede depressive responses
Examining consequences of depressive behavior	Typical example: Avoidance leads to reduction of anxiety
Identifying goals	Help the patient to develop short-term and long-term behavioral goals that he or she wishes to accomplish
Reward planning	Have the patient list positive behaviors enjoyed in the past or anticipated in the future
Activity scheduling	Have the patient schedule rewarding activities, rating each activity for pleasure and mastery, and then self-monitor actual activities
Graded task assignment	Encourage the patient to self-assign increasingly demanding and challenging positive behaviors
Self-reward	Help the patient to increase use of positive self-statements and identify tangible reinforcers that may be associated with positive behavior
Decreasing rumination and excessive self-focus	Encourage the patient to develop distracting and active behaviors to replace passivity and rumination; to set aside rumination time; and to delay rumination
Social skills training	Help the patient to increase positive and rewarding behaviors toward others, such as complimenting and reinforcing other people; to become more reliable with others; to improve personal hygiene, appearance, approach behavior, etc.; and to decrease complaining and negative social behavior
Assertiveness training	Help the patient to increase responsible positive assertion (reinforcing others, giving compliments, making requests, and knowing when to escalate assertion)
Problem-solving training	Train the patient in problem recognition, definition, identifying resources, generating possible solutions, developing plans, and carrying out solutions

tive fashion: “I am a failure” (labeling) or “It’s terrible that this happened” (catastrophizing). The consequences of this pervasive negativity are that the individual becomes depressed, experiences even more negativity, and becomes even less motivated to pursue rewarding behaviors.

Vulnerability to future depressive episodes is predicted by a patient’s endorsement of “maladaptive assumptions.” (During nondepressed phases, the individual may not be more likely to endorse maladaptive assumptions, but these cognitive biases may be more likely to be manifested

through “priming”; that is, they are latent and more accessible, given negative affect or triggering events. (See Scher, Ingram, & Segal, 2005.) As indicated in Chapter 10, maladaptive assumptions are the guiding principles that underlie distorted automatic thoughts and that include “should” or “must” statements—for example, “I should succeed at everything I try,” or “I must be accepted by everyone.” Assumptions also include “if–then” statements—for example, “If I don’t succeed on this, then I am a failure,” or “If someone doesn’t love me, then I am unlovable.” These underlying assumptions are “maladaptive” in that they are rigid, punitive and almost impossible to live up to.

Consider the following: A patient, Susan, predicts that she will do poorly on an exam. This would qualify as the type of automatic thought called “fortunetelling”—that is, a negative expectation for the future. (Of course, this thought could prove to be true.) The thought becomes problematic for Susan because of an underlying assumption or rule. What will it mean to Susan if she does do poorly on the exam? If she adheres to the assumption that “I must do well on everything in order to be worthwhile,” then she is vulnerable to depression whenever she falls short of her expectations on exams. Because underlying assumptions confer greater risk, the cognitive therapist seeks to modify both depressive symptoms and underlying cognitive vulnerabilities.

Beck has proposed that when an individual is confronted with loss or failure, early maladaptive negative concepts of the self and others are activated (Beck & Alford, 2008; Beck et al., 1979). These “schemas” constitute the deepest level of thinking. They reflect core beliefs about the self (e.g., the self is unlovable, helpless, vulnerable to abandonment, controlled by others, unlovable, ugly, and incompetent) and about others (e.g., others are judgmental, unreliable, controlling, or superior). In the example above, Susan predicts that she will do poorly on the exam because she believes that she is basically incompetent and prone to failure. Getting “better” in cognitive therapy is not only a matter of feeling better, but also of thinking and acting differently by modifying the core negative schemas that underlie distorted automatic thoughts and maladaptive assumptions.

Schemas (sometimes called “core beliefs”) have been proposed as a model for understanding personality disorders (Leahy, 2002a; Young, Klosko, & Weishaar, 2003). Personality disorders are related to specific core beliefs about self and others that result in specific coping styles (such as avoidance or compensation). For example, individuals whose core belief is that they are irresponsible or lazy may compensate through excessively high standards for self and others, thereby leading to a vulnerability to depression in the event of “failure” in achieving desired goals. Specific dimensions on the Young Schema Questionnaire are related to depression: Shame, Defectiveness, Insufficient Self-Control, Failure to Achieve, and Social Isolation (McBride, Farvolden, & Swallow, 2007; Oei & Baranoff, 2007). The schema model stresses linking the origins of these beliefs to early childhood experiences, using experiential techniques, imagery induction, role play, cognitive restructuring, and “reparenting” to modify these early maladaptive schemas (Young et al., 2003). Thus far, however, there is no empirical evidence that adding this schema-focused component to traditional cognitive-behavioral therapy enhances treatment efficacy for depression.

Cognitive therapy involves the initial assessment of the patient’s depression, with a focus on automatic thoughts, maladaptive assumptions, and core beliefs/schemas. (Table 2.3 provides examples of all three of these types of cognitive distortions.) The therapist develops a case conceptualization with the patient, linking the three levels of thinking with earlier socialization

TABLE 2.3. Examples of the Three Types of Cognitive Distortions in Depression

<u>Distorted automatic thoughts</u>
Labeling: “I’m a failure.”
Dichotomous (all-or-nothing) thinking: “Nothing I do works out.”
Fortunetelling: “My life won’t get better.”
Personalizing: “My depression is entirely my fault.”
<u>Maladaptive assumptions</u>
“If I don’t pass the exam, it means that I’m a failure.”
“I’m weak because I have problems.”
“If I’m depressed now, then I’ll always be depressed.”
“People will think less of me if I’m depressed.”
“My value depends on what people think of me.”
“I don’t deserve to be happy.”
<u>Negative schemas</u>
Undeserving: “People have treated me poorly because I don’t deserve better treatment.”
Failure: “I’m doomed to fail.”
Unrelenting standards: “I can only succeed and gain approval if I’m perfect.”
Approval: “People will reject me if I’m imperfect. I need their approval to be worthwhile.”

experiences, current relationships and life stressors, triggers for depressogenic thinking, maladaptive coping strategies (e.g., avoidance, compensation, rumination), and other relevant material (Kuyken, Padesky, & Dudley, 2009). Therapy proceeds through socialization to the cognitive model (especially with the use of bibliotherapy); use of behavioral activation (activity scheduling, structuring reward menus, establishing short-term and long-term goals); addressing hopelessness and suicidal ideation or risk; and monitoring distorted automatic thoughts. Cognitive therapy techniques cover a wide range of interventions, including categorizing thoughts, examining costs and benefits of thoughts, evidence for and against thoughts, semantic techniques, continuum techniques, the double-standard technique, reverse role play, and many other behavioral and cognitive experiments to test and modify the patient’s thinking and coping styles. (See Leahy’s [2003] *Cognitive Therapy Techniques* for a fuller discussion, as well as Chapter 10 and Appendix B of this volume, plus the CD-ROM.)

Although cognitive therapy and medication are both effective for treating depression, greater change in dysfunctional attitudes is seen as a result of cognitive therapy than as a result of medication (DeRubeis et al., 1990). In some cases, patients experience improvement in their depression in as few as one or two sessions of therapy (Tang, DeRubeis, Hollon, Amsterdam, & Shelton, 2007). Patients with such sudden improvement are even more likely to maintain their improvement a year later (Tang, DeRubeis, Beberman, & Pham, 2005). Researchers have found that changes in negative thinking precede this improvement—so there is now support for the concept that changing the way you think changes the way you feel. In short, there is considerable evidence that cognitive therapy is just as effective a treatment for depression as medication is (DeRubeis et al., 2005).

Other Cognitive Models

Seligman's (1975) earlier behavioral model of depression stressed that the noncontingency of behavior and consequences can lead to a learned belief in the self's helplessness—that is, “No matter what I do, it doesn't matter.” Seligman and his colleagues later revised the noncontingency model to include cognitive components to explain individual differences relevant to the depressive syndrome—namely, the tendency of depressed persons to explain their helplessness? by referring to stable internal causes of failure (lack of ability) and the belief that their failure will generalize to other situations. Later, however, Abramson, Seligman, and Teasdale (1978) proposed a reformulated model of “learned helplessness.” According to the reformulated model, self-critical depression and helplessness are consequences of a particular pattern of explanations, or “attributions,” that the individual makes for his or her failure. Depression results from the tendency to attribute failure to internal, stable qualities (e.g., lack of ability) as opposed to internal but unstable qualities (e.g., lack of effort). The individual who believes that he or she can try harder (more effort) is less likely to feel helpless, hopeless, self-critical, and depressed. Furthermore, attributing failure to task difficulty (“Everyone does poorly on biochemistry”) as opposed to internal deficits (“I'm no good at biochemistry”) may lead to giving up on the task, but not to getting depressed and self-critical.

Seligman's learned helplessness model has been further modified by Abramson, Metalsky, and Alloy (1989) into a “hopelessness” model of depression. According to the hopelessness model, specific symptoms of depression (e.g., lack of energy, lack of goal-directed activity, lowered self-esteem, suicidal ideation, and sadness) are partially the result of specific interpretations about negative events—namely, that they are due to stable, global, and internal causes (e.g., “I am always a loser”). This is particularly the case for events with high importance and/or for events that are deemed to have considerable negative consequences for the self (Abramson et al., 1989). Both cross-sectional and longitudinal research supports hopelessness as a significant cognitive vulnerability to depression (Alloy, Abramson, Safford, & Gibb, 2006; Haefel et al., 2005).

The attribution-based models may be incorporated in a cognitive-behavioral treatment program by helping patients attribute their failure to lack of effort or bad luck (unstable factors) and/or to task difficulty (external factor), and to attribute their successes to ability, to overcoming difficult tasks, and to permanent qualities about themselves. Another aspect of attribution training is to help a patient evaluate a goal as an *alternative* rather than a necessity—that is, to help him or her modify the idea that this particular goal *must* be attained. Evaluating other achievable or controllable goals reduces the sense of hopelessness that may have resulted from overfocus on one goal as a necessary condition.

Several recent cognitive models of depression place less stress on the content of thoughts (such as schemas) and more on the process, function, or strategy of thinking. Depression is often characterized by the response style of “rumination”—that is, a passive and excessive focus on thoughts, feelings, and problems associated with negative affect, without a focus on active problem solving or distraction (Nolen-Hoeksema, 1991; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Ruminators get “stuck” in their rumination: Their repetition of negative thoughts traps these thoughts in their minds, increases their access to negative content, reduces their self-efficacy, limits their alternatives, and restricts their productive problem solving. A rumina-

tive response style is associated with greater risk for depression and with female gender (Nolen-Hoeksema, Larson, & Grayson, 1999).

Wells (2009) has proposed a metacognitive model of rumination and depression. Depressive ruminators, with their overfocus on thinking related to negative affect, believe that their rumination will help them solve their problems but that their rumination is uncontrollable. (Note the similarities between rumination and worry.) The pattern of rumination then leads to depressive behaviors (avoidance), depressive thoughts (“It’s hopeless”), and lowered mood (sadness). These unhelpful responses exacerbate the ruminative cycle. Wells’s metacognitive therapy (which has also been discussed as a treatment for anxiety disorders) provides specific interventions to address a patient’s theory of rumination. Techniques include attention training, detached mindfulness, rumination postponement, and a set of interventions to modify beliefs about rumination (Wells, 2006). For example, the therapist can evaluate the costs and benefits of rumination, examine mood fluctuations related to rumination, review the evidence that rumination works, and even assign rumination to test the patient’s metacognitive beliefs about its efficacy (Wells, 2008).

Mindfulness-based cognitive therapy (MBCT) has been proposed as an intervention for reducing the vulnerability to recurrent depressive episodes (Segal, Williams, & Teasdale, 2002)—that is, as a treatment for relapse prevention. Individuals who are prone to recurrent depressive episodes tend to have overgeneralized autobiographical memory, recalling events in vague and general ways. Moreover, these individuals are more likely to ruminate, as noted above (Nolen-Hoeksema, 2000). “Mindfulness” is a technique that assists the patient in focusing attention in the present moment in a nonjudgmental way, relinquishing control of the situation, and experiencing recurrently a sense of letting go of each moment. MBCT has been found to be useful in reducing relapse of MDD for individuals who have experienced three or more prior episodes, but has not been shown to be helpful for individuals with fewer episodes (Teasdale et al., 2000).

Other cognitive models view depression as the failure to use self-enhancing or egoistic thinking, failure to use mitigating excuses, excessive self-focus, and passivity. Thus those with depression are seen as differing from those without depression because they do not engage in ego-boosting, or even distorted, positive illusions that enhance their self-esteem. Similarly, depressed individuals are less likely to discount their negative illusions or to offer situational explanations for failure that do not imply personal responsibility. Self-focus models view depression as increased self-preoccupation, which is seen as a general process that increases negative affect. Supportive evidence on this topic indicates that depressed persons are more likely to ruminate about their negative feelings, especially by asking rhetorical questions that have no answers, and that they are less likely to take an instrumental, proactive, and distracting approach to their negative affect.

A summary of typical cognitive techniques used in the treatment of depression is provided in Table 2.4.

Interpersonal and Social-Behavioral Approaches

Lewinsohn, Peter, Antonuccio, Steinmetz, and Terri (1984) and Coyne (1989) and others have identified maladaptive interpersonal behaviors as a source of depression. According to Coyne’s (1989) interpersonal reward model, depressed individuals begin the maladaptive cycle by com-

TABLE 2.4. Summary of Cognitive Techniques for Depression

Technique	Description
Distinguishing thoughts, feelings, and reality	Socialize the patient in recognizing how thoughts and reality may differ, and how thoughts are related to feelings
Monitoring automatic thoughts	Encourage the patient to track situations, thoughts, feelings, degree of belief in thoughts; degree of emotion
Identifying distorted automatic thoughts	Train the patient in recognizing and categorizing the different types of distorted automatic thoughts (mind reading, fortunetelling, catastrophizing, etc.)
Examining costs and benefits	Help the patient to weigh the costs and benefits of a belief
Examining the evidence	Help the patient to evaluate the quality of evidence for and against a negative belief, as well as the balance of evidence
Defining the terms	Examine how depressive thoughts and terms are defined by the patient (e.g., what is a “failure”?); defining the opposite of the construct (e.g., what is a “success”?)
Vertical descent	Ask, “Why would it bother you if X were true? What would happen next?”
Identifying and challenging underlying assumptions	Examine the patient’s “rule book”—the “shoulds,” “musts,” and “if-then” statements that underlie the depression
Externalization of voices	Have the patient argue back at his or her negative thoughts, using role plays
Double standard	Ask the patient whether he or she would apply the same standards to other as to the self; why/why not?
Acting in opposition to a thought	Have the patient develop a plan of action to act against a thought
Identifying and challenging negative schemas	Examine the patient’s negative views of self and others (e.g., self as defective or having demanding standards, and others as judgmental or abandoning); challenge these negative beliefs
Attribution retraining	Help the patient change from personal, stable attributions for failure to attributions emphasizing universal, variable, and external attributions (e.g., from “I must be a failure” to “Almost everyone would have done poorly, I can change in the future, and it does not reflect on me”); have the patient reexamine the importance of the goal (perhaps there are other goals that can be pursued)

plaining, often obtaining reassurance and attention as a result of their complaints. The depressed persons initially receive positive reinforcement from others for their complaining. However, their continued complaining and self-preoccupation leads others to reject the depressive, which results in a decrease in social reward and support and further confirmatory evidence of the depressive's negative self-concept. As the depressive increases his or her complaining and rejects the help and reassurance provided, others view these behaviors as personally aversive and either withdraw from the depressed person or punish him or her by criticizing. This negative response by others adds further to the depression, and the cycle continues. Consequently, behavioral models that emphasize the interpersonal nature of depression focus on decreasing complaining and increasing positive interpersonal behaviors (e.g., "Rather than complain to others, try rewarding others").

Joiner has proposed an interpersonal theory of suicide and of depression. According to Joiner's model, individuals at highest risk of suicide are those who desire to kill themselves and who are capable of doing so. In particular, suicidal desire is related to one's perceived burden on others and lack of a sense of belongingness. Capability is related to habituation to suffering pain (through life events, injury, or prior experiences of self-harm) (Joiner et al., 2009).

Although not considered a cognitive-behavioral approach, the interpersonal theory of depression, derived from Harry Stack Sullivan's social-psychodynamic model of psychopathology, has considerable relevance to depression. Klerman, Weissman, Rounsaville, and Chevron (1984) have proposed that depression is the result of dysfunctions in interpersonal relationships, such as interpersonal conflict and termination of valued relationships. According to this model, problems in childhood relationships (such as loss of a parent, lack of nurturance, or disrupted communication patterns), as well as current interpersonal difficulties (such as marital conflict or termination, lack of social support, or lack of intimacy), may precipitate or exacerbate depression.

The interpersonal therapist provides the patient with the diagnosis (i.e., depression), encourages the patient to adapt the "sick role" (i.e., the role of a person with an illness), and enters into an agreement with the patient that the two of them will discuss the patient's feelings and interpersonal relationships as related to the depression. As in the cognitive-behavioral model, there is considerable emphasis on the here and now, and on a short-term, active, and relatively structured format of therapy. However, interpersonal psychotherapy differs from cognitive-behavioral therapy in that the former does not logically dispute the patient's negative thinking, nor is there an emphasis on homework. Furthermore, interpersonal therapists place greater emphasis on the interpersonal context of depression. The initial evaluation focuses on when symptoms began; the current stressors; interpersonal conflicts, disputes, losses, or changes; skill deficits (especially in interacting with others); and loneliness. Interpersonal psychotherapy stresses four problem areas: grief, role disputes, role transition, and interpersonal deficits (Weissman, 2000). Specific techniques include nondirective exploration (e.g., open-ended questioning); encouragement of affect (e.g., acceptance of painful affect, relating affect to interpersonal problems, eliciting suppressed affect); clarification; communication analysis; behavior change techniques; and the use of the transference (Klerman et al., 1984; Weissman, 2000).

Marital or couple conflict is often either a cause or a consequence of depression. Fifty percent of individuals seeking treatment for depression manifest such conflict (Rounsaville, Weissman, Prusoff, & Herceg-Baron, 1979), and 50% of couples seeking marital/couple therapy have

at least one depressed member (Beach, Jouriles, & O'Leary, 1985; Beach, Katz, Kim, & Brody, 2003). Weissman (1987) has found that individuals in conflicted marriages are 25 times more likely to be depressed than individuals in nondistressed marriages. Depressed spouses/partners complain more, are less likely to reward others or to be rewarded themselves, show deficits in communication and problem solving, and are more likely to express negative affect. Furthermore, depressed individuals are more likely to elicit negative responses or withdrawal from their spouses/partners.

Because of the high concordance of depression and marital/couple conflict, the clinician may consider individual or couple therapy as the treatment for patients presenting with both problems. Excellent descriptions of behavioral and cognitive approaches to marital/couple therapy may be found elsewhere (Beach et al., 2008; Epstein & Baucom, 2002a). The general approach involves assessment of areas of relationship distress; increasing the awareness, frequency, and contingency of rewards between spouses/partners; assertiveness training; scheduling of "pleasure days" where rewards can be dramatically focused; problem-solving training; communication training focusing on both listener and speaker roles; identification and modification of dysfunctional thoughts and assumptions; use of time out to decrease aggressive interactions; sexual therapy where necessary; and training in acceptance of problems and self-care.

The advantage of couple therapy over individual cognitive-behavioral therapy or medication is that both the individual's depression and the supportive environment (the marital/couple relationship) are significantly modified. Since depression is so highly correlated with relationship conflict, the clinician should always consider whether conjoint therapy should be the treatment of choice or whether it should be used in addition to individual therapy or medication. It is beyond the scope of this volume to describe the marital/couple therapy interventions available, but the reader is referred to the work of Beach, Dattilio, Epstein, and Baucom (Beach et al., 2008; Dattilio, 2005; Epstein & Baucom, 2002a).

OUTCOME STUDIES OF TREATMENTS FOR DEPRESSION

Numerous outcome studies attest to the efficacy of cognitive-behavioral therapy and/or antidepressant medication in the treatment of major depression; cognitive-behavioral therapy is generally found to be equivalent or superior to antidepressant medication (Butler, Chapman, Forman, & Beck, 2006; Williams, Watts, MacLeod, & Mathews, 1997), with a number of studies demonstrating that most patients maintain their improvements 12 months later. In particular, cognitive therapy has been found to be as effective as medication in the treatment of moderate to severe depression (DeRubeis et al., 2005).

An extensive meta-analysis comparing the various types of psychotherapy described above has recently indicated equivalent efficacy for all types in the treatment of depression (Cuijpers, van Straten, Andersson, & van Oppen, 2008). Given this finding that several forms of psychotherapy can be effective, we attempt to include elements of each of these in our coverage of treatment planning for depression. The clinician may use individual judgment to determine the most relevant approach for each patient. Moreover, the multisite Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study indicates that switching nonresponders to different modalities of treatment can increase remission rates significantly, with 67% of individuals completing

treatment (with augmentation or switching) showing remission (Rush, Trividi, et al., 2006; Rush et al., 2009). Finally, although we have not discussed electroconvulsive treatment (ECT), there is clear evidence of its efficacy for refractory depression; therefore, it should be considered as an alternative for patients with severe, life-threatening, and treatment-resistant depression (Kho, van Vreeswijk, Simpson, & Zwinderman, 2003).

ASSESSMENT AND TREATMENT RECOMMENDATIONS

Rationale and Plan for Treatment

The advantage of the cognitive-behavioral approach is that it links symptoms to therapeutic goals to specific interventions. Suicidal ideation should always be considered the highest-priority target for treatment, especially when there is a history of suicidal or parasuicidal behavior. The other specific symptoms of depression may be grouped into the following categories: low level of behavior, lack of pleasure and interest, withdrawal, self-criticism, rumination, sadness, and hopelessness (among other symptoms). The goals of treatment are to decrease or eliminate suicidal risk, increase behavioral activity level, increase pleasurable and rewarding behaviors, increase and enhance social relations, improve self-esteem, decrease self-criticism, and assist the patient in developing short-term and long-term positive perspectives.

The interventions that are generally utilized to achieve these goals include reward planning/activity scheduling, pleasure predicting, and graded task assignment (in order to increase behavioral level and increase pleasurable and rewarding behaviors). They also include social skills training, assertiveness, self-monitoring complaining (to increase and enhance social relations); identifying, challenging, and modifying negative automatic thoughts, assumptions, and schemas (to improve self-esteem and decrease self-criticism); and identifying short-term and long-term goals, developing problem-solving strategies, carrying out and revising plans, and identifying and challenging dysfunctional thinking associated with hopelessness (to assist the patient in developing short-term and long-term positive perspectives).

A behavioral assessment allows the clinician to evaluate the behavioral deficits and excesses associated with depression, such as low activity level, lack of self-reward, complaining, and rumination. In addition, the clinician can evaluate interpersonal problems that may be contributing to the depression, such as frequent arguments, loss of relationships, lack of assertion, and other negative aspects of relating. Finally, a cognitive assessment provides an evaluation of typical distorted automatic thoughts, maladaptive assumptions, and schemas that may be targeted for cognitive examination or disputation.

The approach described here integrates the behavioral activation model with various cognitive models—including traditional cognitive therapy, metacognitive therapy, antirumination approaches, attribution and hopelessness models, mindfulness based cognitive therapy (MBCT), and acceptance and commitment theory (ACT). Moreover, mindful of the importance of interpersonal processes, the clinician will want to be familiar with and able to use behavioral interpersonal approaches and even interpersonal psychotherapy when they are deemed relevant, or to utilize marital/couple therapy where indicated. In some cases, parent training can be helpful in reducing a patient's sense of helplessness in coping with his or her children. The goal is to focus on the patient's needs, not on any particular theory.

Cognitive therapy is not defined by the techniques employed, but rather by the therapist's emphasis on the role of thoughts in causing or maintaining the disorder. Behavioral assignments for patients are excellent (even necessary) vehicles for examining and testing a patient's negative schemas (Bennett-Levy et al., 2004). For example, consider the use of self-reward as a simple intervention. In assigning this task, a therapist might ask a patient what his or her thoughts are about it. A typical depressive response might be to "discount the positive": "It shouldn't be a big deal for me to do that [e.g., go to a museum]. Anyone can do that, so why should I reward myself?" Or negative self-schemas might emerge from the assignment: "I don't deserve to reward myself. I'm worthless." Or even fears of self-reward might emerge. One intelligent, articulate, highly accomplished young woman feared self-reward: "I'll become conceited if I say good things about myself. Then people will reject me."

A patient's distorted automatic thoughts clearly emerge with behavioral assignments. For example, with reward planning/activity scheduling, the patient's fortunetelling ("I won't experience any pleasure") or negative filtering ("I didn't enjoy the lunch with Tom"—although the activity schedule might indicate many other activities with high pleasure ratings) can be examined. Similarly, thoughts indicating low frustration tolerance may emerge ("It'll be too hard to do that" or "I can't stand failing"). With assertion assignments, the therapist can examine the patient's maladaptive assumptions about assertion ("If I get rejected, it's awful; it means I'm unlovable," or "I shouldn't have to ask for those things. My spouse should know what I need"). Maladaptive assumptions about entitlement or about the need to ventilate ("I need to express my feelings; I should always be authentic") can be examined via assigning the task of decreasing complaining.

As these examples demonstrate, behavioral assignments such as activity scheduling, graded task assignment, assertiveness, problem-solving training, and communication skills training are utilized in the treatment of depression not only to increase rewards for patients, but also to help them test or challenge their negative cognitions. For example, the patient who believes that he has nothing to say and that no one would be interested in talking to him might be assigned the task of talking to ten people each day. This would not only help him challenge his idea that he has nothing to say and that everyone will reject him, but it would also help him recognize that others' lack of a positive response is not a catastrophe. Indeed, this is a combination of behavioral activation, assertion, exposure, and challenging negative thoughts. It is hard to do a behavioral assignment without also thinking about it.

Another important component of behavioral assignments in cognitive therapy is to help the patient learn to choose which behaviors to engage in. For example, a depressed patient who sits at home ruminating (thereby getting more depressed) can be asked to consider alternatives to ruminating—for example, going to a museum. The patient can then be asked to calculate a cost-benefit ratio for sitting at home ruminating versus going to the museum. These "choice calculations" are helpful in motivating patients by getting them to focus on how their negative predictions are determining their choices. Behavioral assignments are thus used to collect information about thoughts.

We find that cognitive therapy works best with the integration of these many useful behavioral interventions (as well as the other components mentioned earlier). Patients often get a boost of hopefulness from behavioral assignments and can often convincingly see the difference between their distorted beliefs and reality. Simply having abstract debates with patients about

how good reality is will prove far inferior as a strategy to helping the patients test out their cognitive distortions by engaging in behaviors that “act against the thoughts.”

The steps in our treatment package for depression are listed in Table 2.5. In addition to behavioral and cognitive interventions as listed in this table, we review below several other interventions (problem-solving skills, basic health maintenance, etc.) that may be included, depending on a patient’s needs.

Assessment

All patients complete Form 2.1,* a general intake form that asks for information about problems they would like help with. This “problem list” includes depression, anxiety, fears, marital conflict, self-esteem, anger, alcohol/other substance abuse, and other issues. In addition, the patient is asked after the assessment is completed (see below) to indicate specific goals that he or she would like to work on in treatment.

Tests and Clinical Interviewing

The specific problems of depression may be evaluated by using self-report forms and interview measures. The Quick Inventory of Depressive Symptomatology—Self-Report (QIDS-SR₁₆; Rush et al., 2003; Rush, Carmody, et al., 2006) is in the public domain and provides the clinician with a quick, reliable, and valid self-report assessment of depression; it is correlated .93 with the Beck Depression Inventory—II (BDI-II; Beck, Steer, & Brown, 1996). The QIDS-SR₁₆ is shown in Form 2.2.

Several other self-report and interview measures may be used to evaluate baseline symptoms and problems. These include the BDI-II, the Beck Anxiety Inventory (BAI; Beck & Steer, 1993),

TABLE 2.5. General Plan of Treatment for Depression

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- Assessment
 - Tests and clinical interviewing
 - Evaluation of suicidal risk
 - Consideration of medication
 - Socialization to treatment
 - Establishing goals
 - Behavioral activation and other behavioral interventions
 - Cognitive interventions
 - Inoculation against future depressive episodes
 - Phasing out therapy
 - Maintenance treatment
-

*All forms are at the ends of the chapters.

the Millon Clinical Multiaxial Inventory (MCMI-III; Millon, Davis, & Grossman, 2006), the Dyadic Adjustment Scale (DAS; Spanier, 1976), the Global Assessment of Functioning (GAF; American Psychiatric Association, 2000), the Beck Scale for Suicide Ideation (BSSI; Beck & Steer, 1991), and the Beck Hopelessness Scale (Beck & Steer, 1988).

But no self-report or interview instrument should be used as a substitute for a thorough clinical interview. The clinician's interview should assess for presence of previous depressive and manic episodes; history of suicidal ideation and behavior (both active and passive); history of substance abuse, anxiety or other disorders, and marital conflict; precipitating stressors/events; medical factors; and present suicidal risk. The onset and length of the current depressive episode, as well as current vegetative and other symptoms, should also be determined. If necessary, the patient's spouse/partner or another significant person may be interviewed to collect information about prior manic episodes (for which the patient lacks insight), anger and hostility, relationship conflicts, substance abuse, or other relevant factors. In addition, the clinician will want to assess the patient's hopelessness; situations that elicit depression; automatic thoughts, underlying assumptions, and schemas; reasons why the patient might feel less depressed; and ways the patient has tried to compensate for the depression or avoid situations that might make him or her more depressed. Furthermore, the therapist should do an assessment of behavioral factors (e.g., low levels of behavior, rumination, social skills deficits) and interpersonal factors (e.g., frequent arguments, loss of relationships, lack of assertiveness) affecting depression.

Forms 2.3 and 2.4 provide guidance for therapists in the assessment of depression. Form 2.3 provides space for recording a patient's scores on the most commonly used assessment instruments, for noting other relevant aspects of the patient's history, and for recording treatment recommendations. Form 2.4 permits a detailed interview assessment of cognitive, behavioral, and interpersonal factors that are playing a role in a patient's depression. In addition to completing Forms 2.3 and 2.4, a therapist should do the following as part of the assessment of any depressed patient:

- Consult with the patient's physician.
- Evaluate the need for medication (see below) and consult with a psychopharmacologist if necessary.
- Evaluate the need for substance abuse counseling or detoxification if the patient has alcohol or other substance abuse/dependence.
- Evaluate suicidality (see below).
- Evaluate the need for ECT.
- Evaluate the need for hospitalization.

Evaluation of Suicidal Risk

As noted above, evaluation of suicidal risk is part of the assessment of the patient, but this problem is so important and the link between assessment and intervention is so strong that we place special emphasis on it here. A clinician working with depressed patients should realize that all such patients should be evaluated for suicidal risk. The therapist should ask each patient about the presence of current and past suicidal ideation and behaviors, including passive suicidal behaviors (e.g., failure to take required medication, to avoid dangerous traffic, or to drive at a

prudent speed). Patients are at greater risk if they talk spontaneously about suicide, threaten suicide, leave suicide notes, obtain methods (e.g., harboring pills, purchasing a gun), or have made previous attempts. Prior history of self-harm, prior attempts, perceived burden to others, lack of “belongingness,” living alone, excessive alcohol or drug use, chronic physical illness, old age, recent losses, hopelessness, and the presence of a mood disorder are the best predictors. The therapist should ask the patient directly about the wish to live and wish to die; reasons for living and dying; frequency and intensity of suicidal thoughts, and ability to control such thoughts; passive attitude toward (acceptance of) suicidal wishes; deterrents to suicide (e.g., guilt, hope of improvement, religious concerns); availability of methods; and plans, verbalization, and motives (e.g., to escape pain, to punish others, to gain attention, to manipulate others, or to join someone who has died). Form 2.5 provides guidance in the evaluation of suicidal risk.

Our experience is that a therapist who takes an active and directive role in handling suicidality is much more capable of helping a patient. We insist, as a prerequisite for treatment, that each patient agree to a no-suicide contract. In such a contract, the patient solemnly promises the therapist that under any circumstances, the patient will not harm him- or herself while under the therapist’s care, and that the patient will call and consult with the therapist rather than taking any harmful actions. A sample of a no-suicide contract is provided in Form 2.6. We believe that *it is the responsibility of the patient to prove to the therapist that the patient can be trusted in an outpatient setting*. Thus the burden of proof is on the patient to assure the therapist that no harmful action will be taken. If the therapist believes that the patient is unreliable or unwilling to make this contract, then we recommend hospitalization of the patient in order to protect the patient during this critical time.

Although a few patients may refuse this contract (and therefore refuse treatment), our experience with this directive approach has been overwhelmingly positive. We indicate to a suicidal patient that suicide would be an extreme measure to take at a time when the patient is most irrational and hopeless, and least capable of making life-and-death decisions. Our recommendation is that the patient can now examine all the reasons for his or her hopelessness and can learn to apply the techniques of therapy and medication to resolve the problem.

Consideration of Medication

All patients presenting with depression should be given the option of antidepressant medication as part of their treatment. The patient information handout on depression (see “Socialization to Treatment,” below) as well as the recommended readings, provide information about medications for depression. Various types of antidepressant medications are now available, some of which are more easily tolerated than others. A full history of previous medication trials, as well as dosage, length of time on medications, and side effects, should be obtained from each patient. The physician prescribing any current medication should have a full medical history available to avoid contraindications (especially with other medications or with homeopathic remedies, which can sometimes have dire effects when used with antidepressant medication). If another biological member of the patient’s family has responded well to a specific class of medications, then that medication class is more likely to be effective. Our experience is that medications are especially helpful in increasing motivation, energy, appetite, concentration, and the ability to gain distance from negative thoughts—especially with severely depressed patients. In patients with

chronic depression, there is some evidence that combining medication with a form of cognitive-behavioral therapy increases remission rates (Manber et al., 2008).

Switching the class of an antidepressant medication or augmenting the medication with another class can significantly increase response rates. For example, adding substances such as dextroamphetamine–amphetamine (Adderall) or methylphenidate (Ritalin) can increase energy level. Modafinil (Provigil) is helpful with lethargy or increased somnolence. Tryptophan (Tryptan) is another drug that can be used to augment treatment, although patients should be cautioned about possible side effects of this drug. In some cases, a low dosage of an antipsychotic such as quetiapine (Seroquel), risperidone (Risperdal), or olanzapine (Zyprexa) to reduce the rigidity of negative thinking can be helpful. Also, although lithium is best known as a treatment for bipolar disorders, it is also an effective antidepressant (especially for patients with higher suicidal risk). Lithium, however, requires blood monitoring and careful supervision, and should only be prescribed after other alternatives have failed to work. Finally, thyroid medication can also be used for patients with depression when other treatments are not sufficient. A common medication for this is triiodothyronine (T3).

Some patients complain about sexual side effects of antidepressants, such as loss of desire or erectile dysfunction. The prescribing physician might consider lowering the dosage; giving a patient occasional “drug holidays” (e.g., discontinuing a medication for a day or so); replacing the medication with bupropion (Wellbutrin), nefazodone (Serzone), or mirtazapine (Remeron); or supplementing the medication with ginkgo biloba, yohimbine, or sildenafil (Viagra). Of course, only qualified medical personnel should make these recommendations, and a patient should never self-medicate.

For patients who do not respond positively to medication and therapy, and whose depression is severe and unrelenting, ECT is an alternative treatment with rapid efficacy for many patients. The physician should review the costs and benefits of ECT, which is far more effective today than it was 30 years ago. However, many patients undergoing ECT report memory losses that they find disturbing, although a significant percentage of these people recover these memories over time. Maintenance or periodic ECT can help maintain improvement for some individuals who cannot be maintained on antidepressant medication.

Another electrical stimulation treatment is transcranial magnetic stimulation (TMS), which has recently been approved for the treatment of depression. An electrical coil is placed over the scalp, and an electrical current stimulates the cortex. The patient is not under anesthesia, and many of the side effects associated with ECT (such as memory loss) are nonexistent. Recent reviews of the research indicate that TMS is an effective treatment for treatment-resistant depression, although some have suggested that it may not be as effective as suggested (Herrmann & Ebmeier, 2006; Mogg et al., 2008).

A third electrical stimulation technique that has received attention—but still needs more research to support it—is vagal nerve stimulation (VNS), which involves placing an electrode in the patient’s chest that stimulates the vagal nerve (it can be considered a kind of pacemaker for the nerve). Again, the use of this intervention is still in its initial phase, but anecdotal reports suggest that VNS has some efficacy with some patients (Daban, Martinez-Aran, Cruz, & Vieta, 2008).

A common variant of depression is seasonal affective disorder, with depressive mood during the winter months, when hours of sunlight are decreased. The symptoms of seasonal affective

disorder include increased need for sleep, craving for carbohydrates, and overeating. Up to 38% of patients seeking treatment for depression have a seasonal component to their disorder, and 5% of the general public has seasonal affective disorder (Garvey, Wesner, & Godes, 1988; Kasper, Wehr, Bartko, Gaist, & Rosenthal, 1989). Women are more likely than men to suffer from this disorder. Light therapy can be quite effective, and combining cognitive therapy with light therapy is currently considered the most effective treatment (Golden et al., 2005; Rohan et al., 2007).

Light therapy helps “wake” patients up in the morning and jump-start their circadian rhythms. They can get bright light for 15–30 minutes per day from sunlight, a high-intensity lamp, or a commercially produced bright light specifically designed for this purpose. Lights of this last type are available from Apollo Light (www.apollolight.com), Sunbox (www.sunbox.com), and other manufacturers. Some patients with seasonal affective disorder also benefit from melatonin supplements. Finally, negative air ionization can be effective in reducing seasonal affective disorder (Terman & Terman, 2006).

Socialization to Treatment

The patient should be told that his or her diagnosis is depression as soon as the initial evaluation is completed. Each patient should be given the patient information handout on depression (Form 2.7) and asked to begin reading Leahy’s (2010) *Beat the Blues before They Beat You: How to Overcome Depression*. We find it helpful to indicate to patients that we utilize several models of depression. Specifically, we indicate that depression is due to decreases in rewards and increases in negative events, to problems in exercising needed skills and behavior, and to lack of assertion (behavioral models); to negative biases in thinking and unrealistic standards of perfectionism and approval seeking (cognitive models); to conflicts and losses in personal relationships (interpersonal model); and to biological factors affecting brain chemistry and familial predisposition toward depression (biological model). We emphasize that these models are not mutually exclusive, and that interventions from each model will be utilized (see Form 2.7).

Part of the socialization process is to provide the patient with a case conceptualization and treatment plan. Although we are providing our readers with a “prototypical” guideline for a treatment plan later in this chapter, we recognize that each treatment plan must be tailored for each individual patient and that case conceptualizations will vary (Kuyken et al., 2009; Persons, 2008). For example, some depressed individuals do not present with behavioral deficits, and some do not present with self-criticism or hopelessness. However, the general outline of treatment should include an evaluation of suicidal risk, behavioral deficits and excesses, and cognitive biases or distortions. Following the assessment of the patient, the clinician and patient will examine a conceptualization of the current presenting problem. This conceptualization may include an outline of behavioral excesses and deficits; patterns of life problems; typical automatic thoughts, assumptions, and schemas; and examples of how the patient has avoided or compensated for his or her individual schemas (Kuyken et al., 2009; Leahy, Beck, & Beck, 2005; Persons, 2008; Young et al., 2003). It may also include hypothesized earlier life experiences that may have given rise to specific assumptions or schemas. The treatment plan may outline behavioral, cognitive, interpersonal, marital/couple, and biomedical interventions that may be considered relevant.

A further part of the socialization of patients is to indicate what therapy will be like and

what we expect of them as patients. Cognitive-behavioral therapy is an active, here-and-now therapy requiring a commitment of self-help from a patient. It is collaborative. The handout on cognitive-behavioral therapy provided in Chapter 10 (see Form 10.1) is useful to introduce the patient to the nature of therapy. We also find it useful to review with the patient reasons why he or she might be reluctant to do homework in therapy, or assumptions that the patient might have about the necessity of uncovering early life events in a psychodynamic process.

Establishing Goals

Setting goals is important for all patients, but especially so for depressed patients who feel hopeless. A clinician can help such a patient identify goals for the next day, few days, week, month, and year, continually linking the patient to a proactive stance toward the future. Using the problems the patient has endorsed on the general intake form (see Form 2.1), the therapist can review the goals that the patient wishes to accomplish in therapy (e.g., changes in depression, anxiety, procrastination, self-esteem, assertion, problem solving, marital/couple conflict, etc.). Scores on several of the self-report scales (e.g., the QIDS-SR₁₆, BDI-II, and BAI) can be used as symptom targets or goals for the patient to review periodically to assess progress. Shorter-term goals can include increasing behavioral activity, seeing friends, increasing exercise, or getting work done. (Initially, a shorter-term goal can be quite simple, such as completing the forms or coming to the next session.) Longer-term goals can include taking courses, obtaining credentials, losing weight, or changing one's job. In addition, deeper goals or purposes of life can be examined, so that therapy is not only about overcoming depression but about establishing a life worth living. Such deeper goals can include being a better spouse/partner or parent; becoming a better friend; developing character strengths (integrity, courage, compassion, kindness); or pursuing other values that give meaning to life. The therapist and the patient can agree to review all short-term and long-term goals periodically.

Behavioral Activation (Reward Planning and Activity Scheduling)

Increasing the rewarding and productive behavior of a depressed patient is one of the first goals of therapy. Behavioral activation, which combines reward planning and activity scheduling, is a means of achieving this goal. As a first step, the clinician provides the patient with the Patient's Weekly Activity Schedule (Form 2.8) in order to monitor the activities he or she is involved in for each hour of the day, and to note the amounts of pleasure and mastery (feelings of accomplishment and effectiveness) actually experienced during each activity. This allows the patient and therapist to review how the patient's time is being used; whether the patient generally plans activities; whether many or most current activities are monotonous, ruminative, asocial, and/or unrewarding (this will usually be the case); and which of these activities are associated with the highest and which with the lowest degrees of pleasure.

Next, the therapist reviews with the patient activities that were once enjoyable but that the patient is engaging in less often, or activities that the patient thinks he or she might enjoy but has never tried, and urges the patient to begin planning more of those activities and fewer low-reward activities (watching TV, lying in bed, ruminating, etc.). The patient is then assigned to schedule some of these activities for each day, and to use the Patient's Weekly Planning Schedule

(Form 2.9) to predict the amount of pleasure and mastery he or she expects to obtain from each. Finally, the patient actually engages in the activities and again uses Form 2.8 to record his or her actual ratings for mastery and pleasure. Chapter 9 of this book also provides a discussion of behavioral activation.

The therapist can introduce a cognitive component into the behavioral activation process by having the patient compare expected and obtained pleasure readings (as a check on negative fortunetelling); helping the patient to see that pleasure varies with activities, and that he or she can thereby control the amount of pleasure achieved; and having the patient examine the automatic thoughts associated with various activities. For example, depressed patients will often have discounting thoughts (“This wasn’t as good as it used to be”) or low-frustration-tolerance thoughts (“I can’t stand doing this”). These negative thoughts associated with negative activities may be addressed in therapy. Some patients, driven by their desire to appear unconstrained and spontaneous, may resist scheduling pleasurable activities. They may believe that they are not being authentic or free, and that in order to be themselves, they have to act in accordance with their true feelings. Therapists may address this resistance by reviewing the evidence that the patients’ strategy—of doing what they feel like doing—has been working. We also find it useful to use physical exercise analogies. We may say to patients, “In order to get into better shape, would you only exercise when you felt like it? Have you ever begun to exercise even though you didn’t feel like it? Precisely what would happen if you exercised and you didn’t feel like it?” Patients’ discounting thoughts that activities are not as enjoyable as they once were (prior to the depression) may be examined as well: “Is it possible that positive activities take a while to kick in? Perhaps when you are depressed, these activities are not as enjoyable as they once were, but they may be more enjoyable than doing nothing.”

Other Behavioral Interventions

We have emphasized behavioral activation (reward planning and activity scheduling) here because of its importance in increasing depressed patients’ low levels of behavior, but many other behavioral interventions can and should be used with such patients as the need arises. Table 2.2, earlier in this chapter, has summarized behavioral techniques that can be employed in the treatment of depression; these are described in more detail in Chapter 9 and Appendix A, and most are listed in the CD-ROM accompanying this book.

Cognitive Interventions

The course of cognitive therapy begins with educating the patient about the various types of cognitive distortions. The patient is then helped to identify and categorize distorted automatic thoughts; to identify underlying maladaptive assumptions and negative schemas; and to use a wide variety of techniques to challenge his or her thoughts, assumptions, and schemas. Table 2.4, Chapter 10, Appendix B, and the CD-ROM accompanying this book provide fairly extensive lists of cognitive techniques that are applicable to depression. Indeed, many of the behavioral interventions listed in Table 2.2 may be integrated with a cognitive orientation (e.g., activity scheduling can be treated as hypothesis testing or examining the evidence).

As indicated earlier in this chapter, depressed patients show greater vulnerability to negative life events and recurrence of depression if they continue to have distorted automatic thoughts, to endorse maladaptive assumptions, and to maintain negative schemas. Therefore, all three of

these types of cognitive distortions must be identified and challenged in therapy. Once a patient has been introduced to the concept of distorted automatic thoughts and has been shown how to identify and categorize these, the therapist works with him or her in sessions to challenge these thoughts, using many different techniques. Examples of these techniques include examining the costs and benefits of a thought; examining the evidence for and against a thought; using “vertical descent” (i.e., asking, “Why would it bother you if such and such were true? What would happen next? Why would that bother you?” and so on); applying the “double standard” (i.e., asking, “Would you apply the same standards to other people as you do to yourself? Why/why not?”); and many others (again, see Table 2.4, Chapter 10, Appendix B, and the CD-ROM). As the patient is learning to do this, he or she can use the Patient’s Daily Record of Dysfunctional Automatic Thoughts (Form 2.10) to record such thoughts and their accompanying emotions, to evaluate his or her confidence in the accuracy in these thoughts, and to record rational responses to the thoughts. (The Patient’s Event–Mood–Thought Record in Chapter 10 [Form 10.4] can also be used to record thoughts and emotions.) Maladaptive assumptions and negative schemas can and should also be challenged in many ways, but because they occur at deeper cognitive levels than automatic thoughts, the patient will usually need even more guidance from the therapist in addressing them. Table 2.6 illustrates how the maladaptive assumption “If someone doesn’t like me, then I’m worthless” might be tested and challenged in therapy. Table 2.7 does the same for the negative schema “I’m a rotten person,” which was endorsed by a depressed man who had been physically abused as a child by his father.

Inoculation against Future Depressive Episodes

Since a considerable number of depressed patients are vulnerable to recurrences of depressive episodes, the patient should be cautioned about the possibility of such recurrences. Many patients may benefit from maintenance treatment with antidepressant medication after the initial episode has subsided. Patients may also benefit from preparation for future episodes. A clinician and patient may review the precipitating factors of current and/or previous episodes, examining whether a pattern exists. For example, some patients are especially vulnerable to interpersonal losses, which may activate idiosyncratic schemas such as helplessness and worthlessness.

The inoculation phase includes reviewing the description of typical signs of depression in the patient information handout (Form 2.7), and then working with the patient to develop coping strategies for each cluster of symptoms. For example, the patient who withdraws and becomes passive during the early phase of depression can agree to adopt a coping strategy of behavioral activation, contacting the therapist, and getting out of his or her apartment. Patients with suicidal histories are especially in need of inoculation therapy. These patients may be asked to return to their past suicidal ideation and practice how they would respond differently, now that they have had the benefit of therapy.

Phasing Out Therapy

Abrupt discontinuation of weekly therapy is less desirable than gradually phasing back to less frequent, but regular, sessions—that is, first biweekly, then monthly, and then every 3 months. During the phasing-back period, the patient should be encouraged to develop his or her own homework assignments; continuation of homework is a good predictor of maintaining improvement. Patients are told that they may call the therapist and come back for therapy if depression

TABLE 2.6. Testing and Challenging a Maladaptive Assumption: "If Someone Doesn't Like Me, Then I'm Worthless"

Technique	Questions to test and challenge the assumption
Cost–benefit	What are the costs and benefits of this assumption? What are the costs and benefits of caring less about whether people like you? What would you be able to do, think, feel, and communicate if you cared less about whether people like you?
Semantic technique	How would you define "liking"? What is 100%, 50%, 20%, and 0% liking? How would you define "worthless" and "worthwhile"? What is 100%, 50%, 20%, and 0% worthless or worthwhile? Can you point to the particular part of someone (or behavior) that is totally worthless? Would anyone disagree with your definitions? What do you make of that?
Distinguishing behaviors from people	What are some worthwhile behaviors? Have you ever done a single thing that is worthwhile? Have you completely stopped engaging in worthwhile behaviors? Is there anyone that you know who does everything in a worthless way? If you do some things that are worthwhile, then how can you be worthless?
Examining evidence for and against the assumption	What is the evidence for and against the idea that you are worthless? What is the quality of the evidence? Would a good lawyer, defending you, think that this is good evidence?
Logical analysis	How does someone's not liking you make you worthless? If that person then likes you, then are you worthwhile? If one person likes you and another doesn't, are you worthless or worthwhile?
Double-standard technique	Do you know anyone who is liked by everyone? If not, then does that mean that everyone is worthless? Think of some people you admire and like. Does anyone dislike them? Would you consider them worthless? Why do you apply a different standard to yourself than you do to others?
Revision of assumption	Can you think of a more practical, less negative assumption? (Possible examples: "If someone doesn't like me, maybe we have different standards, styles, or tastes," "If someone doesn't like me, then maybe they don't know me very well.")

recurs. Self-monitoring may be enhanced by giving the patient copies of the QIDS-SR₁₆, BDI-II, or BAI.

Maintenance Treatment

Patients who have had recurrent episodes of MDD are at high risk of future episodes, even after successful treatment for depression. Three alternatives are available for "maintenance": (1) con-

TABLE 2.7. Testing and Challenging a Negative Schema: "I'm a Rotten Person"

Technique	Questions to test the schema
Identifying examples of schema	What are some examples of how you view yourself negatively? If we assume that you have been looking for evidence that you are rotten, how has this distorted your view of yourself? Has this schema (concept of yourself) made you ignore and discount positive information about yourself?
Identifying avoidance and compensation strategies	Have you avoided certain things—work, relationships, or anything—because you thought you were rotten? Have you tried to compensate for the idea that you are rotten by being especially pleasing, nonassertive, or self-defeating?
Cost–benefit analysis	What are the costs and benefits of viewing yourself as a rotten person? What would change in your life if you thought better of yourself?
Activating early memories	Can you recall when you first thought this? [This patient replied, “When my father locked me in the basement.”] If that happened today, would you think it reflected something about you or something about your father?
Imagery restructuring	Try to recall the memory of your father beating you and then locking you in the basement. Except now you’re strong like you are today and you can fight back. Can you create an image of you fighting back against your father? What are some assertive things that you can say to him?
Writing letters to the source	Write an assertive, angry letter to your father—which you don’t have to send him. Tell him that what he did was wrong, and describe how angry you are. Tell him that he’ll never do this to you again.
Examining the evidence for and against the schema	What is the evidence for and against the idea that you are a rotten person? What is the most vivid memory or image that you have of something good that you did? [The patient was a veterinarian. He recalled saving a child’s bunny.] If you saw a man taking care of a child’s bunny, what thoughts would you have about him?
Rewriting a life script	Imagine if your father had been kind, loving, and supportive, and had never hit you or locked you in a basement. What kinds of things would you think about yourself today that are different?
Developing nurturant self-statements	Let’s imagine that you have decided to take over because your father was such a lousy father. You are now taking care of this child—you. Write out as many loving, caring, supportive, and accepting statements as you can—to yourself.
Seeing self from (benevolent) others’ perspective	Are there any people who do not think that you are a rotten person? Make a list of those people who like you. List all the things that you can think of that they like about you. Ask them what they like about you. How does this reconcile with the idea that you are a “rotten person”?
Revising the schema	What would be a new, more positive, more realistic way of viewing yourself—including the good and bad things about you, and including your ability to grow and change?

tinued treatment with antidepressant medication; (2) booster sessions of cognitive-behavioral therapy scheduled periodically; and (3) MBCT, discussed earlier in this chapter. The first two alternatives are quite straightforward. If a medication has been effective in the treatment of a depressive episode, then that medication can be continued (sometimes at a lower dose) indefinitely to prevent breakthrough of future episodes. In regard to maintenance cognitive-behavioral therapy, we have found it helpful to schedule periodic follow-ups (ranging from every few weeks to few months), to catch depressive symptoms early and to encourage patients to utilize the techniques that have been helpful. During these booster sessions medication may be readjusted when this seems indicated.

As described earlier, MBCT is specific intervention model that trains patients in remission to use mindfulness techniques, which may reduce the likelihood of future episodes (Segal et al., 2002). MBCT derives its rationale from the observation that individuals at risk for recurrence of MDD have overgeneralized memory and are prone to rumination. Mindfulness exercises encourage them to observe, in a nonjudgmental and noncontrolling way, the contents of their thoughts. The practice emphasizes awareness with letting go, rather than getting “stuck” in a ruminative manner. Mindful awareness assists patients in being completely present in the current moment, so that awareness of detail is encouraged, rather than reliance on more abstract or schematic content.

TROUBLESHOOTING PROBLEMS IN THERAPY

Depending on the specific needs of the patient, other interventions may also be used to target specific problem areas. These may include the following.

Problem-Solving Deficits

Depression may be viewed as a deficit in problem-solving ability or in the use of problem-solving skills (D’Zurilla & Nezu, 1999, 2010). Life events or conflicts that are currently having an impact on a patient may be conceptualized as problems to solve. The patient may be trained in a specific problem-solving approach (see Table 2.8). When the patient has a negative thought (“I am so lonely”), the therapist can suggest turning this into a problem to be solved. For example, the therapist can ask, “What are some resources that you might have? Who are people that you know? How can you meet people? What are some things that you might do to connect with people? How can you spend time alone more productively?”

Basic Health Maintenance

Basic health maintenance may focus on elementary behavioral skills, such as maintaining hygiene, proper sleep habits, adequate diet, and attention to medical problems. With a severely depressed patient, inadequate bathing and inappropriate dress may lead to decrease in rewards in the environment. Many depressive individuals forgo adequate diet, because of lack of appetite or lack of interest in maintaining well-being. For example, one patient’s fatigue and anhedonia was related to poor nutrition, resulting in anemia. A therapist should not hesitate to encourage a patient to

TABLE 2.8. Problem-Solving Techniques

Topic	Key training objectives and activities
1. Initial structuring	<ul style="list-style-type: none"> • Establish a positive therapeutic relationship. • Present overall rationale and structure of problem-solving training, and describe how it can be of specific help to a given client. • Encourage optimism.
2. Assessment	<ul style="list-style-type: none"> • Formally (e.g., administer a problem-solving inventory) or informally (e.g., interview the client) assess problem-solving strengths and weaknesses. • Assess areas of a client's life that are stressful.
3. Obstacles to effective problem solving	<ul style="list-style-type: none"> • Discuss cognitive limits of conscious mind (i.e., difficulties in "multitasking," especially when under stress). • Discuss ways to foster multitasking: (a) "externalization" (e.g., make lists of ideas); (b) "visualizations" (e.g., covertly rehearse implementing a solution plan); and (c) "simplification" (e.g., break down complex problem into more manageable subproblems).
4. Problem orientation: Fostering self-efficacy	<ul style="list-style-type: none"> • Introduce concept and importance of maintaining a positive problem orientation. • Foster the client's self-efficacy. For example, use visualization exercise to help the client "experience" having successfully solved a problem (i.e., facilitate sense of being able to "see the light at the end of the tunnel").
5. Problem orientation: Recognizing problems	<ul style="list-style-type: none"> • Enhance the client's ability to recognize problems when they occur. • Use feelings, ineffective behaviors, and certain thoughts as cues that a problem exists. • Use problem checklist to help "normalize" the experience of problems.
6. Problem orientation: Viewing problems as challenges	<ul style="list-style-type: none"> • Foster the patient's ability to identify and subsequently alter negative thinking, dysfunctional attitudes, and restricted ways of thinking. • Engage in a "reversed advocate role-play" exercise, where the client argues a contrasting point of view from a given maladaptive belief that he or she holds.
7. Problem orientation: Use and control of emotions	<ul style="list-style-type: none"> • Foster the client's understanding of the role of emotions in problem solving. • Teach the patient to (a) "use" emotions to inform the problem-solving process (e.g., as a cue that a problem exists, to facilitate motivation); and (b) manage disruptive emotions (e.g., via cognitive reframing techniques, relaxation exercises).
8. Problem orientation: Stop and think!	<ul style="list-style-type: none"> • Teach the "Stop, slow down, think, and act" technique to inhibit tendencies to be impulsive or avoidant (i.e., to visualize a red stop sign or traffic light as a cue to "stop" and then to "think" in a problem-solving mode).

(cont.)

TABLE 2.8 (cont.)

Topic	Key training objectives and activities
9. Problem definition and formulation	<ul style="list-style-type: none"> • Foster the client's ability to understand better the nature of the problem (e.g., the reasons why it is a problem for the client as a given individual) and to set realistic problem-solving goals and objectives.
10. Generation of alternatives	<ul style="list-style-type: none"> • Facilitate the patient's creative ability to produce a wide range and variety of potential solution ideas for a given problem, using various brainstorming techniques (e.g., "the more the better").
11. Decision making	<ul style="list-style-type: none"> • Enhance the client's ability to make effective decisions by being able to (a) better identify possible consequences to a given action, and (b) conduct a cost-benefit analysis regarding the value and likelihood of various outcomes of a given action.
12. Solution implementation and verification	<ul style="list-style-type: none"> • Foster the individual's ability to (a) carry out a solution plan effectively, (b) monitor its outcome, (c) evaluate its effectiveness and (d) engage in self-reinforcement in the process of problem solving as well as the possible success of the actual outcome.
13. Guided practice	<ul style="list-style-type: none"> • Maximize the client's proficiency in the application of problem-solving attitudes and skills, and facilitate the transfer and generalization of these attitudes and skills to a variety of current and future stressful problems in the natural environment.
14. Rapid problem solving	<ul style="list-style-type: none"> • Teach the client a set of problem-solving questions/guidelines that help him or her to apply the overall model in just a few minutes.

Note. Adapted from D'Zurilla and Nezu (2010). Copyright 2010 by The Guilford Press. Adapted by permission.

eat small amounts of food frequently, even if the patient lacks appetite; following a heart-healthy diet and planning meals should be encouraged. Indeed, with some patients the goal may be to "eat in order to create hunger," since depression and poor nutrition may decrease hunger. Other patients may binge-eat or prefer high-carbohydrate foods, which then may lead to self-criticism.

Depressed patients may also attempt to counteract their fatigue with excessive caffeine intake, or, if they have insomnia (see below), may self-medicate with alcohol. Finally, many depressed patients do not obtain proper medical evaluations, or, if they require medication for health problems (e.g., for hypertension or diabetes), they are often careless about compliance. In some cases, this lack of attention to health problems may reflect subconscious suicidal ideation and should be addressed accordingly. Similarly, potentially dangerous sexual behavior, illicit drug use, overuse of prescription medication, and hazardous driving may reflect a subintentional or even active suicidal orientation. A clinician should evaluate a patient for all of these risks.

Insomnia or Hypersomnia

Insomnia is a frequent correlate of depression and may be treated with appropriate sleep hygiene, cognitive therapy for insomnia, or sleep restriction therapy. (Form 2.11 is a patient informa-

tion handout on insomnia.) Hypersomnia may be addressed through activity scheduling, use of alarms, changes in medications that make the patient soporific, use of modafinil (provigil), or other interventions.

Communication and Social Skills

Depression is often associated with deficits or problems in social behavior, as noted earlier. A clinician should note a patient's social skills in terms of appropriate greeting, attire, ability to listen, ability to reward others, responsibility in relationships, management of finances, and tendency to complain or punish others. Since any of these deficits may hinder the acquisition of interpersonal rewards, they may be addressed directly through the behavioral component of therapy. Assertiveness training is often useful with a depressed patient; it may be structured by having the patient develop a hierarchy of least to most difficult situations for assertion, and having him or her practice these skills in behavioral rehearsal in the session and *in vivo* exposure outside sessions.

Communication training is frequently indicated for patients whose interpersonal relationships are strained, especially married or cohabiting patients. Here the patient may be trained in active listening skills as well as in effective speaking skills, such as editing statements and clarifying feelings (Baucom & Epstein, 1990; Leahy, 1996). Mutual problem solving is useful with married or cohabiting patients. This involves one partner's volunteering to raise the need for a problem-solving session and follow through in a structured format of acknowledging partial responsibility for the problem, brainstorming, and developing plans (Jacobson & Margolin, 1979). Furthermore, many patients need training in negotiation skills, whether in their personal relationships or in other relationships (especially at work). The excellent book *Getting to Yes*, by Fisher and Ury (1981), is a readable and invaluable guide to practical issues in negotiation.

Marital or Relationship Discord

Since marital or relationship problems are often the center of depression for many patients, the therapist may consider a conjoint format of therapy a more desirable approach (Dattilio, 2010; Epstein & Baucom, 2002b). Cognitive-behavioral interventions involve training partners in attending to, labeling, and reinforcing positives in each other; helping them develop reward menus for each other; helping them schedule pleasure days; teaching sensate focus; teaching positive assertiveness; training partners in communication skills (see above); identifying and modifying dysfunctional or irrational automatic thoughts, assumptions, and schemas; and teaching the use of time-out procedures as well as self-instructions for anger. In addition, many couples are helped by learning to accept the problems that exist, rather than working too hard at trying to make everything right.

Hopelessness

In evaluating hopelessness, the therapist should ask the patient to specify exactly what he or she believes will not improve and why. For example, a woman whose severe depression and obsessiveness had not remitted for several years claimed that she would always be depressed, that she would never stop ruminating, and that she had missed all of her opportunities to have a mean-

ingful relationship with a man. Specifically, she expected that her self-criticism, lack of concentration, and regrets would continue forever, thereby making life unbearable. Since this patient had been in therapy for several years and had tried some medications, it might have been easy for the therapist to buy into her hopelessness. However, following the cognitive model, the therapist decided to treat her hopeless predictions as hypotheses to be tested. For example, her idea that her mood would always be negative was tested in the session by identifying instances when her mood was better, when she laughed, and when she began to challenge a negative thought.

THERAPIST: Have you noticed some change in your mood during today's session?

PATIENT: Yes, I guess I felt a little bit better. But it was only for a few minutes.

THERAPIST: What if you were able to do some of these things on your own—perhaps a little bit every day—perhaps even every hour?

PATIENT: I guess I'd feel better than I do now.

THERAPIST: If you can feel better in a session because you challenge your thoughts, and if you notice that your mood changes with the activities that you pursue, perhaps those might be the keys to long-term change.

PATIENT: But I've had therapy before, and I've taken medications.

THERAPIST: You've had a different kind of therapy, and you have only just begun to pursue medication possibilities. Is it possible that changing your thoughts and changing your biochemistry could have an effect?

PATIENT: I guess it's possible. But there's no guarantee.

THERAPIST: That's right. There's no guarantee—either way. Why don't we see what happens?

Although this patient still maintained some hopelessness, she was more skeptical about her depression than before. In fact, her skepticism about therapy and medication was used as a reinforcement for challenging hopelessness. The goal initially was to create doubt about hopelessness.

THERAPIST: Just as you're skeptical about therapy, why not be skeptical about your hopelessness, too?

PATIENT: I never thought of it that way.

THERAPIST: There's always a different way to think about anything. Let's agree that you will maintain a healthy skepticism—a "wait and see" attitude.

The therapist and the psychopharmacologist worked together to coordinate the therapy. Changes in medication were viewed as experiments, and self-critical and regretful statements were treated as hypotheses. The therapist told the patient that, along with her depression, she had an obsessive-compulsive personality structure, given to doubts, qualifications, perfectionism, and second guessing. (Ironically, this was helpful to her as a lawyer, but it made her daily life difficult.) Rather than trying to change her style of thinking, the therapist indicated to her

that she would probably have to accept a certain amount of doubt and qualification as part of her cognitive nature. Consequently, when she made decisions, she would *inevitably* have doubts, simply because she was extremely adept at seeing both sides of an issue. These doubts were not evidence that she made the wrong decision (as she almost always believed), but simply part of the “noise” of her style of thinking. This normalization of a problematic style proved immensely helpful to her, since she could now accept her obsessive doubting as “coming with the territory” (of being a brilliant lawyer) and did not imply anything negative about the “real world.” After several months, her hopelessness lifted, her depression and regrets abated to a large extent, and (fortuitously) she became engaged. It is important to note that her depression and hopelessness lessened *before* the engagement, so this was not a Cinderella story.

Self-Criticism for Being Depressed

Many depressed patients criticize themselves for their depression; they say such things as “I shouldn’t be depressed,” or “I should have been able to solve my problems on my own.” The patient is locked in a self-maintaining cognitive loop—“I’m depressed because I’m self-critical, I criticize myself for my depression, and I’m depressed because I’m depressed.” It is essential to help the patient recognize that he or she did not choose to be depressed; that depression often has a biological component; that self-criticism does not help anyone snap out of it; that taking responsibility for depression means accepting the fact of depression and pursuing treatment; and that the hopelessness, avoidance, and procrastination exhibited by the patient are to a large extent symptoms of depression.

Noncompliance with Homework

Typical of depression is this belief: “Nothing will work, so why should I bother to carry out cognitive-behavioral homework assignments?” In such a case, the therapist should first elicit the patient’s reasons for noncompliance (e.g., “I didn’t think it would work,” “I don’t have the time,” “I would be embarrassed to show you what I did,” “Homework will just remind me of my problems,” “I shouldn’t have to do homework,” or “I don’t like being told what to do”). The noncompliance should then be directly addressed by taking each of the reasons for noncompliance and treating them as automatic thoughts to be evaluated:

“What are the costs and benefits of doing homework?”

“What’s a better alternative?”

“What is the evidence for and against the idea that homework won’t work?”

“What homework would you assign yourself?”

“What would you recommend to a friend in your position?”

“How is your pessimism regarding homework similar to other thoughts you have about getting better?”

“What reason would you have to believe that the therapist would think less of you if you didn’t do the homework a specific way?”

“Would you be willing to experiment with doing a little bit of homework?”

Compliance may be increased by modeling the homework in the session, anticipating reasons not to do homework and having the patient examine or challenge these thoughts, asking the patient to do homework on reasons not to do homework, having the patient assign his or her own homework, and/or giving smaller or shorter assignments. As with all assignments, the therapist should offer a rationale for the homework and reinforce it when it is done (Leahy, 2002c).

General Self-Criticism

Depression is often characterized by self-critical thoughts (“I am a loser,” “I am a failure”), which then contribute to other depressive symptoms, such as rumination, helplessness, and hopelessness. The therapist can assist the patient by identifying the examples of self-critical thinking, the consequences, and the alternatives. Examples from Leahy (2010) are shown in Table 2.9.

Lack of Motivation

Depressed patients often complain of a lack of motivation: “I can’t get myself to do anything.” The chapter on building motivation in Leahy’s (2010) *Beat the Blues before they Beat You: How to Overcome Depression* can be useful for patients with this common problem. The overall aim here is to help these patients identify goals and habits that would make for a better life (“a life worth living”)—in other words, to become the kinds of persons they want to be. The approach stresses focusing on goals, choice, and the ability to tolerate some discomfort, along with self-reward for the right behavioral habits that take patients closer to their goals. Several motivation-building suggestions from Leahy (2010) are listed in Table 2.10.

TABLE 2.9. Suggestions for Helping Patients Deal with Self-Criticism and Build Self-Esteem

-
1. Identify your negative thoughts about yourself.
 2. Define your terms.
 3. What is the evidence for and against your self-criticism?
 4. What is the advantage of criticizing yourself?
 5. Replace self-criticism with self-reward.
 6. Do you really need to evaluate yourself?
 7. Replace evaluation with observing and accepting.
 8. Don’t take yourself too personally.
 9. Use self-correction.
 10. Use the double-standard technique.
 11. Do you have a self-critical rule book?
 12. What is your core belief about yourself?
 13. How is your thinking distorted?
 14. Look at yourself along a continuum.
 15. Humanize your mistakes.
 16. Use a learning curve: Success through failure.
-

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TABLE 2.10. Suggestions for Helping Patients Build Motivation

-
1. Rely on habits, not on feelings.
 2. Identify your goals.
 3. What kind of person do you want to be?
 4. What did you do when you weren't depressed?
 5. Set specific goals.
 6. Plan and predict your pleasure and effectiveness.
 7. Make choice your choice.
 8. Sample the menu.
 9. Look at your excuses.
 10. Do what you don't want to do.
 11. Act against your thought: "I shouldn't have to do it."
 12. Choose your purpose.
 13. Examine the costs and benefits—short-term and long-term.
 14. Act to create motivation.
 15. Don't expect an immediate payoff.
-

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Fear of Mistakes

Depression is often exacerbated by the catastrophic and judgmental views that depressed people have of their mistakes. Indeed, when considering a new behavior, a depressed person often thinks that running the risk of making mistakes is too high a price to pay; as a result, the person feels trapped in the current situation. These fears are tied to perfectionist thinking, global attributions, and the overimportance of single behaviors. Examples of ways to address this from Leahy (2010) book are shown in Table 2.11.

Indecisiveness

Lack of motivation, helplessness, hopelessness, and self-criticism are often related to problems in making decisions. A depressed individual often fears that decisions will lead to failed outcomes, that failure is unacceptable, and that nothing can really be done anyway to make a difference. Of course, not making a decision is actually itself a decision. Table 2.12 outlines steps toward confronting indecisiveness.

Rumination

Yet another major component of depression is rumination, which can prolong depressive episodes and make recurrence more likely. Patients who ruminate often think that their rumination will provide them with clarity, certainty, and a solution to their problems, but in fact rumination removes an individual from active participation in rewarding activities and contributes further to isolation and passivity. A therapist can help guide the patient to examining the nature of rumination and alternatives to this self-defeating style (see Table 2.13).

TABLE 2.11. Suggestions for Helping Patients Handle Fear of Mistakes

-
1. Are you a perfectionist?
 2. What kind of perfectionist are you?
 3. What are the consequences of perfectionism?
 4. Try successful imperfection.
 5. What's the worst thing about a mistake?
 6. Everyone makes mistakes.
 7. Aren't standards arbitrary?
 8. It's hopeless—but not important.
 9. Why are mistakes so common?
 10. Mistakes are information.
 11. A mistake is not the end of the world.
 12. You don't have to regret mistakes.
 13. Don't be proud of perfection.
 14. Develop your "bill of rights."
 15. Make your perfectionism look dumb.
 16. Being good enough is "good enough."
 17. Mistakes are part of progress.
 18. Make room for mistakes.
 19. Develop an accepting voice.
-

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Targeted Symptoms or Problems

In Table 2.14, we list several specific targeted symptoms or problems and indicate the kinds of questions or other interventions that might be helpful for each.

DETAILED TREATMENT PLAN FOR DEPRESSION

Treatment Reports

Tables 2.15 and 2.16 are designed to help in writing managed care treatment reports for depressed patients. Table 2.15 shows sample symptoms; select the symptoms that are appropriate for your

TABLE 2.12. Suggestions for Helping Patients Make Better Decisions

-
1. Make decisions based on goals and values.
 2. Examine the longer-term and shorter-term tradeoffs.
 3. Think about behavior and discomfort as investments.
 4. How much information is enough?
 5. Accept doubts, but act anyway.
 6. Evaluate the opportunity costs of indecision.
 7. Reject sunk costs.
 8. See decisions as experiments.
 9. Reject perfection as a goal.
 10. Maybe you can absorb some losses.
 11. Reassurance can be self-defeating.
-

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TABLE 2.13. Suggestions for Helping Patients Overcome Rumination

-
1. How does rumination make sense to you?
 2. What are the advantages and disadvantages of ruminating?
 3. Tolerate uncertainty.
 4. Do you have a hard time accepting conflicting information?
 5. Will rumination solve your problem?
 6. Set a time limit to your rumination.
 7. Shift attention.
 8. Would you be better off accepting reality as “a given”?
 9. Why does the past have to make sense?
 10. Are you looking for THE ANSWER?
 11. Are there real problems that you could solve?
 12. What are you missing in life when you ruminate?
 13. Practice mindful awareness.
 14. Accept the intrusive thought—and act in the real world.
-

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patient. Also, be sure to specify the nature of the patient’s impairments, including any dysfunction in academic, work, family, or social areas. Table 2.16 lists sample goals and matching interventions; again, select those that are appropriate for the patient.

Sequence of Interventions

Table 2.17 shows the sequence of interventions for an 18-session treatment plan for depression. (Patients with more severe symptoms may require longer treatment.) The clinician needs to choose the specific areas for intervention by evaluating each depressed patient’s individual presentation. For example, many patients are able to overcome the vegetative symptoms of depression (such as loss of appetite and energy, sleep problems, and anhedonia) by using antidepressant medication. In these cases, the therapist may be more helpful in addressing issues of hopelessness, self-criticism, and underlying assumptions and schemas that contribute to the depressive vulnerability. For other patients, behavioral activation may be just as effective as medication for vegetative symptoms. In the following section, we describe the treatment of depression in a divorced woman, utilizing behavioral, cognitive, interpersonal, and developmental interventions.

CASE EXAMPLE

Sessions 1–3

Assessment

Anne was a 42-year-old divorced woman working in a sales position for a high-tech firm. She reported no history of alcohol or other substance abuse, and indicated that her depression was related to the stress of the separation and divorce, as well as to conflicts with her ex-husband over custody of their 6-year-old child and financial responsibilities. Her depression reflected self-criticism, discouragement about the future, loss of interest in activities, regrets about the past, and irritability, as well as rumination about the current situation and the events leading up to the divorce. Her score on the

Symptoms and comorbid conditions

TABLE 2.14. Targeted Depressive Symptoms Problems and Questions/Interventions

Symptom or problem	Questions and interventions
Self-criticism	What are the costs and benefits of criticizing yourself? Of accepting yourself? Of trying to improve? Specifically, what are you saying about yourself? What standard are you using? How would you define “failure” and “success”? Do you engage in any behaviors that succeed? Even partly? How would you compare yourself to the biggest failure, the average person, and the perfect person? Would you be as critical of someone else who did what you do? Why/why not?
Inactivity	What alternatives are you considering? What are the costs and benefits of each alternative? (Use reward planning, activity scheduling, graded task assignment.) Do your moods vary with activity? With whom you’re interacting? (Develop short-term and long-term goals.)
Lack of pleasure	Are there some activities that you enjoy more than others? (Consider medication, reward planning, activity scheduling, graded task assignment.) Are you discounting the activities that you engage in? Do you have “rules” that you apply to pleasure—for example, “I can’t enjoy anything if I’m alone”?
Social withdrawal	What are the costs and benefits of interacting with people? Are you saying to yourself, “I’m a burden,” or “I have nothing to offer”? When you are with people, are you assuming that they will reject you, or that they will see that you are depressed? Do you complain too much when you are with people? Could you focus on rewarding and empathizing with others? What do you predict would happen if you planned some activities with others?
Sadness	Are you ruminating and focusing on negative memories? Are you spending excessive periods of time alone, inactive? Try to recall pleasurable behaviors and experiences. Identify automatic thoughts and challenge them.
Indecisiveness	What are the alternatives? Are you considering too few alternatives? Weigh the costs and benefits of each. Are you assuming that you have to find a perfect solution? Do you criticize yourself if things do not work out exactly as planned? Examine the costs and benefits of trying to be absolutely certain versus trying to get on with your life. Are you using your emotions to guide you (e.g., “I feel lousy; therefore, there aren’t any good alternatives”)? What advice would you give a friend? If something doesn’t work out, what is the difference between regret and learning from the experience?
Suicidality	What are some reasons for living? If you were not depressed, what would be some pleasurable and meaningful things that you could enjoy? What is the evidence for and against your hopelessness? Before you were depressed, what are some things that you enjoyed? (Establish no-suicide contract; consider commitment; enlist assistance of family members; reduce opportunities; eliminate weapons or large supplies of medications.)

TABLE 2.14 (cont.)

Symptom or problem	Questions and interventions
Negative life events	Exactly what happened? What negative automatic thoughts did this generate? Are you fortunetelling, personalizing, catastrophizing, etc.? (Examine the evidence, look at the event on a continuum, divide up the responsibility, learn from the experience, etc.). What can you still do, even though this event occurred? How will you feel about it in a week, month, or year? If someone else had this problem, what advice would you give him or her? What are some new goals that you can focus on? What are some positive events that could occur in the future?

<i>Evaluation of suicidal risk</i>	BDI-II was 32; her BAI score was 12; and she had a slightly elevated score on the MCMI-III for dependent personality. Since she was not currently in an intimate relationship, she did not complete the DAS. There was no current or past suicidal ideation. There was, however, a family history of depression (both her mother and her maternal grandmother had had major depressive episodes). Anne also described some conflicts with her mother over the divorce; she felt that her mother was not as supportive as she (Anne) would want her to be. She also reported some concerns about her ability to maintain the house while relying primarily on her own income, and about the effects on her son of the disputes with her ex-husband.
<i>Medication evaluation</i>	Anne was not currently on any medication for depression, although she was taking eszopiclone (Lunesta) for sleep, as needed. She and the therapist examined the possibility of medication as part of her treatment, but

TABLE 2.15. Sample Symptoms for Major Depression

<u>Affective Symptoms</u>	<u>Cognitive Symptoms</u>
Depressed mood	Feelings of worthlessness
Irritable mood	Excessive guilt
Anhedonia	Rumination
Low motivation	Pessimism
	Hopelessness
	Impaired concentration
	Difficulty making decisions
<u>Vegetative Symptoms</u>	<u>Other Symptoms</u>
Lack of interest in usual activities	Suicidal ideation (specify whether plan is present and whether there have been prior attempts)
Loss of appetite or increased appetite	Thoughts of death
Weight loss or gain	Specify how long symptoms have been present
Insomnia or hypersomnia	Specify whether there have been prior depressive episodes
Psychomotor agitation or retardation	
Fatigue	
Low energy	

TABLE 2.16. Sample Treatment Goals and Interventions for Depression

Treatment goals	Interventions
Eliminating suicidal ideation	Cognitive restructuring, removing access to means, setting up a contract to contact therapist, developing coping strategies for suicidal impulses; developing short-term and long-term goals
Reducing hopelessness	Examining reasons for hopelessness, examining evidence for and against it, behavioral experiments, activity scheduling
Engaging in one rewarding activity/day	Reward planning, activity scheduling, graded task assignment
Reducing negative automatic thoughts	Cognitive restructuring, distraction
Sleeping 7–8 hours/night	Relaxation, insomnia treatment plan
Reducing rumination	Antirumination interventions, metacognitive therapy techniques
Engaging in one assertive behavior/day	Assertion training
Increasing social contacts (three/week)	Social skills training, reward planning, activity scheduling
Increasing self-reward for positive behaviors (one/day)	Reward planning, self-reward
Modifying maladaptive assumptions	Cognitive restructuring, behavioral experiments
Modifying schema of worthlessness (or other schemas—specify)	Cognitive restructuring, developmental analysis, schema work, empty-chair technique, writing letters to origins of schemas, developing adaptive schemas
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Eliminating most or all depressive symptoms (BDI-II < 10 for 1 month)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

she decided that she wanted to try therapy first without medication. The option of medication was kept open if therapy was not effective enough on its own.

Bibliotherapy and socialization to treatment

The therapist provided Anne with selected chapters from Leahy's (2010) *Beat the Blues before They Beat You*. The therapist outlined for her the nature of her depression, including the symptom clusters mentioned above; her significant life events, losses, and role transitions (separation, divorce, financial pressure, living without her husband, conflicts with her

TABLE 2.17. Detailed Treatment Plan for Depression**Sessions 1–3****Assessment**

Ascertain presenting problem
 Inquire regarding all symptoms
 Assess impairment in social, educational, and occupational functioning
 Administer standard battery of intake measures (see Form 2.3)
 Assess for cognitive, behavioral, and interpersonal deficits (Form 2.4)
 Evaluate for comorbid conditions, especially substance abuse
 Evaluate for suicidal risk (Form 2.5)
 Assess need for medication

Socialization

Inform patient of diagnosis
 Develop list of treatment goals
 Explain cognitive-behavioral therapy
 Provide patient with information handouts on depression (Form 2.7) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
 Assign Leahy's (2010) *Beat the Blues before They Beat You: How to Overcome Depression*

Behavioral Interventions

Identify behavioral targets (behavioral deficits and excesses)
 Instruct patient in reward planning and activity scheduling
 Encourage client to increase self-reward
 Encourage patient to decrease rumination time and passive/socially isolating behavior
 Evaluate need for patient to modify personal hygiene, grooming, diet, bingeing, etc.
 Evaluate/treat insomnia (provide patient with handout—Form 2.11)

Cognitive Interventions

Train patient in relationship between automatic thoughts and feelings
 Train patient in categorizing distorted automatic thoughts (see Form 10.2)
 Elicit and challenge automatic thoughts in session
 Evaluate reasons for and challenge hopelessness
 Establish no-suicide contract (Form 2.6)
 Challenge antipleasure thoughts

Medication

Consider medication
 Evaluate side effects
 Evaluate need to increase dosage

Homework

Have patient continue reading Leahy (2010), record thoughts and moods, categorize automatic thoughts, begin self-directed reward planning and activity scheduling, increase self-reward, assign worry or rumination time, and use graded task assignment

Sessions 4–6**Assessment**

Evaluate homework
 Evaluate depression (QIDS-SR16, BDI-II) and anxiety (BAI)

(cont.)

TABLE 2.17 (cont.)

Evaluate suicidality

Evaluate any side effects from medication

Behavioral Interventions

Teach and practice assertion skills in session

Encourage patient to increase rewarding behavior toward others

Encourage patient to increase positive social contacts—initiating contact, building support network

Evaluate self-reward

Introduce problem-solving skills

Cognitive Interventions

Identify specific targets: hopelessness, helplessness, indecision, self-criticism, rumination, lack of energy, lack of pleasure

Have patient use Patient's Daily Record of Dysfunctional Automatic Thoughts (Form 2.10)

Use specific cognitive techniques to help patient challenge negative automatic thoughts (see Chapter 10 and Appendix B)

Identify and challenge underlying maladaptive assumptions (again, see Chapter 10 and Appendix B)

Medication

Evaluate side effects

Evaluate need to increase dosage

If no improvement, either increase dosage, add another medication, or change class of medication (consider the need to taper or discontinue one class of medication when adding another class of medication)

Homework

Have patient use Form 2.10; assign specific cognitive techniques for challenging automatic thoughts and assumptions; continue with graded task assignment, social skills training, reward planning, activity scheduling, problem solving

Sessions 7–10**Assessment**

As in Sessions 4–6

Behavioral Interventions

Continue to teach and practice problem-solving skills

Train patient in communication skills (active listening, editing communication, empathy)

Continue graded task assignment

Continue assertion and social skills training

Cognitive Interventions

Identify and challenge automatic thoughts that are particularly difficult for patient

Continue identifying and challenging underlying assumptions

Begin to examine personal schemas

Medication

As in Sessions 4–6

Homework

Have patient practice using various techniques to challenge assumptions and schemas; continue graded task assignment, assertiveness, self-reward; and continue practicing communication and problem-solving skills

TABLE 2.17 (cont.)**Sessions 11–14****Assessment**

As in Sessions 4–6

Behavioral Interventions

Continue to teach and practice problem-solving skills

Continue to train patient in communication skills (active listening, editing communication, empathy)

Continue graded task assignment

Continue assertion and social skills training

Cognitive Interventions

Continue identifying and challenging difficult automatic thoughts and assumptions

Review old automatic thoughts (from previous sessions) and see if they still make sense to patient

Examine origins of schemas and evaluate how schemas have affected important experiences throughout life

Use empty-chair role plays to challenge negative schemas and people who have been the sources of negative schemas

Help patient develop more realistic assumptions and schemas

Help patient develop positive self-statements and “bill of rights”

Medication

As in Sessions 4–6

Homework

Have patient continue identifying and challenging automatic thoughts, assumptions, and schemas; develop list of new, adaptive assumptions and schemas; write out “bill of rights”; continue graded task assignment, assertiveness, and self-reward; and continue practicing communication and problem-solving skills

Sessions 15–18**Assessment**

As in Sessions 4–6

Behavioral Interventions

Continue to teach and practice problem-solving skills

Continue graded task assignment

Continue assertion and social skills training

Cognitive Interventions

Help patient continue to develop more realistic assumptions and schemas

Help patient continue work on positive self-statements and “bill of rights”

Review old automatic thoughts (from previous sessions and from homework assignments) and continue challenging them

Plan phase-out of therapy

Have patient identify which interventions were helpful and which were not

Have patient examine previous episodes of depression and describe how he or she will handle depression in the future

Use mindfulness-based cognitive therapy (MBCT)

Emphasize antirumination treatment

Consider maintenance medication

(cont.)

TABLE 2.17 (cont.)

Homework

Develop plans for how problems can be handled in future

Have patient assign own homework

Have patient indicate which problems he or she will work on once therapy ends

Behavioral and skills evaluation

mother, increased demands on parenting); and her family history of depression. Behavioral factors were also identified, such as decreased pleasurable activities, some social isolation, and parenting skills that needed to be improved. Furthermore, her rumination was identified as a factor contributing to her depression.

Introducing cognitive model

The therapist explained to Anne the nature of cognitive-behavioral therapy; how thoughts, feelings, and facts differ; the importance of homework; and the emphasis on functioning in the here and now. A list of distorted automatic thoughts (Form 10.2 in Chapter 10) was given to her, identifying some of her typical patterns of thinking: labeling (“I am a failure”), personalizing (“He left me because I wasn’t interesting enough for him”), fortunetelling (“I will always be alone”), all-or-nothing thinking (“I can’t get anything right”), emotional reasoning (“I feel so lousy. My life is lousy”), and discounting her positives (“A lot of people have friends and good jobs. It’s no big deal”).

*Identifying automatic thoughts**Establishing goals for therapy*

Anne and her therapist agreed to the following goals: increasing pleasurable activities; increasing socializing with friends and dating opportunities; decreasing self-criticism, rumination, personalizing, and fortunetelling; reducing the stress in dealing with her ex-husband; improving her relationship with her son; and improving her sleep. Anne’s BDI-II score after the first three sessions was 24. She showed some improvement in hopefulness and less sadness, and she felt more decisive.

Sessions 4–7*Activity scheduling*

The initial interventions focused on activity scheduling and graded task assignments. Anne was asked to keep track of her activities from hour to hour on Form 2.8, paying special attention to any periods of rumination or worry, and noting her pleasure and mastery for each activity. This assignment immediately led to her recognition that her mood was improved at work and was worse at night, especially when she engaged in ruminating. She was then asked to use Form 2.9 to construct a reward menu of potentially rewarding activities—activities that she got pleasure or mastery from in the past or could imagine doing so in the future. She indicated that she used to enjoy seeing her friends, but that now she felt she was a burden to them. Further inquiry revealed that a significant proportion of her interactions with friends focused on her complaints about her ex-husband. She also indicated that she had become less likely to initiate activities with friends and less likely to respond in a timely manner.

*Tracking pleasure and mastery**Developing a reward menu**Identifying problematic social behavior*

Graded task assignment

The chapters from Leahy (2010) on rumination and friendship were assigned. In particular, graded task assignment focused on relationship skills (avoiding excessive complaining, discussing positive activities with friends, validating friends who validated her, and making plans for joint activities with friends).

Metacognitive therapy for rumination

Antirumination treatment was also commenced, focusing on the metacognitive factors in Anne's rumination. Specifically, Anne was asked to evaluate the costs and benefits of rumination (she indicated that one possible benefit was "to figure out why things fell apart" and "to make sense of things"). The therapist and Anne examined the evidence that rumination would provide "the answer" and whether "an answer" was necessary. In addition, rumination was identified as a form of experiential avoidance (i.e., avoiding emotions, activities, and life in general) that removed her from pleasurable activities and a sense of self-efficacy.

Identifying rumination as depressive coping

Assigning rumination time

Planning rewarding activities, making other positive plans for the near future, practicing mindful meditation, practicing "letting go" of ruminative intrusions, and learning that a thought did not need an answer proved helpful to Anne. She was also asked to set aside "rumination/worry time," so that she could write down any ruminations at other times during the day or night and put them away until the specific time designated for them. During the rumination time, she was to ask herself the following questions: "What are the costs and benefits of repeated thinking or rumination about this? What would be the advantage of accepting as 'given' and 'in the past' what has happened? What are some things that I can do now and in the future to make my life more rewarding?" Having a self-script for rumination proved helpful, as did delaying the ruminations, which helped her realize that thoughts that ordinarily bothered her became less important when they were delayed.

Metacognitive examination of rumination

Improving sleep hygiene

Anne's insomnia was addressed in several ways. First, she was instructed to go to bed every night at the same time; to use the bed only for sleep (or sex); to get out of bed if she began ruminating or couldn't sleep for more than 20 minutes; to write down any worries or ruminations and set them aside for the next day's rumination time; to practice "not falling asleep"; and to avoid naps on weekends. She also kept a sleep log, noting the time when she went to bed, the number of times she awoke at night, estimated time falling asleep and duration to sleep, the time she woke up, her use of medication, and other thoughts and behaviors. Finally, she was asked to avoid checking the clock or "instructing herself" to fall asleep. After seven sessions, her BDI-II score was 19.

Using a sleep log

Decreasing sleep "safety behaviors"

Sessions 8–12

Monitoring negative thoughts

Anne continued with behavioral activation, graded task assignments, rumination time, insomnia treatment, recording and categorizing automatic thoughts, improving her social skills with friends, and other techniques. The therapist began to focus more on the content of her thinking when her mood changed, by having her record her negative thoughts

Identifying automatic thoughts and maladaptive assumptions

between sessions. Anne's automatic thoughts were "I screwed up the marriage," "I will always be alone," "I'm not a good mother," and "I will always be depressed." Her assumptions included "I need a relationship to feel worthwhile" and "I need to make things work out; it's up to me." Her self-schemas focused on abandonment, helplessness ("I am unable to take care of myself"), and defectiveness.

Cognitive restructuring of thoughts and assumptions

The therapist assisted Anne in identifying her automatic thoughts, categorizing them, and examining the evidence for and against her thoughts. Her automatic thoughts were examined via the following techniques: categorizing thoughts; rating the degree of belief and emotion associated with each thought; examining costs and benefits; examining evidence for and against each thought; asking, "What advice would I give a friend?"; role playing against a thought; setting up a behavioral experiment to test a thought; and revising thoughts to be more reasonable. Anne's assumption that she needed a relationship to be worthwhile was tested by evaluating costs and benefits; using the double-standard technique ("Is this what you would tell a friend? Why not?"); using the pie technique ("List the qualities that you have as a human being, and assign them to a percentage of the pie"); listing independent qualities and behaviors; and challenging the meaning of "worthwhile" (with the semantic technique).

Examining self-schemas

Anne's self-schemas (e.g., "I'm helpless") were examined by using the semantic technique ("How would you define 'helpless'?"), examining the consequences for her of this belief (including her history of choosing critical partners and of not pursuing higher, more challenging goals); listing goals that she had achieved and could achieve; examining her tendency to discount the positives; and evaluating how she had learned in her family that a woman could only be worthwhile if she was a good mother and wife.

Identifying origins of schemas

Anne reported more pleasurable times with friends, less self-criticism, more hope about achieving goals in the future (in terms of work, relationships, interests, and hobbies), increased energy, and improved sleep. Her BDI-II score dropped to 10.

Sessions 13–18

Reviewing progress

Anne described herself as ruminating considerably less than before, and her worries were reduced. She had discontinued using rumination time, since she was now more focused on her activities, friendships, and plans for the future. She was able to begin to look at her interactions with her former husband over custody and finances as reflections of why she was better off without him; she was able now to take his behavior less personally and to put it in the perspective that her "larger life" was better without him.

Parent training

In addition, the therapist provided Anne with some parent training: assisting her with "catching her child being good," setting up a reward menu for positive behaviors, and using communication techniques to

*Accepting
limitations and
uncertainty*

validate and elicit feelings from her child. She also became able to recognize that she did not need to look at everything as her responsibility; she did not control all the variables, and therefore she could not always obtain the outcomes she wanted. Accepting her limitations and uncertainty helped relieve her of her relentless quest for control and perfection. She was diplomatically assertive with her mother, but was also able to use acceptance to recognize that her mother was who she was and that Anne could learn to live with that.

*Phasing back
therapy*

Therapy was phased back to once every 2 weeks for a 2-month period, since her BDI-II score had dropped to 7. Anne still reported regrets about the past, some sadness, and still some indecisiveness. But she also felt that she had acquired self-help techniques that would be useful.

Booster Sessions

*Using problem
solving*

*Mindfulness
training*

The therapist suggested that Anne set up some “booster sessions” over the following year, both to catch any problems that might arise and to learn some mindfulness techniques. During the next 18 months, Anne met with the therapist five times. Twice these visits were initiated because of recent conflicts about finances with the former husband. This had activated her sense of being a victim, as well as her fears of becoming helpless. She was able to challenge these ideas successfully by compartmentalizing the problem and by taking a problem-solving orientation (“This is a business issue, not to be taken too personally”). She was also given an audio recording by Jon Kabat-Zinn on mindful meditation (see also Kabat-Zinn, 1994); she was asked to recognize that whatever negative thoughts she had could be envisioned as part of the breathing out and letting go, and that she could recognize that things pass on from one moment to the next. This was helpful to her in providing both a self-soothing form of relaxation and an alternative to ruminating. She reported that it was also helpful to her to recognize that ruminating did not lead to productive activity, and that she had enough positive goals to accomplish without wasting time on rumination.

FORM 2.1. Intake Form

Patient's name: _____ Today's date: _____

Age: _____ Date of birth: _____ Sex: (Circle one) F M

Address: _____

City: _____ State: _____ Zip: _____

Home telephone: _____ Work telephone: _____

Other telephone: _____

Occupation: _____

Employer: _____

Education: _____

Social Security #: _____

Referred by: _____

Next of kin: _____ Telephone: _____

Emergency contact (if different from above):

Name: _____ Telephone: _____

Marital status: (Circle one) Single Married Separated Divorced Widowed Cohabiting

Spouse's (partner's) name: _____

Spouse's (partner's) occupation: _____

Children (names and ages):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Religious denomination (if any): _____

Do you have insurance coverage? (Circle one) Yes No

Policy #: _____ Percentage coverage per session: _____%

Are you presently seeing another therapist? (Circle one) Yes No

If yes, then therapist's name: _____

Names of previous therapists, and dates seen: (Use back of form if necessary)

Name: _____ Dates: _____ to _____

Name: _____ Dates: _____ to _____

(cont.)

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FORM 2.1. Intake Form (p. 2 of 9)

Name: _____ Dates: _____ to _____

Name: _____ Dates: _____ to _____

Are you currently taking, or have you ever taken, medications for a psychiatric problem? (Circle one) Yes No

If yes, please list the name, dosage, and dates of each medication: (Use back of form if necessary)

Please list the name, address, and telephone number of your prescribing psychiatrist:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office telephone: _____

Have you ever been hospitalized for a psychiatric problem? (Circle one) Yes No

If yes, please list the hospital(s), date(s), and reason(s):

When was the last time you had a physical examination by a doctor, and what was the outcome?

Physician's name: _____ Office telephone: _____

Are there any medical problems that have resulted in a significant impact on you? (Circle one) Yes No

If yes, please describe:

(cont.)

FORM 2.1. Intake Form (p. 3 of 9)

Are you currently taking any medications for medical problems? (Circle one) Yes No

If yes, please list the name and dosage of each medication: (Use back of form if necessary)

Please circle *each* problem below for which you would like help:

- | | | | |
|------------------|-------------------------------|---------------------|--------------------|
| Anxiety | Suicidality | Anger | Decision making |
| Depression | Assertion | Aggression | Violence |
| Fear | Loneliness | Low energy | Hopelessness |
| Headaches | Irritable bowel | Problem solving | Work |
| Inactivity | Shyness | Social skills | Friendships |
| Mood swings | Impulsivity | Meeting people | Overweight |
| Regrets | Sexual problems | Insomnia | Underweight |
| Self-esteem | Physical complaints | Self-criticism | Agitation |
| Marital problems | Difficulty controlling eating | Procrastination | Panic |
| Alcohol abuse | Other substance abuse | Conflict resolution | Obsessive thoughts |

Other (please specify):

Have you experienced any sources of stress in the past year? (Circle one) Yes No

If yes, please describe:

(cont.)

FORM 2.1. Intake Form (p. 4 of 9)

Have you ever experienced a trauma? (Circle one) Yes No

If yes, please describe:

Are there any situations or people you avoid because they make you feel anxious? (Circle one) Yes No

If yes, please describe:

Do you exercise? (Circle one) Yes No

If yes, please describe:

Do you consider your exercise excessive? (Circle one) Yes No

If yes, please describe:

What are your typical recreational activities?

(cont.)

FORM 2.1. Intake Form (p. 5 of 9)

Please describe your eating habits:

How much coffee, tea, or other forms of caffeine do you consume daily?

Have you ever had a problem with eating disorders? (Circle one) Yes No

If yes, which disorder and when?

Overweight: _____

Underweight: _____

Anorexia: _____

Bulimia: _____

Other: _____

Have you ever had, or do you have, a problem with substance abuse? (Circle one) Yes No

If yes, please indicate substance(s) (alcohol, medication, illicit drugs) and dates of use:

Have you ever had a period of 2 days or more when you experienced any of the following? (Circle each one that applies)

Decreased need for sleep

Very talkative

Racing thoughts

Unusually high self-esteem

Unusual desire to spend money

Driving very fast

Easily distracted

Very irritable or angry

(cont.)

FORM 2.1. Intake Form (p. 6 of 9)

Have you ever experienced any of the following? (Circle each one that applies)

Consuming more than five drinks in one day

Feeling an overwhelming need to drink

Driving while intoxicated

Not able to recall events the night after you drink

People close to you thinking you have a drinking problem

Drinking to reduce your anxiety

Is there anything else you would like your therapist to know about you?

FAMILY HISTORY

Mother: (Circle one) Living? Deceased? If deceased, year and cause of death: _____

Marital status: (Circle one) Single Married Separated Divorced Widowed Cohabiting

Occupations: (List past and present)

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

(cont.)

FORM 2.1. Intake Form (p. 7 of 9)

Father: (Circle one) Living? Deceased? If deceased, year and cause of death: _____

Marital status: (Circle one) Single Married Separated Divorced Widowed Cohabiting

Occupations: (List past and present)

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

Siblings: Names, ages, and occupations:

Psychiatric problems? If so, please describe:

(cont.)

FORM 2.1. Intake Form (p. 8 of 9)

Substance abuse? If so, please describe:

Other relatives: Any psychiatric history among your grandparents, aunts, or uncles? If so, please describe:

Stepmother: (Circle one) Living? Deceased? If deceased, year and cause of death: _____

Occupations: (List past and present)

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

Stepfather: (Circle one) Living? Deceased? If deceased, year and cause of death: _____

Occupations: (List past and present)

(cont.)

FORM 2.1. Intake Form (p. 9 of 9)

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

Stepsiblings: Names, ages, and occupations:

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

FORM 2.2. Quick Inventory of Depressive Symptomatology— Self-Report (QIDS-SR₁₆)

Patient's name: _____ Today's date: _____

Please check the one response to each item that best describes you for the past 7 days.

1. Falling Asleep:

- I never take longer than 30 minutes to fall asleep
- I take at least 30 minutes to fall asleep, less than half the time
- I take at least 30 minutes to fall asleep, more than half the time
- I take at least 60 minutes to fall asleep, more than half the time

2. Sleep During the Night:

- I do not wake up at night
- I have a restless, light sleep with a few brief awakenings each night
- I wake up at least once a night, but I go back to sleep easily
- I awaken more than once a night and stay awake for 20 minutes or more, more than half the time

3. Waking Up Too Early:

- Most of the time, I awaken no more than 30 minutes before I need to get up
- More than half the time, I awaken more than 30 minutes before I need to get up
- I almost always awaken at least 1 hour or so before I need to, but I go back to sleep eventually
- I awaken at least 1 hour before I need to, and can't go back to sleep

4. Sleeping Too Much:

- I sleep no longer than 7–8 hours/night, without napping during the day
- I sleep no longer than 10 hours in a 24-hour period, including naps
- I sleep no longer than 12 hours in a 24-hour period, including naps
- I sleep longer than 12 hours in a 24-hour period, including naps

5. Feeling Sad:

- I do not feel sad
- I feel sad less than half the time
- I feel sad more than half the time
- I feel sad nearly all the time

(cont.)

6. Decreased Appetite:

- My usual appetite has not decreased
- I eat somewhat less often or lesser amounts of food than usual
- I eat much less than usual and only with personal effort
- I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat

7. Increased Appetite:

- My usual appetite has not increased
- I feel a need to eat more frequently than usual
- I regularly eat more often and/or greater amounts of food than usual
- I feel driven to overeat both at mealtime and between meals

8. Decreased Weight (Within the Last 2 Weeks):

- My weight has not decreased
- I feel as if I've had a slight weight loss
- I have lost 2 pounds or more
- I have lost 5 pounds or more

9. Increased Weight (Within the Last 2 Weeks):

- My weight has not increased
- I feel as if I've had a slight weight gain
- I have gained 2 pounds or more
- I have gained 5 pounds or more

10. Concentration/Decision Making:

- There is no change in my usual capacity to concentrate or make decisions
- I occasionally feel indecisive or find that my attention wanders
- Most of the time, I struggle to focus my attention or to make decisions
- I cannot concentrate well enough to read or cannot make even minor decisions

11. View of Myself:

- I see myself as equally worthwhile and deserving as other people
- I am more self-blaming than usual
- I largely believe that I cause problems for others
- I think almost constantly about major and minor defects in myself

(cont.)

12. Thoughts of Death or Suicide:

- I do not think of suicide or death
- I feel that life is empty or wonder if it's worth living
- I think of suicide or death several times a week for several minutes
- I think of suicide or death several times a day in some detail, or have actually tried to take my life

13. General Interest:

- There is no change from usual in how interested I am in other people or activities
- I notice that I am less interested in people or activities
- I find I have interest in only one or two of my formerly pursued activities
- I have virtually no interest in formerly pursued activities

14. Energy Level:

- There is no change in my usual level of energy
- I get tired more easily than usual
- I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking, or going to work)
- I really cannot carry out most of my usual daily activities because I just don't have the energy

15. Feeling Slowed Down:

- I think, speak, and move at my usual rate of speed
- I find that my thinking is slowed down or my voice sounds dull or flat
- It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed
- I am often unable to respond to questions without extreme effort

16. Feeling Restless:

- I do not feel restless
- I'm often fidgety, wringing my hands, or need to shift how I am sitting
- I have impulses to move about and am quite restless
- At times, I am unable to stay seated and need to pace around

Total scores can range from 0 to 27. The key to scoring the QIDS-SR₁₆ is as follows:

- Enter the highest score on any one of the four sleep items (items 1–4).
- Enter score on item 5.
- Enter the highest score on any one of the four weight-related items (items 6–9).
- Enter sum of scores for items 10–14.
- Enter the highest score on either of the two psychomotor items (15 and 16).
- Sum the item scores for a total score.

Severity ranges on the QIDS-SR₁₆ are the following: mild depression (6–10), moderate (11–15), severe (16–20), very severe (21–27).

FORM 2.3. Evaluation of Depression: Test Scores, Substance Use, History, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Beck Depression Inventory–II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Global Assessment of Functioning (GAF) _____ Beck Hopelessness Scale _____

Quick Inventory of Depressive Symptomatology–Self-Report (QIDS-SR¹⁶) _____

Dyadic Adjustment Scale (DAS) _____

Elevations on Millon Clinical Multiaxial Inventory–III (MCMI-III): _____

Other questionnaires (specify): _____

Substance use

Current use of psychiatric medications (include dosage): _____

Who prescribes? _____

Past medications (include dosage): _____

Use of alcohol/other drugs (kind and amount): _____

Past substance abuse: _____

(cont.)

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History (intake only)

Previous episodes of depression:

Onset	Duration	Precipitating events	Treatment
-------	----------	----------------------	-----------

Previous manic/hypomanic episodes (if any):

Onset	Duration	Precipitating events	Treatment
-------	----------	----------------------	-----------

Suicidal intent: None Weak Moderate Strong

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 2.4. Cognitive, Behavioral, and Interpersonal Assessment of Depression

Patient's name: _____ Today's date: _____

COGNITIVE ASSESSMENT

Describe a situation in which you feel sad or depressed: _____

Complete the following sentence: "I would feel sad because I am thinking ... ": _____

"And this would bother me because it would mean ... ": _____

"I would feel less depressed if ... ": _____

Typical distorted automatic thoughts of this patient:

Mind reading:

Fortunetelling:

Catastrophizing:

Labeling:

Discounting positives:

Negative filtering:

Overgeneralizing:

Dichotomous thinking:

Personalizing:

Blaming:

(cont.)

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Unfair comparisons:

Regret orientation:

What if?:

Emotional reasoning:

Inability to disconfirm:

Judgment focus:

Low frustration tolerance:

Underlying maladaptive assumptions of this patient:

Underlying negative schemas (specify):

Hypothesized earlier childhood or life events:

Compensatory strategies:

Avoidant strategies:

(cont.)

BEHAVIORAL ASSESSMENT

People mean different things when they talk about depression. When you feel sad or you are feeling down, what are you typically doing?

Are there situations that you avoid when you are depressed?

What are some things that you try to do to become less depressed?

Do you find yourself getting stuck on negative thoughts that keep going through your mind?

What do you do to cope with those thoughts and feelings?

Specify examples of each that apply, indicating, if possible, frequency, duration, intensity, and situational determinants:

Low level of behavior:

Withdrawal from others:

Rumination:

(cont.)

Social skill deficits:

Inadequate self-reward:

Inadequate reward in environment:

Exposure to aversive situations:

Inadequate challenge and novelty:

Poor problem-solving ability:

Lack of resources (e.g., financial):

Loss of past rewarding activities:

INTERPERSONAL ASSESSMENT

Specify examples of each that apply:

Frequent arguments:

Loss of relationships:

Lack of assertion:

Not rewarding to others:

Punitive to others:

Frequent complaining:

Rejects support from others:

Few contacts with others:

Deficient or inappropriate appearance/grooming:

FORM 2.5. Evaluation of Suicidal Risk

Patient's name: _____ Today's date: _____

Therapist's name: _____

Evaluate for current suicidal ideation and behavior and for any past incidence of suicidal plans, intentions, or behavior.

Question	Current	Past
Do you have any thoughts of harming yourself? [If yes:] Describe.		
Have you ever felt indifferent about whether something dangerous would happen to you and you took a lot of risk—like you really didn't care if you died or hurt yourself? [If yes:] Describe.		
Have you ever threatened that you would hurt yourself? [If yes:] Whom did you say this to? Why?		
Have you ever tried to hurt yourself on purpose? [If no, go on to p. 3 of form]		
Exactly what did you do to try to hurt yourself?		
How many times have you tried this? When? Describe.		
Did you tell anyone before or after your attempt? Had you threatened to hurt yourself or talked about it before? [If yes:] Describe.		

(cont.)

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FORM 2.5. Evaluation of Suicidal Risk (p. 2 of 5)

Question	Current	Past
Had you planned to hurt yourself, or was it spontaneous?		
What was your state of mind when you attempted to hurt yourself? Were you depressed, spaced out, anxious, relieved, angry, excited? Were you using alcohol, medication, other drugs?		
Did you call someone at that time, or were you discovered by someone? What happened?		
Did you go to a doctor or to the hospital? [If yes:] Which doctor/hospital? [Obtain release of information.]		
Did you feel glad that you were alive? Embarrassed? Guilty? Sorry you didn't kill yourself?		
Did you want to hurt yourself soon after your attempt?		
Was there any event that triggered your attempt? [If yes:] Describe. [If no, go to next page of form]		
What were you thinking after this event that made you want to hurt yourself?		
If something like that happened again, how would you handle it?		

(cont.)

FORM 2.5. Evaluation of Suicidal Risk (p. 3 of 5)

Question	Current	Past
Has any family member or close friend ever hurt him or herself?		
How would you describe your current [past] desire to live? None, weak, moderate, or strong?		
How would you describe your current [past] desire to die? None, weak, moderate, or strong?		
[If current or past desire to die:] What would be the reason for wanting to die or harm yourself? Hopelessness, depression, revenge, getting rid of anxiety, being with a lost loved one again, other reasons?		
[If current or past desire to die:] Have you ever planned to hurt yourself? What was that plan? Why did you [did you not] carry it out?		
Are there any reasons why you would not harm yourself? Explain.		
Do you have more reasons to live than reasons to die?		
[If not:] What would have to change so that you would want to live more?		
Do you own a weapon?		

(cont.)

FORM 2.5. Evaluation of Suicidal Risk (p. 4 of 5)

Question	Current	Past
Do you live on a high floor or near a high bridge?		
Are you saving medications for a future attempt to hurt yourself?		
Do you drive excessively fast?		
Do you ever space out, not knowing what is going on around you? [If yes:] Describe.		
Do you drink more than three glasses of liquor or beer a day? Do you use any medications? Other drugs? Do these substances affect your mood? [If yes:] How?		
Have you written a suicide note? Have you recently written out a will?		
Do you feel there is any hope that things can get better?		
What are the reasons why things could be hopeful?		
Why would things seem hopeless?		
Would you be willing to promise me that you would not do anything to harm yourself until you have called me and spoken with me?		

(cont.)

FORM 2.5. Evaluation of Suicidal Risk (p. 5 of 5)

Question	Current	Past
Is your promise a solemn promise that I can rely on, or do you have doubts about whether you can keep this promise? [If doubts:] What are these doubts?		
Can I speak with [loved ones or a close friend] to be sure that we have all the support that we need?		
[Does this patient need to be hospitalized? Increase frequency of treatment contact and level or type of medication? ECT?]		

Therapist: Summarize dates, precipitating factors, and nature of the patient’s previous suicide attempts, if any:

FORM 2.6. No-Suicide Contract

I, _____ [patient's name], agree to contact my therapist and speak with him or her rather than cause any physical harm to myself or commit suicide. If there is an emergency and I am not able to contact my therapist or his or her colleagues, I promise that I will call 911 and/or go to the emergency room for evaluation and help.

Patient's name: _____ Today's date: _____

Signature: _____

Name of witness: _____

Signature: _____

FORM 2.7. Information for Patients about Depression

WHAT IS DEPRESSION?

Many of us have changes in mood, and sometimes we need help. But sometimes we can get stuck in a “down” mood and need help. Depression has a variety of symptoms, such as loss of energy, loss of interest in activities and in life, sadness, loss of appetite and weight, difficulty concentrating, self-criticism, feelings of hopelessness, physical complaints, withdrawal from other people, irritability, difficulty making decisions, and suicidal thinking. Many depressed people feel anxious as well. They often feel worried, nauseated, or dizzy, and sometimes have hot and cold flashes, blurred vision, racing heartbeat, and sweating.

Clinical depression varies from mild to severe. For example, some people complain of a few symptoms that occur some of the time. Other people, suffering from severe depression, may complain of a large number of symptoms that are frequent, long-lasting, and quite disturbing.

Clinical depression is not the same as grieving after the loss of a loved one through death, separation, or divorce. Feelings of sadness, emptiness, low energy, and lack of interest are normal during grief; anger and anxiety can also be part of the normal grief process. Clinical depression differs from normal grief, however, in that clinical depression sometimes may occur without a significant loss. In addition, depression may last longer than grief and includes feelings of self-criticism, hopelessness, and despair.

It would be an unusual person who said that he or she never felt “depressed.” Mood fluctuations are normal and help inform us that something is missing in our lives and that we should consider changing things. But clinical depression is worse than simple fluctuations in mood. Because there are various degrees of depression, the severely depressed patient may wish to consider a number of treatments in combination.

WHO GETS DEPRESSED?

Depression is not something that happens to people who are “unusual” or “crazy.” It is everywhere. Along with anxiety (which occurs more frequently than depression), it is the common cold of emotional problems. During any given year, a large number of people will suffer from major depression: 25% of women and 12% of men will suffer a major depressive episode during their lifetime. The chances of recurrence of another episode after the initial episode are high. Fortunately, there are highly effective treatments that can significantly reduce the likelihood of a relapse.

The reason for the sex difference in prevalence of depression is not entirely clear. Possible reasons may be that women are more willing to acknowledge feelings of sadness and self-criticism openly, whereas men may “mask” or hide their depression behind other problems, such as alcohol and drug abuse. In addition, women are often taught from an early age to be helpless and dependent. Women may also control fewer sources of rewards than men do, and their achievements may be more often discounted.

WHAT ARE THE CAUSES OF DEPRESSION?

There is no one cause of depression. We view depression as “multidetermined”—that is, a number of different factors can cause it. These factors can be biochemical, interpersonal, behavioral, or cognitive. Depression may be caused in some people by factors in one of these areas, but it is just as likely to be caused by a combination of factors from all these areas. Biochemical factors can include your family’s genetic predisposition and your current brain chemistry. Conflicts and losses in interpersonal relationships can be factors in causing depression, as can

(cont.)

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behavioral factors, such as increases in stress and decreases in positive, enjoyable experiences. Cognitive factors include various distorted and maladaptive ways of thinking. Let us look at the behavioral and cognitive factors in a little more detail.

HOW DOES BEHAVIOR AFFECT DEPRESSION?

The following is a more specific list of behavioral factors involved in depression.

1. **Loss of rewards.** Have you experienced significant losses in your life recently—for example, loss of work, friendships, or intimacy? There is considerable research evidence that people who suffer significant life stresses are more likely to become depressed—especially if they lack or do not use appropriate coping skills.

2. **Decrease of rewarding behavior.** Are you engaged in fewer activities that were rewarding for you in the past? Depression is characterized by inactivity and withdrawal. For example, depressed people report spending a lot of time in passive and unrewarding behaviors, such as watching television, lying in bed, brooding over problems, and complaining to friends. They spend less time engaged in challenging and rewarding behaviors, such as positive social interactions, exercise, recreation, learning, and productive work.

3. **Lack of self-reward.** Many depressed people fail to reward themselves for positive behavior. For example, they seldom praise themselves, or they are hesitant to spend money on themselves. Many times depressed people think that they are so unworthy that they should never praise themselves. Some depressed people think that if they praise themselves, they will become lazy and settle for less.

4. **Not using skills.** Are there any social skills or problem-solving skills that you are not using? Depressed people may have difficulty asserting themselves, maintaining friendships, or solving problems with their spouses, friends, or work colleagues. Because they either lack these skills or do not use the skills they have, they have greater interpersonal conflict and fewer opportunities to make rewarding things happen for them.

5. **New demands.** Are there new demands for which you feel ill prepared? Moving to a new city, starting a new job, becoming a parent, or ending a relationship and trying to find new friends can cause significant stress for many people.

6. **Being in a situation where you feel helpless.** Depression may result from continuing to stay in a situation in which you cannot control rewards and punishments. You feel sad or tired, lose interest, and feel hopeless because you believe that no matter what you do, you cannot make things better. Unrewarding jobs or dead-end relationships can lead to these feelings.

7. **Being in a situation of continual punishment.** This is a special kind of helplessness: Not only are you unable to get rewards, but you find yourself criticized by others and rejected. For example, many depressed people may spend time with people who criticize them or hurt them in various ways.

8. **Avoidance and passivity.** You may tend to avoid difficult or unpleasant experiences or feelings. This leads to fewer rewards and a greater sense of helplessness.

Although each of the factors of stress and loss described above may make you prone to depression, they do not necessarily have to result in depression. (For instance, a person may experience a loss but deal with it by increasing rewarding behaviors, learning new skills, redirecting attention and energy toward new goals, and using self-assertion.) Certain ways of thinking can increase your chances of becoming depressed, however. You are more likely to become depressed if you think that you are entirely to blame, that nothing can change, and that you should be perfect at everything. These *interpretations* of stress and loss are the “cognitions” or thoughts that you have about yourself and your environment. Cognitive therapy is specifically focused at identifying, testing, challenging, and changing these excessively negative views of life.

(cont.)

HOW DOES THINKING AFFECT DEPRESSION?

Certain ways you think (your cognitions) can cause depression. Some of these are described below:

1. **Dysfunctional automatic thoughts.** These are thoughts that come spontaneously and seem plausible; however, they reflect distorted perceptions and are associated with negative feelings such as sadness, anxiety, anger, and hopelessness. Examples of some types of these thoughts are the following:

Mind reading: "He thinks I'm a loser."

Labeling: "I'm a failure," "He's a jerk."

Fortunetelling: "I'll get rejected," "I'll make a fool of myself."

Catastrophizing: "It's awful if I get rejected," "I can't stand being anxious."

Dichotomous (all-or-nothing) thinking: "I fail at everything," "I don't enjoy anything," "Nothing works out for me."

Discounting positives: "That doesn't count because anyone could do that."

2. **Maladaptive assumptions.** These include ideas about what you think you *should* be doing. They are the rules by which depressed people think they have to live. Examples include the following:

"I should get the approval of everyone."

"If someone doesn't like me, that means I'm unlovable."

"I can never be happy doing things on my own."

"If I fail at something, then I'm a failure."

"I should criticize myself for my failures."

"If I've had a problem for a long time, then I can't change."

"I shouldn't be depressed."

3. **Negative self-concepts.** People who are depressed often focus on their shortcomings, exaggerate them, and minimize any positive qualities they may have. They may see themselves as unlovable, ugly, stupid, weak, or even evil.

4. **Negative preoccupation with thinking.** Many people get stuck on their negative thoughts and feelings, leading to greater passivity and avoidance.

WHAT IS COGNITIVE-BEHAVIORAL TREATMENT OF DEPRESSION?

The cognitive-behavioral treatment of depression is a highly structured, practical, and effective intervention for patients suffering from depression. This type of therapy treats depression by identifying and addressing the behaviors and thinking patterns that cause and maintain depression. This therapy focuses on your present, here-and-now thoughts and behaviors. You and your therapist will look at how actions, or lack of actions, contribute to your feeling bad or good. There are actions you can take to start feeling better. You and your therapist will also look at the negative and unrealistic ways of thinking that may make you feel depressed. Therapy can give you the tools to think more realistically and feel better.

In cognitive-behavioral therapy, you and your therapist will first identify your symptoms and how mild or severe they are. You will be asked to fill out forms or standardized questionnaires that can scientifically measure your symptoms. These may include the Beck Depression Inventory–II, the Quick Inventory of Depressive Symptomatology–Self-Report, the Global Assessment of Functioning, or other questionnaires. In the initial meetings, you will be asked to select goals you wish to attain—such as increasing self-esteem, improving

(cont.)

communication, reducing shyness, or decreasing hopelessness and loneliness. You and your therapist will monitor your progress in therapy by referring to your initial measures of symptoms and your movement toward the goals that you establish.

HOW EFFECTIVE IS COGNITIVE-BEHAVIORAL THERAPY FOR DEPRESSION?

Numerous research studies conducted at major universities throughout the world have consistently demonstrated that cognitive-behavioral therapy is as effective as antidepressant medication in the treatment of major depression. Moreover, most patients in cognitive-behavioral therapy maintain their improved mood when checked 2 years after ending therapy. In cognitive-behavioral therapy, we hope not only to reduce your symptoms, but to help you learn how to keep those symptoms from coming back.

ARE MEDICATIONS USEFUL?

Various medications have been found to be effective in the treatment of depression. It takes 2 to 4 weeks for you to build up a therapeutic level of the medication in your system. Some medications may have negative side effects. Some of these side effects may be temporary and decrease over time, or they may be handled with combinations of other medications.

WHAT IS EXPECTED OF YOU AS A PATIENT?

Cognitive-behavioral treatment of depression requires your active participation. During the initial phase of therapy, your therapist may request that you come to therapy twice per week until your depression has decreased. You will be asked to fill out forms evaluating your depression, anxiety, and other problems, and to read materials specifically addressing the treatment of depression. In addition, your therapist may ask you at later points, or on a weekly basis, to fill out forms evaluating your depression and other problems that are the focus of therapy. Your therapist may also give you homework exercises to assist you in modifying your behavior, your thoughts, and your relationships. Although many patients suffering from depression feel hopeless about improvement, there is an excellent chance that your depression may be substantially reduced with this treatment.

FORM 2.8. Patient's Weekly Activity Schedule

Patient's name: _____ Today's date: _____

For each hour of the week, fill in what you *actually did* and ratings for how much pleasure and mastery you *actually experienced*. To rate pleasure, use a scale where 0 = "no pleasure" and 10 = "the most pleasure you can imagine," with 5 indicating a moderate amount of pleasure. For example, fill in "talked with friend, 6" in the box for Tuesday at 10 A.M. if you rate yourself as experiencing that amount of pleasure from talking with a friend at that day and hour. To rate mastery (the feeling of effectiveness or accomplishment you get from an activity), use a similar 0–10 scale, and write the rating as the second number after the activity (e.g., "talked with friend, 6/5").

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6 A.M.							
7							
8							
9							
10							

(cont.)

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FORM 2.8. Patient's Weekly Activity Schedule (p. 2 of 3)

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
11							
12 noon							
1 P.M.							
2							
3							
4							
5							
6							

(cont.)

FORM 2.8. Patient's Weekly Activity Schedule (p. 3 of 3)

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7							
8							
9							
10							
11							
12 midnight							
1-6 A.M.							

FORM 2.9. Patient's Weekly Planning Schedule: Predicting Pleasure and Mastery

Patient's name: _____ Date: _____

For each hour of the week, fill in what you *plan to do* and how much pleasure and mastery you *think you will experience*. To rate pleasure, use a scale where 0 = "no pleasure" and 10 = "the most pleasure you can imagine," with 5 indicating a moderate amount of pleasure. For example, if you predict that you will derive a pleasure rating of 6 if you exercise at 8 A.M. on Monday, then write "exercise, 6" in the box for Monday at 8 A.M. To rate mastery (the feeling of effectiveness or accomplishment you get from an activity), use a similar 0–10 scale, and write the rating as the second number after the activity (e.g., "exercise, 6/8").

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6 A.M.							
7							
8							
9							
10							

(cont.)

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FORM 2.9. Patient's Weekly Planning Schedule (p. 2 of 3)

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
11							
12 noon							
1 P.M.							
2							
3							
4							
5							
6							

(cont.)

FORM 2.9. Patient's Weekly Planning Schedule (p. 3 of 3)

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7							
8							
9							
10							
11							
12 midnight							
1-6 A.M.							

FORM 2.10. Patient's Daily Record of Dysfunctional Automatic Thoughts

Patient's name: _____ Date: _____

Time	Situation: Specify what happened, where, and who was involved.	Emotions: Specify emotion and rate its intensity (0–100%).	Automatic thoughts: Write automatic thoughts that preceded emotions; rate each for confidence in accuracy (0–100%).	Rational responses: Write rational responses to automatic thoughts; rate each for confidence in accuracy (0–100%).	Outcome: Now rate present confidence in accuracy of original thought, and present intensity of emotion (0–100%).	
					Thought	Emotion

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FORM 2.11. Information for Patients about Insomnia

One of the most troubling consequences of anxiety and depression is insomnia. Some people experience difficulty falling asleep (“onset insomnia,” which is usually linked to anxiety), while others tend to wake prematurely (“early-morning insomnia,” linked to both anxiety and depression). Usually when anxiety and depression lift as a result of treatment, insomnia decreases and sleep becomes more restful. However, several cognitive-behavioral interventions may be used to address your insomnia directly. This handout will outline some of these interventions. However, before undertaking any of them, you should record some baseline information concerning your sleep patterns. You can then compare any changes in these patterns with the baseline measures.

An issue to be addressed at the outset is sleep medication. In general, your sleep problems are related to how various factors affect your “circadian rhythms.” These are the daily hormonal changes that influence when you feel sleepy and when you feel awake. It’s important to let those natural rhythms assert themselves. Therefore, in order for the cognitive-behavioral approach to have its proper effect, you may want to consider getting off whatever sleeping pills you may be taking. Sleeping pills artificially alter your circadian rhythms; they will interfere with the techniques outlined here. Actually, research shows that cognitive-behavioral therapy is far more effective than sleeping pills in reversing insomnia. (Pills rarely work other than in the short term.) Before you make any changes in medication, consult your physician.

It takes a certain amount of time for progress to be felt—perhaps weeks. Because your disturbed sleep patterns have taken a long time to learn, it may take you a while to unlearn them. Do not expect immediate results.

HOW TO OVERCOME YOUR INSOMNIA

1. **Develop regular sleep times.** Try to arrange your life so that you go to bed and get up at about the same times. This may mean sometimes retiring or rising regardless of how tired you are.
2. **Avoid naps.** Naps may feel good and make you feel as if you’re catching up on sleep, but they can throw off your circadian rhythms. You need to retrain your brain to fall asleep and wake up at certain consistent times. So eliminate naps.
3. **Use the bed only for sleep (or sex).** Insomnia is often stimulated by increased arousal just before bedtime or while you are lying in bed awake. Many people with insomnia use their beds for reading, watching television, phone calls, or just plain worrying. As a result, the bed becomes associated with arousal and anxiety. It’s important that the bed be used only for sleep (or sex). Read or talk on the phone in another room. Discourage friends from calling after you are in bed.
4. **Avoid anxiety arousal during the hour before bedtime.** Avoid arguments and challenging tasks before you go to bed. You don’t want to be revved up. Have a wind-down time for the hour before bed. Do something relaxing or boring. Don’t exercise before going to bed.
5. **Get your “worry time” and “to do lists” over with earlier.** Most insomnia is due to excessive mental activity. You are simply thinking too much before you go to bed. You may be lying in bed thinking about what you have to do tomorrow. Or you may be thinking about what happened today. *This is too much thinking.* Set aside a worry time *3 hours or more before* you go to bed. Write out your worries; ask yourself if there is some productive action you need to take; make up a to-do list; plan what you will do tomorrow or this week; accept some limitations (you won’t get everything done, it will be imperfect); and accept some uncertainty. If you are lying in bed at night worrying about something, get out of bed, write down the worry, and set it aside for tomorrow morning. You don’t need to know the answer right now.

(cont.)

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6. **Discharge your feelings.** Sometimes insomnia is due to harboring emotions and feelings that are bothering you. It is useful to set aside “feeling time” several hours before you go to bed and write out your feelings—for example, “I was really anxious and angry when Bill said that to me,” or “I really got depressed after I had lunch with Joan.” Try to mention as many feelings as you can in your writing. Try to make sense of your feelings. Have compassion for yourself, validate your right to have feelings, and recognize that it is OK to feel anxious or depressed some of the time. Then set this aside. Do this 3 hours or more before you go to bed.
7. **Reduce or eliminate intake of liquids and some foods in the evening.** Sleep is often disturbed by urinary or digestive urgency. Avoid liquids in general (especially alcohol), caffeine products, heavy foods, fats, and sugar in the evening. If necessary, consult a nutritionist to plan a diet that encourages sound sleep.
8. **Get out of bed if you’re not sleeping.** If you are lying awake at night for more than 15 minutes, get up and go in the other room. Write down your negative thoughts and challenge them. Typical negative automatic thoughts are “I’ll never get to sleep,” “If I don’t get enough sleep, I won’t be able to function,” “I need to get to sleep immediately,” and “I’ll get sick from not getting enough sleep.” The most likely consequence of not getting enough sleep is that you will feel tired and irritable. Although these are uncomfortable inconveniences, they are not catastrophic.
9. **Don’t try to force yourself to fall asleep.** This will only increase your frustration, and in turn will increase your depression or anxiety. A more effective attitude is to let go of the attempt to fall asleep. Paradoxically, a very effective way of increasing sleep is to practice *giving up* trying to fall asleep. You can say to yourself, “I’ll give up trying to get to sleep and just concentrate on some relaxing feelings in my body.”
10. **Practice repeating your depressed or anxious thoughts.** Like any feared situation or thought, if you repeat it long enough, it becomes boring. You can practice this thought slowly: Stand back in your mind as if you are just “observing the thought,” and repeat it slowly and silently in your mind hundreds of times. Imagine that you are almost a zombie repeating this thought. Don’t try to reassure yourself; just stay with the thought and go slowly.
11. **Eliminate safety behaviors.** To combat your sleep anxiety, you may have been resorting to superstitious behaviors, such as checking the clock, counting, keeping your body motionless, or repeating injunctions to yourself like “Stop worrying.” Try and become aware of these, and give them up. You can, for example, turn the clock away from your bed. Or you can just allow whatever comes into your mind to be there, without trying to control it.
12. **Challenge your negative thoughts.** The whole process of going to sleep is complicated by the fact that your mind develops a whole range of negative thoughts about it. These thoughts then prevent you from sleeping. If you question their validity, they will have less power to cause you anxiety. Here are some typical negative thoughts of people with insomnia, together with what a reasonable response to each one might look like:

Negative thought: “I’ve got to fall asleep right now, or I won’t be able to function tomorrow.”

Rational response: “Actually, there’s no urgency. You’ve done without sleep before. You’ll be a little tired, which is uncomfortable and inconvenient, but hardly the end of the world.”

Negative thought: “It isn’t normal to have this kind of insomnia. It means there’s something wrong with me.”

Rational response: “Unfortunately, insomnia is quite common. Almost everyone experiences it sometimes. No one will think less of you for having it.”

(cont.)

Negative thought: "I could will myself to go to sleep if I tried hard enough."

Rational response: "Trying to force yourself to sleep never works. It increases anxiety, which only fuels your insomnia. It's better to let go of the attempt, and give in to *not* sleeping. Then you can relax a little."

Negative thought: "I need to remember all the things I'm lying awake thinking about."

Rational response: "If something is worth remembering, get out of bed, write it down, and go back to bed. There's plenty of opportunity to plan things tomorrow."

Negative thought: "I never get enough sleep."

Rational response: "This is probably true for most people, but it's simply uncomfortable and inconvenient. It's not the end of the world."

SLEEP RESTRICTION THERAPY: A POWERFUL ALTERNATIVE

There's a more dramatic treatment for insomnia that is sometimes effective. It's called "sleep restriction therapy." It's based on the idea that you need to retrain your brain to adjust to a circadian rhythm. This is more challenging than the program outlined above, but sometimes it's what works best. It may involve the use of special "bright light" to establish a regular pattern of light and darkness. This can come from sunlight (if controlled by shades or blinds), high-intensity lamps, or certain commercially produced bright lights designed for this purpose. (Lights of this last type are available from Apollo Light, at www.apollolight.com, or Sunbox, at www.sunbox.com, as well as other manufacturers.)

The steps involved in sleep restriction therapy are as follows:

1. **Go without sleep for 24 hours.** This is quite a difficult first step, and many people will feel quite exhausted from it. But it may help you reestablish your circadian rhythms. If you cannot bring yourself to go without sleep for 24 hours, then you can start with the second step.
2. **Start with your minimum sleep time.** Look at your baseline information. What's the minimum amount of sleep you've had over the preceding week? If it's 4 hours, plan to begin by sleeping only 4 hours, no matter how tired you are. If you plan to get up at 7 A.M., then go to bed at 3 A.M.
3. **Increase sleep time gradually.** Add 15 minutes per night to your sleep. Go to bed 15 minutes earlier each night. For example, if you went to bed at 3 A.M., then go to bed at 2:45 A.M. the next night and 2:30 A.M. the night after.
4. **Don't demand 8 hours.** Many of us don't really need a full 8 hours of sleep. See if you're developing less fatigue and more alertness during the day before leveling off.

Although sleep restriction therapy seems quite difficult to many people, it can be highly effective. After you have completed sleep restriction therapy, you may use the 12 steps outlined earlier for healthy sleep. An occasional night of insomnia is to be expected for all of us, but developing the proper sleep habits is quite important. Improving your sleep can have a significant impact on your anxiety and depression.

Panic Disorder and Agoraphobia

DESCRIPTION AND DIAGNOSIS

Symptoms

A panic attack is a sudden and distinct episode of discomfort and/or fear that is accompanied by various physical symptoms (e.g., heart palpitations, trembling, sensations of choking or shortness of breath, sweating, chest pain, nausea, dizziness, numbness, tingling, hot or cold flashes, lightheadedness) and cognitive symptoms (e.g., fear of losing control, fear of dying, and feelings of detachment or unreality). These attacks begin abruptly and are brief, seldom lasting longer than 30 minutes, with peak anxiety reached at 10 minutes or less.

Panic attacks can come seemingly from nowhere (“unexpected” attacks), or they can occur in the presence of a feared situation (“situational” attacks; e.g., an individual with a fear of elevators has attacks upon entering an elevator). Cognitive symptoms such as a fear of losing control, going insane, or dying, along with an urge to escape or flee the situation, are cardinal features of unexpected attacks. Over time, recurring unexpected attacks often become situational.

Although panic attacks can occur in the context of other anxiety disorders, and situational attacks can occur in panic disorder, a patient *must* experience unanticipated panic attacks in order to be assigned a diagnosis of panic disorder. Panic disorder is diagnosed if the individual experiences persistent, unforeseen attacks and experiences continual apprehension either about having future attacks or about the repercussions of these attacks—or, alternatively, modifies his or her behavior as a result of having panic attacks.

After the first panic attack, individuals with panic disorder typically become overly focused on the physical sensations of panic (“interoceptive stimuli”). They begin to worry about repercussions of these physical symptoms (e.g., “My racing heart might lead to a heart attack”), with the result that they develop persistent anticipatory anxiety about having future attacks. Many individuals with panic disorder also change their behavior because of the attacks and may develop agoraphobic symptoms.

Approximately one-third to one-half of individuals with panic disorder in the community also meet criteria for agoraphobia, although this proportion is much higher in those presenting for treatment. Unlike specific phobia, agoraphobia is not a fear of an object or situation. It is a fear of being in places in which one might experience a panic attack and cannot easily get help, along with a fear that the panic attack will lead to loss of control, illness, or death. Commonly feared

places include open or closed spaces; being alone or in crowds; public places; bridges, tunnels, or elevators; and traveling in buses, trains, automobiles, or airplanes. However, individuals may fear or avoid a variety of situations, including their own homes. Persons suffering from agoraphobia may either avoid these situations entirely or endure them but with distress. They may also develop “safety behaviors” to cope with situations they are unable to avoid. For example, a man may only be able to go to a shopping mall if his wife accompanies him.

For detailed descriptions of the current diagnostic criteria for panic disorder and for agoraphobia, refer to DSM-IV-TR (American Psychiatric Association, 2000, pp. 430–443).

Although agoraphobia is a result of panic disorder for many individuals, it can also occur in individuals without panic disorder and has also been shown to predict future episodes of panic disorder (Craske & Barlow, 2008). Individuals with a diagnosis of agoraphobia without a history of panic disorder are far less likely to present for treatment than are those who have panic disorder with agoraphobia. Although they do not have full-blown attacks, individuals who only have agoraphobia appear to experience panic-like sensations (e.g., stomach distress, loss of bladder or bowel control), and up to 57% report limited-symptom attacks. The pattern of agoraphobic avoidance and the treatment approach are similar to those individuals who have panic disorder with agoraphobia (Barlow, 2002).

Because of the generality, seeming unpredictability, and lack of control that characterize panic attacks, individuals who have panic disorder—and especially those who also have agoraphobia—find their lives greatly constricted by the need to avoid a variety of situations. As they seek ways of adapting to their symptoms, the consequence for many is depression as their zone of comfort gets narrower over time. Some will only live or work on the first or second floor of buildings, thereby avoiding the risk of being trapped in an elevator or a stairwell. Others arrange to do all their shopping by phone or accompanied by a family member (the “safety person”). Many individuals self-medicate with alcohol and sedative drugs, and present to clinicians with substance abuse as their primary diagnosis. In fact, their other symptoms may not be evident until after detoxification has begun.

Individuals with panic disorder may also be awakened from sleep with panic attacks. Nocturnal panic attacks appear to occur in approximately 50% of individuals with panic disorder; they tend to occur between 1 and 4 hours after sleep onset, during the transition into slow-wave sleep (Craske, 1999; Uhde, 1994). This indicates that unlike daytime attacks, nocturnal panic attacks occur when individuals are in a relaxed, deep state of sleep and have reduced eye movements, lowered blood pressure, and reduced heart rate and respiration. According to Barlow (2004), nocturnal attacks may be similar in nature to relaxation-induced panic attacks, which appear to be triggered by fear associated with the physical sensations of relaxation. In addition, nocturnal panic attacks may be more severe than daytime panic attacks (Barlow & Craske, 1988; Craske & Rowe, 1997). Some evidence also suggests that individuals who suffer from nocturnal panic attacks may have more severe and frequent daytime attacks, more comorbid illnesses, and an earlier onset of illness (Barlow, 2004).

Prevalence and Life Course

Panic attacks, in the absence of a diagnosable anxiety disorder, occur in 22% of the general population (Kessler, Berglund, et al., 2005). By contrast, lifetime prevalence of panic disorder with

or without agoraphobia typically ranges between 1% and 3.5%, while the 12-month prevalence rate ranges from 0.5% to 1.5%; however, 12-month rates as high as 2.7% have been reported (American Psychiatric Association, 2000; Grant et al., 2006; Kessler, Chiu, et al., 2005). Rates of panic disorder with and without agoraphobia are considerably higher in clinical samples, with 10% of individuals referred for mental health consultation meeting diagnostic criteria for panic disorder; the vast majority of these also present with agoraphobia. From 10% to 30% of individuals presenting at general medical clinics, and up to 60% of those presenting to cardiology clinics, meet criteria for panic disorder.

Panic disorder occurs more frequently in women, occurring approximately 1.3 times more frequently among individuals without agoraphobia (Pollack, 2005). Among those who have panic disorder with agoraphobia, this proportion is greater; women are three to four times more likely than men to meet this diagnosis (Eaton, Dryman, & Weissman, 1991; Kessler, Berglund, et al., 2005; Pollack, 2005). Various reasons have been posited to explain these discrepant findings, including differences in coping strategies, a greater cultural acceptability, hormonal influences, and other (Barlow, 2002).

Although epidemiological studies have found similar rates of panic disorder in European American, African American, and Hispanic American groups (Eaton et al., 1991; Horwath, Johnson, & Hornig, 1993), African Americans are underrepresented in clinical samples, tend to have a later age of onset, and may use different coping behaviors (Paradis, Hatch, & Friedman, 1994; Smith, Friedman, & Nevid, 1999). However, studies comparing different ethnic and cultural groups are few and far between, and confounding variables such as the assessment tools used, the effects of socioeconomic status, and the role of social support in studies conducted so far make it difficult to draw firm conclusions (Barlow, 2002).

Although commonalities are present across different cultures, some differences in panic symptomatology are also evident. Panic-like syndromes have been variously described as “brain fog” in West Africa, “ghost sickness” among the Navajo, *hwa-byung* and *shin-byung* in Korea, and *shenjing shuairuo* and *shenkui* in China (Hsia & Barlow, 2001). For example, Cambodians report a panic-like syndrome loosely translated as “sore neck syndrome,” characterized by somatic arousal, headaches, dizziness, and distorted vision (Hinton, Ba, Peom, & Um, 2000). However, given their cultural belief in the concept of *kyol goeu* (“wind overload,” or a syndrome in which an imbalance of wind within the body may have fatal consequences), many Khmer who experience panic attacks also report other symptoms, such as sensations of wind surging out of bodily cavities or upward from the abdomen. They also report catastrophic fears of dying from a rupture of blood vessels in the neck secondary to increased wind pressure and blood flow (Hinton, Um, & Ba, 2001). Although *ataque de nervios* (literally, “an attack of the nerves”—a syndrome observed in Hispanic populations, especially those from Caribbean regions) has many similar symptoms, *ataque de nervios* may be followed by cursing, falling to the floor, or memory loss, and is considered to be a cultural acceptable response to difficult life circumstances (Guarnaccia, Rubio-Stipec, & Canino, 1989).

The onset of a first panic attack is generally in a person’s early 20s, but may occur in late adolescence or in the mid-30s (American Psychiatric Association, 2000; Grant et al., 2006). Few individuals under age 16 or over age 45 report having a panic attack for the first time (Kessler, Berglund, et al., 2005). When agoraphobia is present, it typically occurs within the first year following the occurrence of panic attacks (American Psychiatric Association, 2000). Stressors such

as interpersonal problems, or physical difficulties such as a frightening experience with pharmacological substances, have been linked to panic onset (Barlow, 2002).

Like the other anxiety disorders, panic disorder is a stress-sensitive, chronic condition that waxes and wanes in severity over an individual's lifetime. However, episodic and continuous courses have also been reported in a minority of cases. Higher rates of recovery have been reported in individuals without agoraphobia, suggesting that the presence of agoraphobia is associated with a worse course of illness (Bruce et al., 2005; Yonkers, Bruce, Dyck, & Keller, 2003).

Genetic/Biological Factors

A biological basis for panic disorder can be traced to Klein's (1964) initial finding that imipramine was successful in alleviating panic attacks but not chronic anxiety, whereas benzodiazepines reduced general anxiety but not panic. Although subsequent research has demonstrated that both benzodiazepines and tricyclic antidepressants can alleviate spontaneous panic attacks *and* generalized anxiety, evidence still exists to support the view that panic is distinct from generalized anxiety and has a neurobiological etiology (McGinn & Sanderson, 1995). Support for a biological etiology of panic disorder comes from several lines of evidence, including genetic studies, laboratory provocation models, respiratory physiology theories, and studies assessing the effects of drugs on particular neurotransmitter systems (see McGinn & Sanderson, 1995, for a review).

Genetic Factors

Genetic studies suggest that panic disorder and agoraphobia have a moderate genetic loading (Hettema, Neale, & Kendler, 2001). For example, studies indicate that if one twin has panic disorder, a monozygotic or identical cotwin will be more likely than a dizygotic or fraternal one to have panic disorder. First-degree relatives of individuals with panic disorder are also eight times more likely to develop panic disorder (American Psychiatric Association, 2000; Hofmann, Alpers, & Pauli, 2009). However, monozygotic twins may also share more environmental experiences and be reared more similarly than dizygotic twins may be. Furthermore, 50–75% of patients in clinical samples do not have an affected family member, suggesting that genetics alone may be insufficient to explain why someone develops panic disorder.

Although the exact genes are unknown and findings are inconsistent, preliminary studies have linked panic to loci on chromosomes 13 and 9. Studies involving the adenosine receptor gene, markers for the cholecystokinin-B receptor gene, and studies of genes involved in specific neurotransmitter systems also report inconsistent findings. At this stage, there is no evidence for a link among specific genetic markers, temperament, and panic disorder; however, the bulk of research supports the notion that there may be a nonspecific biological vulnerability in panic disorder (see Craske & Barlow, 2008, for a review).

Hyperventilation Theories

Since the symptoms of a panic attack closely resemble those experienced during hyperventilation, several conceptualizations have been used to explain why hyperventilation may occur

in panic disorder (see McGinn & Sanderson, 1995, for a review). Liebowitz et al. (1986) first proposed that the key disturbance in panic disorder may be a dysfunctional suffocation monitor. Throughout evolution, a highly sensitive “alarm system” has developed to detect when an organism is in danger of suffocation. High carbon dioxide (CO₂) levels usually indicate that the organism is in danger of imminent suffocation, since high levels of CO₂ correspond with low levels of oxygen. Liebowitz et al. (1986) suggested that for individuals with panic disorder, this suffocation threshold is abnormally lowered; that is, their suffocation monitor becomes hypersensitive to CO₂, so that even low levels of CO₂ become a signal for low oxygen supply. As a result, the brain’s suffocation monitor inaccurately signals a lack of oxygen, and thereby triggers a false suffocation alarm. These researchers hypothesized that since these individuals believe they are suffocating, they (1) experience shortness of breath and (2) begin hyperventilating in order to keep CO₂ levels well below the suffocation threshold. Therefore, according to Liebowitz et al., hyperventilation is a consequence and actually a defense against panic onset.

An alternative theory of hyperventilation proposes that hyperventilation is secondary to the experience of fear (see McGinn & Sanderson, 1995, for a review). This model suggests that the fear of having a panic attack gives rise to physical symptoms, which in turn lead to increased fear, hyperventilation, and so on, until an individual experiences a full-blown panic attack. However, this theory does not describe the specific events that give rise to the experience of fear; nor does it explain why panic attacks are not caused in all individuals who experience fear.

Laboratory models propose an underlying biological dysfunction in panic disorder and have been based on studies showing that individuals with panic disorder have elevated responses (e.g., a panic attack) to substances such as sodium lactate and CO₂ (Hofmann et al., 2009; McGinn & Sanderson, 1995). Respiratory physiology theories propose that these substances, which are not believed to trigger any single neurotransmitter system, provoke panic attacks by stimulating the dysfunctional respiratory system (McGinn & Sanderson, 1995). A dysregulation in the noradrenergic, serotonergic, and benzodiazepine systems has also been proposed, on the basis of the fact that antidepressant medications and benzodiazepines alleviate panic attacks.

Overall, findings from provocation and treatment studies show that individuals with panic disorder are more likely than those without the disorder to have panic attacks during laboratory provocations. These studies also demonstrate that laboratory-induced attacks are similar to attacks that occur naturally, and that both naturally occurring and laboratory-induced panic attacks can be blocked or alleviated by antipanic medications (see McGinn & Sanderson, 1995, for a review). However, given the fact that multiple biological substances can induce and alleviate panic attacks, it is likely that a common nonspecific effect rather than any specific biological agent triggers panic attacks (Hofmann et al., 2009). Furthermore, given that psychological therapies can also block and alleviate both naturally occurring and laboratory-induced panic attacks, and that psychological factors such as variations in instructional set and an illusion of control can mediate the induction of panic, biological theories alone appear to be insufficient to explain the etiology of panic disorder (Hofmann et al., 2009; McGinn & Sanderson, 1995).

Evolutionary Models

The evolutionary model of panic and agoraphobia suggests that fear is an unconditioned response to a dangerous situation, and that sensitivity to certain stimuli or conditions (e.g., heights, being

trapped in closed spaces, open fields, public places, being left alone) may be biologically adaptive in the species. For example, crossing an open field poses greater danger because of vulnerability to being sighted and attacked by predators. The response to this is the “fight-or-flight” response, similar to the sympathetic arousal observed during panic attacks. In the psychopathological model of panic, the body’s emergency response to danger or the fight-or-flight response is believed to become unduly hypersensitive, triggered by false alarms rather than truly dangerous situations and hence is no longer adaptive. Furthermore, since the fight-or-flight response is often blocked in contemporary life (e.g., on subways or in supermarkets), the anxiety escalates to a panic attack (Beck & Emery with Greenberg, 1985; Marks, 1987; Ninan & Dunlop, 2005b). The subsequent avoidance prevents the anxiety from escalating again, but inadvertently continues to strengthen the fear connection in the brain, leading individuals to fear and avoid somatic sensations similar to panic (Ninan & Dunlop, 2005b).

Coexisting Conditions

Approximately 50% of individuals with panic disorder present with at least one comorbid disorder; most common are other anxiety disorders, mood disorders, substance use disorders, and personality disorders (Barlow, 2002; Craske & Barlow, 2008). However, research suggests that these comorbid conditions, including personality disorders, improve with treatment of panic disorder.

Frequently coexisting with panic disorder are the following specific Axis I conditions: major depression, dysthymia, social anxiety disorder (social phobia), generalized anxiety, obsessive-compulsive disorder, specific phobia, hypochondriasis, and substance dependence or abuse. Approximately one-quarter of patients with panic disorder have concurrent major depressive disorder, 16% have generalized anxiety disorder, and 15% have social anxiety disorder or specific phobia. In addition, approximately 15% of those who have panic disorder utilize alcohol as a form of self-medication (Robinson, Sareen, Cox, & Bollon, 2009). Withdrawal from alcohol or other substances used may also precipitate panic attacks. Finally, between 25% and 65% of individuals with panic disorder also have a personality disorder—usually dependent, avoidant, or histrionic personality disorder (Barlow, 2002; Grant et al., 2006; Sanderson & McGinn, 1997).

Although a few studies in the past indicated a high risk of suicide in patients with panic disorder, reanalyses of these data along with findings from newer studies suggest that the risk of suicide in panic may be related to the presence of comorbid disorders, such as depression, borderline personality disorder, or concomitant substance abuse. Thus panic disorder per se does not appear to be a strong predictor of suicidal risk, although further data need to be collected to clarify the relationship between panic disorder and suicide (see Barlow, 2002, for a review).

Functional Impairment

The cost of having panic disorder is high, both for the affected individual and for society. Individuals with panic disorder experience high levels of occupational, interpersonal, and physical disabilities. They tend to be among the highest utilizers of medical services, including emergency room visits and inpatient hospitalizations (Barlow, 2002). They also tend to miss twice as many work days as other psychiatric patients do, and to report greater impairment than individuals with many chronic and terminal medical diseases do, leading to both direct (e.g., hospitaliza-

tions) and indirect (work productivity) costs to the health care system (Barlow, 2002). For example, an individual who has panic disorder with agoraphobia may be unable to work outside the home or to work in jobs that require taking elevators or traveling. The person may also regularly present to the emergency room during a panic attack.

Panic disorder and agoraphobia also have substantial consequences for affected individuals' interpersonal functioning. The fear of panic attacks in public places may dramatically curtail the patients' ability to socialize with other people. For example, a single woman with a history of agoraphobia was unable to go to restaurants or theaters, or even to travel more than a few blocks from her house. Consequently, her opportunity to meet people or to develop relationships was substantially diminished. As indicated earlier, many individuals with agoraphobia often rely on "safety persons" who can accompany them in case they have a panic attack, are consequently unable to be alone or drive, and require "escape" from public places or medical attention. They may cling to these persons and/or demand constant reassurance from them. As a result, the burden on the safety persons, who are often parents, spouses/partners, or children, is tremendous and can lead to a strain in the very relationships that the individuals with panic disorder consider to be critical for their survival. Because of their fear of a panic attack, some individuals who have panic disorder with agoraphobia may also be hesitant to assert themselves in close relationships, to avoid risking abandonment and the resulting feelings of helplessness.

Differential Diagnosis

Common Medical or Physical Factors that Mimic Panic

The following physiological disorders are accompanied by panic-like symptoms and should be ruled out (Fyer, Manuzza, & Coplan, 1995; Simon & Fischmann, 2005; Wilson, 2009):

1. **Cardiovascular:** Arrhythmia, tachycardia, coronary heart disease, myocardial infarction (recovery from), heart failure, mitral stenosis, mitral valve prolapse (MVP), hypertension, postural orthostatic hypotension, stroke, transient ischemic attack, pulmonary embolism, pulmonary edema.
2. **Respiratory:** Bronchitis, emphysema, asthma, collagen disease, pulmonary fibrosis, chronic obstructive pulmonary disease, asthma.
3. **Endocrine/hormonal:** Hyperthyroidism, hyperparathyroidism, hypoglycemia, premenstrual syndrome, pregnancy, pheochromocytoma, carcinoid tumors.
4. **Neurological/muscular:** Temporal lobe epilepsy, myasthenia gravis, Guillain–Barré syndrome.
5. **Aural/vestibular:** Meniere's disease, labyrinthitis, benign positional vertigo, otitis media, mastoiditis.
6. **Hematic:** Anemia.
7. **Drug-related:** Antidepressant withdrawal, sedative or tranquilizer withdrawal, alcohol use or withdrawal, stimulant use, side effects of medications, caffeinism.

Since many individuals with panic disorder have initially contacted a physician because of their fear that they have a life-threatening illness, medical causes may already be ruled out by

the time a patient sees a therapist. However, because panic symptoms may reflect other medical conditions or substance use, it is essential for the patient to have a thorough medical evaluation before psychological treatment commences. If panic attacks only occur during a medical illness or during substance use or withdrawal, panic disorder is *not* diagnosed, as the attacks are judged to be direct results of the illness or substance.

Two points in the list above deserve further comment. First, individuals with panic disorder may also have MVP, which in most people is a benign condition that does not require treatment or changes in lifestyle. MVP can be diagnosed by an echocardiogram and should be evaluated to determine whether it requires treatment. Although most patients with MVP do not have panic disorder and most individuals with panic disorder do not have MVP, it is important for the clinician to determine whether patients with comorbid MVP are overinterpreting symptoms of MVP (e.g., dizziness and palpitations), thereby worsening symptoms of panic disorder. (See McNally, 1994, for a discussion of MVP and panic.)

Second, central nervous stimulants (e.g., cocaine, alcohol, amphetamines, and even caffeine), cannabis, or withdrawal from central nervous system depressants (e.g., alcohol, barbiturates) can precipitate panic attacks. Excessive alcohol abuse is also speculated to be a factor leading to the development of panic disorder, with the lifetime risk of this at about 1.2% (Cosci, Schruers, Abrams, & Griez, 2007). A definitive diagnosis of substance-induced panic may only be made once substances are fully withdrawn. It is important to keep in mind that panic disorder may precede substance use and that substances may be used for purposes of self-medication. In that case, both diagnoses may be present.

Other Psychological Disorders

Panic disorder must also be differentiated from other mental disorders that have panic attacks as an associated feature. Given that the diagnosis of panic disorder depends on the presence of recurrent, unexpected panic attacks, other anxiety disorders may be present if panic attacks are only situational. For example, panic attacks in social anxiety disorder occur only in social or performance situations (e.g., eating in public or using a public restroom). Similarly, those in specific phobia occur only in the presence of the specific feared stimulus (e.g., touching a snake), and those in obsessive–compulsive disorder occur only during exposure to the stimulus that is the content of the obsession (e.g., exposure to dirt). If the panic attacks occur only in the context of the feared symptoms characteristic of another anxiety disorder (e.g., worry), then a diagnosis of panic disorder is not made. As indicated above, many individuals may meet criteria for panic disorder and a comorbid anxiety or depressive disorder; in those cases, both disorders should be diagnosed.

Given that a considerable percentage of patients with panic disorder also present with a personality disorder (Chambless & Renneberg, 1988; Mavissakalian & Hamann, 1986; Reich, Noyes, & Troughton, 1987), a differential diagnosis is important to determine whether symptoms are accounted for by one or both diagnoses. For example, if a woman is dependent on her spouse/partner only in situations where she is apprehensive about having panic attacks, a diagnosis of panic disorder may be sufficient to account for her symptoms. However, in other similar cases, panic disorder may be superimposed on preexisting dependent personality disorder, or the symptoms may be best explained by the presence of dependent personality disorder.

Consider the following example of conducting a differential diagnosis with anxiety disorders. A man complains of fear of elevators and will not go into an elevator. The question to be considered is the nature of feared consequences for the patient. Does the patient have a fear that the elevator will crash (specific phobia of elevators), or is he afraid that he will become so anxious that he will have a panic attack and lose control (panic disorder)? The treatment implications are different. Exposure to elevators (i.e., getting on elevators) addressing the catastrophic fears regarding elevators (e.g., that the elevator will crash) should be sufficient to treat symptoms of a specific phobia of elevators. However, if patient has panic disorder, exposure to the somatic sensations of panic attacks and disconfirmation of the catastrophic misinterpretations of having a panic attack (e.g., that the patient will have a heart attack or go insane) will be necessary, along with situational exposure to avoided situations such as an elevator (see Barlow & Cerny, 1988; D. M. Clark, 1986, 1989).

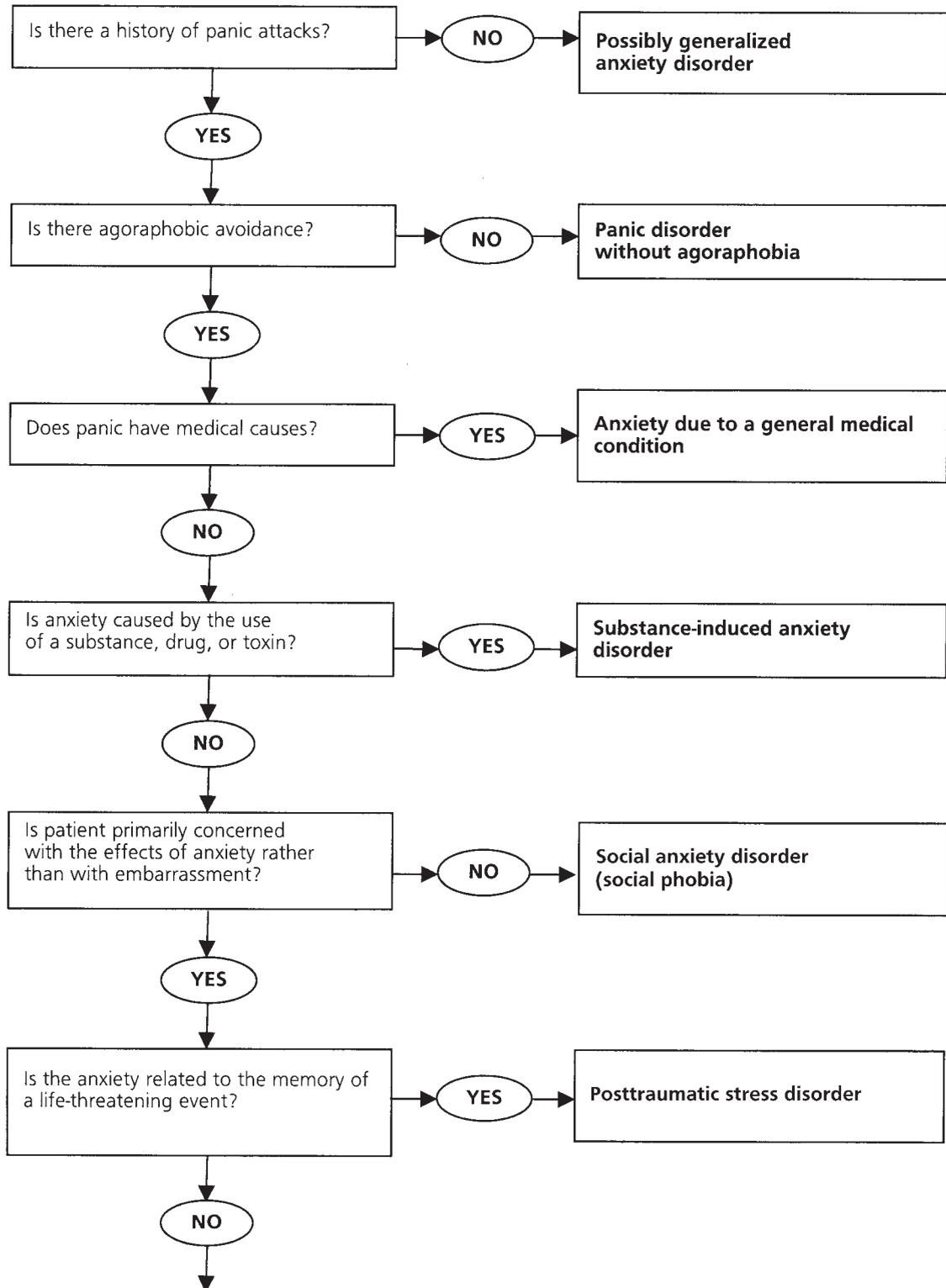
A therapist can determine which anxiety disorder a patient has by determining what the nature of the fear is and/or whether the panic attacks only occur in situations triggering the type of fear characteristic of the particular anxiety disorder. Answers of “yes” to the following questions indicate the probable diagnosis (see also the diagnostic flow chart in Figure 3.1):

- Is the patient afraid of the stimulus itself (e.g., elevators)?: Specific phobia.
- Is the patient afraid of negative evaluation (independent of panic)?: Social anxiety disorder.
- Is the patient afraid of the content of an obsessive thought?: Obsessive–compulsive disorder.
- Do the panic attacks only occur in the presence of general worry?: Generalized anxiety disorder.
- Do panic attacks only occur in the presence of stimuli related to a traumatic event?: Post-traumatic stress disorder.
- Does the patient have recurrent, unexpected panic attacks, and is the patient afraid of the somatic sensations of panic attacks?: Panic disorder (with or without agoraphobia, depending on whether or not there is agoraphobic avoidance).

UNDERSTANDING PANIC DISORDER AND AGORAPHOBIA IN COGNITIVE-BEHAVIORAL TERMS

A Cognitive-Behavioral Model

Our cognitive-behavioral model of panic disorder and agoraphobia is based on the adaptive nature of fears in primitive environments (Barlow, 1990; Beck et al., 1985; Marks, 1987; see also Chapter 7 of this volume). For example, avoiding open fields is adaptive for animals (like early humans) that are subject to predation, because they are at less risk on the periphery of a field. Heights (which often precipitate dizziness) are reasonable stimuli to avoid in the wild, because heights confer greater risk. The fear of being trapped can also be viewed as an “adaptive” fear. (See Marks, 1987, for an excellent discussion of innate fears.) These fears may have been retained in the species because of their potential adaptive value in facing danger—but, as discussed above,



(cont.)

FIGURE 3.1. Diagnostic flow chart for panic disorder with agoraphobia.

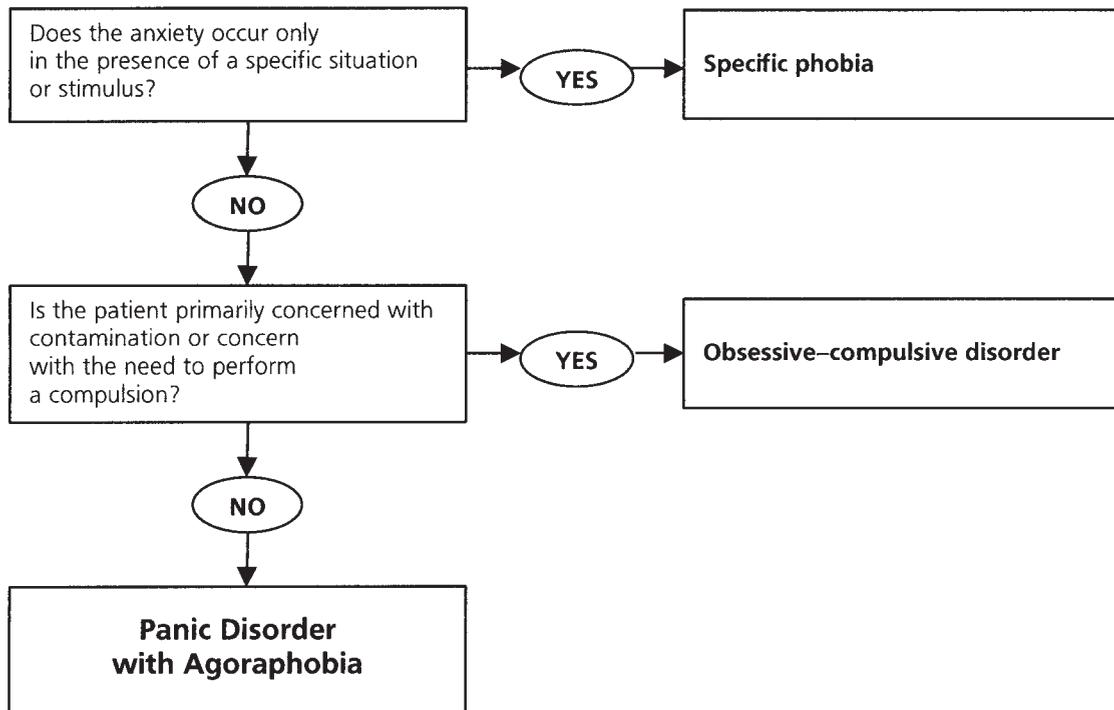


FIGURE 3.1 (cont.)

the fight-or-flight response that individuals experience during panic attacks is not adaptive, given that such attacks occur in the absence of true danger.

The cognitive-behavioral model assumes that individuals with panic disorder may first experience panic or a high level of anxiety due to biological vulnerability, stress, or physical causes (such as illness). The resulting sensations of physiological arousal (e.g., hyperventilation, sweating, dizziness, or heart palpitations) lead to catastrophic misinterpretations (e.g., "I'm having a heart attack!" or "I'm going crazy!"), and thus to hypervigilance. On subsequent occasions, the individual misinterprets the sensations of physiological arousal as indications that catastrophic consequences will inevitably occur (these misinterpretations are "false alarms"), and experiences a full-blown panic attack as a result. Consequently, the individual develops anticipatory anxiety and avoids other situations that he or she associates with the risk of anxiety; this establishes agoraphobia. In some cases patients with agoraphobia use safety behaviors or magical thinking to cope. While these techniques can reduce anxiety, overall they reinforce the agoraphobia and so contribute to it. Form 3.1, a diagram illustrating this cognitive-behavioral model of panic disorder and agoraphobia, is intended for use as a patient handout. We now discuss in more detail various factors that lead to and maintain these disorders.

Behavioral Factors

Behavioral models suggest that panic becomes associated with fear via a process of classical conditioning, and that this fear is maintained through operant conditioning by the decrease in anxiety that occurs when an individual avoids a situation or tolerates it with the use of safety

behaviors (Mowrer, 1939). This relief from anxiety is negatively reinforcing (via operant conditioning) to the individual and results in a stronger tendency to avoid the situation in the future. This avoidance generalizes to similar stimuli and becomes associated with others, thereby narrowing the person's world over time.

Biological and Environmental Factors

A comprehensive model proposed by Barlow (2002) outlines the biological, environmental, and psychological factors that create vulnerability for panic disorder. He proposes that individuals with panic disorder have a generalized, nonspecific biological vulnerability (e.g., heightened somatic overarousal, emotional lability) that may be activated by early psychological experiences related to uncontrollability and unpredictability, which in turn lead to internalized perceptions of lowered control over the environment. This diathesis can create a generalized psychological vulnerability to anxious apprehension in the context of stress and, in combination with a heritable tendency to react to stress with panic attacks, can create a specific neuropsychobiological diathesis for the development of panic disorder. According to Barlow's (2002) model, the initial attack or false alarm is triggered by stress in biologically vulnerable individuals and can be exacerbated by heightened negative affect. Next, in psychologically vulnerable individuals who have learned as young children to fear somatic events as being potentially dangerous, unpredictable, and uncontrollable, this false alarm (a spontaneous panic attack) becomes associated with danger (i.e., becomes a learned alarm), leading to anxious apprehension about future attacks and the development of panic disorder (recurrent, unexpected attacks along with fear of somatic sensations of panic). These individuals' inborn predisposition to be somatically preoccupied becomes intensified as they focus even more attention on themselves, with the result that they become even more sensitive to false alarms than they were when they had their first attack. Furthermore, Barlow believes that avoidance behaviors develop subsequently as a means of coping with unexpected panic, and are also determined at least partly by cultural, social, and environmental factors.

Barlow's theory of panic has received support from several sources (for reviews, see Barlow, 2002; Bouton, Mineka, & Barlow, 2001). There is clear evidence that internal or somatic cues can become conditioned to anxiety, and that exposure therapy can weaken these associations, supporting Barlow's claim that false alarms can become associated with somatic sensations. In addition, findings that patients with panic disorder exhibit greater fear over somatic sensations than do other psychiatric patients or normal controls support Barlow's contention that these individuals learn to become apprehensive about somatic cues. Finally, there is some evidence that individuals with panic disorder may have lowered perceptions of control and may have had more overprotective and overcontrolling parents than controls may. However, it is still not clear whether this trait is specific to these patients, or whether patients with other anxiety and depressive disorders share these features.

Barlow (Craske & Barlow, 2008) has stressed the heritable temperament of neuroticism (Eysenck, 1967, 1981) and the construct of negative affect (Mineka, Watson, & Clark, 1998) as distinguishing individuals with anxiety disorders (including panic) and depression from individuals without a mental disorder. He views neuroticism as a higher-order factor that creates a vulnerability to all anxiety disorders, as compared to the trait of anxiety sensitivity (the belief that anxiety and its symptoms have negative consequences). The latter is believed to provide a

small but significant psychological risk factor for panic disorder although the causal relationship between the two remains to be established (see Craske & Barlow, 2008, for a review).

Cognitive Factors

Cognitive models stress the notion that cognitive misappraisals (e.g., “Panic attacks are dangerous”) lead to avoidance of situations in which individuals fear that they will have a panic attack. As a result, these misappraisals are never disconfirmed (i.e., the individuals continue to believe that panic symptoms are dangerous), and thereby maintain panic and agoraphobic symptoms in the long run.

The cognitive model of panic disorder proposed by David M. Clark (1986, 1989) focuses on proximal factors leading to and maintaining panic attacks in individuals with panic disorder. Similar to Barlow’s model, Clark’s model proposes that panic attacks occur when individuals perceive certain somatic sensations as dangerous, and interpret them to mean that they are about to experience impending doom. For example, individuals may develop a panic attack if they misinterpret heart palpitations as a sign of an impending heart attack, or feelings of depersonalization as indicating that they will lose control or go crazy. Clark believes that these “catastrophic misinterpretations” may arise not only from fear, but from a variety of other emotions (e.g., anger or excitement) or from other stimuli (e.g., caffeine, exercise) that produce sensations or symptoms similar to those of a panic attack. The vicious cycle culminating in a panic attack develops when these stimuli are misappraised as signaling that a panic attack is imminent (e.g., “My heart is pounding, so I must be about to have a panic attack”) even if that is not the case (e.g., an individual’s heart is beating fast because he or she ran up the stairs). The state of anxious apprehension then goes on to trigger more feared symptoms of the fight-or-flight response (e.g., the person’s heart now begins to pound even harder now that anxiety has set in). If the physical sensations that accompany this state of apprehension are catastrophically misinterpreted (e.g., “These symptoms mean I am about to have a heart attack”), the individual experiences a further increase in apprehension, elevated somatic sensations, and so on, until a full-blown panic attack occurs.

Confirmation for this cognitive model of panic comes from the fact that individuals with panic disorder themselves report having thoughts of imminent danger during their panic attacks (e.g., heart attacks, insanity), *and* report that these thoughts typically occur after they notice specific bodily sensation. Other support for Clark’s model comes from the finding that laboratory-provoked attacks lead to similar physiological sensations in both patients with panic disorder and normal controls, but only the individuals with panic disorder catastrophically misinterpret these sensations go on to develop panic attacks. Furthermore, only patients who develop laboratory-induced panic attacks following the administration of a panicogenic substance report fears of going crazy or losing self-control. Additional support comes from studies demonstrating that panic attacks can be alleviated with cognitive techniques such as cognitive restructuring, which attempts to challenge catastrophic misinterpretations and replace them with rational thoughts (see McGinn & Sanderson, 1995, for a review).

COGNITIVE DISTORTIONS

Clark’s model describes how panic is exacerbated when misinterpretations or cognitive distortions by a patient with panic disorder lead to anticipatory anxiety about a future attack. The

initial misinterpretation or distortion (overestimating negative outcomes) focuses on the likelihood of having a panic attack (“My heart is beating, so I must be having a panic attack”); the second level (catastrophic thinking) focuses on the catastrophic misinterpretations of the panic attack (“If I have a panic attack, I will have a heart attack and die”). Patients also underestimate their ability to cope (“If I have a panic attack and faint, I won’t be able to handle it”), engage in self-criticism for having panic and agoraphobia (“I must be weak”), and begin assuming that they will never get better (“I am always going to suffer without relief”). As such, the treatment of panic needs to address and modify all levels of cognitive distortions experienced by a particular patient.

Cognitive therapy techniques—that is, identifying and challenging these cognitive distortions—are essential in identifying and modifying these misinterpretations. A therapist who follows a strictly *behavioral* approach often overlooks the importance of a patient’s interpretations and distortions of events, assuming that cognitions will be automatically corrected. However, simple exposure to feared situations may not be sufficient to reduce panic or anticipatory panic if the patient’s dysfunctional cognitions are not modified. The typical cognitive distortions of individuals with panic disorder include negative automatic thoughts (e.g., overestimating negative outcomes, catastrophic thinking, underestimating ability to cope, labeling, personalizing); underlying maladaptive assumptions (e.g., “should,” “if–then,” or “must” statements); and dysfunctional personal schemas (e.g., deep-seated beliefs in the self’s personal helplessness, vulnerability to harm, abandonment, weakness, and inferiority). Given that panic disorder is a fear of panic attacks, the patient’s erroneous cognitions leading to this fear offer excellent points of intervention, and modifying these beliefs reduces the “fear of fear.”

Table 3.1 illustrates the three categories of cognitive distortions—negative automatic thoughts, maladaptive assumptions, and dysfunctional schemas—for individuals with panic disorder. Later in this chapter, we provide guidelines for how such distortions may be modified.

How Cognitive, Behavioral, and Other Factors Interact

Critics contend that cognitive-behavioral models such as Barlow’s and Clark’s do not explain why individuals with panic disorder continue to misinterpret these somatic sensations, despite evidence to the contrary (i.e., when the catastrophic predictions do not come true). However, since patients with panic disorder take a variety of precautions to prevent the occurrence of an attack (e.g., they avoid or escape situations in which they believe attacks are likely to occur), it is likely that they never truly learn that their panic attacks will not lead to catastrophes, no matter what safeguards they may use. Moreover, since many patients rely on safety behaviors, they may misattribute safety to the use of these behaviors.

PREDISPOSING FACTORS

As discussed above, a predisposition for panic disorder is posited to develop from a combination of sources, including evolutionary factors; genetic factors; a generalized, nonspecific biological vulnerability (e.g., neuroticism, negative affect, heightened somatic overarousal, emotional lability); a psychological vulnerability (e.g., early experiences with uncontrollability and unpre-

dictability, particularly around somatic events leading to internalized perceptions of lowered control); a heritable tendency to react to stress with panic attacks; and a trait of anxiety sensitivity.

PRECIPITATING FACTORS

As discussed within Barlow's model of panic, the first panic attack is often identified with a stressful life event, such as taking on new responsibilities (e.g., a new job), moving, separation/loss, childbirth, physical illness, or relationship conflict. In many cases, however, a precipitating factor is not identified; moreover, for most individuals with panic disorder, these "precipitating factors" were not anxiety-provoking on previous occasions. Stressful triggers are also linked to recurrences of panic in the future.

PERPETUATING FACTORS

As illustrated in Clark's model of panic, the first panic attack is misinterpreted as a catastrophic event. Following the first attack, not only do patients with panic misinterpret stimuli (producing symptoms similar to a panic attack) to mean that they are about to have a panic attack (thereby overestimating the likelihood of having a panic attack); they begin to fear that future panic attacks will lead to catastrophic consequences, such as having a heart attack or going insane. These misinterpretations lead to anticipatory anxiety about having panic attacks in the future and avoidance of symptoms or situations in which the panic is expected to occur. These lead to more panic attacks in the long run, because the patients' sense that they are in danger continues to trigger the fight-or-flight response.

Subsequent panic and agoraphobic avoidance are associated with a variety of stimuli: crowded public places, open spaces, horizons, or situations in which quick exit is blocked (e.g., elevators, trains, planes, automobiles, stairwells); traveling away from home; exercise or activity that increases pulse rate; arousal associated with emotions such as pleasure, excitement, or anger; experiences associated with feelings of unreality (e.g., the use of a local anesthetic at the dentist's office, sudden changes in sunlight or darkness); waiting in line; heat or dehydration; heights; and sudden movements of the head (resulting in dizziness). As mentioned earlier, individuals with panic disorder also develop various "safety behaviors" that provide them with another way of escaping or avoiding a situation or event in which panic is expected to occur (Burns & Thorpe, 1977; D. A. Clark, 1996; D. M. Clark, 1986; Salkovskis, Clark, & Gelder, 1996; Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999). For example, patients may only be able to enter situations when accompanied by a safety person, insist on sitting in an aisle seat or close to exits, insist on being aware of all exits, distract themselves, wear sunglasses, carry a bottle of water, anchor their bodies or vision on "safe" objects, carry antianxiety medications on their persons, and so on. All avoidance and escape behaviors, including safety behaviors, help individuals tolerate frightening situations and create tremendous relief. However, the relief experienced reinforces them in maintaining further such behaviors in the future. These behaviors also prevent the individuals from learning that panic attacks are not dangerous, thereby maintaining their belief that panic attacks are dangerous events to be feared and avoided.

TABLE 3.1. Examples of the Three Types of Cognitive Distortions in Panic Disorder and Agoraphobia

<u>Distorted automatic thoughts</u>	
Fortunetelling: "I'll have an attack," "I'll lose control," "I'll faint."	
Labeling: "There's something wrong with me," "I am a wimp."	
Overestimating danger: "I will faint if I go over the bridge."	
Catastrophizing: "I'm having a heart attack," "I am going to die."	
Personalizing: "I'm the only one with this problem."	
Mind reading: "People can see I'm panicking," "They know I'm neurotic."	
Dichotomous (all-or-nothing) thinking: "Any anxiety is bad," "I'm always panicking."	
Underestimating ability to cope: "I can't handle this," "I will have a breakdown."	
 <u>Maladaptive assumptions</u> 	
"A physical symptom is always a sign that I am ill."	
"If I am not on guard at all times, danger will strike."	
"If I don't make sure I am taken care of, I will fall apart."	
"Having anxiety is intolerable and a sign of weakness."	
"I have to get rid of all of my panic and anxiety."	
"I should never look foolish or out of control."	
"If people know that I'm panicking, they'll reject me."	
"If I don't know for sure what's going to happen, it will be bad."	
"I should worry about panic so that I can prevent it."	
"I should criticize myself for my weaknesses."	
 <u>Dysfunctional schemas</u> 	
Vulnerability to harm: "I am weak, helpless, and fragile."	
Abandonment: "I'll be rejected and abandoned if I panic."	
Biological integrity: "I'll become debilitated, pass out, and die if I panic."	
Control: "I need to control everything about myself."	
Humiliation: "People will make fun of me if I panic."	
Specialness: "Panic is not consistent with my view of myself as successful and strong. This shouldn't be happening to me."	

OUTCOME STUDIES OF TREATMENTS FOR PANIC DISORDER AND AGORAPHOBIA

Outcome studies for cognitive-behavioral treatment of panic disorder and agoraphobia are extremely favorable (75–90% efficacy). These studies demonstrate that 50–70% of patients with mild agoraphobia function as well as normal controls following treatment (Craske & Barlow, 2008). Multiple research studies, meta-analyses, and cost-effectiveness studies show that

cognitive-behavioral therapy is effective in treating panic disorder (e.g., Barlow, Gorman, Shear, & Woods, 2000; Gould, Otto, & Pollack, 1995; McCabe & Gifford, 2009; McHugh et al., 2007; Ninan & Dunlop, 2005a), and that these findings can be generalized to patients seen in general clinical settings (McCabe & Gifford, 2009; Roy-Byrne et al., 2005; Sanderson & Wetzler, 1995; Wade, Treat, & Stuart, 1998).

Cognitive-behavioral treatment has been shown to reduce symptoms of panic and agoraphobia, to improve quality of life, and to have better long-term results than medication. Studies also show that it appears to be effective when panic disorder presents with comorbid conditions (Allen & Barlow, 2006; Brown, Antony, & Barlow, 1995; McLean, Woody, Taylor, & Koch, 1998), and that comorbid conditions also improve when it is used to treat panic (Brown et al., 1995; Tsao, Lewin, & Craske, 1998; Tsao, Mystkowski, Zucker, & Craske, 2002, 2005). Although patients with moderate to severe agoraphobia respond less well to cognitive-behavioral therapy than those with mild agoraphobia (Williams & Falbo, 1996), they continue to improve over time, especially when family members or friends are involved in treatment (Cerny, Barlow, Craske, & Himadi, 1987).

Follow-up 2 years after termination of cognitive-behavioral therapy indicates maintenance of improvement in most cases (Mitte, 2005), with other studies suggesting that gains may be further maintained with booster sessions once a month (Barlow et al., 2000). Furthermore, patients who have been in cognitive-behavioral treatment are far less likely to rely on psychotropic medication and may exhibit less relapse when high-potency benzodiazepines are discontinued (Otto et al., 1993; Spiegel, Bruce, Gregg, & Nuzzarello, 1994).

By contrast, although approximately 80–90% of patients on medication also show improvement, discontinuation of the medication results in substantial relapse of panic symptoms. In a multicenter study comparing imipramine to cognitive-behavioral treatment, patients who received the latter had the lowest rates of relapse; by contrast, the group receiving a combination of medication and cognitive-behavioral therapy were most likely to relapse, even in comparison to those who received a combination of cognitive-behavioral treatment and a pill placebo (Barlow et al., 2000). Likewise, cognitive-behavioral therapy has been shown to be more cost-effective than treatment with antidepressant medications such as imipramine and paroxetine (McHugh et al., 2007). Research into the mechanisms of change that occur during cognitive-behavioral treatment has suggested that automatic thoughts change over the course of therapy and that the changes in cognition are correlated with symptom reduction (Teachman, Marker, & Smith-Janik, 2008).

ASSESSMENT AND TREATMENT RECOMMENDATIONS

Rationale and Plan for Treatment

Each patient is given a thorough assessment to diagnose panic disorder, agoraphobia, and comorbid conditions, and to clarify the patient's symptoms in detail so that treatment can begin. Components of treatment include socialization/education of the patient; construction of fear hierarchies (for future work in exposure); breathing retraining (to reduce hyperventilation and its associated symptoms); relaxation training (only if chronic somatic tension is present); identifying and modifying negative automatic thoughts, along with the maladaptive assumptions and

dysfunctional schemas on which they are based; and exposure to feared and/or avoided symptoms and situations, as well as elimination of safety behaviors. Since stress may precipitate panic attacks, the ability to handle stress in everyday situations is also enhanced through the use of problem solving. Treatment is phased out when acute symptoms have been reduced substantially and specific behavioral goals have been achieved (see Table 3.2).

Assessment

Based on the cognitive-behavioral model outlined above, the clinician must first make a diagnosis of panic disorder (with or without agoraphobia); differentiate it from the other anxiety disorders, as well as from alcohol or other substance abuse; and assess for comorbid conditions. As indicated earlier, medical diagnoses should also be ruled out or considered as comorbid conditions. A full medical checkup is indicated for all individuals presenting with panic disorder, to rule out thyroid conditions, cardiovascular problems, and all other medical conditions noted above. Finally, patients should fill out the standard intake form provided in Chapter 2 (Form 2.1).

Tests and Clinical Interviewing

The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Brown, DiNardo, & Barlow, 2005) and the Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID; First,

TABLE 3.2. General Plan of Treatment for Panic Disorder and Agoraphobia

-
- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
 - Socialization to treatment
 - Construction of a fear hierarchy
 - Breathing retraining
 - Relaxation training (only if chronic somatic tension is present)
 - Cognitive interventions
 - Identifying and modifying automatic thoughts
 - Identifying and modifying maladaptive assumptions
 - Identifying and modifying personal schemas
 - Behavioral interventions
 - Panic induction
 - Construction of a fear hierarchy
 - Exposure to fear hierarchy
 - Coping with life stress
 - Phasing out treatment
-

Spitzer, Gibbon, & Williams, 2002) are semistructured clinical interviews that may be used to assess panic disorder and agoraphobia, and to assist in making differential and comorbid diagnoses. In addition, self-report questionnaires such as the BAI (see Chapter 2), the Agoraphobia subscale of the Fear Questionnaire (Marks & Mathews, 1979), the Mobility Inventory for Agoraphobia (Chambless, Caputo, Jasin, Greeley, & Williams, 1985), and/or the Panic Disorder Severity Scale (PDSS; Shear et al., 1997) are typically used to assess the exact nature of symptoms and the severity of illness.

Forms 3.2 and 3.3 provide guidance for therapists in the assessment of panic disorder and agoraphobia. Form 3.2 provides space for recording a patient's scores on the most commonly used assessment instruments, for noting other relevant aspects of the patient's history, for noting treatment progress, and for recording treatment recommendations. And since no test data should ever be used as a substitute for a thorough clinical interview, Form 3.3 permits a detailed interview evaluation of a patient's symptoms. The therapist also tracks the number of panic attacks; closely assesses the situations in which the individual has panic attacks and/or that the person avoids; and examines the subjective experiences before and after each attack—all in order to understand how the panic attacks are being triggered. Patients are asked to monitor their own physical symptoms, as well as the severity of their anxiety and other factors, between sessions on a panic record (see Form 3.4). This method of tracking not only assists in confirming the diagnosis, but provides a wealth of information that can be used in treatment (see later discussion under "Cognitive Interventions").

Identifying all feared and/or avoided situations (e.g., driving over a bridge) and internal symptoms (e.g., hyperventilation, dizziness, heart palpitations) will also prove useful in developing a hierarchy of stimuli for the therapist to use in treatment. The symptoms of avoidance, anticipatory anxiety, autonomic arousal, dizziness, catastrophic thinking (e.g., "I'm choking," "I'm going crazy," and "I'll lose control"), and superstitious behaviors employed to gain "safety" are all linked to specific goals in therapy.

Consideration of Medication

Although panic disorder may be treated effectively without medication, all patients should be given the option of medication as part of their treatment. Many different antidepressants (e.g., fluoxetine [Prozac], sertraline [Zoloft]) and high-potency benzodiazepines (e.g., alprazolam [Xanax], clonazepam [Klonopin]) have proven effective in inhibiting panic attacks. Antianxiety medications should be considered cautiously for patients with a current or previous of abusing medications or other substances, however. In addition, the use of medications should not preclude the use of cognitive-behavioral treatment.

Socialization to Treatment

Socializing the patient into therapy and educating him or her about the nature of panic is an essential component of therapy. Results of the assessment are provided, and it is helpful to inform the patient that panic disorder with or without agoraphobia is the diagnosis (or one of the diagnoses, if comorbid diagnoses are present). The therapist educates the patient about the diagnosis

and provides demographic and etiological information about the illness. Gaining this information allows patients to see that they are suffering from a disorder that can be treated, and helps them to begin the process of reconsidering their beliefs that they have a medical or psychiatric condition that can kill them or make them go insane.

Given that the essence of panic disorder is a misunderstanding about the symptoms of panic attacks, education about panic symptoms is a core component of treatment. Patients are not only educated about the diagnosis; they are also educated about factors that are hypothesized to predispose, precipitate, and perpetuate symptoms (see above). Also discussed in detail is the evolutionary basis of anxiety, including the nature of the fight-or-flight response and the adaptive function of symptoms in protecting individuals from truly dangerous symptoms. The concepts of false alarms and learned alarms are presented, so that patients understand how panic attacks are triggered and maintained in the absence of true danger, and how fear can be learned and generalized. They are helped to examine the irony that they fear the very symptoms designed to protect humans from danger, and that by doing so, they inadvertently trigger panic attacks. By interpreting internal arousal as dangerous, patients signal to the brain that danger is imminent, thereby triggering the fight-or-flight response.

Patients are given two information handouts to educate them further: Form 3.5, which describes the nature of panic disorder and agoraphobia; and Form 10.1 in Chapter 10, which describes cognitive-behavioral therapy in general. Books such as *Anxiety Free: Unravel Your Fears before they Unravel You* (Leahy, 2009) or *Don't Panic* (Wilson, 2009) are also offered as bibliotherapy supplements to treatment.

Patients generally respond well to being educated about panic disorder and socialized to treatment. Many of them have never been properly diagnosed as having panic disorder and have been either misdiagnosed (it was not uncommon 40 years ago for these patients to be diagnosed as having schizophrenia), informed that “nothing is wrong with them,” or told that they are “just anxious.” Learning that they have a treatable but harmless condition provides tremendous relief for most patients.

The general cognitive-behavioral model presented above is offered as a rationale for treatment and linked to the components of treatment, including breathing retraining, cognitive restructuring, and exposure. Form 3.1, which illustrates this model, is given to patients along with the other two handouts. The therapist and patient now collaboratively formulate specific therapy goals, which involve exposure to an increased range of situations, tolerating and decreasing both anxious apprehension and autonomic arousal, regulating overbreathing, modifying cognitive misappraisals to reduce the fear of panic attacks, and developing a more realistic assessment of internal sensations.

The list of feared situations collected during assessment is arranged in a hierarchy of least to most feared (see “Construction of a Fear Hierarchy” under “Behavioral Interventions,” below), as the basis for future imaginal and *in vivo* exposure. All safety behaviors used to tolerate distress or ward off perceived danger—such as the patient’s reliance on others to accompany him or her; a tendency to sit down, lie down, or seek physical support when uncomfortable; carrying water bottles or other safety objects; and the like—are also arranged hierarchically in order of least to most difficult to relinquish. In addition, patients’ specific misinterpretations of their arousal are identified and become targets for cognitive disputation in future sessions.

Breathing Retraining

A high percentage of individuals with panic disorder tend to hyperventilate during a panic attack, and a substantial proportion of patients tend to experience subthreshold symptoms of hyperventilation. They tend to breathe in short, rapid breaths when confronted with a phobic stimulus, and given their fear that they are not getting sufficient air, these individuals exacerbate symptoms in their desire to “catch” their breath (i.e., they hyperventilate further). Individuals who experience chronic hyperventilation often sigh, take deep breaths, and report themselves as being “short of breath.”

Breathing retraining assists individuals in proper breathing, which regulates the balance of oxygen and CO₂ and increases the threshold for hyperventilation. Individuals learn to slow their breathing down, to breathe with their abdominal muscles, and to enhance relaxation further by using a meditative procedure (Sanderson & McGinn, 1997). This technique is designed to reduce the general risk of hyperventilating, to increase the threshold for panic attacks, and to promote general relaxation. D. M. Clark, Salkovskis, and Chalkley (1985) recommend providing patients with a tape that instructs them to inhale and exhale for 2–3 seconds each with a pause in between, followed by a repetition of the entire cycle until the desired breathing patterns and the state of relaxations are achieved (usually about 10 minutes). The following instructions (based on Wilson, 2009) may be used to help train patients: “Gently and slowly inhale a normal amount of air through your nose, filling only your lower lungs. Exhale easily. Continue this slow, gentle breathing with a relaxed attitude. Concentrate on filling only your lower lungs.” Patients may be instructed to lie on a couch, place a small book on the stomach, and breathe so as to raise the book with each breath. This assures diaphragmatic breathing rather than shallow chest breathing.

Patients are instructed to practice approximately 10 minutes twice a day, first during a relaxed state and then during periods of somewhat greater stress (Sanderson & McGinn, 1997). However, patients are asked not to engage in deep breathing exercises *during* panic attacks, as breathing retraining is not expected to end a panic cycle that has already begun, nor is it intended for use as a safety behavior to ward off a “dangerous” event. Furthermore, breathing retraining is not used during exposure sessions, given that tolerating anxiety (rather than regulating breathing) is believed to provide the corrective emotional experience (Craske & Barlow, 2008). Given some recent studies suggesting that the mechanism of action for breathing retraining may either be distraction or the sense of control it affords patients, and those showing that breathing retraining may result in poorer outcomes than other cognitive-behavioral strategies may, these strategies have been deemphasized in recent years (Uliaszek et al., 2009; see Craske & Barlow, 2008, for a review).

Relaxation Training

Although relaxation training has shown to be effective in the treatment of panic disorder (Öst & Westling, 1995; Öst, Westling, & Hellstrom, 1993), it is unclear whether it provides benefit when it is conducted without the exposure-based procedures typically used during applied relaxation (Barlow, Allen, & Basden, 2007). Furthermore, although initial conceptualizations focused on the paradoxical effect of relaxation to anxiety and panic, the mechanism of action in applied

relaxation is now considered to be the sense of control it affords the patient. Given recent findings, applied relaxation is now used primarily if patients experience chronic somatic tension between panic episodes. As noted above for breathing retraining, the use of relaxation is not recommended during panic episodes, and the therapist needs to be alert to the possible use of relaxation as a safety behavior. Disconfirming the belief that panic attacks are dangerous, and assisting the patient in facing anxiety, are key elements in the treatment of panic disorder; hence it is recommended that relaxation not be used during exposure exercises or as a way to ward off the feared consequences of panic attacks.

Jacobson's (1938) method of alternating tension and relaxation is used to help patients experiencing chronic somatic tension discern symptoms of tension and promote relaxation. Twelve core muscle groups are targeted, and sessions are taped so that patients can practice at home. Once relaxation exercises are mastered at home, relaxation may be facilitated during the day by asking patients to focus on four key muscle groups, using cue-induced relaxation, and using relaxation by recall (McGinn & Sanderson, 1995).

Relaxation exercises are useful in reducing the general level of arousal, although a sizable proportion of individuals with panic disorder may experience "relaxation-induced attacks"; that is, relaxation exercises paradoxically *increase* the likelihood of attacks. Although the reasons why this occurs is not entirely clear, it is plausible that there may be a "homeostatic" self-regulation of heartbeat in some patients with panic disorder, such that the lowering of heart rate during relaxation or sleep activates a self-correcting increase in arousal (which is experienced as panic). Because of the unexpected and uncontrollable nature of panic during relaxation or sleep, many individuals with panic disorder are alarmed by these precipitants. It is also possible that individuals with panic disorder are unused to sensations of relaxation and hence experience apprehension about experiencing these unfamiliar somatic sensations, because they perceive them to be a sign that panic is imminent (Barlow, 2002). We have found that inquiring about these specific "paradoxical panic attacks" is helpful to patients, and that providing them with explanations based on homeostasis (self-correction) or unfamiliarity with relaxation allows them to decatastrophize these experiences. Patients are also informed that relaxation-induced panic attacks dissipate with practice, which further alleviates their anxiety about practicing relaxation exercises.

Cognitive Interventions

Identifying Automatic Thoughts

Although the therapist notes down the automatic thoughts spontaneously reported by the patient in the assessment session, a historical report is generally considered insufficient. Patients are asked to begin logging their thoughts on a thought record (see, e.g., Form 3.4, the Patient's Panic Record) when a panic attack occurs or whenever they begin to experience apprehension that one may be imminent. Patients are asked to note down how much anxiety they experience (e.g., 90% on a scale of 0–100%); the exact situation in which it occurred (e.g., "I ran up the stairs"); the automatic thoughts (e.g., "My heart is pounding, so I must be having a panic attack"); and the behaviors they employed to cope with their anxiety (e.g., "I lay down and called my doctor").

Using Socratic questioning, the therapist then guides a patient to identify all automatic

thoughts (see Table 3.1), noting possible misinterpretations being made. Identifying automatic thoughts is initially difficult for individuals with panic disorder, because they are extremely focused on the discomfort they experience during panic and their urge to flee or fight the situation (which would be adaptive if they were in true danger) and don't have access to their thoughts. By asking patients to hypothetically close all exits (e.g., "What do you think would have happened if you had not been able to get out of the subway?"), the therapist can help them gain access to their thoughts and the feared consequences they contain. For example, "My heart is pounding, so I must be having a panic attack" may contain these feared consequences: "I will collapse, faint, and die unless I get help," and "I won't be able to cope with it."

Using guided discovery, the therapist also helps identify how and when physical sensations arise, and helps patients see how a panic sequence is generated by helping them link thoughts, emotions, and behaviors in the context of the fight-or-flight response:

"I ran up the stairs" (situation).

"My heart began pounding" (physical sensation).

"My heart is pounding, so I must be having a panic attack" (first-level thought).

"I became anxious, and my heart began pounding even more" (emotion, physical sensation).

"I will collapse, faint, and die unless I get help" (second-level thought).

"I became dizzy, got light-headed, and broke out into a sweat" (escalation of anxiety).

"I won't be able to cope with it" (third-level thought).

Full-blown panic attack ensues.

"I lay down and called my doctor" (behavior).

Patients are first taught how to identify automatic thoughts in session, and then are asked to complete thought records between sessions.

Modifying Automatic Thoughts

As indicated in Chapter 10, Appendix B, and the CD-ROM, a clinician can use a wide variety of techniques in challenging the automatic thoughts of an individual with panic disorder. Form 3.6 is a checklist that can be used to identify the automatic thoughts a patient has most often. Using a process of collaborative empiricism, the therapist and the patient then begin to examine these thoughts scientifically, to determine whether misappraisals are present and to modify them so that anxiety and future panic episodes will be reduced.

Let's consider the questions a therapist might ask to challenge the first-level automatic thought identified above. ("My heart is pounding, so I must be having a panic attack") and the second- and third-level thoughts it contains ("I will collapse, faint, and die unless I get help," and "I won't be able to cope with it"). (In the following list, the therapist's questions are in italics; the patient's answers are in roman with quotation marks.)

1. *What categories do these thoughts belong to?* "Fortunetelling, overestimating negative outcomes, catastrophic thinking, underestimating ability to cope."
2. *What emotions or feelings do you have when you have these thoughts?* "Anxious, depressed."

3. *Rate your confidence in the accuracy of your thoughts, and the intensity of your feelings, from 0% to 100%. Thoughts: 90%. Feelings: Anxiety 90%, depression 50%.*
4. *Is there a misappraisal present in the thought "I must be having a panic attack"?*
 - a. *What is the evidence for and against this thought?* "For: I've had panic attacks in the past. I'm feeling anxious right now. Against: I've usually been wrong about my predictions. I have fewer panic attacks than I assume I do."
 - b. *How would you evaluate the evidence? If you had to divide 100 points between the evidence for and against your thought, how would you divide these points?* "I'd say 30 points in favor of having a panic attack, 70 points against."
 - c. *Can you consider any alternative explanations?* "I'm usually not having panic attacks. I just ran up the stairs, so it is possible that my heart is pounding because everyone's heart pounds when they run up the stairs. The likelihood that I was about to have a panic attack is smaller than I thought."
5. *Is there a misinterpretation present in the thought "If I have a panic attack, I will collapse, faint, and die"?*
 - a. *Have you ever collapsed, fainted, and died?* "No."
 - b. *What is the probability that you will collapse and faint if you have a panic attack?* "Although it is theoretically possible to faint during hyperventilation, the odds of fainting in panic disorder are negligible, given that the vast majority of patients with panic disorder do not faint, as well as the fact that my heart rate and blood pressure go up instead of down when I have a panic attack. Also, I have never fainted, so that lessens my chances to almost zero."
 - c. *What is the probability that you will die if you have a panic attack?* "Zero. Panic disorder is an anxiety disorder and does not lead to death. I don't have heart disease or any other condition that might lead to sudden death. I have been thoroughly tested several times."
6. *What is the worst that could happen if you did have a panic attack?* "Well, the worst that could happen is that I could faint, because it is theoretically possible. However, it is highly unlikely, given that panic attacks rarely lead to fainting—and my personal odds are close to zero, given that I have never fainted. Most likely I will have a panic attack, become very uncomfortable and anxious for a short period of time, and then it will pass like it always does."
7. *If the worst that can happen is that you will have a panic attack that subsides, can you tolerate that?* "I get very anxious when I get a panic attack, but if the worst that happens is that I get a panic attack and then it subsides, I guess I can tolerate it. I have had many panic attacks in the past, and I have coped with them, so I guess I will manage even if I am very anxious inside. Being anxious does not mean I can't cope. Being anxious just means I have an anxiety disorder, which I already know."
8. *Even though the odds are close to zero, if the worst happens and you faint, can you cope with it?* "Although the chances are that I won't faint, if it happens and that is the worst thing that can happen, I guess I can deal with it. Someone will call the ambulance, and the ambulance will take me to the hospital. I would probably wake up in a few minutes and then be fine. When I say I can't handle it, I start to believe that I can't. I have handled a lot of negative things in my life, so I am sure I will cope with it. Just because I feel anxious

doesn't mean I am 'not handling' it. I have an anxiety disorder, so it is natural that I will feel anxious. If I *really* feel I need help with coping, I will use some of my coping statements." (Form 3.7 is a list of coping statements for patients.)

For an individual who relies on a safety person, it is useful to explore the patient's interpretations of what the safety person can do that the patient cannot. Many patients believe that they will become so disoriented by their anxiety that they will not be able to get out of the situation, and therefore the safety person will assist in getting them out. Others believe that they will require medical attention, and hence the safety person can ensure that they receive the appropriate medical care. For example, they may fear that the anxiety will result in their physical collapse or a heart attack, and the accompanying person can take them to the hospital. Others believe that if they are driving and they have a panic attack, the other person can take control of the driving and avoid a fatal accident. Since none of these feared events may have ever occurred in the past, the therapist may inquire about the probability of these events and, if they should happen, how the patients can rescue themselves. Interpretations regarding use of safety objects (e.g., a bottle of water) or other safety behaviors (e.g., leaning on a hard surface) should be challenged similarly. In this way, patients can begin to realize not only that their reliance on acquiring "safety" is unnecessary, given that there is no true danger, but that relying on the safety person or object only further strengthens their sense that they are in danger.

Behavioral experiments may be set up to test patients' interpretations that their feared outcomes will happen or that they will not be able to cope unless they rely on a safety behavior. For example, patients who insist on carrying a water bottle may be encouraged to ride the subway for one or two exits without a water bottle to determine whether the water bottle is helping them cope with their panic attack or prevent a fainting spell or a heart attack. When their feared consequences don't occur (i.e., they have a panic attack or get anxious, but they don't faint or have a heart attack despite not having a water bottle), they are encouraged to test their thoughts further by riding the subway for longer and longer periods of time until their appraisal that "I will have a panic attack and faint and die unless I carry a water bottle" is modified (see Table 3.1).

Identifying and Modifying Maladaptive Assumptions

Assumptions are the general "rules" or "imperatives" held by individuals and represent general forms of their specific automatic thoughts. Assumptions include "rules" such as "should" statements ("I shouldn't be anxious"), "if-then" statements ("If I am anxious, people will reject me"), and "must" statements ("I must get rid of all my anxiety"). Once a therapist and patient have identified many automatic thoughts, the therapist can begin to empirically formulate the maladaptive assumptions upon which these thoughts may be based. Through cognitive restructuring, the therapist then begins to challenge the maladaptive assumptions (see examples in Table 3.1).

The therapist may initiate this process in this way: "We have been examining your automatic thoughts for several weeks now, and if we look at what they have in common, it seems that they all seem to be based on an assumption that any physical sensation you experience is a sign of poor health. What do you think?"

Even though modifying automatic thoughts and the misappraisals upon which they are based is believed to modify maladaptive assumptions indirectly, modifying assumptions directly

may facilitate the process by further helping patients see that their automatic thoughts derive from closely held assumptions that they may have had for a long time, rather than being “true facts” about a situation. For example, through guided discovery, a patient may be helped to say the following: “My automatic thought that I am about to collapse, faint, and die right now (because my heart is pounding) may be based on my long-held assumption that any physical sensation is a sign of poor health and may not be what is actually happening right now. What is happening right now is that my heart is pounding because I ran up the stairs.”

Often individuals with panic disorder have perfectionistic assumptions about their anxiety—they believe they have to eliminate anxiety completely. Let us consider how a cognitive therapist would handle this perfectionistic assumption.

1. *How much do you believe this assumption?* “About 85%.”
- 2a. *What are the costs and benefits of this assumption?* “Costs: Makes me anxious. Impossible to achieve. Makes me obsessive about my anxiety. I’m intolerant of any anxiety. Makes me feel out of control and self-critical. Benefits: Maybe if I try to get rid of all my anxiety, I’ll be able to get rid of panic attacks. If I catch myself feeling anxious, maybe I can prevent it from escalating. Or maybe I can escape before it gets too bad.”
- 2b. *How would you divide 100 points for the costs and benefits of your assumption?* “Well, I can see that the benefits are unrealistic. I know I can’t get rid of all of my anxiety. It adds pressure to me. I’d say 80 points for costs, 20 points for benefits.”
3. *What is the evidence for and against the idea that you could get rid of all of your anxiety?* “For: There are times that I’m not anxious. Against: My anxiety comes and goes. Everyone is a little anxious at times.”
- 4a. *What do you think would happen if you did not eliminate your anxiety?* “Maybe I’d go crazy. Or my heart might just get worn out.”
- 4b. *Have you gone crazy or had a heart attack?* “No.”
5. *Do you know anyone else who has eliminated anxiety completely?* “No, everyone I know feels anxious some of the time.”
6. *What would be the advantage of accepting anxiety as a natural part of life, the same way you accept hunger and drowsiness as part of life?* “I’d feel a lot less pressure about having anxiety. I’d feel less like a freak. I’d be less self-critical.”
- 7a. *From 0% to 100%, how much do you believe right now that you should eliminate all your anxiety?* “Probably only 10%. But I sure wish I could.”
- 7b. *Why did you decrease your belief in this assumption?* “I can see how unrealistic it is—you can’t eliminate anxiety completely. A little anxiety now and then won’t hurt me.”

Identifying and Modifying Dysfunctional Schemas

Schemas are the deep-level constructs that the patient uses in thinking about self, others, and the world (Beck, 1976; Beck, Freeman, & Associates, 1990; Beck, Freeman, Davis, & Associates, 2004). For example, central schemas for patients with panic disorder is that the world is a dangerous place, that they are vulnerable to harm, and that they are helpless in the face of danger (see Table 3.1). However, other schemas may be present as well. For example, is the patient primarily concerned about being special, unique, in control, invulnerable, loved, acceptable to everyone,

and capable of perfect knowledge of the future? Does the patient view others as rejecting, abandoning, domineering, humiliating, rescuing, intolerant, or inferior? Panic may mean different things to different people. For a narcissistic patient, with a belief that he or she is uniquely superior, the existence of panic disorder is inconsistent with the patient's self-schema. If the patient views others as humiliating, then he or she has even more reason to be anxious.

Although panic disorder can be effectively treated without addressing a patient's underlying schemas about self and others, the treatment of panic often leads the patient to an exploration of dysfunctional schemas and may ensure that the change in automatic thoughts is long-lasting. Like assumptions, schemas are indirectly modified by working on automatic thoughts and assumptions. However, directly exploring and modifying personal schemas can further help patients see that their beliefs that the world is a dangerous place and that they are helpless in the face of danger are fueling their panic disorder, and they are not objectively in danger.

Now let us consider the example of a patient with a different personal schema. A 28-year-old male who had been suffering from panic disorder for 6 years, and who had previously abused alcohol as a means of self-medication, was successfully treated for panic disorder via cognitive-behavioral techniques. During the course of the treatment, the therapist assisted him in examining his personal schemas of being "special" and needing to be "in control" of himself, as well as his fear that he would be humiliated. These schemas became apparent as the patient recounted his attempts to achieve perfection in his studies and in his work. The idea of having panic attacks was inconsistent with his view of himself as perfect and in control.

The patient recalled his childhood and adolescence. His father, an aristocratic refugee who socialized with internationally famous people, would insist that the son had to achieve "as much as Mozart." The narcissistic father demanded perfection in his son and would humiliate him whenever he disagreed with him or did not live up to his expectations. The patient's perfectionism, need to be special, and need to be in control were interpreted as attempts to avoid further humiliation with others—specifically, his colleagues. His schema about others was that they would be critical and intolerant of any of his weaknesses, just as his father had been.

The therapist helped the patient to examine the illogical nature of his father's expectations and the evidence that many of his colleagues had psychological problems that would dwarf his own. An exercise in which the therapist role-played the father, and the patient role-played himself as an adolescent asserting himself with his father, also helped the patient to restructure his perfectionistic expectations. The patient's panic and general anxiety abated, and his work with colleagues became more productive and relaxed.

Behavioral Interventions

Panic Induction

Panic induction is a central component of treatment and is used for patients who have panic disorder with or without agoraphobia, as it specifically targets the physical symptoms of panic feared by patients, and studies demonstrate that panic induction alone may be successful in alleviating panic symptoms (D. A. Clark, 1996; Craske & Barlow, 2008). Physical symptoms of panic are artificially triggered in patients during and between therapy sessions, with the goal of reducing fear of panic symptoms in the long run. Initially, an assessment is conducted to induce a range of

symptoms so that the therapist can ascertain which symptoms trigger fear. The symptoms that produce fear are then induced until the fear associated with them subsides. Patients are required to let the fear spiral up naturally and are not permitted to use safety behaviors (e.g., distraction, sitting down to keep from fainting) during panic induction. The use of safety behaviors is seen as preventing patients from learning that the physical symptoms of panic are not inherently dangerous. Hence it is critical that the fear associated with the symptoms diminishes on its own and is not attributed to the use of safety behaviors. For example, some patients may assert that they prevent themselves from fainting during panic by making sure they sit down. Because they always sit down, however, they never test their thought, and instead maintain the link between panic and fainting. When they induce panic without sitting down, patients learn that they do not faint during panic episodes and that this is not just because they sat down.

Patients may be asked to take rapid, shallow breaths to induce hyperventilation. Cardiovascular symptoms (produced in session by having a patient engage in vigorous exercise—e.g., running in place or using a stationary bicycle), audiovestibular sensations (produced in session by having the patient spin around in a chair), tension in the chest (produced by having the patient tighten the chest muscles), and symptoms of depersonalization (induced by having the patient stare at a bright light or engage in relaxation/meditation exercises) may also be used to trigger sensations of panic artificially (see Barlow, 2002; Barlow & Cerny, 1988; Huppert & Baker-Morrisette, 2003). However, inducing hyperventilation is successful in producing a variety of symptoms, including dizziness, blurred vision, tingling, numbness, and depersonalization; hence it is most commonly used during panic induction. The limitation of overbreathing in panic induction is that some patients with asthma, cardiovascular, or pulmonary disorders should not engage in it. Furthermore, not all individuals with panic experience fear during hyperventilation exercises.

Panic induction is a key component of all cognitive-behavioral treatments, although the methods of induction vary slightly, and cognitive and behavioral models propose different mechanisms of action. In D. M. Clark's (1986) panic induction treatment, the mechanism of action is believed to be cognitive reappraisal, because the purpose of the induction is to disconfirm the patient's beliefs that physical sensations of panic are dangerous. For some patients, simply *describing* Clark's model provides relief from panic attacks; this suggests that merely "understanding" what is going on and developing a less catastrophic interpretation of panic attacks may be sufficient for some individuals. As described above, the cognitive model suggests that catastrophic cognitions ("I'm having a heart attack," "I'll never catch my breath," or "I'm going to lose control and embarrass myself") lead to panic attacks and hence must be disconfirmed for treatment to be successful.

In Clark's treatment, the patient is guided by the therapist to breathe rapidly and shallowly until panic symptoms are induced. The therapist then instructs the patient to breathe into a bag, which then restores the proper CO₂ balance, thereby ending the "panic attack." This technique is remarkably useful for individuals who fear hyperventilation symptoms, because it demonstrates that panic attacks are induced by overbreathing and can be terminated by regulating breathing. It helps patients decatastrophize symptoms of panic attacks as being dangerous. Since the central fear for individuals with panic disorder is the fear of the panic attack itself (not, say, the fear of a subway, store, or open area), exposure to somatic sensations allows the patients to disconfirm their beliefs that panic attacks are dangerous.

Again, methods other than hyperventilation may be used as appropriate. For example, patients who fear dizziness may be asked to spin slowly in a chair, thereby inducing dizzy sensations. One patient who had a reflexive panic reaction to dimming lights (such as on an intermittently clouded day) was exposed in session to recurrent dimming of lights in the therapist's office. This elicited the panic symptoms and allowed the patient and therapist to test his catastrophic thought that he would "go crazy." His anxiety abated rapidly. *In vitro* (i.e., in-session) exposure to panic sensations or symptoms is a dramatic demonstration for patients of the fact that their panic symptoms are not dangerous, and in fact are both evocable and controllable.

Panic induction or interoceptive exposure is also a key element of Barlow's panic control therapy (Barlow, 2008). Patients are expected to engage in a variety of exercises producing panic symptoms during therapy sessions for as long and as often as necessary until the fear is reduced. For example, instead of ending a hyperventilation exercise by breathing into a bag, a patient is encouraged to hyperventilate for 30–60 seconds, to wait until the breathing goes back to normal on its own, and then to repeat the exercise several times during the session until the anxiety associated with it is substantially reduced. The patient's subjective experience of anxiety is closely monitored and is used to gauge when the exercise should be terminated. Cognitive restructuring and deep breathing exercises are employed after the exposure exercise is completed, along with a brief discussion about what the patient has learned during the session. The patient is asked to repeat the exercise between sessions until it is clear that the stimulus being confronted (e.g., hyperventilation) no longer produces distress in at least two consecutive exposure sessions. Physical sensations creating the least distress for the patient (e.g., heart pounding) are induced first, with more and more anxiety-provoking sensations (e.g., dizziness, depersonalization) introduced in later sessions. In contrast to Clark's model, which considers the induction to be a behavioral experiment used to disconfirm cognitive misappraisals, the primary mechanism of action in Barlow's model is considered to be the extinction of the conditioned (learned) process, although recent formulations stress both mechanisms of action (Barlow & Craske, 2006; Craske & Barlow, 2008).

Construction of a Fear Hierarchy

Patients with panic disorder almost always avoid situations or experience extreme anxiety in a variety of situations. A therapist can assist a patient in constructing a fear hierarchy, from least to most feared situations. The therapist asks the patient which situations are feared and/or avoided, requests him or her to rank-order these, and has the patient assign each situation a distress rating on a scale from 0 to 10 (these ratings are often referred to as "subjective units of distress" or "SUDs" ratings). Form 3.8 can be used with the patient to create a fear hierarchy in this manner.

Although it is best to design a fear hierarchy by grading situations to which a patient can expose him- or herself without the use of any safety behaviors (e.g., "going to a movie theater"), the fear hierarchy can be designed by incorporating safety behaviors in early sessions (e.g., "going to a theater with my wife"), but *only* if a patient is unable to confront any situation without the use of safety behaviors (e.g., the patient can't even leave the house unless accompanied). Even if safety behaviors are incorporated into the hierarchy, they should be phased out as soon as possible. A list of safety behaviors arranged hierarchically helps to inform the therapist about the

items that would be easiest or hardest to relinquish; it also helps the therapist to better understand the behaviors' safety potential, monitor their use, and help the patient discontinue their use (response prevention).

Common safety signals include the presence of another person (including the therapist) and the use of medications, food, or drink (Craske & Barlow, 2008). However, it is important for the therapist to identify all idiosyncratic safety behaviors, because many other behaviors besides those just mentioned may be used to create a sense of safety. For example, someone with a fear of passing out may lean on a solid object because of the belief that it will help prevent him or her from falling down, while another patient may use an object as a visual anchor to reduce the fear that he or she will go insane. Although a large number of patients report feeling safer in the company of others so that they can be "helped" if needed, those who fear that they will be embarrassed or humiliated would rather be alone, lest someone see their anxiety and judge them negatively. Hence the fear hierarchy should be tailored to the needs of the individual patient.

Exposure to the Fear Hierarchy

Agoraphobic fear and avoidance are also targets of treatment. After the construction of the fear hierarchy, the therapist establishes a sequence of steps to be taken by the patient, beginning with the least feared situation in the hierarchy (e.g., driving around the block) and ending with the most feared situation (e.g., driving on a highway).

If a patient is too fearful to begin doing *in vivo* exposure to even the least fear-provoking item on the hierarchy, exposure may begin with having the patient confront the situation in his or her imagination ("imaginal exposure"). Imaginal exposure may also be indicated if patients do not have access to their feared consequences, despite attempts to create awareness through cognitive strategies. A patient is asked to form a vivid image of the stimulus during imaginal exposure and is helped to access the feared consequences (e.g., "I lose control of the car and ram into other cars"). The patient is encouraged to stay with the image until the fear subsides, and is asked to repeat the exercise until the anxiety associated with that image has diminished. (The Patient's Imaginal Exposure Practice Record—Form 9.1 in Chapter 9—can be given to patients who are engaging in imaginal exposure.) However, if patients remain unable to access feared consequences during initial sessions, imaginal exposure need not be continued.

Patients are asked to discontinue the use of all safety behaviors during *in vivo* or imaginal exposure sessions, and fear is allowed to spiral up naturally and subside on its own. As stated earlier, safety behaviors are seen as harmful to the overall outcome of exposure, since they prevent patients from learning that the situation being confronted is not inherently dangerous; instead, patients continue to assume that they narrowly avert danger by using the safety behavior. For example, consider the case of a woman who only drives when accompanied by her husband, because she is fearful that she will crash into other cars if she has a panic attack. She wants her husband to accompany her because she believes that if she should lose control, he will help with gaining control of the car. It is important for this patient to learn that she will not lose control and crash into other cars when she has a panic attack, even if her husband is not in the car with her.

As noted above, all safety behaviors should be given up immediately (or at least as soon as possible), and the situations should be graded according to the level of fear that the patient is able to tolerate without the use of safety behavior. However, if patients are unable to enter even

the least feared situations without the use of safety behaviors, these may be sparingly included in the exposure hierarchy and then faded out as soon as possible. For example, the woman in the example above may first be asked to sit in the car with her husband, then without him. Next, she may be permitted to drive half a block with him, and then without him, and so on.

In the past, fear habituation was used as the signal for termination any given exposure session. However, recent findings indicate that *tolerating* fear (as opposed to *eliminating* fear) and experiencing self-efficacy appear to predict overall outcome, whereas neither the degree of fear reduction nor the amount of physiological habituation within an exposure session appears to predict overall outcome (Craske & Mystkowski, 2006; Eifert & Forsyth, 2005; Williams, 1992). Given these findings, the emphasis on completely eliminating fear during an exposure session has changed. Instead, an exposure session is now terminated when it is clear that the patient's misappraisals have been disconfirmed, when the urge to escape the situation has subsided, or when the patient has learned that he or she can tolerate feelings of anxiety and cope with being in the feared situation. Similarly, there has been a shift in the proposed mechanism of action in exposure-based learning. Although previously the exposure was posited to work through extinction, at present the mechanism of action is thought to include extinction of the conditioned emotional responses and disconfirmation of misappraisals (Craske & Barlow, 2008).

Exposure sessions are conducted both during and between treatment sessions, so that patients may repeatedly confront a particular stimulus until the anxiety associated with the situation is minimal over two consecutive exposure sessions. To minimize the chance of relapse, it is recommended that exposure sessions be conducted in multiple contexts (Craske & Barlow, 2008).

To facilitate disconfirmation of misappraisals, patients may be asked to write down their predictions about what will happen in a feared situation before exposure begins. For example, one patient's anxious thought was that she would lose control of her car when crossing a bridge. She was instructed to write down her degree of anxiety, her prediction, and her confidence in the accuracy of this prediction before each time she crossed the bridge, and then to write down her actual degree of anxiety and the outcome of the situation after she had crossed the bridge. She was instructed to do this 10 times, and, then on each succeeding day to try a more difficult bridge. Over time, her appraisals changed, and she saw that what she feared did not come true. As a result, she was able to overcome her long-standing avoidance of bridges, which had greatly curtailed her movements for several years. (The Patient's *In Vivo* Exposure Practice Record—Form 9.2 in Chapter 9—can also be given to patients who are engaging in this form of exposure.)

Coping with Life Stress

Many patients with panic disorder are so focused on their physical sensations that they often overlook how life events are affecting them. Some patients feel trapped in relationships or jobs; other patients feel angry but have difficulty expressing their anger for fear of alienating a safety person; and still other patients overrespond to simple life stressors. As part of the treatment of panic disorder and agoraphobia, the patient is also presented with a brief introduction to cognitive restructuring of anxious and depressive thoughts about life events and other factors besides their panic symptoms. Patients with panic disorder often have non-panic-related negative automatic thoughts (e.g., fortunetelling, mislabeling, and selective filtering of information), maladaptive assumptions (e.g., "I should be able to handle my problems on my own"), and dysfunctional

schemas. By addressing these general cognitive distortions about everyday life stressors or other matters, a therapist can help reduce a patient's overall level of anxiety.

When both panic disorder (with or without agoraphobia) and depression are present, we recommend focusing on the treatment of the panic rather than the depression, since the depression is often secondary to the anxiety disorder. As the patient gains greater flexibility in behavior, and both anticipatory anxiety and panic subside, the depression may often abate. Furthermore, many of the cognitive therapy techniques that address the patient's sources of anxiety are also relevant to the patient's depression. However, if the depression is severe, then it may become the focus of treatment, even if it is secondary to the panic.

Phasing Out Therapy

Although many patients report rapid improvement in panic and agoraphobia, we caution patients against premature termination of treatment. The goal of therapy is not only the elimination of panic attacks, but also the acquisition of a variety of coping skills that will decrease the likelihood of relapse. Conversely, although our treatment package recommends 12 sessions, it may be possible to provide adequate treatment in fewer sessions if the condition is relatively mild, comorbid conditions are absent, there is no agoraphobic avoidance, and so forth.

Phasing out to biweekly or monthly sessions for the last few sessions helps the patient practice functioning independently of therapy, thereby increasing the likelihood that improvement can be attributed to self-help rather than to the relationship with the therapist. During phase-out, the patient is encouraged to self-assign homework. Homework may focus on a review of typical difficult situations (those listed in the exposure hierarchy) and the cognitive distortions associated with these situations. Booster sessions may be offered periodically to ensure maintenance of gains, practice of skills, and early detection of relapse indicators. Form 3.9, which is a "new rule book" for panic disorder and agoraphobia, can also be given to patients at this stage.

TROUBLESHOOTING PROBLEMS IN THERAPY

Although the treatment package for panic disorder appears to be relatively straightforward, patients who have panic disorder (with or without agoraphobia) may present a number of problems. When we find that our patients are unable to comply with the prescribed treatment package, we usually find that the cognitive components of therapy are particularly helpful. Common problems with these patients are fear of intrapsychic processes, anxiety intolerance, noncompliance with homework, and unrealistic expectations.

Fear of Intrapsychic Processes

Patients with panic are often fearful of any experiences that may arouse anxiety. A patient may be fearful that therapy will lead to examination of psychological material that may threaten him or her. Just as the patient may fear that anxiety portends insanity, he or she may also fear that uncovering intrapsychic processes will lead to the discovery of "unconscious" material revealing either insanity or other unacceptable characteristics. This is especially true in patients present-

ing with an obsessive style of thinking regarding anxiety. The therapist can guide such a patient to examine their assumption that self-reflection leads to insanity or loss of control. Since this fear may be recurrent throughout therapy, it is useful to indicate to the patient that his or her fears of examining psychological processes have not been borne out.

Anxiety Intolerance

A patient may present with “emotional perfection”—that is, the belief that all anxiety is to be avoided and that no anxiety can be tolerated. The patient can examine the costs and benefits of this belief, and the evidence for and against the belief that anxiety is intolerable and dangerous. We also find it helpful to indicate to the patient that while anxiety, like other emotions, provides useful information that something is wrong that it is not itself a source of danger. One of the most interesting books on this subject is *The Meaning of Anxiety*, by the existential psychoanalyst Rollo May (1977). May reviews the evidence that anxiety is an informative source of information about the self. For example, a 24-year-old male patient with emotional perfectionism found the discussion of May’s book helpful, because it led him to refocus from his symptoms of anxiety to the nature of conflicts in his everyday life. These conflicts included decisions about graduate school and career. As he began to recognize that he was “legitimately” anxious about making important decisions, he became more tolerant of his anxiety, and consequently less anxious.

Another way to approach intolerance of anxiety is to examine a patient’s predictions of what will happen if he or she is anxious. Many patients with panic believe that the onset of anxiety “always leads to panic,” or that anxiety “will never go away” or “will lead to a nervous breakdown.” These dire predictions may be tested by having the patients rate and record their anxiety over a period of time. Such a record will indicate that anxiety rises and subsides, and does not lead to a “nervous breakdown.”

Noncompliance with Homework

There may be numerous reasons for noncompliance with homework. For a patient with panic disorder, frequent reasons include the belief that anxiety can only be faced if a safety person or therapist is there to rescue or direct him or her; that engaging in exposure to fearful situations will make matters worse; that writing down automatic thoughts will open up a “can of worms” of uncontrollable anxious thoughts; or that since all anxiety cannot be eliminated immediately, then things are hopeless. The therapist can submit each thought or assumptions to cognitive evaluation: What are its costs and benefits? What is the evidence for and against it? Does this thought or assumption apply to other people as well? What is the evidence within therapy—is anxiety always dangerous? And, specifically, what will the safety person do that the patient cannot do him- or herself?

As with any treatment that involves exposure outside sessions, homework noncompliance may also result from the therapist’s failure to engage in exposure “rehearsal” in the session *prior to assigning the exposure homework*, as well as from a failure to review homework in the next session. The “rehearsal” should involve specific instructions of exactly what the patient will do for homework—where, when, and for how long the exposure will occur. The therapist can ask the patient to imagine the feared situation, to activate mental images about the situation, and

to determine his or her automatic thoughts. We find it very helpful to use a “stress inoculation” approach (Meichenbaum, 2009), in which the therapist role-plays the negative thoughts and the patient practices responding rationally. The therapist can also elicit any task-interfering thoughts prior to the exposure outside sessions—for example, “What could be some reasons for *not* doing the homework?” Finally, given that noncompliance increases if the therapist omits to review assigned homework, any homework should always be reviewed during the next session to see whether it was completed as expected and to review progress.

Finally, homework noncompliance may also be due to the fact that the therapy is moving too quickly—that is, the therapist is demanding more than the patient is ready for. A good rule to use is to *reduce* the amount and degree of homework, instead of eliminating homework altogether.

Unrealistic Expectations

Perhaps because cognitive-behavioral therapy has the reputation of solving problems rapidly, some patients have unrealistically positive expectations for therapy. Many cognitive-behavioral therapists find it helpful to examine these expectations up front with their patients, including the patients’ expectations about and willingness to do self-help assignments. The information hand-outs for patients that we provide in this treatment package may be helpful in dispelling some of these unrealistic expectations and providing the basis for a therapeutic contract and alliance that can moderate the patients’ expectations.

Many patients with panic disorder may also have unrealistic expectations about psychological and physiological discomfort. We have already referred to these in regard to the all-or-nothing attitude toward anxiety and the intolerance of any anxiety. Finally some patients may have unrealistically negative expectations—especially patients with chronic problems that have been unsuccessfully treated in the past. Many of these patients have been “pathologized” by clinicians as “resistant,” “psychotic,” or “deeply disturbed.” We find it helpful to inform these patients that the cognitive-behavioral approach to panic disorder is relatively new, that their other therapists may have been trained in another treatment modality developed at an earlier time, and that the treatment approach that we will use is quite different.

DETAILED TREATMENT PLAN FOR PANIC DISORDER

Treatment Reports

Tables 3.3 and 3.4 are designed to help in writing treatment reports for patients with panic disorder (with and without agoraphobia). Table 3.3 shows sample symptoms; select the symptoms that are appropriate for your patient. Be sure also to specify the nature of the patient’s impairments, including any dysfunction in academic, work, family, or social areas; for patients with agoraphobia, this dysfunction is usually considerable. Table 3.4 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

Sequence of Interventions

Table 3.5 shows the sequence of interventions for a 12-session treatment plan for panic disorder and agoraphobia. The clinician may choose to abbreviate therapy by emphasizing interventions

focused on panic disorder and agoraphobia—such as relaxation and breathing training, exposure to the fear hierarchy, cognitive restructuring (e.g., decatastrophizing anxiety), and in-session induction and exposure to panic symptoms. D. M. Clark and his colleagues at Oxford University report a high degree of success with an abbreviated treatment package. The 12-session treatment package in Table 3.5 may be lengthened or shortened where necessary.

CASE EXAMPLE

Session 1

Assessment

Sara was a 29-year-old married woman who reported a 2-year history of anxiety, panic, worries, and agoraphobic avoidance. Her anxiety symptoms included heart palpitations, hyperventilation, feelings of derealization/depersonalization, and dizziness. On many occasions she avoided subways, trains, planes, long trips in cars, and crowded theaters. Although she did walk in the city on her own, she reported considerable fear at times that she would become so anxious that she would hyperventilate and collapse.

Symptoms and comorbid conditions

Sara reported mild dysphoria (her BDI-II score was 11), and she complained of nervousness, repeated unpleasant thoughts, suddenly scared for no reason, feeling blue, worrying, feeling no interest in things, feeling fearful, heart pounding or racing, trouble falling asleep, fear of traveling on subways and trains, fear (trouble) getting her breath, avoidance of various places, feeling tense and keyed up all the time, and frightening thoughts (e.g., “I may collapse”) and images (e.g., falling down the stairs after fainting).

Sara reported no significant marital discord, no history of drug or alcohol abuse, and abstinence from caffeinated drinks and foods. Her parents had divorced when she was 5, and her grandmother had been housebound with agoraphobia for several years. She reported such considerable anxiety giving public speeches that she had made a career change *downward* to take a job as a secretary (for which she felt overqualified). This resulted in feelings of resentment toward her supervisors and self-criticism that she was not fulfilling her potential. She had the desire to avoid subways (especially the express train with less frequent stops and therefore fewer opportunities for escape), trains, planes, and walking any considerable distance.

Although generally healthy, Sara reported that she suffered from Crohn’s disease, which had its onset 6 years before her agoraphobia began. Crohn’s disease is characterized by diarrhea and painful gas. This was in remission at the time of her intake for cognitive-behavioral treatment.

Sara described a panic attack on the subway in August of the previous year, when her heart began to race, she felt dizzy and hot, and she had difficulty breathing. At that time, she had worried that she might pass out. During the last 2 years, she added, she had begun to get preoccupied with not getting enough air. Her automatic thoughts regarding this were “I’ll have trouble breathing,” “I’ll pass out,” and “I’ll become an agoraphobic like my grandmother.”

Diagnosis

The diagnosis was panic disorder with moderate agoraphobia and comorbid social anxiety disorder (social phobia). (Sara’s therapy included treatment

for the social anxiety disorder, but the present discussion focuses on treatment for her panic disorder and agoraphobia.) Crohn’s disease was in remission. There were moderate stressors focused on the change in her job. The marital relationship was good.

Negative automatic thoughts and maladaptive assumptions

During the assessment, it became clear that Sara was extremely ambivalent about therapy, fearing that seeking therapy meant she was neurotic and that she would uncover upsetting information about herself. Her beliefs were that she should be able to solve all her problems without help and that others would think less of her if they knew she was anxious. Even though she knew that her grandmother had suffered from an anxiety disorder, she also strongly believed that her family was physically weak and more prone to getting diseases (her Crohn’s disease was the evidence she provided to support her position).

Session 2

Providing feedback

The therapist provided Sara with feedback regarding the intake forms and interview, including the diagnosis of the problem. She was given the general information handout for patients about panic disorder and agoraphobia (Form 3.5), as well as Leahy’s (2009) *Anxiety Free*. She was also presented with a general outline of treatment options.

Medication evaluation

Although medication was one option presented to her, Sara rejected this option because of her belief that she should be able to solve her problems on her own. Because of her high compliance with homework, the degree of her symptoms, and her reluctance to take medications, a collaborative decision was reached to initiate treatment using CBT alone.

TABLE 3.3. Sample Symptoms for Panic Disorder and Agoraphobia

<u>Panic disorder</u>	Fear of dying
Panic attacks (specify frequency)	Fear of going crazy
Heart racing	Fear of having future panic attacks
Palpitations	Specify any change in behavior as a result of panic attacks
Sweating	
Shaking	<u>Agoraphobia</u>
Difficulty breathing	Specify situations feared—examples:
Chest pain	Fear of being alone
Tightness in chest	Fear of crowded places
Nausea	Fear of being in public
Dizziness	Fear of bus, subway, car, train, plane
Feeling faint	Fear of having a panic attack
Derealization	Unable to go places without a companion
Depersonalization	Specify which feared situations are avoided
Numbness	
Tingling	
Chills	
Hot flashes	
Fear of losing control	

TABLE 3.4. Sample Treatment Goals and Interventions for Panic Disorder and Agoraphobia

Treatment goals	Interventions
Reducing physical symptoms of anxiety/panic	Muscle and breathing relaxation training
Acquiring breathing skills	Breathing relaxation and rebreathing training
Eliminating conditioned anxiety response to physical sensations	Exposure
Stating belief that physical anxiety symptoms are not harmful	Cognitive restructuring, behavioral experiments
Engaging in all previously avoided activities	Exposure
Eliminating safety behaviors	Exposure
Modifying schemas of vulnerability and need for control (or other schemas—specify)	Cognitive restructuring, developmental analysis
Reporting that fear of future panic attacks has been reduced to less than 1 on a scale of 0–10	Cognitive restructuring, skills review, and practice
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
No panic attacks for 1 month	All of the above
Eliminating all avoidance behavior	All of the above
Scores on anxiety tests (BAI, PDSS, etc.) in normal range	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

Socialization to treatment

Sara's ambivalence about therapy was explored. She was helped to see that therapy would focus on alleviating her symptoms of panic and agoraphobia, and that specific goals would be set collaboratively with her so that she would not feel that therapy would veer off in areas that she did not want. Her fears of being neurotic were normalized as typical fears held by patients, not only because of misunderstanding the nature of the problem, but also because of the stigma of having a "mental illness." It was suggested that she view her panic disorder as a specific and limited vulnerability, instead of equating her entire identity with a diagnosis.

Introducing cognitive-behavioral model

Sara was helped to understand the function of the fight-or-flight response in protecting humans, as well how her fight-or-flight response was being triggered in the absence of danger (panic attack). She was relieved to learn that anxiety was a protective mechanism and amazed to learn that it was being triggered to protect against itself. Understanding that what she experienced as difficulty breathing was the result of overbreathing and not underbreathing was extremely helpful to her. As she began to see the connection between each

TABLE 3.5. Detailed Treatment Plan for Panic Disorder and Agoraphobia**Session 1****Assessment**

Inquire regarding all symptoms

Administer standard battery of intake measures (see Form 3.2), plus additional anxiety questionnaires as appropriate

Administer Evaluation of Anxiety and Avoidance for Patients (Form 3.3)

Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)

Assess motivation and eligibility for treatment

Evaluate patient's ability to induce relaxation in session

Refer for evaluation of, or evaluate, need for medication

Evaluate need for substance abuse counseling or detoxification

Evaluate reliance on safety behaviors or safety persons

Homework

Have patient begin self-monitoring of panic and anxiety symptoms (Form 3.4)

Have patient begin identifying automatic thoughts and emotions in feared situations (Form 3.6)

Have patient construct a list of feared and avoided situations

Session 2**Assessment**

Examine patient's typical thoughts and feelings in feared situations

Examine panic and anxiety symptoms listed in self-monitoring

Socialization to treatment

Inform patient of diagnosis

Describe panic disorder and agoraphobia

Provide patient with information handouts on panic disorder and agoraphobia (Form 3.5) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)

Develop list of treatment goals

Medication

Consider medication (if patient is not already using it) and review side effects and efficacy

Homework

Assign self-help material: Wilson's (2009) *Don't Panic* or Leahy's (2009) *Anxiety Free*

Have patient continue self-monitoring with Forms 3.4 and 3.6

Session 3**Assessment**

Readminister self-report questionnaires to assess mood and track progress

Review panic symptoms, avoidance/escape/safety behaviors

Interventions

Teach breathing retraining (caution against using it as a safety behavior)

Teach progressive muscle relaxation (only if chronic overarousal is present; caution against using it as a safety behavior)

Medication

Evaluate side effects

Evaluate need to adjust dosage

(cont.)

TABLE 3.5 (cont.)

If no improvement, either increase dosage, add another medication, or change class of medication
(consider the need to taper or discontinue one class when adding another class)

Homework

Have patient practice breathing exercises (assigned each week except during exposure and unless used
as a safety behavior)

Have patient continue self-monitoring as above

Session 4**Assessment**

Readminister self-report questionnaires to assess mood and track progress

Review panic symptoms, avoidance/escape/safety behaviors

Behavioral Interventions

Prove rationale for exposure

Have patient begin constructing a fear hierarchy of items from least to most feared (Form 3.8)

Introduce patient to panic induction, imaginal exposure, and/or *in vivo* exposure (as deemed
appropriate)

Medication

As in Session 3

Homework

Have patient engage in panic induction, *in vivo* exposure, and/or imaginal exposure (as appropriate) at
home

Have patient continue self-monitoring as above

Sessions 5–8**Assessment**

Readminister self-report questionnaires to assess mood and track progress

Have patient complete and modify fear hierarchy if needed

Cognitive Interventions

Elicit patient's automatic thoughts associated with anxiety/panic

Identify patient's misappraisals about panic and modify/challenge as appropriate (see Chapter 10 and
Appendix B)

Other Interventions

Introduce stress management

Medication

As in Session 3

Homework

Have patient continue panic induction, *in vivo* exposure, and/or imaginal exposure (as appropriate)
exercises at home

Have patient identify and modify automatic thoughts

Sessions 9–10**Assessment**

Readminister self-report questionnaires to assess mood and track progress

Track progress in identifying and modifying thoughts and in conducting panic induction/exposure

TABLE 3.5 (cont.)**Cognitive Interventions**

Help patient identify underlying themes evident in automatic thoughts (i.e., maladaptive assumptions)
 Examine advantages/disadvantages of assumptions, evidence for/against assumptions
 Help patient generate new, adaptive assumptions
 Help patient continue modifying automatic thoughts (focus on self-instruction to decatastrophize panic symptoms)
 Help patient develop self-instructions for anxiety and stress

Behavioral Interventions

Help patient plan and conduct exposure to situations higher in fear hierarchy

Medication

As in Session 3

Homework

Have patient continue modifying automatic thoughts and maladaptive assumptions
 Have patient continue *in vivo* exposure, imaginal exposure, and/or panic induction (as appropriate)
 Have patient test appraisals (write down predictions before exposure, and test outcome of predictions after exposure session is over)

Sessions 11–12**Assessment**

Readminister self-report questionnaires to assess mood and track progress
 Assess attainment of goals to determine whether treatment may be tapered off
 Track progress in identifying and modifying automatic thoughts and maladaptive assumptions
 Track progress in conducting exposure/panic induction
 Assess and address any residual symptoms (including symptoms of comorbid disorders)
 Assess any residual life problems related to panic/agoraphobia

Cognitive Interventions

Help patient identify schemas
 Examine schema maintenance behaviors, origins of schemas
 Help patient modify schemas
 Help patient continue modifying automatic thoughts and assumptions
 Review past negative predictions and outcomes

Behavioral Interventions

Continue with panic induction, imaginal exposure, and/or *in vivo* exposure (as necessary/appropriate)

Other Interventions

Stress management: Help patient develop self-instructions for anxiety and stress
 Begin planning phase-out of treatment
 Evaluate need for assertion training, relationship enhancement skills, mutual problem solving, ability to construct alternatives

Homework

Have patient develop own homework
 Assign continued exposure to anxiety-provoking situations/panic induction (as necessary/appropriate)

(cont.)

TABLE 3.5 (*cont.*)

Have patient write down predictions before exposure, identify cognitive challenges, and record outcome
Have patient monitor and challenge all types of cognitive distortions related to current everyday conflicts
Have patient anticipate anxiety-provoking situations that might arise and list possible coping strategies (behavioral, interpersonal, and cognitive)

physical symptom (e.g., her heart pounding) and its protective function in true danger (pumping oxygen through the blood supply to give her more energy to flee or fight), her optimism about beginning treatment grew. She got tears in her eyes as she finally understood that her desperate urge to run out of different places didn't mean she was crazy; she was merely responding to her brain's signals that she was in danger and had to flee.

Session 3

Breathing retraining

Given her symptoms of chronic somatic tension and feeling keyed up, Sara was trained in session in the use of progressive muscle relaxation and deep diaphragmatic breathing. She was helped to see that these exercises would help her feel less tense and stressed and promote overall relaxation, but were not intended to ward off panic attacks.

Breathing retraining was initiated in session with the therapist first modeling slow inhaling and exhaling, demonstrating that the goal of proper breathing would be for Sara to raise a small book placed on her abdomen (but not raise a book placed on her chest). She was cautioned against shallow chest breathing, but was told that if she did this it would be natural, since she had not yet mastered how to breathe deeply through her diaphragm.

Relaxation training

For Sara's chronic symptoms of muscle tension, the therapist also demonstrated the correct way to contract and relax each of the 12 muscle groups, and explained that the goal was to help her detect early signs of tension and learn how to relax her muscles. She was told that the session would be recorded and that she would be asked to practice at home with the digital recording.

Next, Sara was asked to lean back in her chair in a comfortable position. She was asked to visualize lying down in a place she associated with relaxation and to breathe slowly and deeply, in through her nose and out through her mouth. She was also asked to mentally repeat the word "relax" each time she exhaled. After 5–10 minutes of slow, deep breathing, the therapist introduced deep muscle relaxation exercises, helping her to alternately contract and relax all muscle groups in a slow, systematic manner.

At the end of the session, Sara stated that although she felt more relaxed than she had felt in a long time, there were moments when she experienced panic and had the urge to get up and pace around the room. Her tendency to interpret somatic sensations as threatening, as well as the high probability that she was still overbreathing, were offered as possible explanations. She was

informed that these were normal feelings and would pass as she kept practicing.

Sara was asked to practice both types of exercises once a day during periods where she felt no anxiety. She was also educated and cautioned about using deep breathing and relaxation as safety behaviors to ward off panic attacks, and she was asked not to use them during exposure sessions. She was reminded that deep muscle relaxation exercises were intended to help alleviate her chronic muscle tensions and were not intended to ward off panic attacks.

Session 4

Rationale for exposure

The rationale for confronting feared symptoms and situations via exposure was once again presented to Sara. She was helped to see that confronting these feared items would help her learn that the bad outcomes she feared would not happen because these situations and symptoms were not inherently dangerous, and that her anxiety would decrease naturally without the use of her safety behaviors, as her brain realized that she was not truly in danger. She was informed that she would begin by confronting her fears about symptoms directly during this session and would begin confronting her other fears in subsequent sessions.

Fear hierarchy

A fear hierarchy was constructed by asking Sara to rate her feared situations from least to most feared (accompanied or unaccompanied). All safety behaviors were also identified (e.g., sitting down, carrying around a bottle of Xanax and some energy bars, distracting herself, anchoring her vision on an object) and ranked to see which ones she would be able to relinquish (e.g., the energy bars) immediately and which would have to be built into her hierarchy (e.g., being accompanied by her husband).

Sara's highest-ranked fear was traveling alone on a transatlantic flight without any safety behaviors (where escape would be blocked for hours and public humiliation in case of panic would be high). Her most mildly feared situation was walking down the street accompanied by her husband.

Panic induction

Sara was helped to experience panic during sessions. An assessment exercise was first conducted, in which she was asked to hyperventilate, jog on the spot, spin around in the chair, and stare at a bright light, and was then asked to record her fear before, during, and after the exercise. Hyperventilation and spinning in the chair successfully brought up symptoms that mimicked a panic attack and created tremendous anxiety. Following this assessment, Sara was helped to hyperventilate for 1 minute repeatedly during the session, with pauses in between to allow her breathing to return to normal. When her anxiety associated with the hyperventilation exercised reduced substantially, the exercise was terminated, and she was asked to practice the exercise daily until the next session. (Within the next few weeks, Sara no longer experienced anxiety during the hyperventilation exercise.) She was not yet ready to induce her symptoms of dizziness during this session (Session 4), but by Session 8 she was willing to do so.

In vivo exposure

In addition to practicing the hyperventilation exercise over the next week, Sara was encouraged to begin walking down the street accompanied by her husband, but without the use of any other safety behaviors. She was encouraged

to continue walking until her urge to flee the situation had subsided and her anxiety had decreased significantly. A consultation session had already been scheduled with her husband, to help him understand panic and his role in being an effective coach during exposure.

Sessions 5–8

Identifying automatic thoughts

Sara was asked to begin logging her automatic thoughts during moments of increased panic, along with the level of anxiety induced, specific details about the situation in which it was triggered, and the behaviors she felt compelled to perform. It became clear that Sara feared symptoms of dizziness and depersonalization the most, and believed that she would pass out if she experienced these symptoms. Through guided discovery, Sara was able to see that she truly believed that if she did not get the appropriate medical care or exit a situation where she experienced panic, she would have a stroke and die. She also feared that her anxiety would make her “flip out”: She feared that she would begin screaming and crying, and that everyone around her would think she was insane. As she continued identifying her thoughts when she had panic, it became clear that Sara also feared that she would go insane, and that her attempts to anchor her vision during moments of panic were her way of “grounding herself” so she would not go insane.

Modifying automatic thoughts

As Sara became aware of her misappraisals about panic, and was successful in eliciting her own distorted automatic thoughts during panic, the therapist began helping her modify these thoughts. Specific categories of automatic thoughts were addressed, including her tendencies to overestimate a negative outcome (“I am having a panic attack”), to catastrophize (“I will have a stroke”) and to underestimate her ability to cope (“I am weak and can’t handle stress”). She also had a tendency to predict things in the future (fortunetelling) and to assume she knew what people were thinking about her (mind reading).

Sara was helped to examine the evidence for her thoughts (e.g., had she ever had a stroke?), as well as to consider more benign alternatives (e.g., hyperventilation creates dizziness, but does not lead to strokes). Behavioral experiments involving panic induction sessions were also conducted to test specific appraisals. Over time, Sara began to gain further distance from her automatic thoughts, and her belief in them gradually subsided as she continued chipping away at them each time they occurred. The therapist also gave her a “coping card” designed especially for her anxious thoughts (see Table 3.6).

More panic induction

By Session 8, Sara was ready to induce symptoms of dizziness in session, given that she had now begin to consider the possibility that dizziness was a symptom of hyperventilation and not a sign of an impending stroke. Nonetheless, she was extremely anxious (a rating of 8–10) before beginning the exercise, and she began to feel lightheaded even before the exercise had been initiated. She was asked to stand up and spin around the room for 30 seconds. Within 10 seconds, she began to cry and stopped spinning. She began shaking and expressed her fear that she was going to faint, have a stroke, and/or go insane; she repeatedly urged the therapist to let her go home. She was encouraged to reiterate the rationale for exposure to herself and to continue when she felt ready. Next time, she tolerated the exercise for 15 seconds and did not ask

TABLE 3.6. "Coping Card" for Sara

-
1. Specifically, what am I predicting will happen?
 2. How often have I predicted this incorrectly?
 3. What is the worst possible outcome?
 4. What is the best possible outcome?
 5. What is the most likely outcome?
 6. Aren't some anxiety and discomfort normal? Can I tolerate them?
 7. Remember: I've never stopped breathing. My heart has never stopped. I'm healthy.
 8. Escape is not relevant, because there is no danger.
 9. I have a lot of unrealistic, "magical" thoughts. These are fearful thoughts, not facts.
 10. If I have a panic attack, I can think of it as a variation in arousal. It's not dangerous.
 11. Anxiety is a protective reaction against danger. It is not dangerous. Getting anxious about anxiety is like getting afraid of the fire alarm instead of the fire.
-

to leave the office, although she was extremely anxious (a rating of 10). The exercise was repeated several times during the session, with pauses between repetitions to allow her dizziness to return to normal. Ultimately Sara was able to tolerate the 30-second exercise with an anxiety rating of 4.

During feedback, Sara expressed relief that she had stuck it out and tolerated the exercise, but expressed disbelief that she had actually gone through with an exercise she had been dreading for weeks. She said that her fears about dizziness leading to a stroke or insanity were less, and that she now recognized it as just an unpleasant symptom. She was encouraged to practice at home on a daily basis over the next few weeks, and was helped to practice in session over the next few sessions for up to a minute. Within a few weeks, her anxiety about dizziness was substantially reduced.

*Stress
management*

Stress management included examination of the pros and cons of Sara's current job, acceptance of her anxiety's variability, the double-standard technique regarding intolerance of anxiety, and consideration of occupational and training opportunities available to her.

*Imaginal
exposure*

When it was time for Sara to confront her fear of subways, it became clear that she was not ready to do so *and* that she needed to get on the subway to function in her daily life. As a result, in-session imaginal exposure was used to help her first confront her fears in imagination before confronting them in her real life. This involved asking Sara to imagine being on the subway alone in a crowded, hot car, feeling anxious, short of breath, and dizzy. She was asked to describe step by step exactly what she saw happening, as well as to imagine her catastrophic consequences (having a panic attack, falling down, fainting, and then not getting help, having a stroke, and dying). She was asked to replay this scene in her mind over and over again, and her anxiety was monitored throughout on a scale of 1–10.

Although her initial anxiety was extremely high (10), Sara soon began to see that her fears were not rational and that her misappraisals were based on her lack of understanding about panic. Her anxiety slowly subsided. She spontaneously stated that she now realized that the feared outcome she had initially envisioned (e.g., having a stroke) was unlikely. When her fear habituated

after 15–20 minutes, the exercise was terminated, and Sara was helped to imagine the more likely outcome: that she had a panic attack in the subway, got extremely anxious, tolerated it with distress until it subsided, and then exited the subway and came home.

During the feedback at the end of the session, Sara expressed disbelief that she had become “bored” with the catastrophic image—an outcome that she had never dreamed would ever happen, since even the mere mention of the word “subway” had in the past sent her into a tailspin. She was asked to practice exposing herself to the same image at home over the next week.

Sessions 9–10

Examining patterns in automatic thoughts and identifying assumptions

Sara’s typical automatic thoughts were:

“I’ll have an anxiety attack. I won’t be able to get out. My heart will start racing. I won’t be able to breathe. I’ll pass out, and no one will help me. I will have a stroke and die.”

“I will have a panic attack, and then I’ll start screaming. Everyone will look at me and think I am insane. I won’t be able to handle it.”

“Everyone thinks I have it ‘together.’ People might find out I’m anxious and think less of me.”

“If I say something [about anxiety], I’ll jinx it.”

“My heart is racing, which means I am having a heart attack.”

Using guided discovery, the therapist helped Sara see that patterns of dysfunctional rules and assumptions were beginning to emerge. It became clear that Sara had several assumptions on which these thoughts were based:

“A physical symptom is always a sign that one is ill.”

“One should be careful and on guard at all times.”

“Danger is lurking everywhere.”

“If I don’t make sure I am taken care of, I will fall apart.”

“It is important to manage on your own without help.”

“Having anxiety is intolerable and a sign of weakness.”

Modifying assumptions

The therapist helped Sara understand the rule inherent in each thought, and helped her directly modify the rule or assumption to further chip away at her beliefs about panic.

Increased exposure

Exposure exercises continued over sessions. Sara began exposure by walking on the street with her husband. Once she was able to walk down the street unaccompanied by her husband (and without distracting herself, anchoring her vision on objects, carrying medicine and water, etc.), she then began confronting her fears of taking a subway. After confronting her fears of riding on a subway in her imagination, she began taking a local subway that would stop every couple of minutes (first with and then without her husband), and gradually increased the level of difficulty in her exposure exercises by taking the express subway.

Over subsequent weeks, Sara also began going out to restaurants and theaters more. Prior to each step in the exposure hierarchy, the therapist would rehearse with Sara images of panic and anxiety in the feared situation if necessary, and help her challenge her negative thoughts prior to and after the exposure exercise.

Sessions 11–12

Identifying and modifying schemas

By examining an array of Sara's negative automatic thoughts during episodes of anxiety, along with the maladaptive assumptions on which they were based, the therapist also began understanding the personal schemas or beliefs she held about herself, the world, and others. It became clear that although her beliefs were now shifting, Sara had begun treatment with strong beliefs that she was weak, fragile, and helpless, and that the world was a dangerous place. She believed that she couldn't survive without the help of others, yet believed that people were critical and judgmental.

- *Self*: Weak, helpless, fragile
- *World*: Dangerous, unpredictable
- *Others*: Critical, judgmental

Examining schema compensation and avoidance

Sara compensated for her vulnerability by attempting always to be rational and in control. She also avoided situations where she might be trapped (subways) or might be evaluated negatively for her anxiety (e.g., public speaking).

- *Avoidance*: "I should avoid danger at all costs."
- *Compensation*: "I shouldn't be anxious. I should always be in control."

Submitting schemas to challenges; examining origins of schemas

Sara's all-or-nothing view of anxiety, her sense that she was weak and in need of protection, and her need for control were addressed by using the cost-benefit technique, examining evidence for and against the idea that she needed to be in complete control, and examining the origins of her schemas about emotionality. Sara recalled that her mother was a highly emotional (probably histrionic) individual about whom Sara felt quite embarrassed. As a result, she equated strong emotions with "weakness" and "irrationality," which she and the therapist contrasted with "being more fully alive" and "being a complete human being." Sara found the double-standard technique useful when she and the therapist applied it to friends who might be anxious.

Sara also acknowledged that the ideas of fragility and physical danger had been themes in her maternal family. She realized that her mother and her grandmother were both fearful in general, and that her grandmother was particularly cautious about trying anything new. She also recalled her mother's alarm when she fell sick as a child, her level of agitation when Sara had her annual visit to the doctor, her tendency to protect her against the dangers in the world, and her emphasis on feeling safe in general.

In addition, Sara began to experience a growing realization through

cognitive strategies that her general sense that “something was wrong,” as well as her beliefs that she was “weak” and “in danger of coming to harm,” had been triggered when she had developed Crohn’s disease.

*Stress
management
for other areas
of her life*

Sara had other sources of stress that she raised in therapy—specifically, her ambivalence and anger at feeling trapped in her job (a job she had chosen because of her social anxiety). Cognitive therapy was helpful in challenging her self-critical thoughts about her position and in helping her examine her all-or-nothing thinking about anxiety and weakness.

*Continued
exposure*

As therapy progressed, Sara began normalizing her life by using all forms of public transportation, as well as increasing distances that she could walk comfortably in the city. She almost never used the breathing exercises when she became anxious, because she now “knew” that her sense that she was in danger was not real and instead came from childhood experiences that helped her learn to expect danger lurking everywhere. Sara became quite adept at anticipating how she would handle future situations, such as travel or public speaking, which might arouse anxiety.

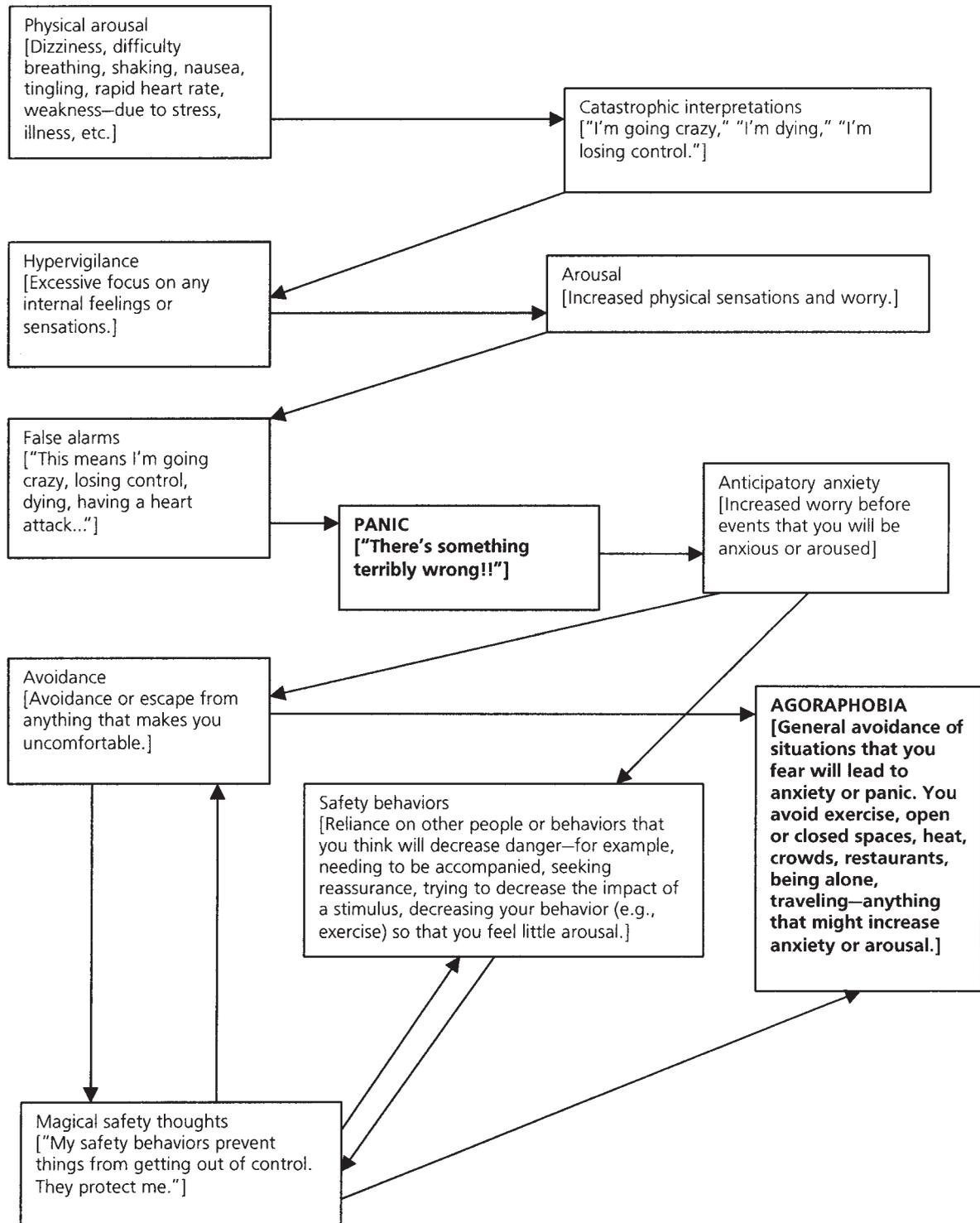
Assertiveness

Sara became more assertive at work (where she was “underemployed”) and began considering the possibility of further professional training in graduate school. Her perfectionism about anxiety—that is, her early goal of trying to eliminate all anxiety—was challenged and modified when she began examining the value of accepting sensations and feelings as potentially useful signs of other problems in her life (especially her feelings of resentment and being trapped in her job).

*Phasing out
therapy*

Therapy was phased out by reducing sessions to biweekly and then once per month with no relapse of symptoms. Reviewing her typical automatic thoughts, assumptions, and schemas, and providing her with an outline of the treatment package, helped her to phase out comfortably.

FORM 3.1. Cognitive–Behavioral Model of Panic Disorder and Agoraphobia for Patients



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FORM 3.2. Evaluation of Panic Disorder and Agoraphobia: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Structured Clinical Interview for DSM-IV-TR Axis I (SCID) _____

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) _____

Beck Depression Inventory-II (BDI-II) _____

Beck Anxiety Inventory (BAI) _____

Panic Disorder Severity Scale (PDSS) _____

Mobility Inventory _____

Fear Questionnaire (Agoraphobia subscale) _____

Global Assessment of Functioning (GAF) _____

Other questionnaires (specify): _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of panic/agoraphobia:

Onset

Duration

Precipitating events

Treatment

(cont.)

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Key symptoms

Panic attacks (indicate average frequency, duration, intensity, whether limited or full-blown symptoms, and physical and cognitive symptoms): _____

Avoidance/escape and safety behaviors: _____

External triggers of anxiety (list places, situations, activities avoided or feared): _____

Internal triggers of anxiety (list panic symptoms avoided or feared): _____

Feared consequences (if none reported, reevaluate after implementing cognitive strategies): _____

Treatment progress (later evaluations only)

Situations still avoided: _____

Situations approached that were previously avoided: _____

Recommendations

Medication evaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 3.3. Evaluation of Anxiety and Avoidance for Patients

Patient's name: _____ Today's date: _____

Which of the following situations do you avoid? (Circle each one.)

Restaurants	Stores	Malls
Subways	Buses	Airplanes
Elevators	Stairwells	Trains
Walking outside	Exercise	Bridges
Driving	Riding in a car	Viewing horizons
Being out alone	Tunnels	Open fields
Sunlight	Heights	Being home alone

Other situations avoided: _____

The three situations that I fear the most are:

1. _____
2. _____
3. _____

Do you avoid any of the following public situations because you might appear anxious? (Circle.)

Public speaking, eating, or drinking	Using a toilet or urinal not in your house
Undressing in a locker room	Parties
Family gatherings	Classrooms
Eye contact	Standing close to someone

Other situations: _____

I fear that in the situations circled in the lists above, I will become anxious and (check as many of the following that apply):

- ___ I will have a heart attack or become physically ill.
- ___ I will lose control and go insane.
- ___ I will lose control and embarrass myself.
- ___ I will not be able to get to a toilet in time.

(cont.)

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FORM 3.3. Evaluation of Anxiety and Avoidance for Patients (p. 3 of 3)

How many coffees or caffeinated drinks do you have per day? _____

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

Have you ever been diagnosed as having hyperthyroidism, Cushing's syndrome, hyperventilation, mitral valve prolapse? (Circle.)

What medical conditions do you have now?

Who treats each of these?

Which of the following do you do to make yourself feel safe when you are afraid of having a panic or anxiety attack? (Circle any that apply.)

Ask for reassurance

Take someone along when you go out

Repeat thoughts or words to yourself

Look around for signs of danger

Focus on physical sensations to see if you are OK

Clutch things for support

Sit down

Pace

Tense my body or hands

Take deep breaths (try to calm myself)

Other behaviors: _____

FORM 3.4. Patient's Panic Record

Patient's name: _____

Date/time/ situation	Anxiety before entering situation (0–100%)	Predictions/ thoughts and confidence in accuracy of them (0–100%)	Physical sensations while in situations	Rating of actual anxiety in situation (0–100%)	Outcome (what happened)

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FORM 3.5. Information for Patients about Panic Disorder and Agoraphobia

WHAT ARE PANIC DISORDER AND AGORAPHOBIA?

Almost everyone feels anxious at times. But panic attacks are characterized by severe levels of anxiety, which you may misinterpret as an indication that you are having a heart attack or another medical problem, going insane, or completely losing control. During a panic attack, you may feel shortness of breath, tingling sensations, stomach distress, ringing in your ears, a sense of impending doom, trembling, light-headedness, sensations of choking, chest pain, sweating, and heart pounding. You should first see your physician in order to rule out medical causes for these symptoms, such as hyperthyroidism, caffeine addiction, mitral valve prolapse, or other causes. Once medical causes are ruled out, it is important that a qualified mental health professional evaluate you to determine whether you suffer from “panic disorder.”

Panic disorder is often called the “fear of fear,” because people who suffer from this disorder become afraid of the symptoms of fear (or a “panic attack”) and interpret these symptoms to mean that something is imminently wrong with them. Fear normally occurs when we are in true danger, and it serves as an alarm or a signal to our brains that we are in danger, so that we can protect ourselves against it. The symptoms of fear (heart pounding, overbreathing, etc.) are designed to energize us for either running or fighting danger (this is called the “fight-or-flight response”). For example, our hearts pound fast when we are in danger in order to pump more blood, which carries oxygen. Oxygen gives us more energy to run or fight when we are faced with danger. This is a natural response to actual danger, or what we call a “true alarm,” and we have had this system built in for millions of years.

In panic disorder, your body thinks you are in danger, even though no danger is actually present. When fear comes in the absence of danger, we call it a “false alarm.” It is like a fire alarm going off even though there is no fire. Over time, this false alarm becomes a “learned alarm,” meaning that you begin to fear the very symptoms of fear that are designed to protect you from true danger, because you don’t understand why you are experiencing these symptoms. You begin to assume that having a panic attack is dangerous—that it means there is something wrong with you. But as you begin to perceive panic attacks as dangerous, you keep triggering more fear or more panic attacks in the future, as a way of coping with what you believe is dangerous. The irony of panic disorder is that you begin to fear the very symptoms that are designed to protect you from danger. “Believing” that you are in danger, your brain keeps producing more and more fear (or more and more panic attacks), because in a sense it “does not realize” that what you are afraid of are the very symptoms of fear itself and that there is no true danger present.

Given that they believe that panic attacks are dangerous, individuals with panic disorder begin to worry about having future attacks. They also begin to fear and avoid anything that mimics symptoms of panic and brings on similar sensations (heat, exercise, sunlight, pleasure or excitement, sexual arousal, anger, etc.). Individuals with panic disorder begin to focus on these internal sensations: “My heart is pounding—I’m going to have a heart attack,” or “I’m feeling weak and dizzy—I’m going to collapse.” Many individuals with panic disorder also experience panic when they are asleep.

Many patients who have panic disorder also experience “agoraphobia.” Individuals with agoraphobia fear places or situations from which escape might be difficult if they have a panic attack (e.g., “I may have an anxiety attack on the subway and faint in front of everyone”). They may avoid being out alone, being home alone, supermarkets, trains, airplanes, bridges, heights, tunnels, open fields, driving, elevators, and the like. These individuals fear that they will have a panic attack in these situations and, as a result, exert great efforts either to avoid or to escape the situations (e.g., “I need to get out of here”). In fact, avoidance and escape become

(cont.)

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the major coping mechanisms for handling anxiety. When these situations cannot be avoided, the individuals typically come up with various ways to make themselves feel “safe” (e.g., carrying around a bottle of water). Many people with panic disorder and agoraphobia enlist a “safe person”—someone who accompanies them in case they become anxious and need to escape.

Even though their avoidance/escape may have led to few or no anxiety attacks in months, individuals with panic disorder and agoraphobia continue to worry about the next attack. The world becomes smaller and smaller as a result of their avoidance. Because of this constriction in their lives, many individuals with panic disorder and agoraphobia become depressed and chronically anxious, and they begin to medicate themselves with alcohol, Valium, or Xanax.

Furthermore, although these efforts are successful in the short term, in the long run they actually strengthen these individuals’ beliefs that they are in danger and in need of protection. Therapy is designed to help “retrain” the brain that the feared situations are not dangerous, that panic attacks are harmless symptoms of fear, and that no safety behaviors are needed.

WHAT ARE THE CAUSES OF PANIC DISORDER AND AGORAPHOBIA?

Although in any given year 30–40% of the general population will have a panic attack, most of these people will not have a catastrophic interpretation of their panic attack and develop panic disorder. Panic disorder and agoraphobia occur in individuals who appear to be vulnerable to them. Research suggests that they run in families and appear to result from a combination of genetics, temperament, biological factors, and psychological vulnerabilities. People with anxiety may have a temperament that makes them more vulnerable to developing panic disorder. Research also shows that anxiety can be inherited, may be the result of biological factors, and/or may be learned through early experiences. Early experiences linked to the development of panic disorder include those that teach individuals to perceive the world as a dangerous place, and specifically to perceive internal bodily sensations as harmful. Individuals with panic disorder tend to focus excessively on their physical sensations and to develop catastrophic interpretations of sensations. For example, they may focus on their heart rate and jump to conclusions about having heart attacks.

Many situations that activate panic and agoraphobia are also situations that earlier in our evolutionary history were truly dangerous to our ancestors. For example, being trapped in a tunnel could lead to suffocation or collapse; heights might be dangerous; in open fields, individuals were more susceptible to predators (like lions or wolves); public places might have brought our ancestors into contact with hostile strangers. Thus we now view many of the fears of agoraphobia as reminiscent of these earlier instinctive and adaptive fears. However, these situations are not dangerous today.

Initial panic attacks may also be activated in vulnerable individuals by stressful situations—for example, leaving home, relationship conflict, surgery, new responsibilities, or physical illness. Many people who have panic disorder and agoraphobia also experience depression, partly as a consequence of their feeling out of control and feeling unsure about how to handle their problem.

WHAT ARE SOME COMMON MISCONCEPTIONS ABOUT PANIC DISORDER AND AGORAPHOBIA?

Most individuals misinterpret their panic symptoms as a sign of a dangerous medical condition, serious mental illness, or loss of control. They may believe that they actually have heart disease or schizophrenia; that they may lose touch with reality, faint, or have a stroke; or that other frightening things may or will happen. Individuals with panic disorder and agoraphobia may also fear that having panic attacks is a sign of a flaw or weakness, and may become depressed, dependent, and self-critical as a result.

(cont.)

Some people may also incorrectly believe that panic attacks are just a symptom of deeper-seated problems. Individuals with panic disorder and agoraphobia often have unrealistic beliefs about anxiety, such as “All anxiety is bad” and “I have to get rid of my anxiety immediately.” Others believe that because they have had panic attacks and agoraphobia for many years—and because traditional therapy has not been helpful for these problems—they can never improve.

Educating patients that panic disorder and agoraphobia are extremely responsive to treatment is critical for treatment to succeed. Cognitive-behavioral therapy, with or without medication, is extremely effective in the treatment of panic disorder and agoraphobia. This type of therapy helps people correct their myths, misconceptions, and judgments about these disorders. Patients are helped to accept that they have an illness that can be treated by using psychotherapeutic strategies, and are helped to understand that it can be treated effectively without long-term therapy exploring childhood experiences.

HOW EFFECTIVE IS COGNITIVE-BEHAVIORAL THERAPY FOR PANIC DISORDER AND AGORAPHOBIA?

Fortunately, there have been a number of studies examining the effects of cognitive-behavioral therapy for panic disorder and agoraphobia. These studies have been done at Oxford University in England, the University of Pennsylvania, the State University of New York at Albany and at other universities, medical schools, and clinics. Over a course of 12–15 sessions, the efficacy ranges from 85% to 90%. Furthermore, once treatment is terminated, most patients who are tested 1 year later have maintained their improvement.

MEDICATIONS FOR PANIC DISORDER AND AGORAPHOBIA

Many medications that are useful in the treatment of panic disorder and agoraphobia. These include a wide range of antidepressants (such as Prozac, Zoloft, and, Tofranil), as well as Xanax and other medications for anxiety. These medications help reduce symptoms of panic disorder and agoraphobia, but once you terminate the medication, your panic symptoms may return. Consequently, we recommend that even if you use medication, you should also include cognitive-behavioral therapy.

WHAT ARE SOME OF THE STEPS IN COGNITIVE-BEHAVIORAL TREATMENT?

The cognitive-behavioral treatment of panic disorder and agoraphobia is organized around several goals: first, helping you to understand the nature of anxiety, panic, and agoraphobia; second, determining the range of situations that you avoid or fear; third, evaluating the nature of your symptoms, their severity and frequency, and the situations that elicit your panic; and, fourth, determining whether any other problems coexist with panic—for example, depression, other anxieties, substance abuse, overeating, loneliness, or relationship problems.

Your therapy may include some or all of the following treatments: educating you about panic so that you learn not to fear it; breathing retraining; relaxation training; inducing panic (to show your brain that panic attacks are harmless and that you are not in danger); gradual exposure to situations that elicit panic; identification and modification of your misinterpretations of your panic or arousal (e.g., “My heart is pounding, so I must be having a heart attack”), as well as the assumptions (e.g., “Physical sensations are dangerous”) and beliefs (e.g., “I am fragile and weak”) on which the misinterpretations may be based; coping with life stresses; assertion training (when needed); and training in the ability to recognize and reduce your panic symptoms when they occur. Any other problems that you may have (such as depression) may also be addressed in the therapy.

(cont.)

WHAT IS EXPECTED OF YOU AS A PATIENT

Cognitive-behavioral therapy is not a passive experience for patients. You are expected to come to sessions weekly (sometimes more than once per week), fill out forms that evaluate your problems, and do therapy assignments between sessions that you and your therapist plan and assign. As indicated, most patients who participate in this treatment experience improvement—and some experience rapid improvement. *Even if you experience rapid improvement, however, you should complete the full treatment package.* Premature dropout from treatment increases the likelihood that you will have relapses.

The course of treatment is planned for 12 sessions. The first few sessions are used for evaluation and explanation of the treatment with the remaining sessions used to implement strategies. After acute treatment is over, follow-up sessions may be scheduled biweekly, monthly, and so on to maintain gains and prevent relapse.

The treatment package that we use combines the treatment techniques developed at Oxford University, the University of Pennsylvania, and the State University of New York at Albany. We view the treatment as a way in which you can learn how to help yourself. That is why doing homework in therapy is so important.

FORM 3.6. Patient's Most Common Automatic Thoughts When Anxious/Panicking

Patient's name: _____ Today's date: _____

Check every automatic thought that you have when you start getting anxious or panicking. Then rank your top three automatic thoughts, using 1 for the thought you have most often, and 2 and 3 for the next most frequent thoughts.

____ I'll go insane.

____ I'll embarrass myself.

____ I'll lose control.

____ I'll start yelling.

____ I'll have a panic attack.

____ I'll become violent.

____ I'll have a heart attack.

____ I'll start crying.

____ I'll faint.

____ I'll start shaking.

____ I'll go into a coma.

____ I'll kill or harm myself.

____ I'll be unable to escape.

____ I'll never stop feeling this way.

____ I'll be unable to get home.

____ I'll vomit.

____ I'll be unable to get to the bathroom.

____ I won't be able to breathe.

____ I'll choke/suffocate.

____ I will die.

____ I'll be unable to handle it.

____ I'll have a nervous breakdown.

Other thoughts: _____

FORM 3.7. Coping Statements for Patients

Normalize your anxiety:

Anxiety is normal.

Everyone has anxiety.

Anxiety shows that I am alert.

Anxiety may be biologically programmed (this may be the “right response at the wrong time”—there is no danger that I have to escape from).

Take the danger away:

Anxiety is arousal; it is not dangerous.

I’ve been through this before, and nothing bad has happened.

Anxiety passes and goes away.

Challenge your negative thoughts:

I’m having false alarms.

I’m not going crazy or losing control.

These sensations are not dangerous.

People can’t see my feelings.

I don’t need to have 100% control.

Learn from the past:

I’ve made many negative predictions before that haven’t come true.

I have never gone crazy, had a heart attack, or died from my anxiety.

Remember that panic is overbreathing not underbreathing—I will not die from it.

Plan acceptance:

I can sit back and watch my arousal.

I can accept that my arousal goes up and down.

I can observe my sensations increasing and decreasing.

I can accept my arousal and examine my negative thoughts.

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FORM 3.9. Your New Rule Book for Your Panic and Agoraphobia

Steps in developing panic and agoraphobia	Rational way of looking at the situation
<p>Initial physiological arousal [Dizzy, difficulty breathing, shaking, nausea, tingling, rapid heart rate, weakness due to stress/illness, etc.]</p>	<p>Arousal is not dangerous. It's perfectly reasonable for anyone to have some unpleasant or unexpected experiences of feeling dizzy, short of breath, or rapid heartbeat. If you know that almost everyone has these experiences at times, then maybe this is normal.</p>
<p>Catastrophic interpretation ["I'm going crazy," "I'm dying," "I'm losing control."]</p>	<p>Nothing terrible is really happening. People don't go crazy because they feel dizzy or because their hearts are beating rapidly. Insanity is defined by hearing voices, seeing apparitions, or having delusions that the world is plotting against you. Heart attacks are not the same thing as your heart beating rapidly. Your heart beats rapidly when you are excited, exercising, or having sex. Arousal is not the same thing as losing control.</p>
<p>Hypervigilance [You are overly focused on any internal feelings or sensations.]</p>	<p>You don't need to detect danger—because there is no danger. You may think that focusing on your heartbeat, breathing, and dizziness will help you catch things before they get out of hand. But it is really this overfocus on your internal sensations that makes you more anxious. You can direct your attention to things outside of you. For example, when you find yourself focusing on your heartbeat, redirect your attention back to the situation you are in.</p>
<p>False alarms ["This means I'm going crazy, losing control, dying, having a heart attack ... "]</p>	<p>Nothing terrible is happening—once again! Increased heart rate and rapid breathing may simply be signs of feeling anxious. How many times before have you misinterpreted these sensations? Why should they be dangerous now? Hasn't your doctor told you that you are OK? People don't go insane because they are anxious. Have you really lost control because you were breathing rapidly or because you were dizzy?</p>
<p>Anticipatory anxiety [Increased worry before events that you will be anxious/aroused.]</p>	<p>You don't need to worry, since there is nothing dangerous about anxiety or arousal. What if you are anxious in the future—so what? Anxiety is normal; everyone feels anxious some of the time. Haven't you done a lot of things even when you were anxious? Do you think that worrying about it will keep you from being anxious? You should plan on tolerating anxiety, so that you can learn that there is nothing to be afraid of. Think of anxiety as increased arousal—very much like the arousal (such as increased heart rate and breathing) that you feel when you are exercising.</p>

(cont.)

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Steps in developing panic and agoraphobia	Rational way of looking at the situation
<p>Avoidance [Avoiding or escaping from anything that makes you uncomfortable.]</p>	<p><i>You need to do the things that make you anxious.</i> Avoiding situations that make you anxious only adds to your future anxiety. Exactly what do you predict will happen if you confront these situations? Have these terrible things really happened? Have you really gone insane, had a heart attack, or lost complete control? Or did you simply feel anxious and afraid? As unpleasant as anxiety may be, it is temporary, normal, and nonlethal. It may feel momentarily more comfortable to avoid these situations, but you are teaching yourself that the world is a dangerous place. You should make a list of places and experiences that you are avoiding and list them in your hierarchy of feared situations. Then you can practice imaginal and direct exposure as described by your therapist. You will find that facing your fears—and conquering them—will make you feel less anxious in the future.</p>
<p>Safety behaviors [Reliance on other people or behaviors that you think will decrease danger—for example, needing to be accompanied; seeking reassurance; trying to decrease the impact of a stimulus; decreasing your behavior (e.g., exercise) so that you feel little arousal.]</p>	<p><i>You don't need safety behaviors to control anything, since there is nothing dangerous happening.</i> These safety behaviors maintain your belief that the situation is really dangerous. You think, "The only way I got through this is because I relied on my safety behaviors." You should make a list of every behavior that you engage in that makes you feel safer, and then practice giving it up. What do you predict will happen? Do you think that you will not be able to survive the situation without the safety behavior? What will it mean if you actually get through the situation without any safety behaviors? Does this mean that the situation is actually safe? Giving up safety behaviors will help you get the most out of practicing your exposure to your fears.</p>

Generalized Anxiety Disorder

DESCRIPTION AND DIAGNOSIS

Generalized anxiety disorder (abbreviated GAD in the text of this chapter) has gained increasing attention during the last decade, as several theoretical models have been advanced to address its core cognitive feature—worry. GAD is generally a chronic condition, often preceding the onset of depression by several years. Many people with GAD appear to “normalize” their problem, describing themselves as “worriers” all their lives. They also hold an ambivalent view of their problem: They believe that they need to worry to be prepared, but at the same time they feel that their worry is causing them harm and that they need to stop worrying.

Symptoms

Persons who suffer from GAD exhibit extreme and/or chronic apprehensive worry, as well as related physical symptoms. These persons find it difficult to control their worry and complain of such problems as fatigue, restlessness, irritability, muscular tension, and insomnia. GAD is distinguished from other anxiety disorders in that individuals with GAD are worried about a variety of events, rather than specific stimuli or issues. Persons with panic disorder fear panic attacks; those with social anxiety disorder (social phobia) fear embarrassment in public; those with obsessive–compulsive disorder fear contamination or the consequences of not performing rituals. As in assessment of other anxiety disorders, the clinician assessing for GAD should rule out that the worry is due to a general medical condition or to use of/withdrawal from alcohol or drugs.

For a detailed description of the current diagnostic criteria for GAD, refer to DSM-IV-TR (American Psychiatric Association, 2000, pp. 472–476).

Prevalence and Life Course

Epidemiological studies indicate that lifetime prevalence of GAD varies between 5.8% and 9%, with greater risk for women (the male–female ratio is 2.5:1), young adults, and blacks (Blazer, George, & Winfield, 1991; Breslau & Davis, 1985; Kessler, Walters, & Wittchen, 2004). Patients presenting with GAD often claim that onset has been gradual and that they have been anxious since childhood; some studies indicate that the average duration of this problem prior to treat-

ment is 25 years (Butler, Fennell, Robson, & Gelder, 1991; Rapee, 1991) Because of its chronicity, its self-perpetuating quality, and often its lack of response to treatment, some clinicians and researchers view GAD as a lifelong illness (similar to diabetes or essential hypertension), while others view GAD as representing a personality disorder.

Genetic/Biological Factors

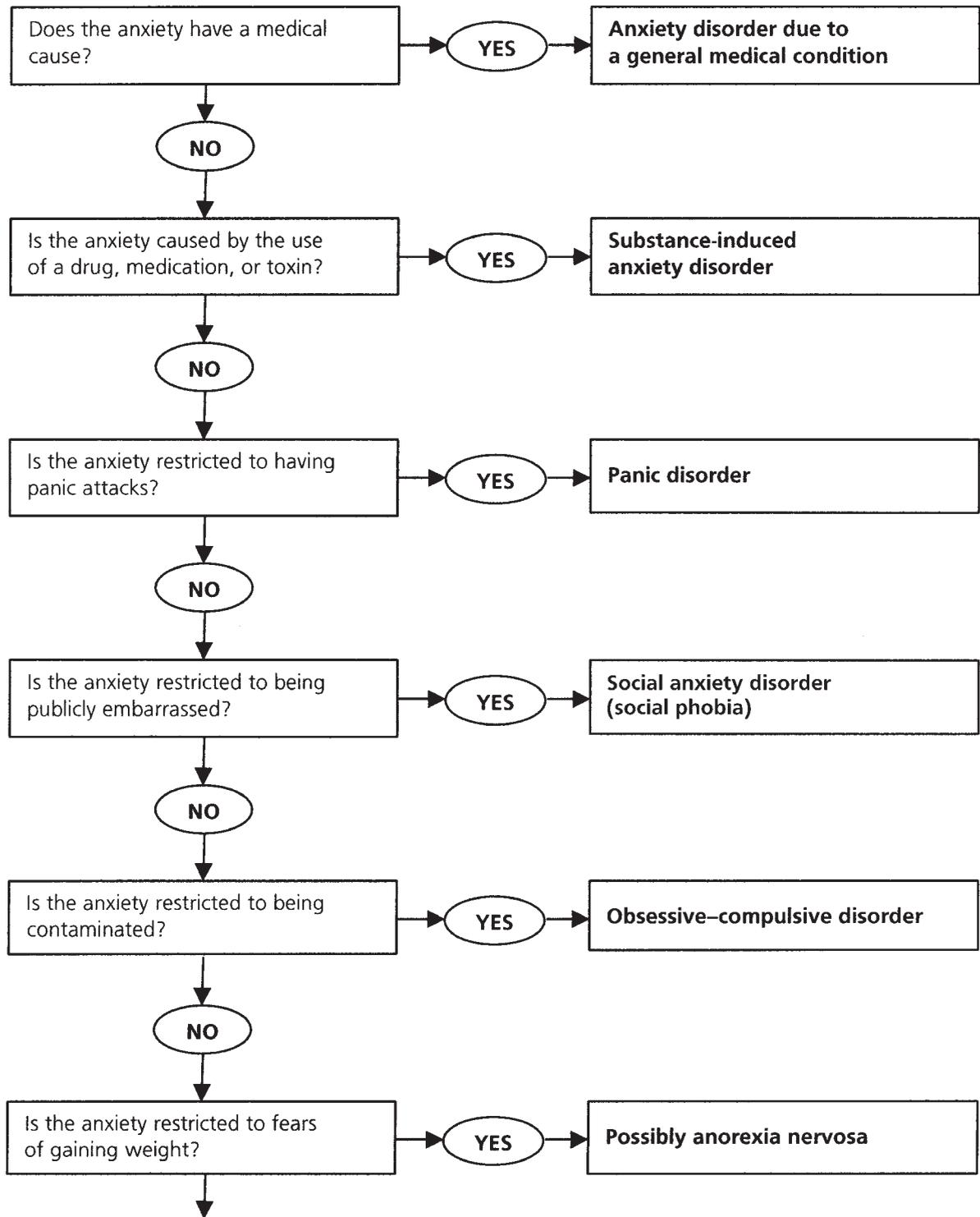
Although some estimates indicate that GAD may have a moderate heritability of 30%, other findings suggest lack of specificity of transmission (Hettema et al., 2001; Kendler et al., 1992; Weissman & Merikangas, 1986). GAD is associated with other specific traits, such as neuroticism, nervousness, depression, low frustration tolerance, and inhibition (Angst & Vollrath, 1991).

Coexisting Conditions

Most patients with GAD present with a variety of other diagnoses, including social anxiety disorder, specific phobia, depression, irritable bowel syndrome, and personality disorders (see Borkovec & Roemer, 1996; Brown & Barlow, 1992; Brown, Moras, Zinbarg, & Barlow, 1993; Hettema, Prescott, & Kendler, 2003; Sanderson & Wetzler, 1991; Tollefson et al., 1991). Up to 8.5% of patients seeing physicians for any medical reason have GAD, and 37% of patients with GAD suffer from irritable bowel syndrome (Roy-Byrne & Wagner, 2004; Tollefson, Tollefson, Pederson, Luxenberg, & Dunsmore, 1991). Ninety percent of individuals who develop GAD during their lifetimes also have another psychiatric condition, with 42% qualifying for a diagnosis of depression (Wittchen, Zhao, Kessler, & Eaton, 1994); there is an increased risk of suicidal behavior in GAD as well (Coughe, Keough, Riccardi, & Sachs-Ericsson, 2009). Agoraphobia, panic disorder, specific phobia, dysthymia, major depression, and mania predict later onset of GAD (Kessler et al., 2002). Close to 50% of patients with GAD have been found to qualify for a diagnosis of some personality disorder (Sanderson, Beck, & McGinn, 1994). The most common personality disorders associated with GAD are avoidant and dependent, although obsessive–compulsive personality disorder proved most common in one study (Nestadt, Romanoski, Samuels, Folstein, & McHugh, 1992). Recent threatening events and recent life stresses are associated with GAD, although its chronicity suggests that the *perception* of stress and threat may partly result from GAD (Blazer, Hughes, & George, 1987; Finlay-Jones & Brown, 1981). With increasing age (after 50), GAD tends to subside and is replaced in many cases by somatization concerns (Rubio & López-Ibor, 2007).

Differential Diagnosis

The nature of GAD is that the individual is worried about a number of things, not simply one or two. Consequently, GAD can be differentiated from specific phobia, in which patients fear a well-defined stimulus (e.g., animals). It is also to be distinguished from social anxiety disorder, in which patients are specifically worried about or avoid situations in which negative evaluation is expected. Furthermore, GAD can be distinguished from obsessive–compulsive disorder, panic disorder, other anxiety disorders, and disorders in other DSM categories. Anxiety may also result from a number of medical conditions (e.g., hyperthyroidism, hypoglycemia, adrenocortical tumor, HIV); when this is the case, the diagnosis should be anxiety disorder due to a general medical



(cont.)

FIGURE 4.1. Diagnostic flow chart for generalized anxiety disorder.

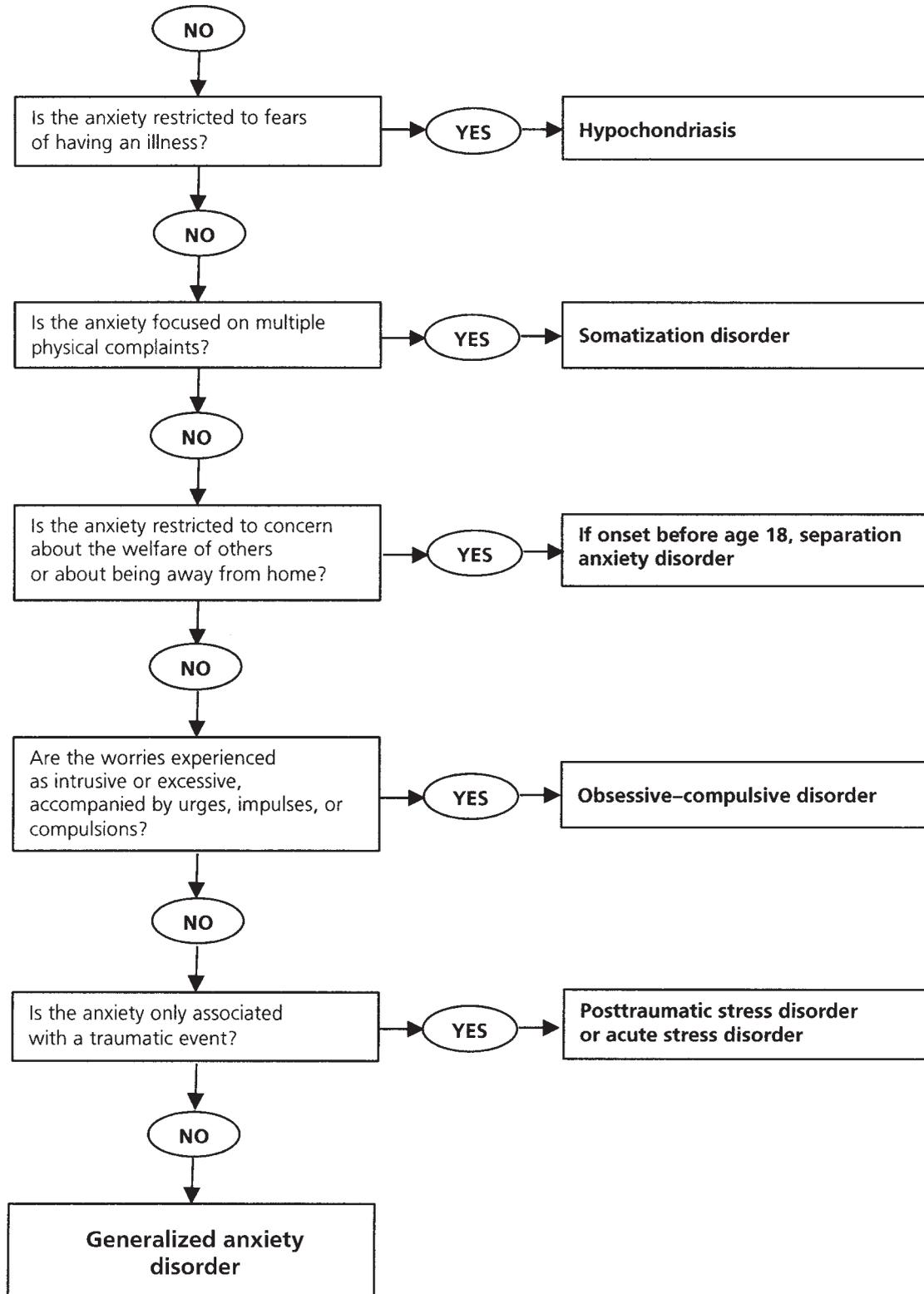


FIGURE 4.1 (cont.)

condition, and treatment of the medical condition should be the top priority. Finally, anxiety often results from the use of or withdrawal from certain substances (e.g., anxiolytics, alcohol), and this anxiety is also to be distinguished from GAD. Figure 4.1 is a diagnostic flow chart that provides more details about differential diagnosis of GAD.

UNDERSTANDING GENERALIZED ANXIETY DISORDER IN COGNITIVE-BEHAVIORAL TERMS

Several cognitive-behavioral conceptualizations of GAD are of value to the clinician. In this section, we first discuss behavioral models, emphasizing conditioned anxiety, and cognitive models, emphasizing information processing and appraisal of stress. We then discuss several models that combine cognitive and behavioral elements. Interpersonal models have been incorporated within cognitive-behavioral approaches or used in addition to them.

Behavioral Factors

Wolpe (1990) proposed that a neutral stimulus becomes conditioned to an unconditioned fear-arousing stimulus, leading to the acquisition of fear. His model of reciprocal inhibition proposes that fear may be “unlearned” by pairing the feared stimulus or response with a response that is incompatible with fear, such as relaxation, assertiveness, or sexual arousal. Other models of fear reduction include extinction, habituation, exposure, changes in expectancy, and self-efficacy. As described in Chapter 9 of this volume and the accompanying CD-ROM, a clinician may use various behavioral techniques: construction of fear hierarchies (noting subjective units of distress or SUDs); planned exposure to feared situations, images, or ideas; pairing of relaxation with the feared stimulus; guided imagery paired with relaxation (i.e., self-directed desensitization); modeling; vicarious reinforcement (and punishment); assertiveness training; self-efficacy training; problem-solving training; and a variety of others. Since avoidance is a central feature of GAD, identifying the experiences that are avoided and increasing exposure or direct coping with those experiences will be an essential component of treatment.

Cognitive Factors

According to Aaron T. Beck and his colleagues, anxiety responses had adaptive value in the evolution of the human species. Anxiety responses, such as mobilization, inhibition, and demobilization, reflect active defense, avoidance of risky behavior, and collapse, respectively, which were protective in the face of threat (Beck & Emery with Greenberg, 1985, 2005). Active defense, involving hypervigilance, sensitivity to sound, and increased heart rate, may assist an individual in either flight or fight. Inhibitory responses, such as blocking of thinking, clouding of consciousness, and muscle rigidity, prevent the individual from taking unnecessary risks (as evidenced in fear of heights or in social anxiety disorder). Demobilization is reflected in weakness, fatigue, lowered blood pressure, and heart rate, leading to collapsing or freezing in place, which decrease the likelihood that the individual will be detected by predators (Beck et al., 1985, 2005; Marks, 1987; Nesse & Ellsworth, 2009).

Responses to threat include fight, flight, freezing, fainting (collapse), retraction, dodging, clinging, calling for help, and other reflexes (blinking, gagging, coughing), with corresponding cognitive implications: “I have to get out of here,” “I can’t move,” “What is happening to me?” or “Don’t leave me.” The cognitive model stresses the importance of various information-processing distortions in anxiety—specifically, hypervigilance, false alarms, loss of objectivity, generalization of danger to other stimuli, catastrophizing, excessive focus on negative outcomes, no tolerance for uncertainty, and “lack of habituation” (Beck et al., 1985, 2005).

Lazarus and his colleagues have proposed a model of appraisal and stress, in which the experience of stress is determined by an interaction between a stressor (event) and the appraisal that one is able to cope with the threat or burden of the event (see, e.g., Lazarus & Folkman, 1984). Cognitive appraisals determine the emotional impact of the event, and appraisals of inability to cope and overwhelming threatening stressors are the focus of cognitive approaches to the treatment of anxiety.

Cognitive models acknowledge that individuals may differ in the extent of their biological predisposition toward the arousal of anxiety symptoms and the perception of threat. However, once the anxiety is aroused, it is increased or maintained by specific cognitive distortions. Some examples of the three types of cognitive distortions in GAD are provided in Table 4.1.

TABLE 4.1. Examples of the Three Types of Cognitive Distortions in Generalized Anxiety Disorder

<u>Distorted automatic thoughts</u>
Catastrophizing: “Something terrible is going to happen,” “I am going to fail.”
Labeling: “I’m a failure,” “My boss is a tyrant.”
Dichotomous thinking: “I am always anxious,” “I’m never good enough.”
Overgeneralizing: “I can’t handle my anxiety. I can’t handle anything.”
<u>Maladaptive assumptions</u>
“I must get rid of all anxiety—immediately and forever.”
“Anxiety and worry are unhealthy.”
“If people knew that I was anxious, they would reject me.”
“Anxiety is a sign of weakness. I should never be weak.”
“I shouldn’t be anxious.”
“I have to watch out for my anxiety so it doesn’t catch me by surprise.”
<u>Dysfunctional schemas</u>
Biological threat: “Anxiety means I’m sick.”
Humiliation: “People will laugh at me.”
Control: “I am either in complete control or I have no control.”
Autonomy: “Anxiety means I’m weak and dependent. I can’t survive on my own.”
Abandonment: “I will be abandoned.”

Note. Adapted from Leahy (1996). Copyright 1996 by Jason Aronson, Inc. Adapted by permission.

Other Cognitive–Behavioral Models

Barlow's Model

Barlow has proposed models for several anxiety disorders that integrate various modalities of experience and learning. GAD, with its focus on arousal, hypervigilance, and worry, is explained by reference to five factors operating in interaction with one another (Barlow, 1988): negative life events, biological vulnerability, diffuse stress response, psychological vulnerability (with accompanying sense of lack of control and predictability), and presence or lack of coping skills or support that might mitigate lack of controllability. During the “anxious apprehension cycle,” there may be accompanying “false alarms” that serve to exacerbate the sense of uncontrollability and vulnerability. With the focus on (sometimes) minor life events and the accompanying sense of loss of control over worry, the anxiety may generalize to a variety of innocuous situations and increase. Barlow (2000) has extended his model into “emotion theory,” proposing that anxiety arises from an interaction of a “generalized biological (heritable) vulnerability, a generalized psychological vulnerability based on early experiences in developing a sense of control over events, and a more specific psychological vulnerability in which one learns to focus anxiety on specific objects or situations.” Recognizing the genetic component of anxiety and of psychological problems in general, Barlow has proposed that these biologically determined traits are also related to anxiety sensitivity and general neuroticism. False alarms are learned through associations with internal and external stimuli, which then lead to maladaptive coping through hypervigilance and avoidance. The recommended treatment involves reducing autonomic arousal via relaxation techniques, improving coping skills, and cognitive restructuring. More recently, acceptance and mindfulness have been included as part of a treatment package (Orsillo, Roemer, & Barlow, 2003).

Borkovec's Model

Borkovec's model of worry and GAD has evolved over the years, beginning with his description of the role of attempts at suppression of negative images as a manifestation of avoidance. Anxiety is maintained through the negative reinforcement of escape and/or avoidance, which perpetuates the belief that these are the only ways to cope. The anxious individual, beset by concerns about negative and catastrophic outcomes, attempts to prevent these outcomes by anticipating escape or avoidance (which presumably will suppress the occurrence of the negative outcome images). For example, an individual who begins to worry about going bankrupt then examines all the evidence that he or she will not be able to pay the bills, attempting to figure out how these problems could occur and be avoided or solved. Borkovec's model has stressed the fact that worry serves the function of temporary “emotional avoidance” of anxious arousal (Borkovec, Alcaine, & Behar, 2004). More recently, Borkovec and colleagues have integrated interpersonal and emotional coping factors in a more comprehensive approach to GAD (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008).

Wells's Model

Wells and colleagues have advanced a sophisticated model of GAD (and other disorders), which proposes that worry is maintained by a set of beliefs about the function and danger of worry

(Wells, 1997, 2004, 2008). “Metacognition” refers to one’s beliefs about the nature and function of thinking. Wells has identified five general factors reflecting metacognition about worry—for example, Positive Worry Beliefs (“Worry helps me to solve problems”) and Cognitive Self-Consciousness (“I am constantly aware of my thinking”). A questionnaire developed by Wells (2009), included in this chapter as Form 4.4, assesses these five metacognitive factors.

Wells and Butler (1997) indicate that patients with GAD overestimate the likelihood of negative events, rate the cost of threatening events as very high, and interpret ambiguous events as more threatening. Wells and Butler distinguish between Type 1 and Type 2 worry. Type 1 worry refers to concern or vigilance about external or internal (e.g., health) threats. Type 2 worry, or “metaworry,” refers to negative appraisals of one’s own cognitive processes—for example, “Worrying will make me crazy.” According to this model, the anxious individual is locked in a conflict between the fear that worry is uncontrollable and the belief that worry protects him or her.

The therapeutic model derived from this theory involves identification of the patient’s beliefs about the costs and benefits of worrying, experiments in “letting go” of worry or postponing worry, challenging avoidance of activities or thoughts about which the patient worries, and constructing positive outcomes in imagery (Wells, 2004, 2008; Wells & Butler, 1997). Other aspects of the metacognitive approach include (1) testing the patient’s belief that worry will lead to insanity by instructing the patient to “attempt to go crazy”; and (2) using mindfulness exercises to illustrate that the patient can observe worry without controlling it, and can engage in an observing stance toward personal thought processes without judging or directing them.

Intolerance of Uncertainty

Dugas, Ladouceur, Freeston, and their colleagues have identified “intolerance of uncertainty” as a significant predisposing process underlying worry and GAD (Dugas, Buhr, & Ladouceur, 2004; Ladouceur et al., 2000). This is defined as the underlying belief that uncertainty is associated with negative outcomes, lack of responsibility, and other problems. Increasing tolerance of uncertainty reduces worry and can lead to remission of GAD symptoms. The approach advocated by Dugas and colleagues helps patients identify their intolerance of uncertainty, their beliefs about the negative implications of uncertainty, and their endless search for perfect solutions that will reduce uncertainty. Individuals who are intolerant of uncertainty attempt to reduce uncertainty by generating possible problems, examining possible solutions, measuring these solutions against the criteria of certainty and perfect outcomes, rejecting these solutions, and then utilizing worry as a way to achieve certainty. The search for certainty also accounts for the “reassurance seeking” that is so characteristic of worried patients. Because the search for certainty is the underlying process in worry, there is an endless self-perpetuation of worry about a variety of topics. Dugas and colleagues have developed a cognitive model for treating GAD that incorporates training in tolerance for uncertainty with practical problem solving.

Additional Models

Interpersonal and Emotional Processes

Several lines of research converge on the view that GAD is related to emotional avoidance and difficulties in interpersonal relations. Worriers focus on abstract linguistic content rather than

emotionally laden visual imagery; worry distracts from emotional issues; worriers have negative views of emotion and more difficulty in labeling emotion; and worry may temporarily suppress arousal (Borkovec et al., 2004; Borkovec & Hu, 1990; Mennin, Turk, Heimberg, & Carmin, 2004; Newman et al., 2008). An integrative interpersonal–emotional processing approach stresses examination and expression of interpersonal conflicts and meanings, as well as evocation and acceptance of difficult emotions (Safran & Segal, 1990). The interpersonal–emotional approach can be added to more traditional cognitive-behavioral approaches (Newman et al., 2008).

Developmental History

Chronic worriers report a history of overprotection from parents, role reversal and reverse parenting, less parental love, divorce or separation of parents, and more difficulty recalling childhood experiences (Cassidy, Lichtenstein-Phelps, Sibrava, Thomas, & Borkovec, 2009). Lack of perceived control in the context of demanding greater control appears implicated in the developmental histories of chronic worriers (Chorpita & Barlow, 1998). However, no single parenting style or developmental history appears strongly associated with the emergence of GAD.

Form 4.1 is a general schematic depiction of the various antecedents and processes underlying GAD, which can be given as a handout to patients.

OUTCOME STUDIES OF TREATMENTS FOR GENERALIZED ANXIETY DISORDER

Given the apparent chronicity and poor spontaneous remission rates of GAD, it is promising that there are now treatments with some demonstrated efficacy. As indicated above, there are various cognitive-behavioral approaches to treating GAD, and studies differ in the evaluation of their outcome and efficacy. Each of the clinical cognitive-behavioral models described here has been found to be effective in reducing worry and other symptoms of GAD (Covin, Ouimet, Seeds, & Dozois, 2008; Norton & Price, 2007). In addition, cognitive-behavioral treatment was found to be effective in reducing worry for older adults (mean age 66.9) in one study (Stanley et al., 2009). However, although significant improvement has been obtained with these treatments, many patients after completion of therapy are still somewhat symptomatic.

Borkovec and Whisman (1996) indicate that psychosocial treatments (especially cognitive-behavioral treatment) have proven to be more effective than nondirective treatment, a placebo, or a benzodiazepine; that gains are maintained by cognitive-behavioral therapy or behavior therapy; that cognitive-behavioral therapy leads to a reduction in the use of benzodiazepines; that these gains are clinically significant; and that for some patients, gains actually improve even after therapy is discontinued. (For more recent research confirming these findings, see Butler et al., 2006; Covin et al., 2008; Hofmann & Smits, 2008.) Butler et al. (1991) found that cognitive-behavioral therapy was superior to behavior therapy in producing “good outcome” for patients 6 months after treatment ended (42% vs. 5%, respectively), although another study found statistically similar outcomes for cognitive-behavioral therapy and behavior therapy (58% and 38%, respectively) (Durham et al., 1994). Ladouceur et al. (2000) found that 77% of patients no longer met criteria for GAD after treatment with their cognitive-behavioral therapy inter-

ventions focused on increasing tolerance for uncertainty and increasing active, problem-solving coping. Open trials have indicated efficacy for metacognitive approaches and emotion regulation therapy (Mennin, 2004; Wells, 2009). When compared with psychoanalytic treatment, cognitive-behavioral therapy was far superior—a “good outcome” rate of 72% vs. 31%, respectively (Durham, 1995).

ASSESSMENT AND TREATMENT RECOMMENDATIONS

Rationale and Plan for Treatment

A patient presenting with GAD has symptoms that include physiological arousal (restlessness, muscle tension, sleep disturbance), as well as cognitive symptoms (worry, difficulty controlling worry, and inability to concentrate). The goals of treatment are to reduce the overall level of autonomic arousal, to decrease the concern about worry, and to assist the patient in reducing worry to a reasonable level. In addition, therapeutic goals can include improvement in quality of life; improved interpersonal relations; reduction of avoidance; decreased reassurance seeking; and greater comfort with, and more effective processing of, emotions. Since the patient is worried about a variety of situations and themes, more “general” interventions are employed. That is, the therapist will use interventions such as relaxation, biofeedback, breathing exercises, and behavioral treatment of insomnia in order to reduce overall levels of anxious arousal, and will employ a variety of cognitive interventions to address the worry. These cognitive interventions include assisting the patient in distinguishing between productive and unproductive worry; addressing the patient’s concern that worrying too much may be harmful; assessing the patient’s tendency to jump to conclusions and catastrophize possible outcomes; and helping him or her learn to distinguish between anxiety and actual facts. We have developed an extensive self-help form called *Questions to Ask Yourself If You Are Worrying* (see Form 4.9, below), which may be tailored to the individual patient. In addition, since a patient with GAD is worrying throughout the day, the clinician will assist the patient in limiting worry to “worry time” and will help the patient monitor the different themes of worry. Finally, the treatment approach will help the patient recognize that he or she may be quite able to cope with a variety of problems, should they arise.

The integrative approach described here also recognizes the value of increasing tolerance of uncertainty, modifying dysfunctional emotional schemas and strategies for coping with emotion, and assisting in enhancing interpersonal functioning. In regard to the patient’s problematic evaluation of the intrusive thoughts underlying worry, we include in this treatment plan metacognitive and acceptance/mindfulness approaches. The clinician may need to use his or her judgment to determine which of these various strategies needs more emphasis for a particular patient.

The treatment of a patient with GAD often involves addressing more than one disorder, since 82–90% of these patients present with more than one diagnosis (such as social anxiety disorder, specific phobia, dysthymia, or depression). The treatment package for GAD is outlined in Table 4.2. In practice, the sequence of the elements listed in this table is variable, with the therapist often using several techniques simultaneously. Moreover, since GAD is frequently comorbid with depression and other anxiety disorders, the clinician will need to refer to more than one treatment package although the remission of GAD, especially worry, may lead to improvement across different disorders.

TABLE 4.2. General Plan of Treatment for Generalized Anxiety Disorder

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- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
 - Socialization to treatment
 - Relaxation training
 - Mindfulness training
 - Assessing and confronting avoidance: Exposure and other techniques
 - Monitoring worries and assigning “worry time”
 - Cognitive evaluation and treatment of worrying
 - Step 1: Distinguishing between productive and unproductive worry
 - Step 2: Acceptance and commitment
 - Step 3: Challenging worried automatic thoughts and maladaptive assumptions
 - Step 4: Examining core beliefs about self and others
 - Step 5: Examining fear of failure
 - Step 6: Using emotions rather than worrying about them
 - Step 7: Putting time on the patient’s side
 - Interpersonal interventions
 - Problem-solving training
 - Phasing out treatment
-

Assessment

Tests and Clinical Interviewing

Evaluation of anxiety during the intake and after may involve a number of self-report and interview instruments. The BAI, mentioned in Chapters 2–3 is similar in structure to the BDI-II; there are 21 questions scored from 0 to 3, yielding a score ranging from 0 to 63, with higher scores indicative of greater anxiety. Brown et al.’s (2005) ADIS-IV allows the clinician to evaluate anxiety, depression, substance abuse, and other disorders. These forms are not sufficient by themselves for a diagnosis (and certainly not for differential diagnosis), but they do provide the clinician with baseline measures for evaluating therapeutic efficacy, and they do assess a variety of symptoms to allow for direction in reaching a diagnosis. Other evaluations include the State–Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). We provide the Leahy Anxiety Checklist for Patients as a measure of anxiety (see Form 4.2).

Since worry is the central feature of GAD, the clinician will particularly want to assess the level of worry and the processes underlying worry. Three self-report questionnaires are useful. First, the Penn State Worry Questionnaire (PSWQ; see Form 4.3) assesses overall levels of worry (Meyer, Miller, Metzger, & Borkovec, 1990). In fact, the PSWQ really consists of one general factor—worry (Ladouceur et al., 1992). However, scores on the PSWQ are related not

only to overall anxiety level, but also to problematic coping styles—such as self-blame, dread, wishful thinking, and avoiding problems (Molina & Borkovec, 1994). Second, the Metacognitions Questionnaire 30 (MCQ-30; see Form 4.4) assesses five general factors of the structure and processes underlying worry (Wells, 2009). Third, the Intolerance of Uncertainty Scale (IUS; see Form 4.5) assesses the individual's ability to tolerate uncertainty or incomplete information.

Form 4.6 provides space for recording scores on these instruments. It also enables the clinician to record the patient's medication and alcohol/other substance use, to record the history of previous episodes of anxiety, to note treatment progress, and to indicate treatment recommendations. Finally, Form 2.1 in Chapter 2 should be used as a general intake form.

Consideration of Medication

Treatment with medication may involve both acute and chronic (or maintenance) treatment. Benzodiazepines and selective serotonin reuptake inhibitors (SSRIS) are the most commonly used and effective pharmacological treatments for GAD and can be combined with cognitive-behavioral treatment.

Socialization to Treatment

We recommend that patients with GAD read *The Worry Cure: Seven Steps to Stop Worry from Stopping You* (Leahy, 2005) and *Anxiety Free: Unravel Your Fears before They Unravel You* (Leahy, 2009). *The Worry Cure* is a detailed account of how to use seven different sets of strategies to address worry and outlines specific plans for specific worries (e.g., relationship, health, financial, work, and other worries). This book incorporates approaches from traditional cognitive and behavioral approaches, as well as metacognitive, acceptance/mindfulness, and other models.

The patient should be told that he or she has an anxiety disorder known as “generalized anxiety disorder” or “GAD.” This means that the patient worries about a variety of things and may experience muscle tension, insomnia, physiological arousal, fatigue, and other symptoms. We find it helpful to explain that everyone has worries some of the time, and that some worrying is productive (useful) while other worries are unproductive and cause unneeded anxiety. We indicate that medication may be included in the treatment plan, which will emphasize teaching the patient how to relax, improving his or her ability to handle stress, enhancing his or her ability to cope with interpersonal issues, evaluating how the patient is thinking about his or her worrying and other problems, and providing the patient with useful self-help techniques. Form 4.7 is an information handout about GAD that can be given to patients. Our handout about cognitive-behavioral therapy in general (Form 10.1 in Chapter 10) can also be used.

Relaxation Training

The therapist may indicate to the patient that anxious thoughts and feelings are more likely to occur when the patient is physiologically aroused. Consequently, the patient can learn any number of relaxation techniques (e.g., progressive muscle relaxation, breathing relaxation; see Chapter 9 and the CD-ROM), and can be encouraged to practice more than one technique.

Patients may also be assisted in guided imaginal exposure to feared situations or to their internal physiological symptoms. In addition, the use of stimulants (such as caffeinated beverages) should be discouraged, as should the excessive use of alcohol. Patients complaining about insomnia should be given the information handout on insomnia (see Chapter 2, Form 2.11); the use of the bed only for sleep and sex should be emphasized. Finally, overall relaxation is increased if the patient can regularly engage in aerobic exercise.

Mindfulness Training

As in the treatment of other anxiety disorders, mindfulness training can be utilized as a component of treatment for GAD. Specific goals of such training for patients with GAD are to practice awareness or observation of thoughts and feelings without attempting to control or judge them. Thus patients who have been plagued by intrusive worries can practice observing a worry, recognizing it as “just a thought,” and bringing the mind’s awareness back to the breath in mindful breathing. This allows for both acceptance and metacognitive awareness of intrusive and bothersome thoughts (Hayes et al., 1999; Wells, 2008).

Assessing and Confronting Avoidance: Exposure and Other Techniques

A patient with GAD may actually present with few anxious symptoms. On closer inquiry, however, the clinician may find that numerous situations are avoided and that the patient is underperforming at work or in personal relations because he or she fears an increase in anxiety. When this is the case, the therapist and patient may construct a hierarchy of avoided situations, rate the SUDs for each situation, and identify the negative thoughts associated with these situations. (The appropriate forms in Chapter 3 can be used for this purpose.) The therapist may use behavioral rehearsal, cognitive rehearsal, and/or modeling of confronting avoidance. Or the therapist may guide the patient through imaginal exposure to the feared situations. Homework assignments may involve planned *in vivo* exposure to avoided situations. (See Chapter 9 for a fuller discussion of exposure.)

Desensitization: Pairing (or Not Pairing) Exposure with Relaxation

The foregoing intervention (exposure, etc.) may be viewed as a form of desensitization. The patient may also be trained in pairing his or her relaxation response with imaginal exposure to the feared stimulus, with the patient moving up the hierarchy from less to more feared thoughts or images. In addition, the patient may practice pairing relaxation with exposure in the actual situations. Alternatively, the patient may be instructed *not* to pair exposure to the stimulus with relaxation; instead, the patient may simply practice experiencing the anxious arousal in the presence of the feared images and situations, and note how the anxious arousal decreases on its own with increased length of exposure. Our current preference is to forgo the older approach of pairing relaxation with aversive stimuli, since this may reinforce the belief that anxiety cannot abate without relaxation interventions. One can view this as the difference between the “reciprocal inhibition” model advocated by Wolpe on the one hand, and the “cognitive disconfirmation”

model advocated by Beck, Wells, and their associates or the “acceptance” model advocated by Hayes and colleagues on the other hand. However, relaxation therapy has proven to be effective in reducing GAD (Siev & Chambless, 2007).

Evaluating Worry

After the patient has completed the forms for evaluating worry, the clinician can review the level of worry (PSWQ), the metacognitive factors (MCQ-30), and intolerance of uncertainty (IUS). The initial level of worry may be used as a baseline measure for treatment, and repeated evaluations can be made during the course of treatment. The MCQ-30 can help the clinician identify with the patient the specific problematic factors underlying worry. Finally, targeting intolerance of uncertainty can help the patient recognize that the problem is less the content of the worry and more the underlying endless and futile search for certainty. Throughout treatment, repeated measures of worry and anxiety (these three forms, the BAI, or other self-report forms) can be administered.

In evaluating the process of worry, the therapist can ask the patient to identify its advantages and disadvantages. For example, the patient may believe that an advantage of worry is that he or she will avoid surprise and will be prepared. The disadvantages may be that the patient is anxious, worried, and pessimistic; is constantly seeking reassurance; and cannot enjoy the present moment. Closer inquiry may help the patient examine the evidence whether worry has actually been helpful in preparing him or her, or whether it has been largely useless and demoralizing. Learning to abandon the fruitless search for certainty by using worry as a “tool” or “strategy” can provide the motivation to utilize other techniques in this treatment package.

Monitoring Worries and Assigning “Worry Time”

Two distinguishing elements for many patients with GAD are that their worries focus on more than one theme and that their worries seem to pervade their day. The clinician and patient should assess various characteristics of worries: their content areas and situational elicitors, the specific predictions they entail, the level of anxiety these predictions generate, and the strength of the patient’s confidence in these predictions. The Patient’s Worry Log (Form 4.8) is useful in evaluating these specific features of worries and in helping the patient recognize his or her tendency to make “false predictions.” As Borkovec and Wells suggest, worries are reinforced by the nonoccurrence of negative events and by the magical belief that worries are protective and preparatory.

In addition, “worry time” should be assigned to the patient. That is, the patient should be *required* to worry for a specific period of time (e.g., 20 minutes) at an assigned time and place. Other worries that occur during the day are to be delayed until worry time. The patient can write down worries at times other than worry time and save this list for the assigned time. This allows stimulus control of worries; it also helps the patient recognize that worries are about finite themes. Moreover, worry time helps the patient realize that worries that are postponed often seem irrelevant by worry time, and this realization may decrease the patient’s sense of urgency about “responding” to a worry.

Cognitive Evaluation and Treatment of Worrying

We utilize a seven-step program to deal cognitively with worries, based on a variety of theoretical orientations (e.g., metacognitive therapy, evaluation of productive worry, acceptance/commitment, emotional processing, standard cognitive therapy, intolerance-of-uncertainty training, and other approaches). The patient can follow this program with the self-help book *The Worry Cure* (Leahy, 2005).

Step 1: Distinguishing between Productive and Unproductive Worry

Many worriers believe that their worry will prepare them, prevent surprise, and help them solve problems before they get out of hand. Indeed, some worry can be useful. For example, if I need to get from New York City to San Diego, California, it would be useful for me to “worry” about having plane and hotel reservations and ground transportation in California. The question is how long this worry needs to be sustained. Productive worry is a set of questions leading to solutions to a problem that can be addressed *today* (Leahy, 2005). For instance, I can get reservations for a flight, hotel, and rental car today. Unproductive worry involves a series of “what-if” questions about problems over which I have no control and that I cannot really solve today. In the present example, these might include “What if my car breaks down in California?” or “What if my talk goes badly?” The therapist and patient categorize the patient’s worries as productive or unproductive, using the following list as a guide:

Signs of unproductive worry:

- You worry about unanswerable questions.
- You worry about a chain reaction of events.
- You reject a solution because it is not a perfect solution.
- You think you should worry until you feel less anxious.
- You think you should worry until you control everything.

Signs of productive worry:

- There is a question that has an answer.
- You are focused on a single event, not a chain reaction.
- You are willing to accept imperfect solutions.
- You do not use your anxiety as a guide.
- You recognize what you can control and what you cannot control.

Step 2: Acceptance and Commitment

The second step involves acceptance of limitations, such as uncertainty, imperfection, and lack of complete control. The patient can be asked to indicate the advantages and disadvantages of accepting these limitations; to give examples of current acceptance of limitations; and to decide whether acceptance of limitations implies lack of responsibility or bad outcomes. Intolerance of uncertainty can be addressed with the patient in the following ways:

1. Ask yourself, “What are the advantages and disadvantages of accepting uncertainty?”
2. In what areas of your life do you currently accept uncertainty?
3. Are you equating uncertainty with a negative outcome?
4. If you had to make a bet, how would you bet? For instance, if you think, “It’s possible that this blemish is cancer,” how much would you bet that it is?
5. What would be the advantage of saying, “It’s good enough for me to act on?”
6. Practice repeating to yourself, “It’s possible that something bad will happen.” Repeat this slowly, over and over, for 20 minutes each day. Repeat your specific worries in this way as well.
7. Ask yourself, “Do I actually have a need for some uncertainty?” Life would be boring otherwise. Would you watch the same television program if it were entirely predictable—or watch a sporting event if you always knew the final score before the game occurred—and you knew before the game exactly what would happen?

In addition, a worried thought can be treated as an intrusive thought that the patient negatively evaluates. For example, the patient may believe that an intrusive thought about a possible bad outcome needs to be addressed immediately, predicts the future, is personally relevant, and needs to be suppressed or feared (D. A. Clark, 2005; Purdon, Rowa, & Antony, 2005; Wells, 2003). A number of interventions may be useful. One is to have the patient flood him- or herself for 30 minutes with the negative thought until it becomes boring; another is to practice mindful awareness and nonjudgmental, noncontrolling observation of the thought (e.g., to observe “This is just a thought,” or “I can see that there is a mental event”). A worried thought can be imagined as a small figure marching out of one’s head, or some other diminishing/externalizing acceptance technique can be used.

Commitment to change involves two processes: (1) “successful imperfection,” in which the individual is willing to accept less than 100% in order to make progress; and (2) “constructive discomfort,” in which the individual tolerates unpleasant emotions and sensations in order to get things done (Leahy, 2005). Worry is a form of emotional or experiential avoidance, and these guidelines can be helpful in breaking free from maladaptive beliefs such as “I can’t do anything until I am ready,” or “I can’t do it because I am anxious.”

Step 3: Challenging Worried Automatic Thoughts and Maladaptive Assumptions

Many of the thoughts characterizing worry are negative automatic thoughts or maladaptive assumptions (see Table 4.1 for some GAD-specific examples of these types of cognitive distortions). The therapist and patient can utilize Form 4.9, Questions to Ask Yourself If You Are Worrying, to evaluate specific predictions; the tendency to jump to conclusions; the difference between possibility and probability; the safety or protection factors available; the tendency to catastrophize outcomes; and other responses that may indicate a sense of negativity, imminence, and exaggerated outcome. (This form may be simplified, expanded, or modified by the therapist to fit the needs of the individual patient.) In addition, the patient may be assigned to write a story where positive instead of negative outcomes occur, and to outline the actual steps, he or she might need to take to make this happen. The therapist can also address the specific categories

of negative automatic thoughts underlying worrying, such as labeling (“I’m incapable of handling stress”), catastrophizing (“I’m going to lose everything”), fortunetelling (“I’ll get rejected”), dichotomous thinking (“Nothing is working out”), and discounting the positives (“I don’t have anything going for me”). The therapist can focus as well on the patient’s particular maladaptive assumptions (needs for approval, perfection, and certainty; assumptions of essentialness and emergency; etc.). Finally, the patient’s rhetorical questions that reflect worrying, such as “What if it doesn’t work out?” or “What’s wrong with me?”, can be examined and rephrased as propositional statements that can be tested, such as “Nothing will work out,” or “Everything is wrong with me.” Specific techniques to examine and challenge these worries are described in Chapter 10, as well as in Leahy’s (2003) *Cognitive Therapy Techniques: A Practitioner’s Guide* and J. S. Beck’s (2011) *Cognitive Behavior Therapy: Basics and Beyond*.

Step 4: Examining Core Beliefs about Self and Others

Core beliefs or personal schemas are often the fundamental sources of worries. For example, patients who view themselves as helpless and unable to take care of themselves may worry about being abandoned. Overly conscientious individuals may worry that they won’t get all their work done. Narcissistic patients with excessive standards for admiration and needs to be special may worry about defeat, humiliation, or mediocrity. Table 4.3 provides several examples of the relationships between core beliefs and worries, and of how these may be examined with patients.

Core beliefs about defectiveness, abandonment, excessive responsibility, and so forth may be examined via standard cognitive therapy techniques. For example, the therapist can ask the patient to examine these beliefs in the following ways:

1. Identify your core beliefs about yourself and other people.
2. Examine the costs and benefits of these beliefs.
3. How has your belief affected you in the past?
4. Are you viewing yourself in all-or-nothing terms?
5. What is the evidence for and against your belief?
6. Would you be as critical of other people?
7. Is there some truth in your belief?
8. Can you act against your belief?
9. Can you develop a more positive belief?

After this discussion, Form 4.10 may be used for homework.

Step 5: Examining Fear of Failure

Worry is often an attempt to avoid failure at all costs, since failure may be viewed as catastrophic, humiliating, permanent, overgeneralized, and unique to the self. The therapist can help the patient to “deconstruct” the meaning of failure and to challenge the idea that failure is intolerable. Once failure is feared less, then worry becomes less compelling as a strategy to avoid failure. The examples of challenging fear of failure in Table 4.4 can be helpful.

TABLE 4.3. Examining Relationships between Core Beliefs and Worries with Patients

Personal beliefs	Example	Worries	How you adapt to your belief
Defectiveness	You think that you are incompetent and inferior.	“If they get to know me, they’ll reject me. No one wants defective people.”	You avoid letting people really get to know you. You avoid taking on challenging tasks or relationships. You try to please other people so that they won’t see that you are really “inferior.”
Abandonment	You believe that people will leave you and that you will end up alone and miserable.	“My partner is no longer interested in me. Other people are more appealing. If I am on my own, I can’t be happy.”	You continually seek reassurance that you are loved and accepted. You check on your partner to see whether your jealousy is valid. You don’t express your true opinions because you are afraid people will leave you.
Helplessness	You think that you can’t take care of yourself.	“If _____ leaves me, I won’t be able to make myself happy or take care of myself. I won’t be able to survive.”	You stay in unrewarding relationships or jobs because you are afraid of making a change that will result in being alone and helpless.
Specialness	You think you are superior and deserve a lot of attention and praise.	“If I don’t excel, then I am just inferior and worthless. “If people don’t respect my outstanding qualities, then I can’t stand it. “Maybe I’ll just end up ordinary. I might be humiliated.”	You surround yourself with people who need you so that they will tell you how great you are. You break the rules so that you can get your way. You demand that others give in to your needs.
Responsibility	You take pride in being rational and diligent and in getting things right.	“If I make a mistake, it means that I’m careless. I might forget something. Things might get out of control.”	You exhaust yourself with work so that you can feel you are doing the right thing. You review what you do to make sure you didn’t make mistakes.
Glamour	You focus on being attractive and impressive to other people.	“If I have any imperfections in my appearance, then I won’t be loved and admired.”	You spend considerable effort trying to be physically attractive or fascinating. You flirt and seduce people. You check the mirror.
Autonomy	You value your freedom to do things your way.	“If someone intrudes on my time and space, then I will have no freedom at all.”	You put up barriers to letting people have authority over you. You refuse to comply with others’ requests. You insist on doing things your way.
Caretaking	You think you are responsible for making everyone feel comfortable and happy.	“Did I say something that hurt others’ feelings? Have I disappointed them? Could I do something to take care of them?”	You constantly sacrifice yourself for the needs of other people. You apologize and play the part of someone who is always pleasing and cooperative.

TABLE 4.4. Suggestions for Helping Patients Overcome Fear of Failure

-
1. You didn't fail; your behavior failed.
 2. You can learn from your failure.
 3. You can be challenged by your failure.
 4. You can try harder.
 5. Maybe it wasn't a failure.
 6. You can focus on other behaviors that will succeed.
 7. You can focus on what you can control.
 8. It wasn't essential to succeed at that.
 9. There were some behaviors that did pay off.
 10. Everyone fails at something.
 11. Maybe no one noticed.
 12. Did you have the right goal?
 13. Failure is not fatal.
 14. Were your standards too high?
 15. Did you do better than before?
 16. You can still do everything you always did, even though this failed.
 17. Failing at something means you tried; not trying is worse.
 18. You've just begun.
 19. Tomorrow is another success.
 20. Tomorrow is today.
-

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Step 6: Using Emotions Rather Than Worrying about Them

Borkovec's emotional avoidance theory of worry stresses the fact that worry temporarily blocks emotional arousal. Research on emotional schemas illustrates that worry is associated with negative views of emotions. Leahy (2002b, 2007a) has proposed that individuals have specific interpretations, intolerance, and strategies for their emotional experiences. Applying this emotional schema model to worry, worriers often believe that their emotions will last indefinitely, that emotions will overwhelm them, that their emotions don't make sense, and that mixed feelings are intolerable. In this sixth step for handling worry and GAD, the therapist can assist the patient in validating his or her right to have feelings; can use emotion-focused techniques to help identify, label, and differentiate emotions; can link emotions to needs and higher values; can help the patient recognize the temporary or transient nature of emotion; and can encourage him or her to practice acting against the emotion in order to obtain valued goals or needs.

Step 7: Putting Time on the Patient's Side

Worriers often report a sense of time urgency about their worrying. That is, they feel that they need answers or solutions to their problems immediately. A worrier's intolerance of uncertainty, along with the sense that danger is looming, can propel him or her into a cascade of catastrophic predictions for which immediate answers are required (Riskind, 1997). This process may also drive reassurance seeking, which in itself may alienate supportive people in the patient's life. Several techniques may be employed to address this: encouraging the patient (1) to turn the urgency

off by recognizing that answers are not required and can be delayed; (2) to accept impermanence of thoughts and feelings since these will change during the course of the day; (3) to stay in and appreciate the moment; (4) to improve the moment; (5) to stretch time to realize that whatever is bothering the patient now will pass; and (6) to plan time so that the patient is not overwhelmed with too many tasks (Leahy, 2005).

Interpersonal Interventions

Anxious patients often have interpersonal problems that contribute to their worries and general discomfort. Indeed, worry about relationships and what people think are among the most common themes for patients with chronic GAD. A clinician can assist a patient in learning more effective alternatives to complaining and other negative strategies—appropriate assertiveness, social skills (e.g., rewarding and attending to others), mutual problem solving, active listening and other communication skills, acceptance of others, negotiation skills, and conflict resolution skills. Specific cognitive interventions may focus on the tendency to engage in cognitive distortions (at all three levels) in regard to other people. The clinician may assist the patient in learning appropriate behavior through modeling and behavioral rehearsal, as well as in constructing specific interpersonal goals (e.g., complimenting five people every day or calling up three people each week to pursue rewarding behaviors).

Finally, many patients with GAD experience marital/couple conflict, partly because of their tendency to view neutral events as potentially negative or even dangerous. Continual worry in an intimate relationship results in overfocus on the most negative interpretation of potentially neutral events (e.g., “She’s reading the paper because she finds me boring”), excessive reassurance seeking, and passive and withdrawn behavior (e.g., pouting). If necessary, the patient’s spouse or partner may be included in the treatment, with an emphasis on increasing positive reinforcement, positive tracking for both members of the couple, modification of problematic thinking styles, and encouraging the patient to avoid enunciating too many worrisome thoughts.

Problem-Solving Training

Worriers often rely on anticipation of problems by trying to eliminate uncertainty rather than solving specific real problems. As described above, two cognitive components of the present treatment package are (1) distinguishing between productive and unproductive worry and (2) practicing acceptance of uncertainty and limitations. However, the evaluation of productive worry may identify real problems that can be solved, but that may be avoided because of fear of negative affect, fear of outcome, or reliance on the experiential avoidance of worry (Dugas & Robichaud, 2007). A cognitive-behavioral approach to problem solving may be employed as part of treatment (Dugas, Freeston, & Ladouceur, 1997; Nezu, Nezu, & D’Zurilla, 2007). This involves defining the problem, clarifying how a solution would be defined, reviewing resources, brainstorming possibilities, rank-ordering options, setting up a plan of action, stipulating behaviors, and carrying out the plan to see what happens. In addition, time management (with an emphasis on being careful not to plan too many things), introduction of stress breaks, self-contingency contracting (e.g., establishing positive rewards and other reinforcements), anger control, and other techniques are useful (Leahy, 2004; Novaco & Taylor, 2006).

A Summary of Interventions

A summary of possible interventions is provided in Form 4.11 as a guide to self-help. Some or all of them may be used. Detailed descriptions and guidelines for patients can be found in Leahy (2005, 2009).

Phasing Out Treatment

As in the case of panic disorder and agoraphobia, we caution against premature termination of treatment for GAD—especially since GAD in many cases has been chronic for years and is resistant to treatment. Accordingly, the treatment package described in this chapter calls for 20 sessions, although it may sometimes be possible to provide adequate treatment in fewer sessions. Phasing back to biweekly or monthly sessions after the patient shows some improvement helps the patient to begin functioning independently of therapy. During phase-out, as noted in connection with other disorders in other chapters, the patient is encouraged to self-assign homework; this can focus on various aspects of treatment that have been particularly challenging for the patient.

TROUBLESHOOTING PROBLEMS IN THERAPY

Patients presenting with GAD have experienced significant anxiety for most of their lives (the average length of time between onset of the disorder and first treatment is 10 years or more). Consequently, they may be impatient, demanding, skeptical, hopeless, or minimally compliant with treatment. In addition, if a patient self-medicates with alcohol or other substances, the therapy may be compromised. The following problems are often confronted in treatment.

Beliefs That Worries Are Realistic

Some patients may claim that their worries are “realistic” because “they could happen.” This claim may be addressed by having such patients assign subjective probabilities to feared events and evaluate whether these are related to actual facts. For example, having heard of an airplane crash on the news, one patient estimated her significant chances of being in a similar crash at 10%. She was surprised to learn that the facts indicate that one can take a round trip on a commercial airliner every day for 45,000 years and expect one fatal accident. Confusing subjective feelings of anxiety with probabilities often contributes to extreme estimates of danger. Furthermore, a patient may be asked to estimate the sequence of probabilities of feared events. Almost always, this estimation will result in an extremely low probability of the ultimate outcome, since all prior events (the probabilities of which are usually very low themselves) have to occur.

Beliefs That Worry Protects

As indicated throughout this chapter, many worriers believe that worry is a self-protective strategy. Such beliefs can be addressed through a number of interventions. For example, practicing

“worry time” by delaying worry can test out whether terrible things happen during the period when the patient is delaying the worry. Or the therapist can ask this question: “If worry is associated with anxiety and depression, should you conclude that the best way to handle real problems is to make yourself anxious and depressed?” Another inquiry can focus on the illusory correlation—that since bad things are seldom happening, the patient is attributing a *safe reality* to worry, rather than to the real and external world. Again, the distinction between productive and unproductive worry may be helpful.

Difficulty in Identifying Automatic Thoughts

Because of the intensity of patients’ feelings or because of their exclusive focus on their discomfort, many anxious patients claim that they cannot identify their thoughts. The therapist may ask such a patient to slow down the process through the use of guided imagery in the session, in which anxiety-provoking situations are described and the patient slowly goes through his or her feelings, images, and thoughts. If the patient describes visual images, these can then be used as primes for automatic thoughts, as in this example:

 THERAPIST: You said that you had the image of your head exploding. Complete this sentence: “When I think of my head exploding, it makes me anxious because I think that what is happening is . . .”

 PATIENT: I’m losing control. I’m going crazy.

Another technique that can be useful is to suggest automatic thoughts that the patient may or may not have had and ask, “Could this be what you were thinking?” (See J. S. Beck, 2011, for a description of these techniques.)

Demand for Immediate Results

Anxious patients often demand immediate, total relief from their negative feelings, hoping for a “magic bullet.” This demand can be addressed in the following ways: clarifying that anxiety has been a lifelong problem, and thus requires an investment of time and effort to treat; stressing that old habits of thinking, feeling, and behaving do not change overnight; examining the costs and benefits of demanding immediate results; examining what will happen if immediate results are not obtained and what will happen if results are obtained gradually; evaluating how the demand for immediate results (low frustration tolerance) actually results in greater vulnerability to anxiety; and indicating how these demands contribute to feelings of hopelessness. Indeed, the sense of time urgency may underlie worry (“I need the answer right now”), and the lack of a definitive answer may be equated with danger and uncontrollability.

Perfectionistic Beliefs in Anxiety Reduction

Similar to the demand for immediate results is this dichotomous belief about anxiety: “Either I am totally anxious, or I should have no anxiety.” We tell patients that eliminating all anxiety is

impossible, except for dead people! Reducing, moderating, coping with, and not catastrophizing anxiety are suggested as alternative appropriate goals. Furthermore, a patient can examine how small amounts of anxiety can be useful to motivate the self or to indicate that something may be problematic. In addition, the patient can recognize that he or she can still engage in productive activities even while feeling anxious or uncomfortable.

Demands for Certainty

Patients who ask rhetorical “What if . . . ?” questions may demand certainty about feared events or about the outcome of therapy. These demands for certainty in an uncertain world are modified in therapy to statements about probability: “What is the probability that you will fail? Be rejected? Have cancer?” Patients who dwell on “What if . . . ?” are asked to examine the costs and benefits of demanding certainty about every possible imagined event. The therapist may indicate many situations—for example, driving a car, eating chicken in restaurants, or walking across the street—that are possibly dangerous, but that are generally tolerated as acceptable risks. Magical, absolutistic beliefs about negligence and responsibility, which contribute to the demand for certainty, are evaluated; the therapist indicates to the patient that responsibilities are not about all possible events, but about reasonable precautions taken by reasonable people.

Difficulty in Relaxing

Some patients describe difficulty in relaxing, even when given relaxation training. The therapist may increase a patient’s ability by including relaxation training in every session for several weeks to evaluate whether the patient is rushing through the exercise or not doing it properly. In addition, it is wise to train a patient in more than one exercise, to assure that the patient does not have time pressures following the exercises, and to check whether he or she is practicing relaxation with distracting stimuli (such as music or TV). Some anxious patients fear that their relaxation will leave them vulnerable and unaware of danger, and these thoughts, when elicited, may be evaluated via the cognitive therapy techniques described earlier. In patients with concomitant panic disorder, the decrease in tension may actually evoke a panic attack (see Chapter 3). The patients should be informed that this may happen in some cases, but that relaxation-induced panic usually subsides with continued practice of the exercises.

Refusal to Engage in Exposure

Some patients fear exposure so greatly that they refuse to confront feared situations. Interventions that may be helpful include using guided imagery in session before actual exposure is employed; extending the fear hierarchy to include even less anxiety-provoking events; modeling exposure; accompanying the patient in the feared situation; cognitive rehearsal of coping statements in the session; eliciting and challenging (through role plays and role reversals) the feared exposure; and using time projection (“How will you feel 30 minutes, 1 hour, 2 days after you have completed this task?”). Many anxious patients have negative emotional schemas about anxiety—that once anxiety arises it will ruin their day, take over, and make them miserable. Behavioral experiments

may be set up to evaluate whether exposure leads to a worsening of the entire day or whether exposure leads to a brief increase in anxious arousal, followed by a decrease (Leahy, 2007a; Sookman & Leahy, 2009).

DETAILED TREATMENT PLAN FOR GENERALIZED ANXIETY DISORDER

Treatment Reports

Tables 4.5 and 4.6 are designed to help in writing managed care treatment reports for patients with GAD. Table 4.5 shows sample symptoms; select the symptoms that are appropriate for your patient. Be sure also to specify the nature of the patient's impairments, including any dysfunction in academic, work, family, or social functioning. Table 4.6 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

Sequence of Interventions

Given the long-standing, chronic, and often treatment-resistant nature of GAD, we advocate that the treatment plan include *at least* 20 sessions of individual cognitive-behavioral treatment, with the opportunity for periodic follow-ups once regular treatment has been completed. Table 4.7 shows the sequence of interventions for a 20 session treatment plan for patients with GAD. (As noted earlier, the sequence of interventions presented here may vary, depending on individual patients' needs.)

CASE EXAMPLE

Sessions 1–2

Assessment

The patient, Jacob, was a 34-year-old single man who described himself as someone who had worried all his life. On intake, he had elevated scores on the BAI (23), the BDI-II (18), the MCQ-30 (on Positive Worry Beliefs, Cognitive Self-Consciousness, and Need for Control), and the PSWQ. He also had a slightly elevated score on the MCMI-III for dependent personality. His worries focused on concerns about how his father viewed him, whether he would be able to make a living, how his other relatives and his girlfriend felt about him, and whether he would ever improve. The patient's adolescence had been characterized by indifference to school, alcohol and marijuana abuse, mild depression, and chronic worry. He described himself as someone who was always trying to please his family members, which led to a great deal of resentment toward them, since he believed that they took advantage of him.

Bibliotherapy

The therapist provided Jacob with Leahy's (2005) *The Worry Cure: Seven Steps to Stop Worry from Stopping You*. The intake forms revealed Jacob's beliefs that worry protected and prepared him, but that his worry was out of control; his elevated cognitive self-consciousness; and his belief in his low cognitive competence. These metacognitive factors suggested

Cognitive/ metacognitive conceptualization:

TABLE 4.5. Sample Symptoms for Generalized Anxiety Disorder

Anxious mood
Excessive worry
Irritable mood
Restlessness
Feeling on edge
Fatigue
Impaired concentration
Digestive problems
Muscle tension
Insomnia
Specify length of time symptoms have been present

TABLE 4.6. Sample Treatment Goals and Interventions for Generalized Anxiety Disorder

Treatment goals	Interventions
Reducing physical symptoms of anxiety	Relaxation or breathing exercises
Reducing agitation about thinking and feeling	Mindfulness training, meditation
Reducing time spent worrying (to under 30 minutes/day)	Distraction, worry time, activity scheduling
Reducing negative automatic thoughts	Cognitive restructuring
Enhancing acceptance	Cognitive restructuring, mindfulness training, metacognitive techniques
Eliminating avoidance (specify)	Exposure, behavioral activation
Eliminating assumptions about danger of anxiety	Cognitive restructuring, behavioral experiments
Eliminating assumptions about positive value of worry (or other assumptions—specify)	Cognitive restructuring, metacognitive techniques
Modifying need for certainty	Uncertainty training (costs–benefits of tolerating uncertainty, flooding oneself with uncertainty, practicing the negative emotional image, problem-solving training)
Modifying schemas of threat/vulnerability/need for control (or other schemas—specify)	Cognitive restructuring, developmental analysis, other schema work
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

TABLE 4.7. Detailed Treatment Plan for Generalized Anxiety Disorder**Sessions 1–2****Assessment**

Evaluate presenting problems

Evaluate specific anxiety problems with the Leahy Anxiety Checklist for Patients (Form 4.2), plus other anxiety instruments as appropriate

Administer worry evaluations (PSWQ, MCQ-30, IUS; see Forms 4.3–4.5)

Administer standard intake battery (see Form 4.6)

Identify specific content of worries, as well as metacognitive factors

Determine differential diagnosis and evaluate for any comorbid diagnoses

Evaluate for substance abuse, use of caffeine or tobacco, sleep disorders

Socialization to Treatment

Provide patient with information handouts on GAD (Form 4.7) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)

Bibliotherapy: Assign *The Worry Cure: Seven Steps to Stop Worry from Stopping You* (Leahy, 2005) or *Anxiety Free: Unravel Your Fears before They Unravel You* (Leahy, 2009)

Indicate how GAD involves motor tension and arousal

Indicate that worries are a central part of GAD, and that worries are reinforced by their nonoccurrence

Develop short-term and long-term goals

Behavioral Interventions

Identify triggers for anxiety and avoidance

Evaluate and decrease use of anxiety-producing substances (e.g., caffeine, amphetamine) and abuse of self-medicating substances (e.g., alcohol, benzodiazepines)

Cognitive Interventions

Normalize worrying—review productive versus nonproductive worrying

Determine whether patient “worries about worrying” (e.g., “Worrying means I’m going crazy or I have no control over my thoughts and feelings”)

Introduce Patient’s Worry Log (Form 4.8)

Medications

Consider use of SSRIs or benzodiazepines

Homework

Have patient begin reading Leahy (2005) or Leahy (2009)

Assign use of Patient’s Worry Log to monitor worries

Sessions 3–5**Assessment**

Evaluate anxiety (BIA) and depression (BDI-II)

Continue to identify themes of patient’s worries

Review Patient’s Worry Log—frequency, duration, situations (triggers), precursors, and consequences of worries

Behavioral Interventions

Train patient in progressive muscle relaxation and/or relaxing breathing, and/or use mindfulness exercises

Use reward planning/activity scheduling to monitor pleasure, mastery, and anxiety

Describe and encourage “worry time”

Evaluate need for exposure to avoided situations; discuss exposure with patient

TABLE 4.7 (cont.)

Evaluate need for assertion training, communication training, conflict resolution, couple therapy
 Encourage exercise
 Treat insomnia, if necessary

Cognitive Interventions

Introduce Questions to Ask Yourself If You Are Worrying (Form 4.9)
 Begin to identify and categorize automatic thoughts (with specific emphasis on fortunetelling, catastrophizing, discounting positives, personalizing, etc.)
 Begin challenging thoughts by evaluating costs and benefits of worrying, using other cognitive techniques (see Chapter 10 and Appendix B)
 Utilize acceptance strategies (advantages and disadvantages of accepting limitations and uncertainty, current examples of acceptance, etc.)
 Utilize metacognitive strategies (identify patient's theories about worry, increase recognition that worry is a mental event, modify beliefs that worry needs to be controlled)

Medication

Evaluate side effects of medication
 Evaluate need to increase dosage
 If no improvement, either increase dosage, add another medication, or change class of medication (consider need to taper or discontinue one class when adding another class)

Homework

Assign breathing relaxation, progressive muscle relaxation, mindfulness exercises
 Have patient follow self-help tips for insomnia (Form 2.11 in Chapter 2)
 Assign worry time
 Have patient increase exercise
 Have patient engage in reward planning/activity scheduling
 Have patient continue to monitor worries, test predictions, track negative thoughts, and categorize those thoughts
 Assign continued reading

Sessions 6–8**Assessment**

As in Sessions 3–5
 Review homework

Behavioral Interventions

Train patient in generalizing relaxation and/or mindfulness to new situations
 Encourage patient to decrease rumination time—develop an antirumination script
 Examine situational/life sources of stress (e.g., financial, interpersonal, work, family, etc.)
 Introduce problem-solving skills and apply to situational sources of stress
 Guide patient in confronting avoided situations

Cognitive Interventions

Identify patient's underlying maladaptive assumptions
 Challenge assumptions via cost–benefit analysis, other cognitive techniques (see Chapter 10 and Appendix B)
 Continue challenging automatic thoughts
 Introduce Patient's Daily Record of Dysfunctional Automatic Thoughts (Form 2.10 in Chapter 2)

(cont.)

TABLE 4.7 (cont.)

Use vertical descent on worries

What is the ultimate outcome or fear that the patient anticipates?

Distinguish between possible and probable outcomes

Examine worries for probability, plausibility

Medication

As in Sessions 3–5

Homework

As in Sessions 3–5

Have patient begin use of Form 2.10

Encourage patient to schedule stress breaks, self-reward for behavior

Assign use of problem solving

Encourage patient to decrease rumination through distraction, activity scheduling, rational responding

Sessions 9–15

Assessment

As in Sessions 6–8

Behavioral Interventions

Continue with assertion training and introduce anger control training (if needed)

Continue with problem-solving training

Begin self-efficacy training: Have patient list personal positives, take credit for positives, continue with self-reward

Cognitive Interventions

Continue evaluating and challenging automatic thoughts

Identify, evaluate, and modify dysfunctional personal schemas (see Chapter 10 and Appendix B)

Examine how worries are related to schemas (about defectiveness, failure, biological vulnerability, abandonment, responsibility, etc.)

Continue to evaluate and modify maladaptive assumptions (about control, excessive responsibility, time pressure, what is “essential,” and imminence of “disasters”)

Identify beliefs about failure, and introduce rational responding to fear of failure

Identify and modify emotional schemas (beliefs about emotions as dangerous, out of control, incomprehensible, shameful, etc.)

Encourage patient to practice self-validation for emotional distress

Focus on putting time in perspective—living in the moment, mindfulness, stretching time, looming-vulnerability interventions (slowing down image of impending threat and identifying intervening or contingent events)

Medication

As in Sessions 3–5

Homework

As in Sessions 3–5 and 6–8

Have patient increase exposure to feared situations as appropriate

Assign assertion and anger control practice

Have patient increase self-reward

Have patient identify and challenge maladaptive assumptions and dysfunctional schemas (including beliefs about control, responsibility, and imminence)

TABLE 4.7 (cont.)

Sessions 16–20**Assessment**

As in Sessions 6–8

Behavioral Interventions

Plan phase-out of treatment

Have patient identify short-term and long-term goals for self-help

Identify how behavioral techniques can be used in future

Cognitive Interventions

Review what has been learned about automatic thoughts, assumptions, and schemas

Use rational responding to play “devil’s advocate” for patient

Help patient develop new, more pragmatic assumptions and schemas

Homework

Have patient self-assign homework focused on troubleshooting future problems

Identifying automatic thoughts, assumptions, and core beliefs

that he was conflicted by the beliefs that worry served positive functions but was something that needed to be controlled or eliminated. His core beliefs about himself were that he was inadequate and undeserving, and that people would reject him if he asserted his needs. He revealed that he had used alcohol and marijuana as strategies to handle his worry.

Sessions 3–5

Mindful breathing

Jacob was guided through the exercise of mindful breathing; he was asked to focus on noticing and letting go of the breath, while also being aware of how the mind drifted away from the breath. A tape was made of this exercise, and he was instructed to practice mindful breathing for 20 minutes every day. Mindfulness exercises throughout therapy helped him recognize how active and distracting his thinking was, and realize that he might be able simply to notice a thought without having to respond to it or suppress it.

Worry time

In addition, Jacob was asked to write down worries as they occurred during the day or evening, and to set aside “worry time” for 4:30 in the afternoon. Initially, he thought that it would be impossible to set aside the worries, “since they just come to me”; with practice, however, he realized that they could be postponed and that by worry time they seemed largely irrelevant. Worry time also helped him challenge the sense of urgency about finding answers, since worries delayed became worries denied.

Examining beliefs about worrying; evaluating costs and benefits of worrying

The therapist and Jacob examined the advantages and disadvantages of worrying. The advantages, as Jacob saw them, were that worry prepared him and avoided surprise; the disadvantages were anxiety, depression, irritability, and generally feeling out of control. He also indicated his belief that if he didn’t stop worrying, he would “probably eventually go crazy.”

<i>Distinguishing productive from unproductive worry</i>	<p>This was linked to his belief that telling himself to stop worrying would help him, although it generally led to more frustration.</p>
<i>Uncertainty training</i>	<p>The therapist suggested that Jacob distinguish between productive and unproductive worry, in that productive worry could lead to a “to-do list today.” He realized that almost none of the things that he worried about could lead to a to-do list, and so they were categorized as unproductive.</p>
<i>Flooding of feared thoughts</i>	<p>Jacob and the therapist then examined the advantages and disadvantages to accepting some uncertainty and some lack of control. He acknowledged that he already accepted some uncertainty in the work he was doing and in driving on the highway. He also recognized that accepting some uncertainty might free him from the task of worrying and that he might enjoy his present life more. The therapist and Jacob examined how he equated uncertainty with a bad outcome, rather than viewing uncertainty as neutral. In order to “practice accepting uncertainty,” he was asked to repeat for 10 minutes, “It’s possible I could lose my job.” His anxiety initially increased to a SUDs level of 8, but gradually subsided to 2. He was instructed to repeat the feared thought “like a zombie” for 20 minutes each day. The therapist also engaged him in an exercise called “On My Mind,” in which an intrusive thought is depicted as a character who comes to visit a therapist. Jacob was asked to pay attention to the fact that the thought could be accepted, much as a therapist would accept a patient, or a person would accept a relative at a dinner party.</p>
<i>Examining beliefs about control</i>	<p>Next, the therapist and Jacob examined his beliefs about control. First, they targeted his belief that he had to “control” or “eliminate” his worry thoughts. This was addressed first by evaluating the costs and benefits of this belief, weighing the evidence whether it was possible, examining the rationale of “don’t think of white bears,” and nothing the futility of trying to control your inner thoughts and sensations. Second, he practiced “thought flooding” as described above. Third, he and the therapist examined his belief that when he was with his family, “he had to get them to calm down.” He was instructed to view his family as if he were a journalist who was collecting information for an interesting story. The goal of this new approach was to observe, rather than to judge and control. He reported after a family holiday dinner that it was the best time he had had in years, since “I didn’t have to get involved in their craziness.”</p>
<i>Practicing acceptance and mindful observing</i>	<p>Jacob then began making regular use of the Patient’s Worry Log (Form 4.8) to track his worries. Initially, the goal was simply to write down the situation and the actual worries. As therapy progressed, the Patient’s Worry Log was used to challenge his worried thinking.</p>
<i>Patient’s Worry Log</i>	<p>In reviewing his worries and in using the checklist of distorted automatic thoughts (see Chapter 10, Form 10.2), he was able to realize that he repeatedly engaged in the same categories of thoughts: mind reading, personalizing, fortunetelling, catastrophizing, all-or-nothing thinking, and labeling himself. His worries seemed to follow a pattern, which gave him some comfort, since he was able to realize that they were finite and therefore possibly open to modification.</p>
<i>Categorizing automatic thoughts</i>	

Sessions 6–8

Specific challenges to worries, using the form Questions to Ask Yourself If You Are Worrying

Jacob continued to track his worries with the Patient's Worry Log. The log indicated that he worried about things that were beyond his control, about losing his job, about what family members thought of him, about his finances, and even about his worrying too much. The therapist introduced a number of challenges and questions to ask when he noticed a worry. Using the form Questions to Ask Yourself If You Are Worrying (Form 4.9), Jacob went through each of the points and provided responses. Examples of these responses are given below. (The questions from the form are presented in italics; Jacob's responses are in roman with quotation marks.)

Specifically, what are you predicting will happen? "My aunt will be angry with me because I'm not working with them any more."

How likely (0–100%) is it that this will actually happen? "Likelihood: 80%."

How negative an outcome are you predicting (from 0% to 100%)? "How negative: 80%."

What is the worst outcome? "Worst: She will be so angry at me that she will never talk to me again."

The most likely outcome? "Most likely: She'll be angry for a while and get over it."

The best outcome? "Best: She will find someone to replace me and be happier with that person."

Are you predicting catastrophes (awful things) that don't come true? "Yes—I think that if someone is angry at me it's terrible, and that it will be the end of the relationship."

What are some examples of the catastrophes that you are anticipating? "I'm predicting that my entire family will be so angry at me that it will be impossible for me to see them. That I will get fired, not have any money, and end up alone."

What is the evidence (for and against) your worry that something really bad is going to happen? "Evidence for: There are continual conflicts in my family. We all need therapy. Evidence against: My family has always had a lot of conflict, but we still manage to get along. We are a bunch of yellors and screamers. I'm doing a good job—bringing in money. It would be hard to replace me."

If you had to divide 100 points between the evidence for and against, how would you divide these points? For example, would it be 50–50? 60–40? "Points: Evidence for = 10. Evidence against = 90."

Are you using your emotions (your anxiety) to guide you? Are you saying to yourself, "I feel anxious, so something really bad is going to happen"? Is this a reasonable way to make predictions? Why/why not? "I am doing a lot of emotional

reasoning, which I seem to do most of the time. My emotions seem to be a bad way to predict—for one thing, people are not making their decisions based on my emotions. They have their own problems to deal with.”

How many times have you been wrong in the past about your worries? What actually happened? “I’m continually wrong in my predictions. I’ve been worried I would get fired, my family would disown me, and that I would end up with no money. The fact is that I am probably one of the most liked people in my family. They all turn to me with their problems. Which is a problem!”

What are the costs and benefits to you of worrying about this? “Costs: Anxious, angry, helpless, frustrated, and confused. Benefits: I think I might be able to prevent things unraveling. I keep thinking I can keep people from being angry with me.”

What evidence do you have from the past that worrying has been helpful to you and hurtful to you? “Sometimes I think that people like me because I’ve been able to figure out how to avoid getting them angry. But the reality is that some of my family members get angry and frustrated because they are unrealistic. And then they get over it.”

Jacob completed the rest of this form in the same way. He found these challenges to his negative thoughts quite useful.

Sessions 9–11

Identifying maladaptive assumptions

A considerable amount of Jacob’s worry was related to his concern about how others felt about him. He and the therapist now focused on identifying his maladaptive assumptions—his “if–then” rules and his “shoulds.” These included “I should always make other people like me,” “If people don’t like me, then I’ve done something wrong,” “It’s intolerable to be disliked,” and “I need to know why someone is upset.” This sensitivity to rejection, and his tendencies to personalize it and to catastrophize not getting approval were at the heart of his worries.

Modifying maladaptive assumptions

The therapist and Jacob then worked on modifying his maladaptive assumptions by examining the costs and benefits of these rules, asking whether he would apply these rules to other people (the double-standard technique), noting the impossibility of attaining approval from other people, and using the empty-chair technique (talking back to the negative voice). He realized that his assumptions about getting approval had contributed to his frustration, his anger, his anxiety, and even his use of alcohol and marijuana over the years, and that modifying this need for approval would free him up considerably.

Jacob indicated that he would not apply these rules to other people: “It’s not fair to expect someone to get approval from everyone. It’s impossible, anyway. Sometimes you have to assert yourself.” We also looked at his assumption that if he disagreed with someone or asserted himself, then he would be marginalized and rejected completely. He set up a behavioral experiment in which he diplomatically but firmly asserted himself with his father. The

outcome was that his father initially disagreed with him, but eventually reached a compromise.

*Examining
core beliefs*

The therapist and Jacob next turned to his core beliefs or personal schemas. These included his belief that he wasn't "good enough": "Because I never went to college, I went into the family business." Another core belief was that he had to sacrifice his own needs to be accepted, because his needs were not important. These core beliefs about being defective and unworthy were linked to his excessive need to please and to his worries. Jacob and the therapist went on to examine the developmental origins of his beliefs: "My older brother always had problems with drugs. He had gotten arrested a few times, and my parents were always bailing him out of trouble. Everything was about him. I had to be the 'good kid.'" I had to make things easier for Mom and Dad, because they already had enough problems with my brother." This situation contributed to his belief that his needs were not important, that he had to "earn love," and that everything could be taken away by the family (or other people) because he wasn't important enough.

*Developmental
origin of core
beliefs*

*Schema
therapy for
core beliefs*

The therapist and Jacob then focused on using schema therapy techniques to modify his core beliefs. The therapist asked questions such as these: "What are the costs and benefits of these beliefs about yourself—especially your needs?", "What is the rationale that your needs are just as important as someone else's needs?", "If you assert yourself, does it always happen that you are rejected?", and "Are you teaching other people that you don't matter? If you asserted yourself, could you teach them—and yourself—that you do matter?" The therapist also had him do a role play, with the therapist as his "judgmental father" and the patient as himself: Jacob was able to say assertively, "You have always taken me for granted. You always thought I should do whatever you wanted, because my brother was such a screw-up. But my needs are just as important. I will not always do what you want. I will do what I want to do."

*Modifying
beliefs about
failure*

Jacob's sense of "failure" was that he had failed if someone was dissatisfied. This helped him recognize that other people could have unrealistic expectations of him, but that this did not mean he had failed. In fact, by asserting himself (which now was categorized as successful behavior), he could recognize that this led other people to be unhappy with him on occasion. In other words, their problem might be the result of his personal growth. "I failed to satisfy unreasonable people" became a new way for him to reframe what was going on.

*Examining
beliefs about
emotions*

In addition, Jacob and the therapist examined his beliefs about his anxiety and discomfort. These included his thoughts that his feelings didn't make sense, that others would not understand his anxiety, and that he had to get rid of the discomfort immediately. Mindful breathing became the analogue for understanding that sensations and thoughts come and go—and that their impermanence is why they do not need to be avoided or controlled. In addition, the cognitive evaluation (automatic thoughts, assumptions, and core beliefs) helped him understand how his emotions (anger, anxiety, frustration, helplessness) all made sense, given the way he was thinking about things. Of course, his thinking was changing.

Sessions 12–16

Assertiveness training As Jacob continued to examine his assumptions and core beliefs, he realized that he had felt oppressed, even humiliated, by his father and controlled by other family members. But he also realized that he was an essential part of the family business—and, in fact, that they needed him more than he needed them. He and the therapist then decided to focus on his interpersonal relationships. This included becoming more assertive with his father and expanding his social network, including dating (he had just broken up with his girlfriend). The more he was able to recognize that he could find rewards, appreciation, and respect outside the family, the freer he became from their evaluations. In addition, the therapist and Jacob examined alternatives to working with family members, including possibly starting up his own business outside the city. As he constructed his own alternatives, he began to feel less trapped and less angry. He worried less, because pleasing others was now only one alternative; he could also please himself.

Examining previous history of nonassertion As Jacob reviewed his history of intimate relationships, he realized that his past relationship with a woman had been one-sided. That is, he had deferred to her needs, had not asserted himself, and had felt guilty about disappointing her. As a result, he had stayed for several years in a relationship that he did not find rewarding. He and the therapist then examined his fear of getting involved at the present moment because of his fear of being “trapped” by his lack of assertiveness. His goal now was to be free to be assertive, rather than worry that he was responsible for making other people happy all the time. He was able to be assertive by setting limits with a “new” woman he was beginning to date; that is, he was able to indicate that he was under no obligation to be available to her if he wasn’t interested. Initially he felt guilty and worried about this, but he then realized that he had the right to say “no” and to pursue what he felt was his interest, not hers.

Developing a “bill of rights” In order to continue his assertive approach, Jacob was asked to develop a “bill of rights”: “What are your rights with other people and your rights in living your own life?” He realized that he had the right to an individual life, the right to say “no,” and the right to disappoint other people.

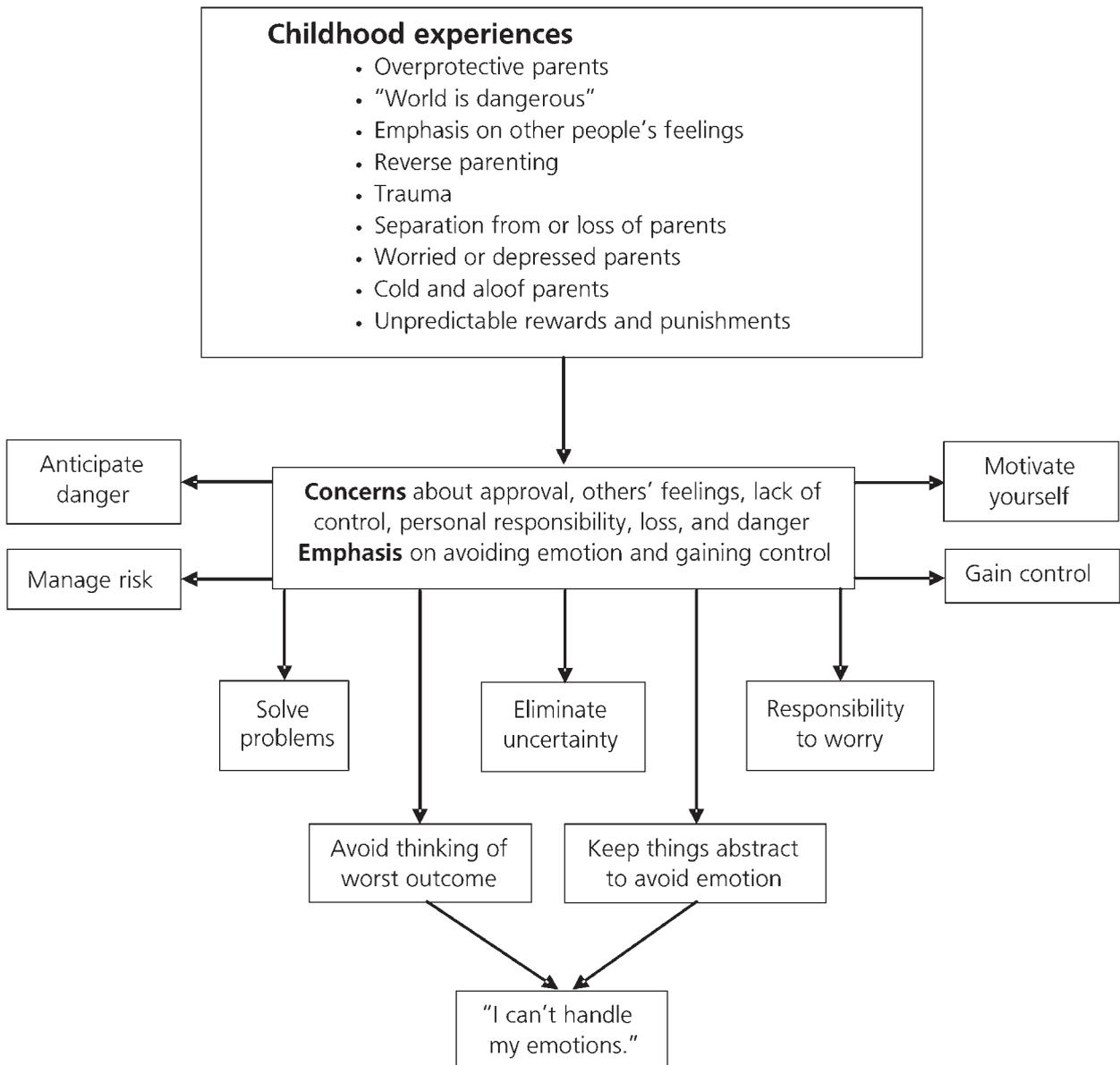
Sessions 17–20

Phasing out treatment Jacob continued to make progress in accepting limitations about getting approval all the time. He came to value the idea of being an “observer”—or, as he labeled it, a “Zen warrior.” The idea of being a Zen warrior was to observe and empathize with others rather than try to control them, struggle against them, or feel defeated. In other words, he was “there” without being “against.” He could also accept others’ being disappointed without having to do anything.

The phase-out of therapy began with sessions once every 2 weeks, then sessions once per month, and finally a booster session after 3 months. The phasing-out process began with summarizing what was learned in therapy

about productive versus unproductive worry, accepting limitations and uncertainty, examining his negative automatic thoughts, setting aside worry time, recognizing that he didn't have to get rid of worries as much as make space for them, examining and modifying his assumptions and core beliefs, practicing assertion, knowing his rights, and creating alternatives to the family with other relationships and other possible work venues.

FORM 4.1. Generalized Anxiety Disorder: Antecedents and Underlying Processes



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FORM 4.2. Leahy Anxiety Checklist for Patients

Patient's name: _____ Today's date: _____

Place a number next to the answer that best describes how you have been feeling generally during the past month. Use the scale below:

1 = Not at all 2 = Slightly true 3 = Somewhat true 4 = Very true

1. Feeling shaky _____
2. Unable to relax _____
3. Feeling restless _____
4. Get tired easily _____
5. Headaches _____
6. Shortness of breath _____
7. Dizzy or light-headed _____
8. Need to urinate frequently _____
9. Sweating (unrelated to heat) _____
10. Heart pounding _____
11. Heartburn or upset stomach _____
12. Easily irritated _____
13. Startled easily _____
14. Difficulty sleeping _____
15. Worried a lot _____
16. Hard to control worries _____
17. Difficulty concentrating _____

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FORM 4.3. Penn State Worry Questionnaire (PSWQ)

Patient's name: _____ Today's date: _____

Enter the number that best describes how typical or characteristic each item is of you, putting the number next to the item.

- | | 1 | 2 | 3 | 4 | 5 |
|-------|--------------------|---|------------------|---|--------------|
| | Not at all typical | | Somewhat typical | | Very typical |
| _____ | 1. | | | | |
| _____ | 2. | | | | |
| _____ | 3. | | | | |
| _____ | 4. | | | | |
| _____ | 5. | | | | |
| _____ | 6. | | | | |
| _____ | 7. | | | | |
| _____ | 8. | | | | |
| _____ | 9. | | | | |
| _____ | 10. | | | | |
| _____ | 11. | | | | |
| _____ | 12. | | | | |
| _____ | 13. | | | | |
| _____ | 14. | | | | |
| _____ | 15. | | | | |
| _____ | 16. | | | | |

Your total score: _____

Note that (R) after a question indicates a reverse score. Thus, to reverse-score your question, if you give an answer of 1 (Not at all typical), score it as a 5.

Add up your scores on the test—and be sure to note which items are reversed-scored (see above for how to reverse score your responses). On the average, people with some problems with worry score above 52, and really chronic worriers score above 65. “Nonanxious” people have average scores around 30. It is also quite possible to score below the clinical range (somewhere between 30 and 52) but still feel that your worries are bothering you.

The PSWQ itself (not the scoring instructions) is from Meyer, Miller, Metzger, and Borkovec (1990). Copyright 1990 by Pergamon Press. Reprinted by permission of Elsevier B. V.

Score ranges are based on Table 11-2 from Molina and Borkovec (1994).

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FORM 4.4. Metacognitions Questionnaire 30 (MCQ-30)

Patient's name: _____ Today's date: _____

This questionnaire is concerned with beliefs people have about their thinking. Listed below are a number of beliefs that people have expressed. Please read each item and say how much you *generally* agree with it by *circling* the appropriate number. Please respond to all the items; there are no right or wrong answers.

Metacognitions	Do not agree	Agree slightly	Agree moderately	Agree very much
1. Worrying helps me to avoid problems in the future	1	2	3	4
2. My worrying is dangerous for me	1	2	3	4
3. I think a lot about my thoughts	1	2	3	4
4. I could make myself sick with worrying	1	2	3	4
5. I am aware of the way my mind works when I am thinking through a problem	1	2	3	4
6. If I did not control a worrying thought, and then it happened, it would be my fault	1	2	3	4
7. I need to worry in order to remain organized	1	2	3	4
8. I have little confidence in my memory for words and names	1	2	3	4
9. My worrying thoughts persist, no matter how I try to stop them	1	2	3	4
10. Worrying helps me to get things sorted out in my mind	1	2	3	4
11. I cannot ignore my worrying thoughts	1	2	3	4
12. I monitor my thoughts	1	2	3	4
13. I should be in control of my thoughts all of the time	1	2	3	4
14. My memory can mislead me at times	1	2	3	4
15. My worrying could make me go mad	1	2	3	4
16. I am constantly aware of my thinking	1	2	3	4
17. I have a poor memory	1	2	3	4
18. I pay close attention to the way my mind works	1	2	3	4
19. Worrying helps me cope	1	2	3	4

(cont.)

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FORM 4.4. Metacognitions Questionnaire 30 (p. 2 of 2)

20. Not being able to control my thoughts is a sign of weakness	1	2	3	4
21. When I start worrying, I cannot stop	1	2	3	4
22. I will be punished for not controlling certain thoughts	1	2	3	4
23. Worrying helps me to solve problems	1	2	3	4
24. I have little confidence in my memory for places	1	2	3	4
25. It is bad to think certain thoughts	1	2	3	4
26. I do not trust my memory	1	2	3	4
27. If I could not control my thoughts, I would not be able to function	1	2	3	4
28. I need to worry, in order to work well	1	2	3	4
29. I have little confidence in my memory for actions	1	2	3	4
30. I constantly examine my thoughts	1	2	3	4

This questionnaire pinpoints the five most common types of beliefs about worry. These include Positive Worry Beliefs (e.g., “Worrying helps me to avoid problems in the future”); Uncontrollability and Danger: Negative Beliefs (e.g., “My worrying is dangerous for me”); Cognitive Confidence (or lack of it—e.g., “I have little confidence in my memory for words and names”); Need for Control (e.g., “If I did not control a worrying thought, and then it happened, it would be my fault”); and Cognitive Self-Consciousness (e.g., “I think a lot about my thoughts”).

These factors reflect conflicting functions that you believe worry serves. For example, you may feel conflicted between having positive views of worry and, at the same time, believing that worry is uncontrollable and dangerous. You may also distrust your own memory, believing that there is something that you may overlook. This distrust in your memory may make you worry that you will neglect something. You may be scanning your mind to monitor your own thoughts, continually focusing on what you are thinking, perhaps because you believe your worry thoughts may signal impending danger.

In order to determine your score for each of these five factors on the MCQ-30, use the table below. For example, to find your score for Positive Worry Beliefs, add up your scores for each of this factor’s six questions (1, 7, 10, 19, 23, 28) to get your score. Go through each of the factors this way. Then, at the end, add up your scores for each of the factors. Although there are no established norms yet for this scale, you will be able to see whether you have relatively more elevated scores on certain factors than on others.

Factor—“Your theory about your worry”	Your total score on each factor
Positive Worry Beliefs —questions 1, 7, 10, 19, 23, 28	_____
Uncontrollability and Danger: Negative Beliefs —questions 2, 4, 9, 11, 15, 21	_____
Cognitive Confidence —questions 8, 14, 17, 24, 26, 29	_____
Need for Control —questions 6, 13, 20, 22, 25, 27	_____
Cognitive Self-Consciousness —questions 3, 5, 12, 16, 18, 30	_____

FORM 4.5. Intolerance of Uncertainty Scale (IUS)

Patient's name: _____ Today's date: _____

You will find below a series of statements that describe how people may react to the uncertainties of life. Please use the scale below to describe to what extent each item is characteristic of you (please write the number that describes you best in the space before each item).

1	2	3	4	5
Not at all characteristic of me	A little characteristic of me	Somewhat characteristic of me	Very characteristic of me	Entirely characteristic of me

- _____ 1. Uncertainty stops me from having a firm opinion.
- _____ 2. Being uncertain means that a person is disorganized.
- _____ 3. Uncertainty makes life intolerable.
- _____ 4. It's not fair that there are no guarantees in life.
- _____ 5. My mind can't be relaxed if I don't know what will happen tomorrow.
- _____ 6. Uncertainty makes me uneasy, anxious, or stressed.
- _____ 7. Unforeseen events upset me greatly.
- _____ 8. It frustrates me not having all the information I need.
- _____ 9. Being uncertain allows me to foresee the consequences beforehand and to prepare for them.
- _____ 10. One should always look ahead so as to avoid surprises.
- _____ 11. A small unforeseen event can spoil everything, even with the best of planning.
- _____ 12. When it's time to act uncertainty paralyzes me.
- _____ 13. Being uncertain means that I am not first-rate.
- _____ 14. When I am uncertain I can't go forward.
- _____ 15. When I am uncertain I can't function very well.

(cont.)

The IUS itself (not the scoring instructions) is from Freeston, Rhéaume, Letarte, Dugas, and Ladouceur (1994). Copyright by Elsevier Limited. Reprinted by permission.

Scores ranges are based on Dugas et al. (2004) and Ladouceur et al. (2000).

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FORM 4.5. Intolerance of Uncertainty Scale (p. 2 of 2)

- _____ 16. Unlike me, others always seem to know where they are going with their lives.
- _____ 17. Uncertainty makes me vulnerable, unhappy, or sad.
- _____ 18. I always want to know what the future has in store for me.
- _____ 19. I hate being taken by surprise.
- _____ 20. The smallest doubt stops me from acting.
- _____ 21. I should be able to organize everything in advance.
- _____ 22. Being uncertain means that I lack confidence.
- _____ 23. I think it's unfair that other people seem sure about their future.
- _____ 24. Uncertainty stops me from sleeping well.
- _____ 25. I must get away from uncertain situations.
- _____ 26. The ambiguities in life stress me.
- _____ 27. I can't stand being undecided about my future.

Total score (Sum your scores above) _____

There are five different factors on the IUS. These reflect the following beliefs:

1. Uncertainty Is Unacceptable and Should Be Avoided
2. Uncertainty Reflects Badly on a Person
3. Frustration with Uncertainty
4. Uncertainty Causes Stress
5. Uncertainty Prevents Action

In order to obtain your total score, simply add up your responses for each question. Overall, scores below 40 reflect tolerance of some uncertainty; scores above 50 reflect problems with uncertainty; and scores above 70 suggest real problems in handling uncertainty. People with GAD have an average score of 87 on the IUS. However, even if your score is below 87, your intolerance of uncertainty can be a vulnerability factor for your worry and anxiety.

FORM 4.6. Evaluation of Generalized Anxiety Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Beck Depression Inventory-II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Global Assessment of Functioning (GAF) _____ Leahy Anxiety Checklist _____

Penn State Worry Questionnaire (PSWQ) _____ Metacognitions Questionnaire 30 (MCQ-30) _____

Intolerance of Uncertainty Scale (IUS) _____

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) _____

Other questionnaires (specify) _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Treatment
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(cont.)

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Treatment progress (later evaluations only)

Situations still avoided: _____

Situations approached that were previously avoided: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 4.7. Information for Patients about Generalized Anxiety Disorder

WHAT IS GENERALIZED ANXIETY DISORDER?

People with generalized anxiety disorder (GAD) have persistent and disturbing worries on a daily basis. They also experience physical symptoms, such as restlessness, shortness of breath, palpitations, muscle aches, sweating, and insomnia. Often people with GAD will have another anxiety disorder; for example, many people with GAD also have social anxiety and worry about other people seeing them as anxious. If untreated, GAD often leads to depression.

WHAT CAUSES GENERALIZED ANXIETY DISORDERS?

There are many factors that may account for GAD. Between 30% and 50% of the cause may be genetic, but early childhood experiences (such as loss of a parent, feeling the need to comfort and protect a parent, parental separation/divorce of parents, parental overprotection, or parental statements that the world is a dangerous place), recent stresses in life, unrealistic expectations about yourself and others, relationship conflicts, alcohol or caffeine use, poor coping skills, and other factors all contribute to the experience of anxiety. Studies indicate that the level of anxiety in the general population has been increasing over the last 50 years—perhaps due to a decrease in social connectedness and community, unrealistic expectations about what life should be, an overfocus on bad news in the media, and other social and cultural factors.

HOW DOES THINKING AFFECT GENERALIZED ANXIETY DISORDER?

Anxious persons are plagued with a stream of irrational thoughts that further increase their anxiety: “People can see I’m anxious. They think less of me. I’m the only one with this problem. I can’t stand to be disapproved of. It’s awful that this could happen.” Many people with GAD have an endless stream of worries that begin with “What if?” Typical thoughts of this type are “What if I’m losing control/going crazy/making a fool out of myself?” They may also worry about their worrying—for example, “I need to get rid of this anxiety [obsession, behavior, etc.] immediately. I am going to fail. My worrying is out of control and I’ll go crazy. I should never worry.” Chronic worriers often have mixed feelings and beliefs about their worry. On the one hand, they believe that their worry prepares and protects them. But, on the other hand, they believe that their worry will make them sick and that they need to stop worrying completely. Worriers are also often highly intolerant of uncertainty, often believing that if they don’t know something for sure, then it will turn out badly. People who are anxious tend to predict the worst, expect that they will not be able to handle stress, and demand certainty in an uncertain world. If you are a worrier, you may have difficulty living in the present moment and enjoying your life. You are constantly seeking answers that you may never get.

HOW DOES PERSONALITY AFFECT GENERALIZED ANXIETY DISORDER?

People with GAD are anxious about things that are personally relevant to their concerns. Depending on your personality, you may worry about being rejected, making mistakes, not achieving success, getting sick, or being abandoned. Furthermore, you may avoid or leave situations that make you anxious, or you may try to compensate for your anxiety by trying to be overly controlling, by being overly concerned about approval, or by

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trying to be perfect. Your individual concerns and your style of coping with anxiety may thus actually make you more vulnerable to anxiety.

HOW CAN TREATMENT BE HELPFUL?

Cognitive-behavioral therapy and/or medication are especially useful in treating GAD. Both during therapy sessions and as part of the your self-help homework, you may be instructed in a number of techniques to decrease anxiety. Let's take a look at some of these techniques.

- **Decrease your arousal.** You are more likely to feel anxious when you are physically aroused. You should examine how much caffeine (coffee, teas, sodas) and alcohol you use. Your therapist may teach you breathing and relaxation exercises that can help you moderate your general arousal. Meditation and yoga are often very helpful to calm your body and mind. In addition, regular exercise may be helpful. Medications can also help reduce your arousal.
- **Identify and confront your fears.** Your therapist will assist you in recognizing the specific situations, sensations, or thoughts that are disturbing to you. You may be asked to rank these fears from least to most feared and to identify exactly what you are afraid will happen. Through gradual and guided exposure to these fears, with the help of your therapist, you may begin to modify the way you experience these situations.
- **Modify your thinking.** Your therapist may help you to identify and modify your negative thinking. You may be taking things too personally, engaging in fortunetelling about events that never happen, or predicting catastrophes that turn out to be mere inconveniences. Many worriers have a set of rules about life, such as "If I'm not perfect, I'm a failure" or "If someone doesn't like me, it's a disaster." Other rules might be "I need to know for sure" or "I should never feel anxious." You can learn to use cognitive therapy techniques to identify and modify your thinking in ways that are more realistic and fairer to yourself.
- **Learn how to deal with worry.** Like many worriers, you may believe that your worry prepares and protects you. You can learn how to distinguish between productive and unproductive worry, how to accept limitations and live with reasonable uncertainty, how to enjoy the present moment in a nonjudgmental way, and how to view your worries as "background noise" that does not need to control you. You can learn how to turn off the sense of urgency that makes you feel constantly under pressure.
- **Develop "emotional intelligence."** Many worriers have a hard time coping with their emotions. They often believe that their emotions will overwhelm them, will last indefinitely, or don't make sense. Life is not about eliminating emotions; it entails learning to live meaningfully with your emotions. Cognitive-behavioral therapy can help you come to terms with the emotions that give richness and meaning to your life.
- **Improve your relationships.** Your anxiety may often be related to conflicts and misunderstandings in your relationships. Therapy can assist you in identifying these problematic issues, developing more effective ways of thinking about your relationships, and actively coping to make things better. Communication, listening, assertion, mutual problem solving, and increasing positive experiences can be important parts of your therapy.
- **Become a problem solver.** Worriers often generate a lot of problems that don't exist, but often avoid solving problems that they can address. This is because a lot of their anxiety is based on avoiding

(cont.)

experiences that make them anxious. Your therapist can help you become a practical and productive problem solver, which will make you more confident about "potential" problems.

MEDICATION

Depending on how severe your GAD is, and on whether depression is also part of the problem, your doctor may prescribe any number of medications that have proven effective for these disorders. Cognitive-behavioral therapy may be augmented with medication for anxiety disorders. Benzodiazepines and some antidepressants have been found useful for GAD. Your doctor can assist you with medication. You should never self-medicate.

HOW EFFECTIVE IS TREATMENT?

Until about 10 years ago, treatments for GAD had limited success. However, today the outcome is very promising for GAD and most other anxiety disorders. The newer forms of cognitive-behavioral therapy have proven quite effective for chronic worriers.

WHAT IS EXPECTED OF YOU AS A PATIENT?

The treatment of GAD requires your regular attendance in therapy and your willingness to carry out self-help homework assignments that can be very effective in helping you cope with your anxiety. Many patients also benefit from medication, which should only be taken as prescribed by your doctor.

FORM 4.8. Patient's Worry Log

Patient's name: _____

Content area for each worry	Factors in situation that bring out the worry	Prediction (Specify exactly what you think will happen and when it will happen)	Anxiety rating for each prediction (0-10)	Rating of confidence in accuracy of prediction (0-10)	Actual outcome (Exactly what happened?)	Anxiety rating at outcome (0-10)

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FORM 4.9. Questions to Ask Yourself If You Are Worrying: A Self-Help Form for Patients

Specific worry: _____

Questions to ask yourself:	Your response:
Specifically, what are you predicting will happen?	
How likely (0–100%) is it that this will actually happen? How negative an outcome are you predicting (from 0% to 100%)?	Likelihood: How negative:
What is the worst outcome? The most likely outcome? The best outcome?	Worst: Most likely: Best:
Are you predicting catastrophes (awful things) that don't come true? What are some examples of the catastrophes that you are anticipating?	
What is the evidence (for and against) your worry that something really bad is going to happen? If you had to divide 100 points between the evidence for and against, how would you divide these points? (For example, would it be 50–50? 60–40?)	Evidence for: Evidence against: Points: Evidence for = _____ Evidence against = _____
Are you using your emotions (your anxiety) to guide you? Are you saying to yourself, "I feel anxious, so something really bad is going to happen"?	
Is this a reasonable or logical way to make predictions? Why/why not?	
How many times have you been wrong in the past about your worries? What actually happened?	

(cont.)

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FORM 4.9. Questions to Ask Yourself If You Are Worrying (p. 2 of 2)

Questions to ask yourself:	Your response:
<p>What are the costs and benefits to you of worrying about this? If you had to divide 100 points between the costs and benefits, how would you divide these points? For example, would it be 50–50? 60–40?)</p>	<p>Costs:</p> <p>Benefits:</p> <p>Points: – _____ (costs) _____ (benefits)</p> <p>Subtract costs from benefits: _____ – _____ = _____</p>
<p>What evidence do you have from the past that worrying has been helpful to you and hurtful to you?</p>	
<p>Are you able to give up any control in order to be worried less?</p>	
<p>Is there any way that worrying really gives you any control, or do you feel more out of control because you are worrying so much?</p>	
<p>If what you predict happens, what would that mean to you? What would happen next?</p>	
<p>How could you handle the kinds of problems that you are worrying about? What could you do?</p>	
<p>Has anything bad happened to you that you were not worried about? How were you able to handle that?</p>	
<p>Are you usually underestimating your ability to handle problems?</p>	
<p>Consider the thing you are worried about. How do you think you'll feel about this 2 days, 2 weeks, 2 months, and 2 years from now? Why would you feel differently?</p>	
<p>If someone else were facing the events that you are facing, would you encourage that person to worry as much as you? What advice would you give him or her?</p>	

FORM 4.10. Challenging Your Core Beliefs

1. Identify your core beliefs about yourself and other people.
2. Examine the costs and benefits of these beliefs.
3. How has this belief affected you in the past?
4. Are you viewing yourself in all-or-nothing terms?
5. What is the evidence for and against your belief?
6. Would you be as critical of other people?
7. Is there some truth in your belief?
8. Can you act against your belief?
9. Can you develop a more positive belief?

Conclusions:

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FORM 4.11. Possible Interventions for Worrying: A Self-Help Guide for Patients

1. **Relax your mind and relax your body.** Practice muscle relaxation and mindful breathing. Learn how to stay in the moment and let go of your thoughts and tension.
2. **Examine the advantages of letting go of worry.** Be honest with yourself about your mixed motives about worrying. Part of you wants to decrease worry; the other part feels a need to worry to be prepared. The key here is knowing whether your worry will lead to productive action. If not, then it's useless mental energy.
3. **Keep in mind that a thought is a thought—it's not reality.** Keep your thoughts *in mind*, and recognize that reality is not the same thing as your thoughts. As you become a mindful observer of your breathing, you can practice simply *observing* your thoughts. You can stand back and say, "That's just another thought." And then you can practice saying, "Let it go."
4. **Ask yourself whether your worries are really rational.** Practice the cognitive therapy techniques you have learned. Examine the evidence for and against it; ask yourself what advice you would give a friend; review how many times you have been wrong in the past; and so on.
5. **Set aside "worry time," write out your predictions, and keep a worry log to test out what actually happened.** You will find that your worries are almost always false predictions, and you can set them aside for your worry time—which, let's hope, will eventually bore you!
6. **Validate your emotions.** Keep a daily journal of your emotions, both positive and negative. Identify why your emotions make sense, why they are not dangerous, and why other people would have many of the same feelings. Validate yourself.
7. **Accept uncertainty, and accept your limitations.** You can't control or know everything. It's not all up to you. The more you accept what you cannot do, the greater your sense of being empowered in the real world will become.
8. **Realize that it's not urgent.** You don't need to know right now. Nothing will happen if you don't know. But you can focus on enjoying the present moment—and making the best of the moment in front of you.
9. **Practice losing control.** Rather than trying to stop or control your worry, flood yourself with it. Surrender to the worry, repeat the worry, and bore yourself with constant repetitions of exactly the same worried thought. You will get bored and less worried.
10. **Similarly, try to go crazy.** You can't go crazy from your worry. But you can learn that letting go of control allows you to overcome your fear of losing control.
11. **Practice your worst fears.** Imagine the worst outcome, and repeat imagining it. You will find that with time, your images and thoughts will become boring. Think about it: The "cure" is boredom?

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Social Anxiety Disorder (Social Phobia)

DESCRIPTION AND DIAGNOSIS

Symptoms

Social anxiety disorder (abbreviated in the text of this chapter as SAD; also still referred to by its older name of social phobia) is excessive fear of one or more social situations. Situations that commonly evoke anxiety include giving speeches and other kinds of public performances, attending social gatherings, meeting new people, eating in public, using public restrooms, disagreeing with others, and speaking to authority figures. Faced with such situations, people who suffer from SAD anticipate that others will make negative judgments about them. They may fear being judged for failing to perform adequately, or simply for appearing anxious.

Some people are afraid of only one or two social situations. This form of the disorder is referred to as “discrete” or “performance” SAD. “Generalized” SAD involves fear of a wide range of social situations. Many people who present with discrete fears turn out to have some generalized fears as well. In fact, over two-thirds of people with SAD have the generalized form (Belzer, McKee, & Liebowitz, 2005). In one study, researchers found that the average number of situations feared by people with SAD was seven, with over 93% reporting three or more fears (Grant et al., 2005).

People with SAD either avoid situations they fear or experience significant anxiety while in them. They commonly report physical symptoms including palpitations, trembling, sweating, muscle tension, stomach pain, dry throat, hot or cold flashes, and headaches. For some patients, the physical symptoms reach the level of a full-blown panic attack (Heckelman & Schneier, 1995; Judd, 1994).

SAD can result in serious impairment of academic, occupational, and social functioning. People with SAD have lower average educational achievement and lower average socioeconomic status; they are also more likely to be single, divorced, or separated (Belzer et al., 2005; Judd, 1994).

A number of researchers have proposed that SAD is related to typical social anxieties that exist on a continuum of severity in the general population. Between 20% and 40% of nonclinical samples report feeling shy (Rapee, 1995). In this view, SAD is a more extreme manifestation of these common fears (Belzer et al., 2005).

For a detailed description of the diagnostic criteria for SAD, refer to DSM-IV-TR (American Psychiatric Association, 2000, pp. 450–456).

Prevalence and Life Course

Lifetime prevalence estimates for SAD range from 3% to 13% (Ponniah & Hollon, 2008; Rowa & Antony, 2005). The National Comorbidity Survey Replication (Kessler, Berglund, et al., 2005) found that 12.1% of the U.S. population met criteria for SAD at some point in life, making SAD the fourth most common psychiatric disorder. Women are estimated to be 1.5–2 times as likely as men to have SAD. However, men are represented in equal or greater numbers in clinical samples. The clinical findings may be due to the fact that traditional male roles demand greater assertion, both in dating and in careers; therefore, the symptoms of SAD are likely to be more disturbing to males (Belzer et al., 2005; Chapman, Mannuzza, & Fyer, 1995; Figueira & Jacques, 2002).

The modal age of onset for SAD is between 11 and 16 years. However, many patients report onset in early childhood. SAD rarely emerges after the early 20s, unless precipitated by medical illness or some other change in life circumstances (Belzer et al., 2005; Grant et al., 2005; Rapee, 1995).

The course of SAD is typically chronic and unremitting. Left untreated, generalized SAD can lead to a downward spiral of impaired functioning as people struggle with major developmental tasks, such as school, peer relationships, career, and marriage. Compared to persons with other psychiatric diagnoses of similar severity, people with SAD are significantly less likely to seek treatment: Fewer than 20% of those who meet criteria for the diagnosis ever receive any type of help. The mean age of presentation for treatment is between 27 and 30, and most patients have been suffering with the disorder for 15 years or more before their first contact with the mental health system. The same fears of social judgment and humiliation that define SAD probably make it difficult for people to seek treatment, and those with the disorder often attribute their difficulties to “normal shyness” or to some fixed character defect (Belzer et al., 2005; Curtis, Kimball, & Stroup, 2004; Rapee, 1995).

Genetic/Biological Factors

SAD runs in families. People with first-degree relatives who meet criteria for SAD are 2–3 times more likely to have the disorder than members of the general population, and relatives of people who have the generalized form of SAD are 10 times as likely to have SAD themselves (Merikangas, Lieb, Wittchen, & Avenevoli, 2003). However, genetic transmission accounts for only about 30% of the variance in SAD. The rate of SAD among the children of parents who have SAD is higher than can be explained by genetics alone (Brook & Schmidt, 2008). Thus parenting style and other learning history factors are believed to play a role in the development of the disorder.

Parents who are overcontrolling and overprotective, and/or those who are critical and rejecting, are more likely to have socially anxious children. The parents' own anxiety frequently contributes to these behaviors. Recent research has also suggested a connection between maternal stress during pregnancy and the subsequent development of anxiety in children, including social

fears. Other experiences that have been found to predict increased likelihood of SAD include separation from or death of parents; marital discord; family violence; sexual or physical abuse; childhood illness; and bullying by peers. Women, as well as persons with lower education and lower income, are more likely to develop the disorder (Brook & Schmidt, 2008; Merikangas et al., 2003).

Neuroendocrine mechanisms involving the hypothalamic–pituitary–adrenal (HPA) axis have been implicated in SAD. These include increased activation of norepinephrine, exaggerated sensitivity of serotonin receptors, dysregulation of gamma-aminobutyric acid receptors, decreased levels of dopamine, and increased release of cortisol. Imaging studies have found alterations in functioning in the prefrontal cortex, amygdala, and hippocampus. Hypofunction of the prefrontal cortex is believed to be associated with decreased ability to modulate fear responses, while hyperarousal of the amygdala is associated with increased anxiety. Alterations in the hippocampus are involved in the formation of memories of fear cues and responses (Antai-Otong, 2008).

A diathesis–stress model appears to best explain the development of SAD, with a genetic/biological predisposition that can be potentiated by stressful life events (including maternal stress during pregnancy, illness, controlling and/or rejecting parenting, family conflict, abuse, and negative interactions with peers). The result can be an anxiety response system involving the HPA axis that is permanently set on “high” and learned fear responses to social cues mediated by the prefrontal cortex, amygdala, and hippocampus (Antai-Otong, 2008; Brook & Schmidt, 2008).

Coexisting Conditions

Comorbidity is common for SAD. Between 50% and 80% of people with SAD are estimated to suffer from at least one additional DSM disorder. The most common coexisting Axis I conditions are depressive disorders (41–56% estimated prevalence), other anxiety disorders (50–54%), and substance abuse (39–48%) (Belzer et al., 2005; Curtis et al., 2004; Figueira & Jacques, 2002; Grant et al., 2005; Zaider & Heimberg, 2003). In the majority of cases, SAD precedes the comorbid conditions. Depression and substance abuse are often secondary to SAD (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992).

Axis II disorders are found in over 50% of patients with SAD. The most common is avoidant personality disorder (APD). In fact, 56% of patients with generalized SAD also meet criteria for APD, and it has been argued that APD represents the most severe manifestation of SAD disorder rather than being a distinct disorder. Patients with SAD also have increased prevalence of dependent, obsessive–compulsive, paranoid, and schizoid personality disorders (Belzer et al., 2005; Grant et al., 2005).

Comorbidity can affect treatment outcome. Patients with SAD and comorbid anxiety disorders appear to respond similarly to those with uncomplicated SAD; however, the presence of major depressive disorder predicts more severe social anxiety before and after treatment, as well as slower response to treatment. Similarly, patients with APD are typically more impaired and have poorer treatment outcome. However, it should be noted that patients with all forms of comorbidity have been shown to benefit from cognitive-behavioral treatment and to maintain their gains at follow-up (Rodebaugh, Holaway, & Heimberg, 2004; Zaider & Heimberg, 2003).

Differential Diagnosis

SAD may be difficult to differentiate from panic disorder and agoraphobia. Although some patients with SAD have panic attacks, these are always triggered by social or performance situations. In addition, during panic attacks, they fear that others will notice and judge them for their anxiety symptoms, whereas patients with panic disorder fear physical harm from the symptoms. If unexpected panic attacks occur in the absence of social cues, an additional diagnosis of panic disorder should be considered.

Patients with SAD may have substantial avoidance that restricts their functioning and can resemble agoraphobia. However, in SAD the avoided situations always involve social interaction and the fear of judgment, whereas in agoraphobia patients fear situations in which they could have an unexpected panic attack or other uncomfortable symptoms and be unable to escape or get help. Therefore, patients with SAD typically feel most comfortable when they are alone, whereas patients with agoraphobia are typically more comfortable when others are present. Patients with generalized anxiety disorder may have excessive worries related to a number of issues, including social situations. If there is a fear of being embarrassed or humiliated, an additional diagnosis of SAD should be given.

Social withdrawal and hypersensitivity to criticism may be present in major depression and in the depressive phase of bipolar disorders. However, these symptoms are mood-dependent and remit when the depressive episode resolves. In schizophrenia and other psychotic disorders, and in schizoid and schizotypal personality disorders, avoidance of social contact is due to lack of interest in others and/or delusional fears of harm. In SAD (and APD), there is a desire for social interaction; however, this desire is inhibited by fears of humiliation or embarrassment (Donohue, Van Hasselt, & Hersen, 1994; Heckelman & Schneier, 1995).

A diagnostic flow chart for SAD (Figure 5.1) illustrates the differential diagnosis of this disorder in more detail.

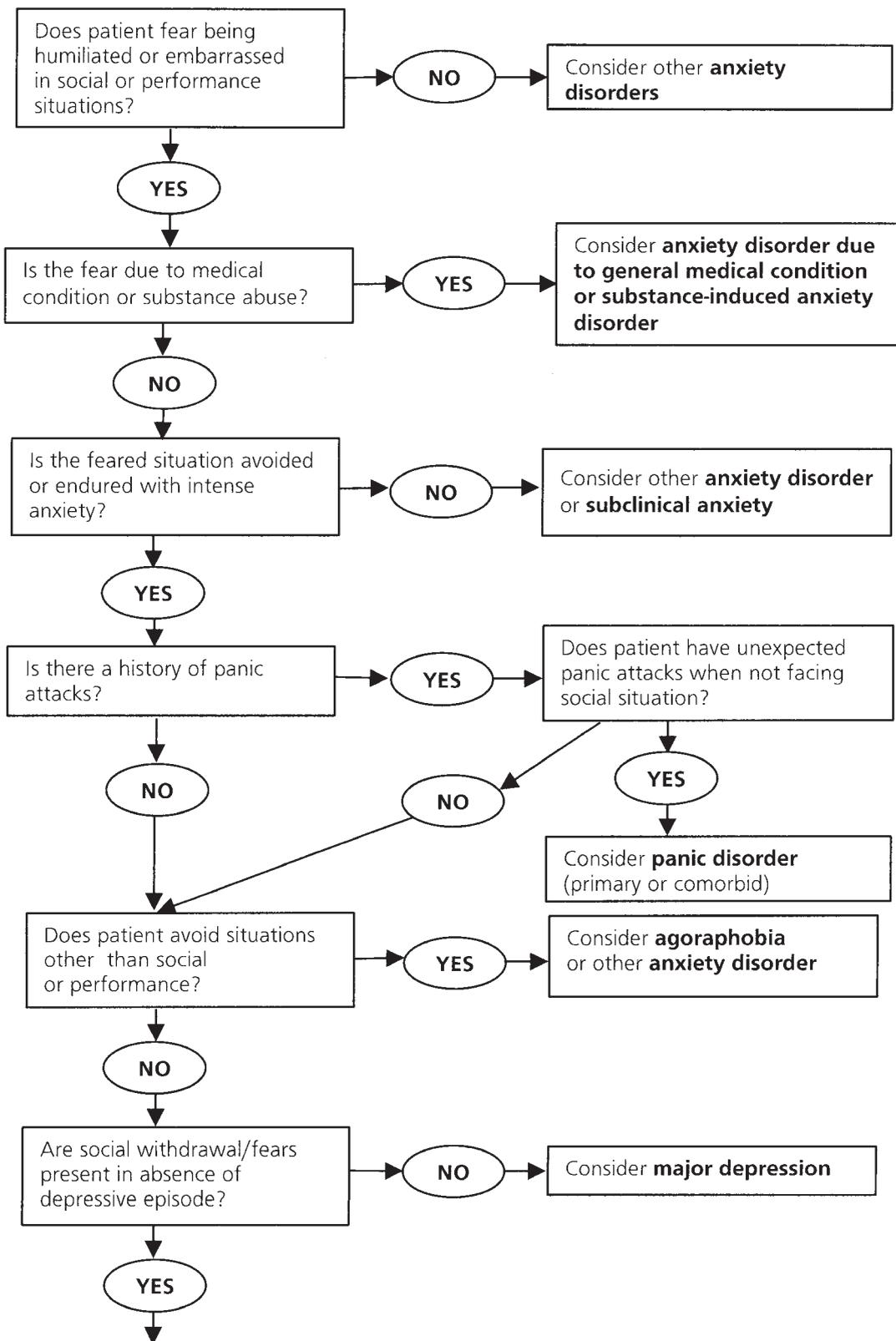
UNDERSTANDING SOCIAL ANXIETY DISORDER IN COGNITIVE-BEHAVIORAL TERMS

Form 5.1, which is intended for use as a patient handout, illustrates our overall cognitive-behavioral conceptualization of SAD. We now discuss the various factors that lead to and maintain SAD.

Behavioral Factors

Conditioning Models

As with other anxiety disorders, Mowrer's (1960) two-factor theory provides a model for understanding the role of conditioning in the acquisition and maintenance of SAD. The experience of traumatic or embarrassing social interactions may cause a person to acquire a conditioned response of anxiety, embarrassment, and/or humiliation. This conditioned response can then be evoked by similar social situations in the future. The range of social cues that elicit the fear response may expand over time through generalization. In addition, it is believed that social fears can be learned through vicarious observation of other people's fear responses of others (Öst &



(cont.)

FIGURE 5.1. Diagnostic flow chart for social anxiety disorder.

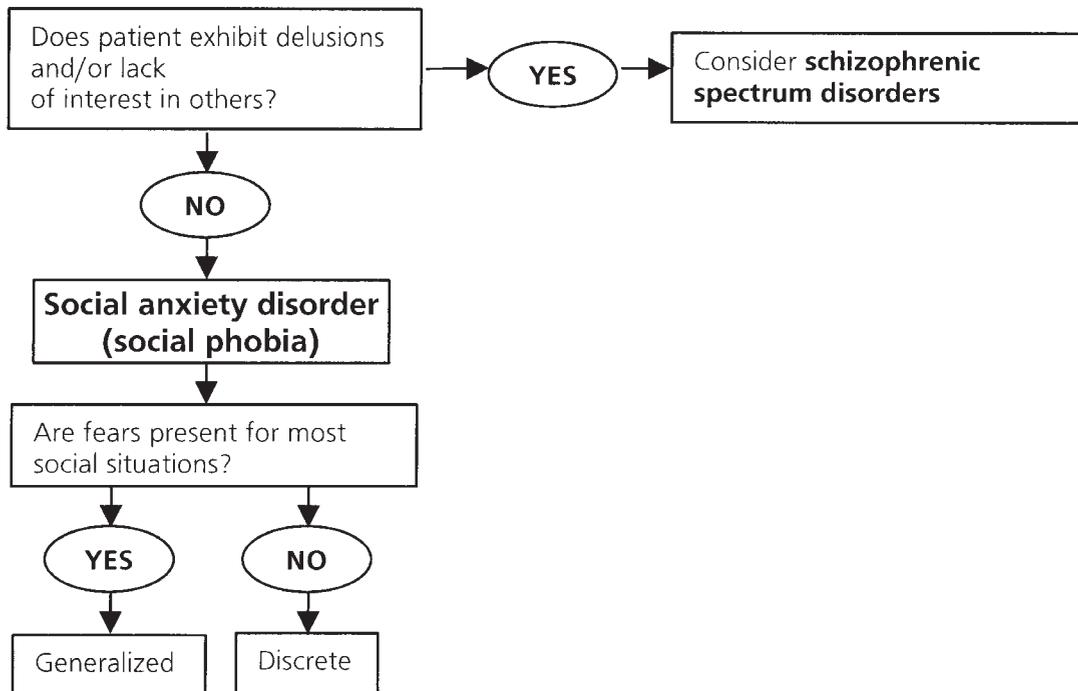


FIGURE 5.1 (cont.)

Hugdahl, 1981). Patients with SAD can often recall a number of experiences of embarrassment and rejection at the hands of caregivers and/or peers.

The concept of “preparedness” (Seligman, 1971) has also been used to help explain the acquisition of social fears. Seligman suggests that species are genetically predisposed to acquire fears to stimuli that have posed survival threats in their evolutionary past. Such “prepared” fears are characterized by rapid acquisition, high resistance to extinction, and apparent irrationality (Mineka & Zinbarg, 1995). Applying this concept to SAD, Baumeister and Tice (1990) point out that humans generally cannot survive in isolation. It would therefore be adaptive to have a mechanism for inhibiting behavior likely to lead to social exclusion. Such a mechanism would involve anxiety as a signal to terminate problematic behavior. Leahy (2009) has suggested that SAD is related to dominance hierarchies found in humans and other species. Behaviors typical of patients with SAD, such as gaze aversion and avoiding disagreement, may be seen as efforts to avoid attack by higher-status individuals. Research with nonhuman species supports the hypothesis that social fears may be “prepared” (Mineka & Zinbarg, 1995).

Regardless of how conditioned fears of social situations are acquired, avoidance serves to maintain them. When patients with SAD avoid feared situations, they experience a decrease in anxiety, which reinforces the avoidance behavior. At the same time, such avoidance prevents these patients from experiencing social situations without negative consequences, and therefore from having their conditioned fears extinguished.

Skills Deficit Model

A second behavioral factor proposed to help explain SAD is a deficit in social skills. Some studies that have looked at the social performance of individuals with SAD have found that they are rated by outside observers as less competent than nondisordered controls. However, this finding is not consistent across all studies. One consistent result is that individuals with SAD underestimate their own competence and overestimate the degree to which they are perceived as anxious, compared to ratings of their performance by others (Herbert et al., 2005; Rapee, 1995).

Even when people with SAD are rated as less socially competent than average, it cannot be assumed that the cause is always absence of social skills. Social performance may be inhibited by anxiety or interfered with by maladaptive coping strategies such as “safety behaviors” (see below). In fact, people with SAD exhibit a range of knowledge of and competence with social skills (Heimberg, 2002; Herbert et al., 2005; Marks, 1985).

Cognitive Factors

D. M. Clark and Wells (1995) and Rapee and Heimberg (1997) have proposed similar models of the role of cognition in SAD. At the core of both models is the concept of a perceived audience. According to these models, people with SAD have a mental representation of a person or group of people who will be observing and evaluating their performance. Key beliefs are these:

1. The target audience is observing the person's behavior.
2. The audience has a high standard for approval.
3. The person is not competent to meet the standard.
4. The person will be unable to control the resulting anxiety, which will be noticed by others and cause additional negative evaluation.
5. The cost of negative evaluation by the audience will be high.

At core, people with SAD see themselves as inadequate, defective, and/or undesirable.

These dysfunctional beliefs are maintained by distorted cognitive processing before, during, and after anxiety-provoking social events. Before an event, people with SAD make excessively negative, catastrophic predictions about what will happen. They engage in worry about their performance, and may attempt to rehearse and prepare themselves for the event, in the belief that this will help reduce their anxiety. In fact, this focus on possible negative outcomes increases anticipatory anxiety.

During the event, socially anxious people selectively attend to signs of possible poor performance. Any negative or ambiguous social feedback will be noticed and taken as a sign of impending failure; this in turn increases anxiety. At the same time, the people with SAD also attend to their own internal experience, monitoring their performance and paying particular attention to signs of anxiety, including physical cues. Given that the persons are almost certainly anxious, this self-monitoring results in even greater anxiety. Furthermore, allocating so much attentional capacity to internal cues means that the persons are likely to miss important external

social cues. This may result in poorer actual social performance. It may also prevent the persons from noticing social feedback that might contradict their negative perceptions.

In addition to focusing on signs of threat during a social event, people with SAD often engage in what are called “safety behaviors.” These behaviors are meant to protect the persons from possible embarrassment or failure. The behaviors may include acts of commission, such as holding a glass very tightly to prevent a hand from shaking, or acts of omission, such as avoiding asking questions in order not to look foolish. The problem is that these safety behaviors, like all forms of avoidance, prevent the persons with SAD from testing and possibly disconfirming their negative beliefs. Furthermore, safety behaviors, like excessive internal focus, can inhibit effective social performance.

Finally, in “postmortem” processing, people with SAD replay an event over and over in their minds, evaluating their performance. Often they are trying to reduce their anxiety by checking for any possible social gaffes. The problem is that this after-the-fact review is subject to the same negative informational biases as the processing before and during the event. As a result, the post-mortem only serves to reinforce the persons’ negative beliefs, resulting in equal or greater anxiety in anticipation of the next social situation.

There is significant experimental evidence for several elements of this cognitive model. People with SAD have been found to have higher frequency of negative thoughts and a lower proportion of positive to negative thoughts. In social situations, they are more likely to make negative self-evaluations. They are also more likely to report images of their performance from the perspective of other people. They more frequently endorse perfectionistic standards for social behavior. Socially anxious individuals also predict a greater likelihood of negative social interactions, estimate that negative outcomes will have a higher cost, and see themselves as less capable of coping with negative events. They are more likely to interpret ambiguous situations negatively. Faced with negative outcomes, they more often view themselves as responsible and make attributions to internal, global, and stable causes. People with SAD show attentional bias to social threat. They are also more likely to attend to internal cues and signs of anxiety during a performance task, and underestimate their performance relative to observers’ ratings (Heimberg & Becker, 2002; Hofmann & Otto, 2008; Ponniah & Hollon, 2008; Rowa & Antony, 2005). Table 5.1 shows typical negative automatic thoughts that occur before, during, and after social events. Table 5.2 shows typical cognitive distortions and dysfunctional schemas in SAD.

OUTCOME STUDIES OF TREATMENTS FOR SOCIAL ANXIETY DISORDER

A number of behavioral and cognitive techniques have been developed for treating SAD, based on the conceptual models outlined above.

Exposure

Exposure treatments are designed to extinguish conditioned fear responses to social cues. This is accomplished by having patients expose themselves repeatedly to the feared cues until their anxiety decreases. As with other anxiety disorders, exposure in SAD may be imaginal (i.e., patients imagine themselves in a feared situation) or *in vivo* (i.e., patients engage in a feared social

TABLE 5.1. Typical Distorted Automatic Thoughts in Social Anxiety Disorder at Each Stage of an Interaction

Categories of distorted	Thoughts before entering interaction	Thoughts during interaction	Thoughts after interaction (the “postmortem”)
Mindreading	“People will see that I am a nervous wreck.”	“She can see that I am anxious. She sees my hands trembling.”	“Everyone saw that I was nervous and that I was losing my train of thought.”
Fortunetelling	“My mind will go blank.”	“I’ll never get through this conversation.”	“I will continue to mess up any time I meet new people.”
Negative filter	“My hand will tremble.”	“I just lost my train of thought.”	“I didn’t tell the story the right way.”
Discounting the positives	“Even though some people like me, there are always people who won’t like me.”	“Even though I am doing OK right now, I could always still mess it up.”	“Even though people seemed interested in my conversation, no one asked me out.”
Catastrophizing	“If I look anxious, it will be just awful.”	“If I keep getting more anxious here, I will be totally unable to speak.”	“I can’t stand the fact that she didn’t seem interested in me.”
Personalizing	“I’ll bet no one else has these fears of speaking.”	“I can see that everyone is focusing on me and noticing what a nervous wreck I am.”	“I was probably the only person at the party who was so uninteresting.”
Labeling	“I’m inept.”	“I must be a loser.”	“I was a loser.”
All-or-nothing thinking	“I am continually messing up when I meet people.”	“My entire performance so far is a disaster.”	“I totally messed up—there was nothing positive in this.”

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activity outside the therapist’s office). Exposure may also be accomplished through the use of role-play exercises, in which patients act out feared situations, either with the therapist or with other members of a treatment group. Patients are encouraged during exposure to focus attention on the feared cues and their anxiety responses, and to resist the urge to use distraction or other coping techniques.

Most commonly, patients are asked to construct a hierarchy of feared social situations,

TABLE 5.2. Examples of the Three Types of Cognitive Distortions in Social Anxiety Disorder

Distorted automatic thoughts

“I won’t be able to think of anything to say.”
“I’ll say something stupid.”
“I’ll freeze.”
“I’m boring.”
“My face is hot. I’m blushing.”
“My hands are shaking.”
“I’m losing control.”
“Everybody is looking at me.”
“People can tell I’m nervous.”
“I’m a loser.”
“They think I’m stupid.”
“They’re better/smarter/funnier than me.”
“They think I’m a fool.”
“That was terrible.”
“No one liked me.”
“I blew it again.”

Maladaptive assumptions

“If I’m quiet, people will think I’m boring.”
“I have to have something intelligent or witty to say.”
“If I’m not perfect, they’ll reject me.”
“If someone doesn’t like me, it means there is something wrong with me.”
“If they see I’m anxious, they’ll think I’m incompetent.”
“I have to make a good impression.”
“I must get everyone’s approval.”
“I must not show any signs of weakness.”
“If I disagree with someone, they’ll get mad or think I’m stupid.”

Dysfunctional schemas

“I’m odd.”
“I’m different from everyone else.”
“I’m weird.”
“I’m a nerd.”
“I’m stupid.”
“I’m ugly.”
“I’m weak.”
“I don’t have what it takes to be successful.”
“I’m not likeable.”
“I’m inadequate.”

ranked from least to most anxiety-producing. Exposure begins with a cue or situation that evokes moderate anxiety. Exposure to this cue is initiated in session, if possible, and continued until the patient begins to habituate to it (i.e., the anxiety begins to decrease). Subsequently, the patient is assigned to engage in *in vivo* exposure to the same situation independently between sessions. The therapist may accompany the patient on *in vivo* exposures if the patient has difficulty doing them on his or her own. Once the patient's anxiety to the first cue has reduced significantly, the exposure to the next highest cue on the hierarchy is initiated. Exposure continues until all items on the hierarchy have been covered and the patient is able to engage in them with minimal anxiety.

Applied Relaxation

Applied relaxation (Öst, 1987) aims to substitute a new conditioned response (relaxation) for the old conditioned response (fear). Patients are trained in progressive muscle relaxation (see Chapter 9 and Appendix A). Once they gain proficiency with the full version of progressive muscle relaxation, they are taught a series of increasingly shorter relaxation exercises and encouraged to practice them between sessions until they are able to relax quickly and automatically to a cue word. Then patients are asked to practice relaxation in non-anxiety-provoking situations. Finally, they are assigned to engage in anxiety-provoking social situations and apply relaxation skills when they become anxious.

Social Skills Training

Social skills training is based on the assumption that people with SAD lack adequate social skills. The content varies from program to program (e.g., Stravynski, Marks, & Yule, 1982; Turner, Beidel, Cooley, Woody, & Messer, 1994), but generally includes such skills as introducing oneself, choosing appropriate topics of conversation, active listening, empathy, self-disclosure, initiating social activities, initiating and maintaining friendships, expressing disagreement, assertion, and public speaking. Therapists teach skills by providing specific instructions, modeling skills, having the patients role-play the skills, providing feedback, and assigning homework to practice the new skills in naturally occurring social situations.

Cognitive Restructuring

Cognitive restructuring seeks to modify patients' dysfunctional beliefs about social situations. Several different approaches to cognitive restructuring have been used, including rational–emotive therapy (Ellis, 1962), self-instructional training (Meichenbaum, 1977), and cognitive therapy (Beck, 1976). Although the approaches differ somewhat in emphasis, all three teach patients to identify negative beliefs and substitute more adaptive beliefs. Cognitive therapy, which has been the most studied cognitive intervention for SAD, involves teaching patients to identify maladaptive automatic thoughts in response to anxiety-provoking situations. These thoughts are challenged by using a variety of techniques, including Socratic dialogue, gathering of evidence, and behavioral experiments (see Chapter 10 and Appendix B). Patients are taught to substitute more realistic, “rational” responses for their automatic negative thoughts (Beck, 1976).

Mindfulness

Mindfulness meditation has been proposed as a potential treatment for SAD. It is believed that training in nonjudgmental awareness of experience may help counter the tendency of socially anxious people to focus on negative self-evaluation and may also reduce physiological reactivity. A program based on Kabat-Zinn's (1994) mindfulness-based stress reduction protocol has been applied to SAD. Patients are provided with psychoeducation about stress and meditation, and are taught techniques such as body scan, mindful yoga, and sitting meditation. Participants are expected to practice these techniques daily (Koszycki, Bengner, Schlik, & Bradwejn, 2007).

Combination Treatments

Several studies have used combinations of the techniques outlined above, including social skills training plus cognitive modification; exposure plus anxiety management training; exposure plus cognitive restructuring; and exposure, cognitive restructuring, and skills training (Ponniah & Hollon, 2008).

Heimberg and colleagues have developed a program called cognitive-behavioral group therapy (CBGT), which includes three primary components: in-session exposure to feared social cues; cognitive restructuring based on Beck's (1976) model; and weekly homework of self-directed *in vivo* exposure and cognitive restructuring. Participants develop a hierarchy of feared social situations. For each item on the hierarchy, exposure is done first in session via role plays with other group members. Behavioral goals for the role play are set in advance. Social skills training is not explicitly included unless a patient demonstrates skills deficits. In-session exposure exercises generally take 5–10 minutes and are continued until the patient begins to experience a decrease in anxiety and the behavioral goals for the interaction are met. Negative thoughts are elicited and challenged before, during, and after each in-session exposure, and rational responses are developed. The group then helps the participant design behavioral experiments to test negative beliefs and *in vivo* exposures to practice between sessions. Participants are told to use their cognitive restructuring skills before, during, and after self-directed exposures as well. CBGT consists of 12 weekly sessions of 2.5 hours each (Heimberg & Becker, 2002). The treatment has also been adapted to an individual therapy format (Hope, Heimberg, & Turk, 2006).

D. M. Clark and colleagues have developed a program that combines cognitive techniques and exposure, and that includes additional procedures designed to address the problematic cognitive processing that Clark and Wells (1995) hypothesize maintains SAD. They have applied this program in both individual and group formats. Specifically, their protocol targets (1) excessive self-focused attention during social interactions; (2) use of internal cues to create unrealistically negative appraisals of actual social performance; (3) use of safety behaviors; and (4) pre- and postevent processing that reinforces negative beliefs. One key intervention is a behavioral experiment in which patients role-play a social interaction using their typical internal evaluative focus and safety behaviors, and then repeat the role play but drop the self-focus and safety behaviors. The purpose of the experiment is to demonstrate the negative impact of self-focus and safety behaviors on social performance. In a second experiment, patients rate their beliefs about how they performed in the first exercise and then observe a video recording of the role plays. This helps patients see that their self-appraisal based on their internal experience is more negative than how they appear externally. In addition, patients are taught to shift their focus from

internal cues to external cues, and are encouraged to practice this skill during role plays and *in vivo* exposures.

Behavioral experiments are conducted both in session and as homework to test patients' negative beliefs about the likelihood and costs of negative outcomes. Although these exercises take the form of exposure, patients are given an explanation emphasizing information gathering and hypothesis testing rather than habituation. For example, patients may be asked to deliberately exaggerate or call attention to anxiety symptoms they normally try to hide (e.g., blushing or sweating), so that they can learn that other people are unlikely to notice and that the consequences, if they do, are minimal and tolerable. Patients are also taught to forgo excessive worry before and after events.

Finally, dysfunctional core assumptions, such as beliefs about personal inadequacy or perfectionistic standards, are identified and modified via behavioral experiments and cognitive restructuring (D. M. Clark et al., 2006; McManus et al., 2009; Mörtberg, Clark, Sundin, & Wistedt, 2007). For example, an imagery-rescripting technique may be used to modify the meanings attached to early memories that contribute to negative self-image. In this exercise, a key memory is identified, and a patient is asked what beliefs are associated with the memory. These beliefs are initially challenged by using standard cognitive techniques. Then the patient is asked to relive the memory in three stages. In the first stage, the patient relives the memory as it happened from the perspective of him- or herself at the age of the event. Second, the patient relives the event from the perspective of his or her adult self, intervening on behalf of their childhood self if they wish. Finally, the patient relives the memory again from the perspective of his or her childhood self, with the adult self present. The childhood self is asked what else it might want from the adult self to help feel better (Wild, Hackmann, & Clark, 2008).

Hofmann and Scepkowski (2006) have tested a program called social self-reappraisal therapy for SAD. This program combines a group format with individual therapist-assisted exposure. As the name implies, social self-reappraisal therapy emphasizes modifying people's perception of their social abilities. It targets many of the same processes as D. M. Clark's model and uses similar techniques, including training in shifting attention from internal to external cues; feedback regarding patients' actual social performance, using video and audio recording, mirror exercises, and input from other group members; helping patients drop safety behaviors; and modifying postevent processing through guided questions meant to help patients accurately assess the actual costs of any perceived negative events. Additional techniques include helping patients identify specific goals for social interactions and problem-solve ways to achieve those goals; helping patients evaluate their performance based on whether they achieved their goals, rather than on their level of anxiety; and prolonged exposure to physiological signs of anxiety, in order to increase patients' tolerance of anxiety and perception of ability to manage their emotions during social interactions (Hofmann & Otto, 2008).

Results

Several meta-analyses (Chambless & Hope, 1996; Federoff & Taylor, 2001; Feske & Chambless, 1995; Gould, Buckminster, Pollack, Otto, & Yap, 1997; Taylor, 1996) have examined the efficacy of the cognitive-behavioral treatments for SAD described above. These studies found that patients receiving applied relaxation, social skills training, exposure, cognitive restructuring, and

exposure combined with cognitive restructuring all performed better than waiting-list controls. No significant differences were found between the different treatment conditions. Gains were generally maintained at follow-up periods of up to 12 months. Individual and group treatments were equally effective.

All of the meta-analyses cited above were completed before 2001, and several additional clinical trials have been conducted since then. Ponniah and Hollon (2008) reviewed 30 randomized controlled trials published through 2005. They found that the combination of exposure and cognitive restructuring met criteria to be considered an efficacious and specific treatment for SAD, meaning that studies had shown it to be more effective than placebo and/or alternative treatments. The studies cited included treatments that combined exposure with rational-emotive therapy, Heimberg's cognitive therapy approach (Heimberg & Becker, 2002), and D. M. Clark et al.'s (2006) cognitive treatment. Exposure plus cognitive restructuring was found to be more effective than pill placebo, placebo plus self-directed exposure, fluoxetine plus self-directed exposure, and educational supportive group therapy. Ponniah and Hollon (2008) also found that exposure alone was an efficacious treatment for SAD, meaning that it had been shown to be more effective than no treatment, but had not been demonstrated to be more effective than alternative treatments. They found little evidence to support the effectiveness of social skills training. They found some evidence that individual treatment produced better outcome than group therapy.

Studies directly comparing exposure to exposure plus cognitive restructuring have yielded mixed results, with some studies showing no difference and some showing better outcomes for the combined treatment (Ponniah & Hollon, 2008). In a more recent study, D. M. Clark et al. (2006) found that their treatment combining exposure with cognitive restructuring outperformed exposure plus applied relaxation. Alternatively, Nortje, Posthumus, and Moller (2008) found CBGT and exposure alone equally effective in treating patients with generalized SAD. Several authors have suggested that exposure and cognitive restructuring are difficult to differentiate both conceptually and practically, since both specifically aim to provide new learning experiences that contradict patients' beliefs about the likelihood and cost of negative social outcomes (Hofmann & Otto, 2008; Rodebaugh et al., 2004). Exposure has been shown to lead to cognitive change (Ponniah & Hollon, 2008), and cognitive techniques, especially behavioral experiments, often involve exposure-like experiences.

Heimberg's CBGT (Heimberg & Becker, 2002) has been subjected to more clinical trials than any other treatment and is often considered the "gold standard" treatment for SAD. It has been found superior to no-treatment and placebo conditions, and gains have been maintained at follow-up periods as long as 6 years (Heimberg, 2002; Hofmann & Otto, 2008; Rowa & Antony, 2005).

Recent trials of the D. M. Clark and Hofmann treatment protocols, which include additional techniques designed to address patients' self-directed attention, reliance on safety behaviors, and distorted perception of actual social performance, have reported larger effect sizes than those obtained in earlier trials of CBGT (e.g., D. M. Clark et al., 2006; Hofmann & Scepkowski, 2006). Studies by Clark's group found evidence of immediate reduction in social anxiety following key interventions in their program—for example, training in dropping self-focus and safety behaviors, along with video feedback (McManus et al., 2009); and rescripting of memories related to social fears (Wild et al., 2008). Rapee, Gaston, and Abbott (2009) compared cognitive

restructuring plus *in vivo* exposure to cognitive restructuring, *in vivo* exposure, and two additional components (instructions to drop safety behaviors during exposures, video feedback). The augmented treatment had better outcome.

In spite of these promising findings, it should be noted that no study has directly compared Heimberg's CBGT to one of the newer treatments. There are several possible alternative explanations for the larger effect sizes found in more recent studies, including improved measurement and more severe cases in the populations tested (Rodebaugh et al., 2004). In a recent meta-analysis, Aderka (2009) looked at the question of whether video feedback improved outcome. Examining clinical trials conducted since 2000, he found no significant effect for video feedback. He did, however, find a modest effect favoring individual over group therapy. Further research is needed to ascertain the extent to which recent innovations improve outcome over exposure plus standard cognitive restructuring techniques. Another alternative treatment, mindfulness-based stress reduction, has recently been compared to CBGT. CBGT resulted in greater reduction in social anxiety (Koszycki et al., 2007).

Herbert et al. (2005) compared CBGT to CBGT plus social skills training. The group that received social skills training had better outcome. However, the CBGT protocol used in this study specifically excluded any elements of social skills training, unlike standard CBGT. Preliminary studies suggest that virtual reality can be an effective form of exposure to feared social situations; however, no evidence exists that virtual reality produces better outcome than standard exposure procedures (Anderson, Rothbaum, & Hodges, 2003; Klinger et al., 2005).

There are relatively few studies of treatment of SAD in children. Those that have been done have found that cognitive-behavioral therapy is effective. There is also evidence that involving parents in the treatment may improve outcome (Curtis et al., 2004; Rodebaugh et al., 2004).

Although it is a consistent finding across many studies that most patients benefit to some degree from cognitive-behavioral therapy for SAD, it is also widely recognized that a substantial portion of patients respond poorly or incompletely. For example, Eng, Roth, and Heimberg (2001) reported that 65% of patients treated with CBGT were rated as improved, compared to 35% who received an educational support group. This means that a third of patients treated with CBGT did not improve. Although some other studies have reported higher rates of improvement (D. M. Clark et al., 2006), it is also known that many patients who do benefit from treatment continue to have residual symptoms and impaired functioning (Aderka, 2009; Ponniah & Hollon, 2008).

Several studies have examined factors that mediate outcome. Patients' expectancy of treatment benefit and homework compliance are related to positive outcome, whereas higher frequency of negative thoughts during social interactions predicts poorer outcome. Patients with generalized SAD and/or APD, and patients with comorbid depression, benefit from treatment but have poorer initial and end-state functioning. Comorbid anxiety disorders do not appear to affect treatment (Heimberg, 2002; Rodebaugh et al., 2004).

Cognitive-Behavioral Treatment and Medication

Studies comparing the effectiveness of cognitive-behavioral therapy to medication have yielded mixed results. The meta-analysis by Gould et al. (1997) found no difference between cognitive-behavioral treatment and medication. Federoff and Taylor (2001) found superior outcome in their meta-analysis for the benzodiazepine clonazepam (Klonopin) over cognitive-behavioral

treatment, but found the SSRIs and monoamine oxidase inhibitors to have outcomes equivalent to those for cognitive-behavioral therapy.

Individual studies conducted since 2001 have continued to yield mixed results. Heimberg et al. (1998) compared CBGT to phenelzine (Nardil). The treatments yielded equivalent numbers of patients rated as responders; however, phenelzine was superior on some measures. A follow-up study of the same patients found that after 12 months, significantly more of the patients with generalized SAD who had been treated with phenelzine than of those treated with CBGT relapsed (Liebowitz et al., 1999). Davidson et al. (2004) compared cognitive-behavioral treatment to fluoxetine (Prozac). They found that patients treated with fluoxetine had a more rapid response, but that the two treatments were equivalent at the end of treatment. D. M. Clark et al. (2003) found that their version of cognitive-behavioral therapy yielded superior outcome compared to fluoxetine plus self-directed exposure. Taken as a whole, these results suggest that cognitive-behavioral treatment and medication are roughly equivalent in efficacy. Medication may result in more rapid improvement, while CBT may provide more enduring results and reduce the risk of relapse (Rodebaugh et al., 2004).

There is little evidence to suggest that combining cognitive-behavioral therapy and medication improves outcome (Rodebaugh et al., 2004). In the Davidson et al. (2004) study, combining cognitive-behavioral treatment and fluoxetine did not improve outcome over either treatment alone. Morissette, Spiegel, and Barlow (2008) investigated the effect of administering alprazolam (Xanax) or propranolol (Inderal) prior to exposure. They found that anxiety declined more steadily in patients who were not taking medication, and that significantly more patients who had taken alprazolam lost their treatment gains after the medication was discontinued.

There has been recent interest in the potential for D-cycloserine (an antibiotic) to improve the effectiveness of exposure. Two studies have found improved outcome of exposure to social fears when augmented by D-cycloserine (Gaustella et al., 2008; Hofmann et al., 2006). The potential for integration of D-cycloserine into standard treatment for SAD has not yet been fully explored.

Conclusions

The results of the outcome studies cited above suggest the following guidelines for treating SAD:

1. All treatments should include exposure to feared social cues, including *in vivo* exposure.
2. Exposure will be more effective when patients are instructed to focus their attention on anxiety-provoking cues and directed to forgo safety behaviors.
3. Combining cognitive restructuring with exposure may result in better outcome.
4. Social skills training is not an essential component of treatment for most patients; however, it may be useful for those patients who demonstrate specific skills deficits.
5. Additional techniques targeting biased cognitive processing may enhance outcome. These include training in attentional focus, provision of feedback about actual social performance, modifying pre- and postevent processing, and restructuring of beliefs related to key memories.

6. Cognitive-behavioral therapy is effective in group or individual formats. However, there may be advantages to having some or all of the treatment conducted individually.
7. Although medication can be helpful for patients with SAD, cognitive-behavioral therapy may provide better long-term outcome. There is no evidence that combining medication and psychotherapy improves outcome. The use of anxiolytics during exposure may result in poorer outcome.
8. Patients with more severe SAD and comorbid mood disorders are likely to have poorer outcome. For these patients, clinicians may elect to extend treatment and/or add more treatment components.

ASSESSMENT AND TREATMENT RECOMMENDATIONS

Rationale and Plan for Treatment

In keeping with the findings of the outcome literature, the treatment package outlined in this chapter utilizes exposure and cognitive restructuring to alter the beliefs and expectations that fuel patients' anxiety regarding social situations. Additional techniques are included to target aspects of cognitive processing that maintain dysfunctional beliefs. Social skills training and applied relaxation are optional components that may be added as needed for specific patients.

The treatment plan provides for 20 sessions, including assessment. Most of the sessions are 45 minutes in length, except for the first one or two exposure sessions, which may be extended to 90 minutes to provide enough time for habituation. Patients with a single discrete social fear may require fewer sessions. Patients with severe generalized symptoms, especially those who also meet criteria for APD, may require longer treatment.

The general treatment plan for SAD is outlined in Table 5.3.

TABLE 5.3. General Plan of Treatment for Social Anxiety Disorder

-
- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
 - Socialization to treatment
 - Cognitive restructuring
 - Examining content
 - Examining information processing
 - Exposure
 - Imaginal
 - Role-play
 - *In vivo*
 - Social skills training (as needed)
 - Applied relaxation (as needed)
 - Phasing out treatment
-

Assessment

The diagnosis of SAD may be missed when patients initially present for treatment. It is not uncommon for patients to come to a first session describing other problems, such as depression, substance abuse, or panic attacks. Only on careful inquiry will it become apparent that SAD has preceded and contributes to these conditions. Other patients will present with specific fears of performance situations. In such cases it is important to inquire about other, more generalized fears, as these are often present.

Tests and Clinical Interviewing

Self-report questionnaires can be useful for assessing patients with SAD. The Social Anxiety Questionnaire (SAQ) for Patients is a symptom checklist we have developed for this purpose. Patients' responses to individual items can help in making a diagnosis, and, when the scale is readministered later, can be used to evaluate therapeutic progress. A total score for the SAQ is derived by totaling the individual items. The SAQ is shown in Form 5.2. Other measures from the standard battery (e.g., the BAI, BDI-II, GAF, DAS, etc.), as well as other anxiety questionnaires (e.g., the ADIS-IV, the Fear Questionnaire), may also be used as appropriate. Form 5.3 provides space for recording scores on the standard intake battery and additional anxiety questionnaires. It also enables the therapist to record the patient's medication, alcohol, and other substance use; to record (at intake only) the history of any previous episodes of anxiety (the nature of these should be specified); to note (on later evaluations) which situations are still avoided and which the patient can now approach; and to indicate treatment recommendations. Finally, patients should also fill out the standard intake form (see Chapter 2, Form 2.1a).

As noted in earlier chapters, however, no test is a substitute for a thorough clinical interview. This initial evaluation should include questions regarding all physical, cognitive, and behavioral symptoms of anxiety. The patient should be asked to list all of the situations he or she currently avoids or feels anxious about, and the degree of distress associated with each. In addition, the patient should be asked to list all safety behaviors. Forms 5.4 and 5.5 are provided to assist patients in creating these lists. It may be helpful to ask patients to self-monitor and record any anxiety, avoidance, and safety behaviors for several weeks, as some of these behaviors may have become so automatic that they are not even recognized.

The presence of any comorbid disorders should also be assessed. In addition, patients' interpersonal, educational, and occupational functioning should be evaluated, as many individuals with SAD have substantial deficits in these areas.

Consideration of Medication

SSRIs are generally considered the first-line medications for SAD, because they have been found effective in a number of studies and have fewer side effects and lower risk for abuse or overdose than alternative medications. Whereas some patients respond to the SSRIs after 4 weeks, it takes 8–12 weeks for others to achieve full response. It is generally recommended that patients continue SSRI treatment for at least 12 months (Antai-Otong, 2008; Blanco et al., 2003; Muller, Koen, Seedat, & Stein, 2005; Rodebaugh & Heimberg, 2005; Rodebaugh et al., 2004). The SSRIs

fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft) are approved by the U.S. Food and Drug Administration (FDA) as treatments for SAD, as is the serotonin–norepinephrine reuptake inhibitor venlafaxine (Effexor). Some authors have recommended that beta-blockers (e.g., atenolol [Tenormin], propranolol [Inderal]) and benzodiazapines (e.g., alprazolam [Xanax], clonazepam [Klonopin]) be considered first-line medications for patients with discrete performance fears (Belzer et al., 2005).

Other classes of medication have been found to have some evidence of effectiveness and are sometimes recommended for patients who do not respond to first-line treatments. These include monoamine oxidase inhibitors (e.g., phenelzine [Nardil]), reversible monoamine oxidase inhibitors (e.g., moclobemide [Manerix]), and anticonvulsants (e.g., gabapentin [Neurontin], pregabalin [Lyrica]) (Antai-Otong, 2008; Belzer et al., 2005; Blanco et al., 2003; Muller et al., 2005; Rodebaugh & Heimberg, 2005; Rodebaugh et al., 2004).

Rodebaugh and Heimberg (2005) have attempted to provide clinical guidelines regarding the use of medication in combination with psychotherapy. For patients who are already taking medication at the start of treatment and who plan to discontinue the medication at some point, they recommend that medication be tapered during the course of psychotherapy. Patients should be told to expect that they will have some resurgence of symptoms as medication is discontinued, and that due to the effects of state-dependent learning, they may need to repeat some exposures. Patients who are not currently taking medication, but wish to start, should be given enough time to stabilize their medication response prior to beginning the active components of treatment. Otherwise, patients may attribute progress to the medication rather than to the new learning provided by exposure and cognitive restructuring. Patients who are responding poorly to cognitive-behavioral treatment should not start medication in the middle of treatment. Rather, the treatment protocol should be completed in order to observe its full effect. Medication should then be added. Once the patient has achieved a stable response, further cognitive-behavioral treatment may be undertaken.

Although these recommendations may represent ideal conditions to distinguish the effects of medication and psychotherapy, it should be noted that patients often choose to start medication and therapy concurrently and/or to make changes to medication during the course of treatment. Clinicians should be prepared to discuss the possible confounding effects of such choices as patients evaluate and make attributions about their progress.

Socialization to Treatment

Once a diagnosis is established, patients should be educated regarding the nature of SAD, the cognitive-behavioral conceptualization of the disorder, the rationale for the various interventions, and treatment options (including medication). It is important to use examples from a patient's own experience to illustrate how the disorder develops and is maintained. Patients are often relieved to learn that their symptoms are common and that proven treatments are available.

Form 5.6 is an educational handout about SAD that can be given to patients as part of the socialization process, along with Form 5.1 (which illustrates the development of SAD) and Form 10.1 in Chapter 10 (which describes cognitive-behavioral therapy in general). Table 5.4 lists “rules” for information processing and behavior that maintain anxiety before, during, and after social encounters (Leahy, 2009); these maladaptive “rules” can be discussed with patients.

TABLE 5.4. Maladaptive "Rules" in Social Anxiety Disorder

Before you interact with people:

1. Think about all the ways you can look foolish and anxious.
2. Rehearse in your mind how anxious you will feel.
3. Try to prepare all kinds of safety behaviors to hide your anxiety.
4. If possible, come up with an excuse to avoid people.

When you are around other people:

1. Assume that people can see every anxious feeling and thought that you have.
2. Focus your attention on how anxious you feel.
3. Try to hide your anxious feelings.

After you interact with people:

1. Review how awful it felt.
 2. Assume that people are now talking about how awkward you looked.
 3. Focus on any signs of imperfection in how you appeared.
 4. Criticize yourself for being less than perfect.
-

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Cognitive Restructuring

Cognitive restructuring targets not only the content of patients' maladaptive beliefs about the likelihood and cost of negative evaluation by others, but the information-processing errors that maintain these beliefs.

Examining Content

First, patients are taught to identify their distorted automatic thoughts by reviewing a recent social interaction and asking what emotions they were feeling and what thoughts were going through their minds. Either the Patient's Daily Record of Dysfunctional Automatic Thoughts (Form 2.10 in Chapter 2) or the Patient's Event–Mood–Thought Record (Form 10.4 in Chapter 10) can be used for this purpose.

Patients are then taught to treat their negative thoughts as hypotheses to be tested rather than as reality. The skills of identifying the categories of distorted thoughts being employed (see Form 10.2 in Chapter 10), gathering evidence, considering alternative explanations, and developing rational responses are taught. Patients are assigned to apply these skills before, during, and after naturally occurring social situations and assigned exposure exercises.

A number of the cognitive techniques outlined in Appendix B may be used to challenge patients' automatic thoughts. Listed below are some techniques we have found particularly helpful for people with SAD:

1. **Observing others' behavior.** Having patients observe the behaviors of other people can be an effective way of challenging negative thoughts. It can also help shift patients' focus from

internal to external cues. For example, patients who fear that others will notice their anxiety can be asked to observe how many people are really looking at them at any given time. Usually the answer will be “Very few, if any.” Patients who worry about being boring in conversations can be assigned to listen in on the conversation of others. Typically they discover that most social conversation is mundane. Patients who assume that no one else feels anxious can be asked to look for signs of anxiety in others, either in social situations or on television and in movies. Again, they are likely to notice that others do sometimes seem anxious and that generally nothing bad happens to them as a result.

2. **Testing predictions.** Before every social event (naturally occurring or assigned exposure), patients should be asked to write their predictions about what will happen—both how they think they will behave and how others will react. These should then be compared to what actually occurs. This helps counteract the natural tendency to fail to notice or remember information that is inconsistent with patients’ personal schemas, and makes it more likely that patients will be able to recall contradictory evidence the next time they have negative thoughts in anticipation of a social encounter.

3. **Double standard.** When patients fear that others will view them negatively if they make any mistakes or show any sign of anxiety, they can be asked what they would think if they saw someone else doing the same thing. Many patients judge others far less harshly than they expect to be judged themselves. The reasons for this discrepancy can then be explored. (Warning: Some patients are just as unforgiving of others as they are of themselves, and this exercise will not be helpful for them. In such cases, their assumptions about the need for—and possibility of—perfect behavior will need to be explored.)

4. **Surveying others.** People with SAD often assume that they are the only ones who have awkward conversations or feel anxious in performance or social situations. Patients can be assigned to ask people they know whether they ever have similar experiences. Patients are often surprised to discover that they are not alone. The point can be made that people who do not have SAD expect to feel anxious at times and to have some conversations to go badly. They just don’t view such occurrences as a sign of personal failure.

5. **Behavioral experiments.** Patients who fear catastrophic negative reactions if they show any behavior they view as inept or as signaling anxiety (e.g., trembling, pausing too long in a conversation, etc.) can be asked to engage deliberately in the feared behavior and see what happens. Either their fears will be disconfirmed, or they will find that the consequences of the negative reaction are minimal. For example, if Maria fears that others will notice her blushing, she may be asked to call attention to rather than trying to hide it. If Jason anticipates judgment for sweating, he can be asked to wet his shirt with water before a social encounter.

6. **Vertical descent.** Some rejection is, of course, inevitable in social encounters. The technique called “vertical descent” can be used to uncover the assumptions that underlie patients’ fear of rejection. These assumptions are typically that the negative judgment is accurate and that if patients are rejected by one person, they will be rejected by others. These assumptions can be challenged by exploring alternative explanations and challenging overgeneralization (see below). Patients can be urged to ask, “So what?” For example, “Suppose you approach someone and he or she refuses to speak to you. Why would that bother you? What would happen next? And why would that bother you? How would this rejection interfere with your life?” Patients often conclude that what would “bother” them is not really that “bothersome.” Behavioral experiments

(see above) can also demonstrate that the actual cost of rejection or other negative reaction is usually minimal.

7. **Alternative explanations.** Patients with SAD often take any rejection or unfriendly behavior as a sign that they are inadequate. It can be useful to have them consider alternative explanations. For example, could the person who was unfriendly have been having a bad day? Might this person have his or her own problems? Perhaps the person treats everyone this way? Would someone else simply consider the person rude?

8. **Challenging overgeneralization.** Patients with SAD often overgeneralize the meaning of rejection. This can be a problem when they are trying to date, make sales calls, or look for a job. Because they have been rejected by one person, patients conclude that they are not good enough for anyone. Socratic questioning can be used to help patients understand that (a) attraction is a matter of taste, not absolute judgment; and (b) dating (or sales or interviewing) is a numbers game. Patients can be asked to assume a certain “hit ratio” (e.g., 1 “yes” for every 10 approaches) and can be urged to collect rejections. They can also be asked whether they would date (hire, buy from) anyone who approached them, and if not, whether the other person should conclude that no one would ever want to date (hire, buy from) him or her.

9. **“Feared fantasy” role play.** In this exercise, the therapist plays the role of a person who verbalizes all the terrible things a patient assumes others are thinking about him or her, and the patient must try to defend him- or herself. This serves several functions: (a) It allows patients to practice rational responses to their negative thoughts; (b) it serves as a form of exposure to their fears of judgment; and (c) patients are able to see that if anyone actually did judge them in such a manner, the patients would probably perceive that person as obnoxious and not worth trying to please.

As therapy progresses and patients become proficient at challenging their distorted automatic thoughts, the focus should shift to maladaptive assumptions and to dysfunctional schemas about the self and others. These can be addressed by looking at the advantages and disadvantages of the assumptions and schemas, examining evidence across the patients’ lives, keeping a daily log of schema-discrepant events, examining whether the patients’ behavior leads to self-fulfilling prophecies that reinforce their schemas, and using developmental analysis to examine and challenge the origins of the schemas. When key memories that contribute to negative views of the self are identified, imagery rescripting may be helpful. For example, Nancy can be asked to relive a memory from the perspective of herself as a child or adolescent. Then she can be asked to imagine her current self or some other kindly adult intervening and protecting and/or comforting her childhood self. Alternatively, she can engage in two-chair role plays in which she, as her adult self, confronts the person or people who caused her embarrassment or humiliation.

Examining Information Processing

In keeping with the work of Hofmann and Otto (2008) and D. M. Clark et al. (2006), specific interventions may be added to target patients’ maladaptive information processing. These include the following:

1. **Training in external focus.** Patients are asked to focus on physical signs of anxiety while performing a role play or performance task in session and to report their anxiety level. Then

they are asked to focus on physical details of the environment and note their anxiety level. Most patients will be able to see that focusing on internal cues increases anxiety. Patients are then asked to practice shifting to external focus during in-session and *in vivo* exposures. In addition to focusing on aspects of the physical environment, patients can be asked to focus on how other people with whom they are interacting look or what they are saying. Ultimately, patients should be encouraged to focus on their goals for a given encounter (asserting themselves, making a request, making someone else comfortable, etc.), rather than on their internal sensations or performance.

2. **External feedback.** The tendency to judge social performance on the basis of internal experience or schema processing can be countered by providing external feedback. It can be helpful to ask patients first to provide written ratings of their own performance. Feedback can then be provided via video or audio recording, or by verbal feedback from the therapist or group members.

3. **Modifying pre- and postevent processing.** Since much of the worry and rumination patients engage in before and after social events serves no practical purpose and heightens anxiety, patients can be encouraged to minimize such processing by using distraction and engaging in more useful activities instead. In addition, thought records and Socratic dialogue can be used to guide pre- and postevent processing into more useful paths by making sure that patients are accurately noticing and remembering discrepancies between their catastrophic predictions and actual outcomes.

Exposure

The situations that a patient either avoids or finds anxiety-provoking have already been listed and rated for degree of distress during the assessment phase. These are now ranked from least to most anxiety-provoking, in order to create a hierarchy of feared situations. (Form 5.4, the Social Anxiety Situations List for Patients, can be used for this purpose.)

Beginning with a situation that evokes moderate anxiety, the therapist initiates exposure in session. Role play and/or imaginal recreations may be used. Once the patient has experienced some habituation, *in vivo* exposure to related situations is assigned as homework. Although it is not usually necessary to do so, the therapist may accompany a patient on the first *in vivo* trial of a new exposure if the patient has difficulty doing it independently. Patients should be assigned to repeat the exposure on their own as homework until it evokes minimal anxiety. Then the next item on the hierarchy is approached in similar fashion, until all feared situations are completed. Forms for recording exposure practice in sessions or as homework are provided in Chapter 9; Form 9.1 is for imaginal exposure practice, and Form 9.2 is for *in vivo* practice.

For imaginal exposure, the therapist narrates a scenario in which the patient participates in an anxiety-provoking social situation. The patient is asked to imagine being in the situation and to describe how he or she would think, feel, and act. The process is audio-recorded. The patient is then assigned to listen to the recording repeatedly, first in session and then as homework, until he or she is able to imagine the situation without feeling anxious. In role-play exposure, the patient and therapist act out a social situation, or the patient is asked to simulate a performance—for example, by giving a talk as if the therapist were the audience. Again, this is repeated until the patient's anxiety decreases.

It is important to include elements of the patient's catastrophic fears in both imaginal and role-play exposures. For example, a patient may be asked to imagine not only giving a musical performance, but making a mistake in a crucial passage; or the therapist may role-play a person who not only refuses an approach for conversation, but is rude or insulting. (More complete descriptions of exposure procedures can be found in Chapter 9.)

Butler (1985) has pointed out that in work with patients who have SAD, it may be difficult to stick to the ideal of prolonged exposure to clearly specified tasks that move precisely up a hierarchy of fears. Social situations are too variable, and many of them (e.g., asking for directions, introducing oneself) involve relatively brief encounters. These problems can be surmounted by having patients repeat brief situations numerous times and by emphasizing consistent practice (i.e., half an hour a day of exposure to a variety of situations) rather than trying to follow a hierarchy exactly. Once patients master the idea of exposure, we have found it helpful simply to assign them to look for opportunities to be anxious every day. These "opportunistic" exposures can be written on the Patient's *In Vivo* Exposure Practice Record (Form 9.2) for review in the next session.

Patients who normally engage in safety behaviors during social interactions should be instructed to drop such behaviors during *in vivo* exposure. Active behaviors (e.g., apologizing frequently or using alcohol) should be stopped, and normally avoided behaviors (e.g., disagreeing with people or telling jokes) should be deliberately pursued. Failure to eliminate safety behaviors will make exposure less effective and maintain anxiety.

Cognitive restructuring and exposure techniques can be combined. For example, patients can be asked to complete thought records before and after exposure exercises. In addition, patients can be instructed to engage in behavioral experiments that involve exposure to actual social situations or feared behaviors, for the explicit purpose of testing specific negative beliefs.

Social Skills Training

Therapists can assess the presence of social skills deficits from patients' reports of their social interactions and/or by role-playing social situations with patients. If patients are interacting via electronic media, transcripts of email and text-message exchanges may also be helpful. When deficits are noted, a therapist should train a patient in the needed skills. These may range from basic skills (such as making eye contact, asking questions, and active listening) to complex ones (such as interviewing for a job or establishing and maintaining friendships). The therapist first models the skills and then has the patient practice them in role play with the therapist. Eventually the patient is assigned to apply the new skills during *in vivo* exposure.

Applied Relaxation

Relaxation training may be helpful for patients who are particularly troubled by physical symptoms of anxiety. Patients can be taught progressive muscle relaxation, breathing relaxation, or both (see Chapter 9 for detailed instructions). However, relaxation must be used cautiously with patients who fear that physical signs of anxiety, such as blushing or sweating, will be noticed by others. It is crucial that these patients do exposure exercises in which they do *not* attempt to control these symptoms, so that they realize other people are unlikely to notice or care. Otherwise,

or care. Otherwise, relaxation may become another safety behavior that maintains rather than breaks the cycle of anxiety.

Phasing Out Therapy

Before therapy can be terminated, several criteria should be met: (1) The patient should have experienced a significant decrease in subjective anxiety; (2) exposure to all items on the patient's hierarchy of feared situations should have been completed; (3) the patient should no longer manifest substantial avoidance behavior; and (4) the patient should be able to apply the skills of exposure and cognitive restructuring (as well as any other skills taught in therapy) independently.

In order to prepare the patient for termination, therapy may be tapered to every other week and finally to once a month. However, it is important not to begin tapering sessions until most of the therapeutic work has been completed. Herbert, Rheingold, Gaudiano, and Myers (2004) found that when the final 6 sessions of a 12-session individual cognitive-behavioral treatment were provided every other week rather than weekly, patients achieved poorer outcome.

During this final stage, the patient should take increased responsibility for designing exposure homework. Before termination, the patient should review the techniques that he or she found particularly helpful. Situations that may prove difficult in the future should be discussed, along with ways of dealing with them. Whenever possible, the patient should have the option of recontacting the therapist should the need arise.

TROUBLESHOOTING PROBLEMS IN THERAPY

Many of the potential problems with exposure-based treatments that are described in connection with posttraumatic stress disorder in Chapter 6 can also be encountered in the therapy of SAD. These include resistance to doing exposure, failure to become anxious, failure to habituate, and noncompliance with homework. These problems can often be dealt with by making sure that the cues used for exposure are relevant, discouraging the use of distraction and other coping behaviors during exposure, making sure that a patient has experienced habituation in session with the therapist present before doing self-directed exposure, accompanying the patient on initial exposures, and choosing an exposure lower on the patient's hierarchy. Readers are referred to the "Troubleshooting ..." section of Chapter 6 for a fuller discussion of how to deal with these problems.

In addition to the standard problems with exposure, patients with SAD frequently present unique problems related to their perception of therapy as yet another social situation in which they may be judged. These patients are often highly anxious during the initial evaluation. They may be reluctant to reveal personal information and may have difficulty communicating their concerns. In addition, they may feel "put on the spot" by repeated questions. As therapy progresses, they may be hypersensitive to perceived judgments by the therapist.

These behaviors provide both a problem and an opportunity. The first goal is to help patients feel comfortable. An approach that is gentle, tactful, empathic, and not too intrusive is important and takes precedence over acquiring all of the relevant details in the first meeting. Open-ended questions, statements, and empathic reflections may be more useful than repeated direct

questions. It can also be helpful to normalize patients' anxiety by informing them that it is common for people to feel anxious when they first come to therapy.

As therapy progresses, the therapist should be aware of any change in a patient's emotional state or behavior during sessions. The patient can be invited to collaborate with the therapist in looking at what led to such changes. This will often uncover beliefs that the therapist is making negative judgments about the patient. Evidence for these thoughts can then be explored. If, as is usually the case, the patient is wrong about the therapist's judgment, it can be helpful for the therapist to tell the patient what he or she was actually thinking. Such discussions are important for two reasons: (1) They provide further evidence to counter the patient's negative beliefs; and (2) they prevent the patient from building up a negative perception of the therapist's feelings about him or her, which could otherwise lead to premature termination.

DETAILED TREATMENT PLAN FOR SOCIAL ANXIETY DISORDER

Treatment Reports

Tables 5.5 and 5.6 are designed to help in writing managed care treatment reports. Table 5.5 shows sample symptoms. Select the symptoms that are appropriate for the patient. Be sure also to specify the nature of the patient's impairments, including any dysfunction in academic, work, family, or social functioning. Table 5.6 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

Sequence of Interventions

Table 5.7 shows the sequence of interventions for a 20-session course of treatment for SAD. As noted above, patients with discrete fears may require fewer sessions, whereas patients with severe generalized symptoms may require more.

TABLE 5.5. Sample Symptoms for Social Anxiety Disorder

Fear of social situations (specify)	Feeling faint
Fear of negative judgment by others	Numbness
Feelings of embarrassment or humiliation	Tingling
Anxious mood	Chills
	Hot flashes
Specify physical symptoms of anxiety:	Specify cognitive symptoms:
Blushing	Mind going blank
Sweating	Difficulty speaking
Shaking	Loss of concentration
Palpitations	Derealization
Difficulty breathing	Depersonalization
Chest pain	Specify behavioral symptoms:
Nausea	Panic attacks
Dizziness	Avoidance (specify)

TABLE 5.6. Sample Treatment Goals and Interventions for Social Anxiety Disorder

Treatment goals	Interventions
Reduce physical anxiety symptoms	Relaxation training, exposure
Reduce fear of scrutiny/evaluation	Cognitive restructuring, exposure
Eliminate safety behaviors	Self-monitoring, exposure
Acquire social skills	Social skills training (modeling, role play, <i>in vivo</i> practice)
Reduce anxiety in specific social situations to 2 or less on a scale of 0–10	Cognitive restructuring, exposure
Eliminate avoidance of social situations (specify)	Exposure
Modify assumption of need for approval (or other assumptions—specify)	Cognitive restructuring
Modify schema of inadequacy (or other schemas—specify)	Cognitive restructuring, developmental analysis
Eliminate impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Eliminate all anxiety symptoms (BAI and/or SAQ in normal range)	All of the above
Acquire relapse prevention skills	Reviewing and practicing techniques as necessary

CASE EXAMPLE

The following example is a composite based on several actual cases. It is meant to illustrate the way in which substantial progress can be made with symptoms of SAD within a 20-session treatment, as well as the fact that some additional treatment may be helpful, depending on a patient's goals.

Sessions 1–3

Presenting problem Paul was a 32-year-old single attorney who self-referred, seeking help for “job stress.” Paul worked in one of the legal departments of a large federal government agency, where he had significant responsibility.

Symptoms Paul reported that he had always been somewhat anxious about academic and work performance, but had generally done well. He reported a significant increase in anxiety after he had transferred to his current department a year and a half ago. He was working long hours, worried about work much of the time when he wasn't there, felt tense and irritable, and was having difficulty sleeping. He also reported that he was becoming increasingly depressed and wondered whether he was perhaps unable to handle the demands of his profession.

TABLE 5.7. Detailed Treatment Plan for Social Anxiety Disorder

Sessions 1–2**Assessment**

Ascertain presenting problems
 Inquire regarding all symptoms
 Administer SAQ (Form 5.2)
 Administer standard battery of intake measures (see Form 5.3), plus additional anxiety questionnaires as appropriate
 Assess avoidance and safety behaviors (have patient fill out Forms 5.4 and 5.5)
 Assess impairment in social, educational, and occupational functioning
 Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
 Evaluate substance use; evaluate need for counseling or detoxification if patient has substance abuse or dependence
 Assess need for medication

Socialization to Treatment

Inform patient of diagnosis
 Indicate that disorder is common and brief treatment is available
 Educate patient regarding option of medication
 Discuss any fears/reservations patient has regarding treatment
 Provide patient with information handouts on SAD (Forms 5.1 and 5.6) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
 Begin developing short-term and long-term goals for therapy

Homework

Have patient use Forms 5.4 and 5.5 to self-monitor avoided situations and safety behaviors
 Have patient write out goals for therapy

Sessions 3–4**Assessment**

Evaluate homework
 Evaluate anxiety (SAQ) and depression (BDI-II)

Cognitive Interventions

Teach identification of automatic thoughts, using recent social situation

Behavioral Interventions

Assess need for relaxation training
 If indicated, begin teaching progressive muscle relaxation and breathing relaxation

Homework

Have patient continue to self-monitor avoided situations, safety behaviors
 Have patient begin recording automatic thoughts (on Form 2.10 in Chapter 2 or on Form 10.4 in Chapter 10)
 Have patient begin practicing relaxation (if applicable)

Sessions 5–6**Assessment**

As in Sessions 3–4

TABLE 5.7 (*cont.*)**Cognitive Interventions**

Teach categorization of automatic thoughts, examination of evidence, and rational responding
 Identify patterns of pre- and postevent processing
 Introduce behavioral experiments

Behavioral Interventions

Help patient create hierarchy for exposure; plan first exposures
 Assess social skills deficits and discuss rationale for training (if indicated)
 Provide feedback about patient's actual performance (video, audio, therapist, and/or group)
 Help patient practice shifting attention from internal to external cues
 Continue teaching relaxation techniques (if indicated)

Homework

Have patient continue using thought records to record/challenge negative thoughts
 Have patient practice external focus of attention in social situations
 Have patient practice modifying pre- and postevent processing
 Have patient continue practicing relaxation (if applicable)

Sessions 7–13

Note: The first session involving exposure may be 90 minutes; subsequent sessions may be 45 minutes, if patient is able to habituate in that time

Assessment

As in Sessions 3–4

Cognitive Interventions

Obtain automatic thoughts before, during, and after exposure, and have patient practice rational responding
 Note changes in patient's mood during sessions, obtain automatic thoughts, and dispute
 Continue behavioral experiments
 Introduce concepts of maladaptive assumptions, dysfunctional schemas

Behavioral Interventions

Begin exposure (imaginal, role-play, and/or therapist-guided *in vivo* exposure)
 As each item is mastered, have patient move up exposure hierarchy
 Plan and discuss self-directed *in vivo* exposures
 Identify safety behaviors
 Continue with social skills training (if indicated) via modeling, role play

Homework

Have patient listen to tapes of imaginal exposure
 Have patient engage in self-directed *in vivo* exposure, dropping safety behaviors
 Have patient practice self-directed application of cognitive skills before and after exposure
 Have patient practice external focus of attention
 Have patient continue practicing social skills (if indicated)

Sessions 14–16**Assessment**

As in Sessions 3–4

(*cont.*)

TABLE 5.7 (cont.)

Cognitive Interventions

Continue identifying and challenging automatic thoughts

Continue behavioral experiments

Identify and challenge core assumptions and schemas (developmental analysis, imagery rescripting, etc.)

Behavioral Interventions

Continue with exposures, moving up hierarchy

Homework

As in Sessions 7–13

Sessions 17–20 (biweekly or monthly)**Assessment**

As in Sessions 3–4

Cognitive Interventions

Continue to focus on assumptions and schemas

Review techniques patient has found useful

Discuss possible future problems and ways of coping with them

Behavioral Interventions

Complete exposure hierarchy

Have patient design own exposures

Review techniques patient has found useful

Discuss possible future problems and ways of coping with them

Homework

Have patient seek opportunities to be anxious and use these for further exposure

Encourage continued practice of all skills

**Current
functioning**

When asked to describe what he felt anxious about, Paul said that the head of his department was well known for being critical. Documents submitted to him were commonly returned with many corrections and revisions. Paul found this unsettling and tried hard to produce work that pleased his boss. However, no matter how much effort he put in, his boss always found something he wanted changed. Paul was spending more and more time researching and rewriting his documents in an effort to circumvent any possible criticism. In addition, he said that he was becoming anxious about doing even simple tasks, like sending emails. He reported that he could spend 2 hours working on an email that he thought others would write in a few minutes, trying to make sure there was nothing with which anyone could find fault.

Paul also described feeling socially isolated at work. He believed that the other attorneys at his level all had better relationships with each other than with him, and that he was not included in social interactions around the office.

At the end of the first session, the therapist told Paul that he believed cognitive-behavioral therapy could help him manage the stress of his current work situation better. Paul was given the standard intake battery to complete for the next session.

*Assessment
Test results*

The second and third sessions were largely devoted to reviewing Paul's history. His test scores from the intake battery indicated that he was currently experiencing moderate depression (BDI-II = 19) and significant symptoms of anxiety (BAI = 26). There was no suicidal ideation.

*History
of prior
symptoms*

Paul denied any prior episodes of major depression, although he said that he had sometimes felt "down" in the past. However, he indicated that he had felt anxious for much of his life. He had been somewhat shy and quiet as a child. During middle school and high school he had always had a few good friends, but in general he felt excluded from the "in group." Paul focused his efforts on his academic performance, where he had more confidence. He reported that he had always felt anxious about doing well and worked hard, but that he got excellent grades and enjoyed being recognized as one of the best students.

Paul continued to do well academically in college, albeit still with a fair amount of anxiety and stress. He had some friends, but again felt that he was outside the mainstream. He subsequently got into a good law school, where he again performed well, although it bothered him that he was not among the top students.

Paul's experience with romantic relationships was limited. He had had one brief relationship with a woman in college, but had not dated since beginning his current job.

*Family
history*

Paul reported that he came from a close-knit family. He had one younger sister. Both of his parents had been born abroad. Paul's father was a successful businessman with interests in both the United States and his home country. Paul described his father as demanding and critical—a man who was proud that he did not "suffer fools kindly." Although Paul believed his father loved him, he felt that he could never meet his father's standards. For example, if Paul came home with a report card with four A's and one A-, his father wanted to know what had "gone wrong" in the course with the A- and what Paul intended to do about it. His father was also frequently critical of how Paul handled interactions with family members and others. Paul reported that his mother was loving, but also quiet and prone to yield control in most matters to his father. She did not have many social contacts outside the family, and Paul thought that she was probably shy. Paul's father's brother and his family lived near them, and Paul was close to his uncle and cousins.

*Automatic
thoughts*

Returning to Paul's presenting problem, the therapist asked Paul what typically went through his mind when he was anxious about work. Paul said that he worried that his boss would think that he was stupid and didn't work hard enough, and that his colleagues thought he wasn't interesting or smart enough. He obsessed about whether he should quit his job and do something less stressful, like running a retail store.

*Socialization
to treatment*

At the end of the third session, the therapist reviewed Paul's history and current situation. He pointed out that Paul's fears at work were primarily about being judged by others (his boss, his coworkers). Although Paul was depressed now, the depression seemed to stem from his anxiety and fear of failure. The therapist also said that Paul's history indicated more general fears about being found inadequate and rejected by others, and that these fears might be contributing to his reaction to his job. The therapist was careful to add that he

suspected many people would find working for Paul's boss stressful. The therapist said that he believed he could help Paul feel less anxious about work. He also suggested that once Paul was feeling better about his job, he could decide whether he wanted to work on his more general social fears.

Diagnosis

Paul agreed with this summary, and said that he felt relieved to be talking about the ways he had felt anxious and shy at other times in his life. Paul was given a diagnosis of social anxiety disorder, generalized subtype, and major depressive disorder, single episode, mild.

Homework

The therapist gave Paul Form 5.6, Information for Patients about Social Anxiety Disorder, and asked Paul to make note of situations in which he felt anxious over the next week.

Sessions 4–6

Cognitive interventions

Paul reported feeling somewhat less depressed after the prior session. However, he continued to feel very anxious at work. He had a legal brief due that week and had been up late several nights working on and worrying about it. In addition to reviewing the case law that seemed most relevant to the brief, he had spent a number of hours searching for any obscure cases that his boss might ask for. The therapist suggested that they use this situation to teach Paul basic cognitive techniques. Together, they filled out a thought record.

Automatic thoughts

Paul's automatic thoughts were as follows:

- “It won't be good enough.”
- “He'll want it all rewritten.”
- “He'll be mad.”
- “He'll think I'm stupid.”
- “He'll think I didn't try hard enough.”
- “I'm just not smart enough.”
- “I hate living like this.”
- “I want to quit my job.”

Examining evidence

The therapist used Socratic questioning to help Paul examine the reality of these thoughts. Paul's boss did in fact almost always request substantial rewrites of Paul's briefs, and often appeared irritated. The therapist asked whether his boss ever did this to any of the other staff attorneys. Paul said that his boss was notorious for making everyone rewrite their briefs multiple times, and that he was generally seen as unreasonable and demanding. The therapist asked Paul whether the boss had ever given any indication that he thought Paul did not work hard enough. Paul said that his boss had never said anything like that. The therapist suggested perhaps that idea was coming from some belief Paul had previously formed about himself. The therapist asked Paul for evidence that maybe he was smart enough, and reviewed Paul's past academic achievements. Paul was then asked whether the problem was more likely to be a lack of intelligence on his part or a pattern of behavior on his boss's part. Paul conceded that the fact that his boss treated everyone this way suggested that the boss

was more likely to be the problem. Still, he reported the thought that if he just worked hard enough, he should be able to meet the boss's standards. Paul was asked to note this as an assumption they could return to look at later.

*Categories
of distorted
thoughts;
rational
response*

Paul identified the categories into which his distorted automatic thoughts fell as personalizing and catastrophizing. He eventually developed this rational response to them: "The boss is never pleased with anyone's work; it can't all be me." He reported that his anxiety level subsequently declined from 80% to 50%.

Homework

Paul was assigned to fill out thought records for any incident of anxiety during the next week.

*Cognitive
restructuring*

In the next two sessions, the therapist and Paul reviewed several thought records and worked on Paul's cognitive skills. Table 5.8 shows an example of automatic thoughts Paul had while working on an email and his rational responses to them. The therapist pointed out that although Paul did a lot of extra work in order to try to avoid possible criticism, the evidence suggested that (1) the boss would be critical no matter what Paul did, and (2) most other people did not seem to judge Paul's work negatively.

*Safety
behavior*

He suggested that they consider the extra work Paul put into drafting legal documents and emails as a safety behavior.

*Preparation
for exposure*

In the fifth session, the therapist reviewed the rationale for exposure and asked Paul to create a hierarchy of feared situations as homework. In the sixth session, they reviewed the hierarchy and agreed that they would begin with imaginal exposure to Paul's fears of judgment from his boss in the next session. Figure 5.2 shows how Paul filled in Form 5.4, the Social Anxiety Situations List for Patients.

TABLE 5.8. Paul's Automatic Thoughts and Rational Responses about Writing an Email

Automatic thought	Rational response
"I don't know what to say."	"I just have to communicate the information."
"This has to be right."	"It's internal. It doesn't matter if it's perfect."
"He'll think I don't know what I'm talking about."	"I know the case better than he does."
"He'll think I'm sloppy and careless."	"I get emails with typos all the time."
"Why can't I do this?"	"I can do this. I just get anxious."
"I just can't hack it."	"If I learn to worry less, maybe I can handle this job."
	Categories of distorted thoughts: Fortunetelling, mind reading, all-or-nothing thinking, catastrophizing

Sessions 7–10

- Imaginal exposure* Session 7 was 90 minutes long. The therapist narrated (and recorded) an imaginal scenario in which Paul prepared a brief for his boss. Paul worked hard on the brief, but decided not to put in the extra work that he had been doing in the recent past. Paul's boss called him into his office, and angrily informed Paul that the brief was totally unsatisfactory and would need to be completely redone. He told Paul that he had serious doubts about Paul's dedication to his job and work ethic, and even had questions about whether Paul had the intellectual firepower required for this level of legal work.
- Habituation* Paul reported a maximum SUDs level of 8 while listening to the scenario. His anxiety peaked during the part where his boss was questioning his commitment and abilities. The therapist had Paul listen to that segment of the recording six more times. His SUDs level eventually dropped to 5.
- Homework* Paul was assigned to listen to the recording every day for the next week. He was instructed to repeat that segment of the scenario each day until his SUDs rating for that day dropped by about half.
- In vivo exposure* The therapist also suggested that Paul begin *in vivo* exposure by limiting himself to no more than 15 minutes for writing a simple internal email and sending it, even though this would be likely to make him anxious. He was asked to write down his fears before he sent out one of these emails.
- In the next session, Paul reported that he had done the imaginal exposure homework and that his SUDs level had come down to 2. He said he was beginning to realize that his boss's criticism didn't really mean that much, even though he still didn't like it. He had also sent out emails without spending too much time on them. The fears he wrote were that people would correct his emails and think he was stupid. Instead, he received standard responses to the content of the emails without criticism. However, he wasn't sure that this meant that people weren't thinking bad things about him.
- Feared fantasy* The therapist then did a "feared fantasy" role play, in which he played a coworker who told Paul how offended he had been that Paul's email had not been perfectly polished and that he felt it reflected poorly on Paul. Paul was able to see how unreasonable such a response would be.
- Exposure; dropping safety behaviors* For homework over the next 2 weeks, Paul was assigned to send out emails to people outside his office without extensive rewrites and to send out internal emails that contained deliberate typos. Although Paul reported a SUDs level of 7–8 at the idea of doing these tasks, he agreed to them.
- The therapist also suggested that Paul begin experimenting with putting a little less work into the documents he wrote for his boss. He was asked to try to limit the work he did to what he felt a bright, competent attorney at his level would do for a reasonable boss, and to forgo the extra work he was doing to try to avoid criticism. Paul's thoughts before and after these exposure exercises would also be reviewed.

Sessions 11–14

<i>Improvement in symptoms</i>	In the next session, Paul reported that he was feeling less anxious about work. He was sleeping better and spending less time worrying on the weekends. However, he still believed that he was failing if he couldn't meet his boss's expectations.
<i>Automatic thoughts about social situations</i>	Paul also said that he wanted to start working on his social relationships. He said that he thought he lacked the necessary skills to engage people in conversation and make a connection with them. He felt this at work, with his friends, and whenever he tried to date. He reported these as typical thoughts in these situations: "I won't be able to think anything to say. Nothing I say is going to be interesting. I don't know how to talk to people. I'm boring. Other guys are funnier than I am." He also believed that other people would notice his anxiety and judge him for it; consequently, he often avoided initiating conversations. The therapist suggested that this might explain why he did not feel as if he were part of the peer group at work.
<i>Role-play exposure</i>	The therapist recommended that he and Paul role-play a casual conversation. Paul was initially very anxious at the idea of doing this, but he agreed. After a couple of false starts, Paul was able to do the role play and demonstrated surprisingly good skill.
<i>Feedback</i>	When the role play was over, the therapist asked Paul how he thought he had done. Paul gave himself a C+ because there hadn't been any awkward pauses, but he hadn't said anything interesting. The therapist told Paul that his own perception was that Paul had actually done quite well. This led to a discussion of Paul's exaggerated expectations of what conversation was supposed to be like.
<i>Homework: Behavioral experiment and exposure</i>	The therapist told Paul that most casual conversation involves routine subjects. Paul was assigned as homework to listen at work to see what people actually talked about, and to try to initiate brief conversations with coworkers about non-work-related topics.
<i>Homework review</i>	Paul came into the next session feeling very upset. He reported that his homework had gone well. He had, in fact, observed several "boring" conversations between other people at work and had initiated some conversations himself.
<i>Detailed examination of social event</i>	However, Paul had gone to a party Saturday night. He had been anxious before the party and decided to drink to try to feel less anxious. He got fairly drunk. He tried to initiate some conversations, including one with a girl he found attractive, but felt they had gone badly. The next day he woke up feeling terrible and spent 2 hours lying in bed replaying the evening over and over in his mind. His thoughts were as follows: "I made a fool of myself. Everyone knew I was drunk. No one wanted to talk to me." On inquiry, Paul admitted that no one had said anything negative about his behavior during or after the party.
<i>Postevent processing</i>	The therapist pointed out the negative impact on Paul's mood of this "postevent" processing. He recommended that when Paul found himself replaying a social event in his mind, he get up and engage in some other productive

activity. If he continued to have negative thoughts later, he could do a thought record.

Cognitive restructuring and exposure

The next two sessions were spent examining Paul's fears about social interactions. Paul's beliefs were that he had to be witty and interesting for people to like him, that he was not either of these, and that his shyness was a personal failing. The therapist worked with Paul to challenge all of these assumptions.

Identification of safety behaviors

As the therapist reviewed Paul's social interactions, it became clear that while Paul could initiate topics and ask questions, he seldom revealed anything about his feelings or experiences. Paul's fear was that if people really knew him, and especially if they knew his weaknesses, they would not like him. The therapist suggested to Paul that this, rather than a skills deficit, might explain why he found it hard to make connections with others. Avoidance of self-disclosure was identified as another safety behavior, and Paul was assigned to be sure to volunteer something about himself in each conversation. The idea of doing this made Paul quite anxious; however, he agreed to try.

Sessions 15–19

In the next session, Paul said that he was feeling better than he had in some time. He felt less anxious about work, and although his boss continued to be critical, Paul took his boss's feedback less personally. He still felt anxious about saying anything personal in conversation, but had been trying to do this more. He reported that he had had some "decent" interactions with coworkers. However, he said that he continued to feel bad about himself, and that he always had a voice in his head telling him what a failure he was.

Automatic thoughts

The therapist asked Paul to write down the kinds of things the voice said to him. Paul wrote:

"You suck at conversation."

"You're lazy. You don't apply yourself."

"You haven't gone anywhere or accomplished anything."

"You're not good with people."

"Your life doesn't amount to anything."

"You're useless."

Rational responses

The therapist noted the very critical, all-or-nothing tone of these thoughts. Together he and Paul reviewed the evidence against them, including how hard Paul had worked all through school and in his career, his significant accomplishments, and the relationships he did have. Paul said that while he knew on some level that the thoughts were exaggerated, he still felt plagued by them.

Exposure to negative thoughts

The therapist suggested that they take another tack in working on these thoughts. He suggested that Paul read the thoughts out loud in session repeatedly for several minutes. At first Paul seemed a little self-conscious and awkward about doing this. However, by the fourth repetition his voice deepened and took on an unfamiliar tone of anger and sarcasm. It became clear

to the therapist that an emotional memory had been tapped. Paul continued repeating the thoughts out loud for approximately 5 minutes, by which time his voice had resumed its normal tone and his emotion had decreased. In discussing the exercise afterwards, Paul said that his SUDs level had gone up significantly after the first few repetitions, but that by the end he had felt calmer and the words were beginning to lose their meaning.

Schema restructuring

Together, the therapist and Paul dubbed the voice behind these thoughts “The Critic.” Paul was assigned to repeat the thoughts to himself for 10 minutes each morning, in addition to his ongoing exposure homework of initiating conversations, saying things about himself, and forgoing excessive effort on work tasks.

In the next session, Paul said that the exercise of repeating The Critic’s accusations out loud had been very helpful. By the end of the week, he was able to see how unreasonable they were. He acknowledged that the tone of the voice was the same as his memory of his father’s voice when he was a child. He went on to say that he realized that part of what had made dealing with his boss so hard was that his boss’s critiques had been similar enough to his father’s that old feelings of inadequacy had been revived in him. Nonetheless, he still felt that The Critic’s voice had power.

For homework, the therapist asked Paul to note any situations in which The Critic’s voice became active. In the next session, Paul reported that he had had a phone conversation with another cousin and his wife from his mother’s side of the family, who lived in the family’s home country. He felt that the conversation had been stilted and awkward, and The Critic had chimed in afterwards to tell him how badly it had gone. Most of the session was devoted to challenging The Critic’s voice.

*Cognitive restructuring:
Point-counterpoint*

Because the degree to which Paul believed the negative thoughts did not diminish much with the first round of rational responses, the therapist employed the “point-counterpoint” technique. After each round of rational responses, Paul was asked to rate the degree to which he still felt the negative thoughts were true. As long as there was significant belief left, Paul was asked, “What would The Critic say now?” The new set of negative thoughts was written down and then challenged. This was repeated until Paul’s emotional belief in the thoughts was mostly eliminated. Table 5.9 shows the full exercise.

Attentional focus

In reviewing what he and Paul had done, the therapist pointed out that The Critic’s standards of perfection drove Paul to attend to and evaluate his performance constantly for any possible flaws. This increased his anxiety and led him to conclude that he failed. However, when he focused instead on the goal of the interaction (in the case of the phone conversation, communicating caring to his cousin and catching up on each other’s lives), it seemed that he had succeeded. The therapist recommended that Paul begin focusing on and evaluating his performance on the basis of his goals with the other person, rather than on his own actions and/or signs of anxiety.

Schema restructuring

Much of the next session was spent reviewing Paul’s current social interactions. However, Paul said that he thought the recent work they had been doing regarding the impact of his father on his self-esteem had been helpful, and he

TABLE 5.9. Point–Counterpoint Exercise Regarding Phone Conversation with Paul's Cousin

The Critic's comments	Rational responses (degree of belief in negative thoughts)
<p>“Ha! You call that a good conversation?” “It was just a bunch of clichés.”</p>	<p>“It wasn't perfect—but most conversations aren't, especially with people I haven't seen in years. I hardly know these cousins, and I'm not so tuned into their lives.” (80%)</p>
<p>“You suck at conversations.” “Everything you said was polite and pat. You can't even remember the kids' names.”</p>	<p>“Many conversations are like that—polite and pat. The conversation with his wife was good—I engaged her by asking about their son. She didn't know I didn't remember his name.”</p>
<p>“You couldn't even speak [the family's native language].”</p>	<p>“I don't suck at conversations. The other persons are just as involved. My cousin is not a talkative guy. The problem is my perception that I suck (and your critical voice).” (50%)</p>
<p>“Yeah, I heard it all before. You make some good points. But the bottom line is you suck at conversations. If you didn't, this wouldn't be an issue.”</p>	<p>“Yes, my [language] is rusty, but I still manage. They are used to it. We even joke about it.” (40%)</p>
<p>“Yeah, I heard it all before. You make some good points. But the bottom line is you suck at conversations. If you didn't, this wouldn't be an issue.”</p>	<p>“It's just like you to nag and look at the glass half empty. Not every conversation has to be or will be perfect. The cousins were just happy to reach me by phone. A warm response from me was good enough for them. You are seeking perfection—again.” (20%)</p>

wanted to continue working along those lines. The therapist suggested that Paul try writing two letters to the father he remembered from childhood. The first was to be from Paul as an adult, the second an imagined letter from his uncle.

*Imagery
rescripting*

Paul brought his letters to the next session. He was asked to imagine his father (as Paul knew him when he was a boy) sitting in an empty chair across from him. He then read each letter out loud to his father. The first letter expressed love for his father, but also spoke of how much Paul had wanted to please him and how much his criticism had hurt. The letter from the uncle, however, was the more moving. It started with great respect for the father, but went on to speak eloquently of the uncle's observations of how his father had treated Paul and the impact he had observed. At the end of the session, Paul said that he had found writing and reading the letters hard, but also very helpful in allowing him to see that the voice of The Critic had more to do with his father's unreasonable expectations than with any failings on his own part.

Sessions 20–24

Application of schema work to current situation

Over the next several sessions, Paul and the therapist continued working on exposure exercises and cognitive challenges to the voice of The Critic. A few weeks after the exercise with the two letters, Paul described an interaction with his boss. His boss had returned a brief with a request for substantial changes. For the first time, Paul said something to the boss about the fact that what the boss was asking for in the revision was very different from the original directions he had given Paul. Paul's boss admitted that Paul was right on this point. He also said that he knew he was sometimes perceived as difficult, but that he felt that this was what his job required. Paul was pleased that he was able to get this much of an acknowledgment from his boss. The therapist reflected that although he had not specifically worked on assertion with Paul or even suggested it, it seemed that something from their recent work regarding his father had enabled Paul to defend himself in this situation.

Sessions 25–42

Extended treatment

Paul indicated that he was feeling much better. He was no longer depressed; he was significantly less anxious about his job; and, although he believed he still had further to go, he felt more comfortable around other people. He said that he wanted to continue working on his social fears, including dating, but that he wanted to meet less often. Given the progress Paul had made, the therapist agreed to meet once every 2 weeks.

Tapering treatment

Paul and the therapist met for approximately 10 more months, eventually stretching out meetings to once a month.

Exposure

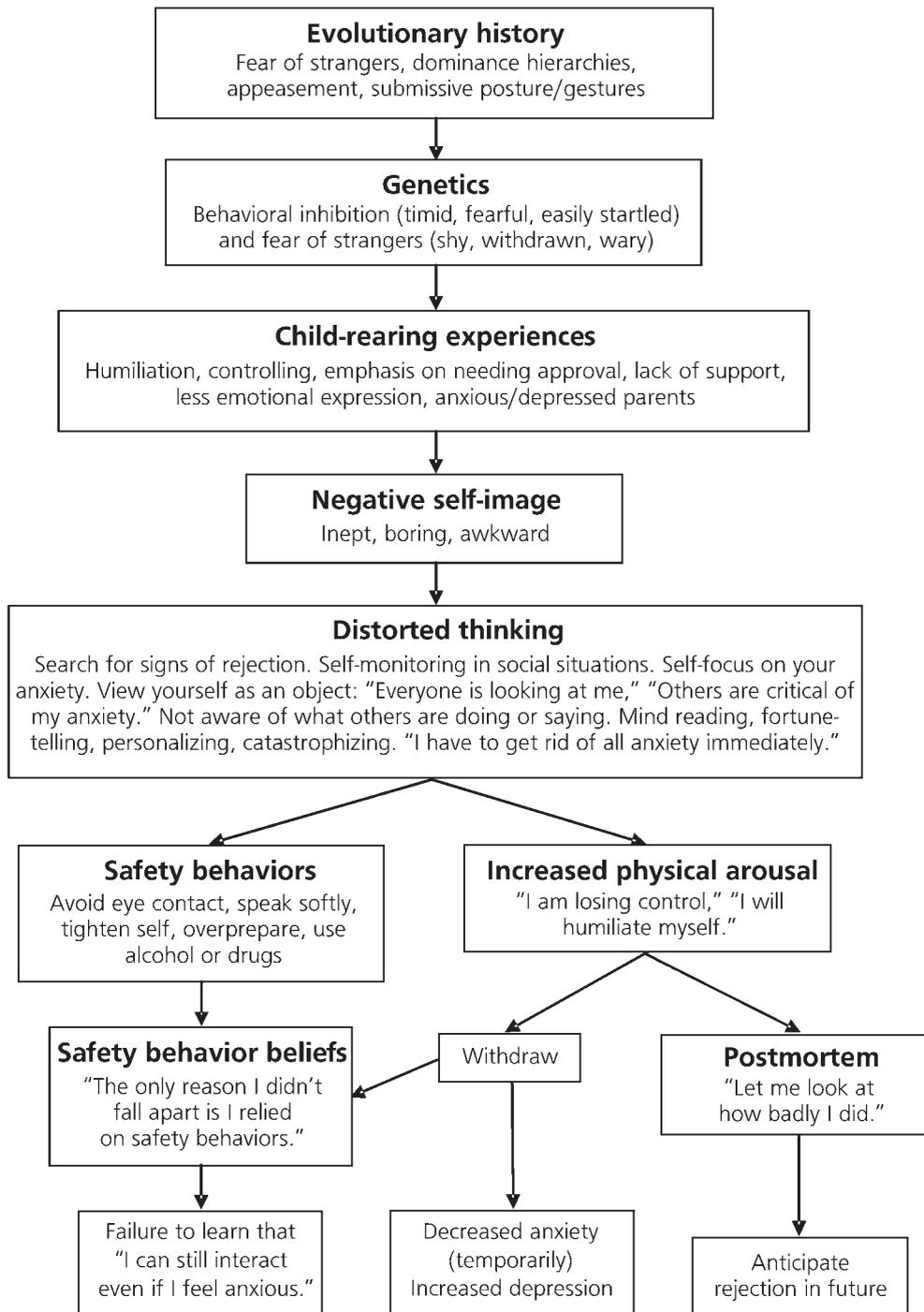
Exposure exercises included talking to women Paul found attractive at social events and dating women he met through online dating services.

Paul continued to make progress. By the end of treatment, he had begun regularly dating a woman he had met through a website. He was no longer as anxious at his job, but he had decided that he did not want to continue to work for his current boss and had begun applying for other positions. He felt that he now had the tools he needed to “fly on his own” for a while. The therapist agreed.

Termination

He and Paul discussed possible future stressors and reviewed techniques Paul had found helpful. Therapy was terminated with the understanding that Paul could contact the therapist again at any point in the future if he felt the need.

FORM 5.1. The Causes of Social Anxiety



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FORM 5.2. Social Anxiety Questionnaire (SAQ) for Patients

Patient's name: _____ Today's date: _____

Listed below are social situations that commonly make people anxious. Please rate how anxious you usually feel in each situation. If the situation is one you avoid, rate how anxious you think you would feel if you were in the situation. Please add any additional social situations that cause you anxiety.

Situation	None (0)	A little (1)	Moderately (2)	A lot (3)
Speaking in front of other people	_____	_____	_____	_____
Going to parties	_____	_____	_____	_____
Meeting new people	_____	_____	_____	_____
Starting a conversation	_____	_____	_____	_____
Disagreeing with someone	_____	_____	_____	_____
Talking to a superior at work	_____	_____	_____	_____
Asking someone for a date	_____	_____	_____	_____
Going to business meetings	_____	_____	_____	_____
Looking someone in the eye	_____	_____	_____	_____
Eating or drinking in front of other people	_____	_____	_____	_____
Writing in front of other people	_____	_____	_____	_____
Asking for help or directions	_____	_____	_____	_____
Using public bathrooms when others are present	_____	_____	_____	_____
Other:	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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FORM 5.3. Evaluation of Social Anxiety Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Social Anxiety Questionnaire (SSQ) _____ Beck Depression Inventory (BDI-II (BDI-II)) _____

Beck Anxiety Inventory (BAI) _____ Dyadic Adjustment Scale (DAS) _____

Global Assessment of Functioning (GAF) _____

Other questionnaires (specify): _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Treatment
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(cont.)

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FORM 5.3. Evaluation of Social Anxiety Disorder (p. 2 of 2)

Previous episodes of depression or other psychiatric disorder (specify nature):

Onset	Duration	Precipitating events	Treatment
-------	----------	----------------------	-----------

Treatment progress (later evaluations only)

Completed exposures: _____

Situations still avoided _____

Remaining safety behaviors: _____

Cognitive distortions to be addressed: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 5.5. Safety Behaviors Inventory for Patients with Social Anxiety

Patient's name: _____ Week: _____

Please list any behaviors that you do or avoid doing in social situations in order to feel less anxious. Examples of behaviors you might do to feel less anxious are holding a glass tightly so no one sees your hand shaking or sitting in the back of a class so no one looks at you. Examples of behaviors you might avoid are introducing yourself to a stranger or disagreeing with someone. In the second column, please note how anxious you would feel if you changed the behavior, from 0 (no anxiety) to 10 (maximum anxiety).

Safety behaviors	Distress (0–10)
Behaviors done: _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____
Behaviors avoided: _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____

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FORM 5.6. Information for Patients about Social Anxiety Disorder

WHAT IS SOCIAL ANXIETY DISORDER?

Social anxiety disorder is the fear of one or more social situations. Commonly feared situations include public speaking, meeting new people, being at parties, asking for dates, eating in public, using public restrooms, speaking to people in authority, and disagreeing with others.

People with social anxiety disorder are afraid they will act in ways that will make other people think badly of them. They often fear that others will see some sign of anxiety, such as blushing, trembling, or sweating. People with social anxiety disorder usually try to stay away from the situations that make them anxious. When they cannot avoid a situation, they tend to feel very anxious or embarrassed. Sometimes they may have panic attacks. Social anxiety disorder is a severe form of shyness that can cause problems in people's lives. Sometimes these problems are minor, such as not being able to speak up in class. Sometimes, however, the problems can be very serious. People with severe social anxiety disorder often have few friends, feel chronically lonely, and have trouble reaching their goals in school or at work.

WHO GETS SOCIAL ANXIETY DISORDER?

Social anxiety disorder is very common. More than one out of eight people will suffer from social anxiety disorder at some point in their lives. Many more people have symptoms of shyness that are not severe enough to be called social anxiety disorder. Social anxiety disorder usually starts when people are in their early teens, but it can begin much earlier. If people do not get help, the problem can last for years.

WHAT CAUSES SOCIAL ANXIETY DISORDER?

A number of factors can contribute to the development and maintenance of social anxiety disorder:

- **Genetics.** People with social anxiety disorder often have relatives who are anxious or shy.
- **Prior experiences.** Many people with social anxiety disorder remember having been embarrassed or humiliated in the past. This leads them to be afraid that the same thing will happen again. Negative experiences with parents, other family members, and/or peers may all contribute to social anxiety.
- **Negative thinking.** People with social anxiety disorder often have negative expectations about what will happen in social situations. Common thoughts are "I won't be able to think of anything to say," "I'll make a fool of myself," and "People will see I'm anxious." They also tend to have standards that are hard to meet, such as "I should never be anxious," "You have to be beautiful and smart to be liked," or "I have to get everyone's approval." Typically they have negative beliefs about themselves, such as "I'm boring," "I'm weird," or "I'm different from other people."
- **Avoidance:** People with social anxiety disorder often avoid situations that make them afraid. This helps them feel less anxious in the short run. In the long run, avoidance prevents them from learning that their social fears are exaggerated, which keeps them feeling anxious.
- **Safety behaviors:** Sometimes people participate in social situations, but do certain things to try to avoid possible embarrassment, such as not asking questions or holding a glass tightly so no one will see their

(cont.)

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hand shake. These “safety behaviors,” like avoidance, prevent people from learning that they can do well in social situations without extra effort.

- **Lack of social skills.** Some people with social anxiety disorder never had the chance to learn social skills. This can cause them to have problems in social situations. Other people with this disorder have good social skills, but get so anxious that they have a hard time using them.

HOW DOES COGNITIVE-BEHAVIORAL THERAPY FOR SOCIAL ANXIETY DISORDER WORK?

Cognitive-behavioral therapy helps you change the beliefs that cause your fear. Your therapist will teach you how to recognize your negative thoughts and to think more realistically about social situations and about yourself. He or she will also help you gradually face the situations you have been afraid of in the past. This allows you to discover that your fears usually do not come true, and that the consequences of any negative things that might happen are not so bad. Over time, you are likely to feel less anxious and more confident. In addition, your therapist can teach you social skills and ways to relax if necessary.

A number of studies have shown that most people who get cognitive-behavioral therapy for social anxiety disorder feel less anxious. People usually continue to feel better even after therapy has stopped.

HOW LONG DOES THERAPY LAST?

For people with mild to moderate social anxiety disorder, 16–20 sessions is usually enough. People with fear of just one social situation, such as public speaking, may need fewer sessions. People with more serious symptoms may need more.

CAN MEDICATION HELP?

Several different types of medication have been found to be helpful for social anxiety disorder. Your physician or a psychiatrist can recommend whether medication might be a good option for you. Medication may provide more rapid initial relief. However, cognitive-behavioral therapy has been found to be at least as effective as medication and may provide better long-term outcome.

WHAT IS EXPECTED OF YOU AS A PATIENT?

Many people feel anxious at the beginning of therapy. It is common to worry about being embarrassed or judged in therapy, and to wonder whether you can be helped. All you have to do is be willing to give therapy a try. Your therapist will teach you things you can do to help yourself and ask you to practice them between sessions. Early exercises will be quite easy, but they will become more challenging as you feel more comfortable. The more you work on these exercises, the more likely it is that your social anxiety disorder will get better.

Posttraumatic Stress Disorder

DESCRIPTION AND DIAGNOSIS

Symptoms

By definition, posttraumatic stress disorder (abbreviated PTSD in the text of this chapter) is a reaction to a traumatic event. Typical traumatizing events include combat, sexual or physical assault, serious accident, disasters, incarceration or torture, and being diagnosed with a life-threatening illness.

The primary symptoms of PTSD include intrusive recollections of the traumatic event. These may come in the form of recurrent memories, nightmares, or flashbacks (in which the person perceives him- or herself to be in the traumatic situation again). In addition, people with PTSD tend to avoid internal and external cues associated with the trauma; this avoidance often leads to feelings of emotional numbness or detachment. They also experience persistent increased arousal, which can result in chronic anger, insomnia, impaired concentration, and an ongoing sense of being in danger.

In order to qualify for a diagnosis of PTSD, a person must have experienced these symptoms for a minimum of 1 month. If the symptoms have lasted less than 3 months, the disorder is described as “acute”; otherwise, it is described as “chronic.” If symptoms did not begin until more than 6 months after the trauma, the disorder is described as “with delayed onset.” People who experienced a trauma less than 1 month ago, but who have had PTSD-like symptoms that result in significant impairment for at least 2 days, are diagnosed with acute stress disorder.

For a detailed description of the current diagnostic criteria for PTSD, refer to DSM-IV-TR (American Psychiatric Association, 2000, pp. 463–468).

Prevalence and Life Course

Approximately 60% of men and 50% of women report experiencing at least one traumatic event in their lifetimes (Schnurr, Friedman, & Bernardy, 2002). However, only a minority of these will develop PTSD. Lifetime prevalence estimates for PTSD in community samples range from 6.8% to 7.8% (Kessler, Berglund, et al., 2005; Mendes, Mello, Ventura, Passarela, & Mari, 2008). Women are twice as likely to meet criteria for PTSD as are men (10% vs. 5%). The most common precipitating events are sexual abuse for women and combat for men (Mendes et al., 2008).

Victims of rape have been found to have prevalence rates between 31% and 57% (Foa & Riggs, 1994). Combat veterans have a 20% occurrence of PTSD (Benish, Imel, & Wampold, 2008). Other common precipitants are natural disaster and life-threatening accidents (Schnurr et al., 2002).

PTSD can occur at any age. Symptoms generally appear shortly after the trauma, and the majority of people who meet criteria for acute stress disorder will go on to develop PTSD. However, in some cases symptoms do not develop until months or even years after the event. For example, one study found that 46% of patients with PTSD did not have significant symptoms in the first month after the trauma (Kleim, Ehlers, & Glucksman, 2007). For those patients who do meet criteria for PTSD, approximately half will have spontaneous remission of symptoms within 3 months. For other patients, however, PTSD symptoms may persist (often for many years) and may cause significant long-term impairment (American Psychiatric Association, 2000).

Research has identified several factors making it more likely that someone who has been exposed to trauma will develop PTSD. Direct exposure to the event, greater severity, longer duration, and perceived threat of death are all associated with increased risk. Dissociation during the event, more severe initial reaction, and poor postevent social support are also risk factors (Schnurr et al., 2002). Premorbid factors that predict development of PTSD include younger age at time of trauma, lower education level, low intelligence, family history of mental disorder, previous psychiatric illness, personality pathology, childhood adversity, and conduct problems in childhood. Studies controlling for type of event have found that women are four times as likely as men to develop PTSD (Schnurr et al., 2002; Stein, Jang, Taylor, Vernon, & Livesley, 2002).

Genetic/Biological Factors

Approximately 30% of the variance in who develops PTSD is attributable to genetics. In one twin study, PTSD was only found in probands whose twins also had an anxiety disorder. The role of genes is believed to be mediated through a causal pathway that includes the influence of the type and severity of the traumatic event, environmental factors, and personality factors (Stein et al., 2002).

Leahy (2009) has proposed a model of PTSD suggesting that the propensity to avoid cues associated with prior traumatic events served an adaptive function in the evolution of the human species: Avoiding places and situations associated with prior trauma to the self or others would increase the odds of survival. PTSD develops when people allow this universal genetic tendency to determine their behavior after a trauma, rather than basing their actions on a realistic appraisal of current risks.

Coexisting Conditions

Comorbidity is the rule rather than the exception for PTSD, with 88% of men and 79% of women reporting at least one other psychiatric disorder (Dunner, 2001). In fact, 59% of men and 49% of women have three or more concurrent diagnoses. Among combat veterans, the rate of comorbidity is 98.9% (Schoenfeld, Marmar, & Neylan, 2004).

Depression, substance abuse, and other anxiety disorders are the most common coexisting

diagnoses. Depression occurs in approximately 48% of those who suffer from PTSD, and in 78% of those cases the depression followed the onset of PTSD. Alcohol abuse is found in 51.9% of men and 27.9% of women with PTSD, while other forms of substance abuse are found for 34.5% of men and 26.9% of women. Other anxiety disorders occur in 55% of those with PTSD (Dunner, 2001; Schoenfeld et al., 2004).

Various other features are commonly associated with PTSD, including intense feelings of guilt, shame, disgust, and/or despair; impaired affect regulation; dissociative symptoms, including depersonalization and derealization; excessive anger and hostility; impulsive and self-destructive behavior; impaired interpersonal relationships; marital/couple distress and sexual difficulties; poor work performance; and somatic complaints, such as headaches, joint pain, colitis, and respiratory problems.

Differential Diagnosis

PTSD is differentiated from adjustment disorder by the severity of the event; in order for a diagnosis of PTSD to be given, the event must be extreme and traumatic. As noted above, acute stress disorder would be a more appropriate diagnosis for a patient whose symptom picture resembles PTSD but who experienced the traumatic event less than 4 weeks prior to the assessment. If intrusive thoughts are present, they must be related to a trauma; otherwise, a diagnosis of obsessive–compulsive disorder should be considered. Similarly, intense flashbacks may at times resemble the hallucinations associated with psychotic disorders. However, as long as they are associated with a trauma, PTSD is more likely to be the appropriate diagnosis.

In the process of diagnosing PTSD, malingering must be ruled out any time there is the possibility of gain from the disorder (e.g., a damage award or veterans' benefits). In such cases, verification of the trauma should be obtained, most commonly from police or military records. More extensive assessment, including use of the Minnesota Multiphasic Personality Inventory–2 (MMPI-2), may be appropriate. The clinical presentation may also hold some clues. If the patient tells the trauma story with eagerness or ease (as opposed to the avoidance more commonly seen), or if the trauma appears vague and nonspecific, the clinician should be alert to the possibility of malingering.

Figure 6.1 is a diagnostic flow chart that depicts the differential diagnosis of PTSD.

UNDERSTANDING POSTTRAUMATIC STRESS DISORDER IN COGNITIVE–BEHAVIORAL TERMS

Behavioral Factors

The behavioral conceptualization of PTSD is based on Mowrer's (1960) two-factor theory of anxiety. According to this model, anxiety and other emotions experienced during a traumatic event become linked in the patient's mind to sights, sounds, and other sensations that occur during the event. This process is a form of classical conditioning. These sights, sounds, and other sensations thus become cues that evoke anxiety when they are encountered again later.

The range of cues that can elicit anxiety increases over time, due to two processes: (1)

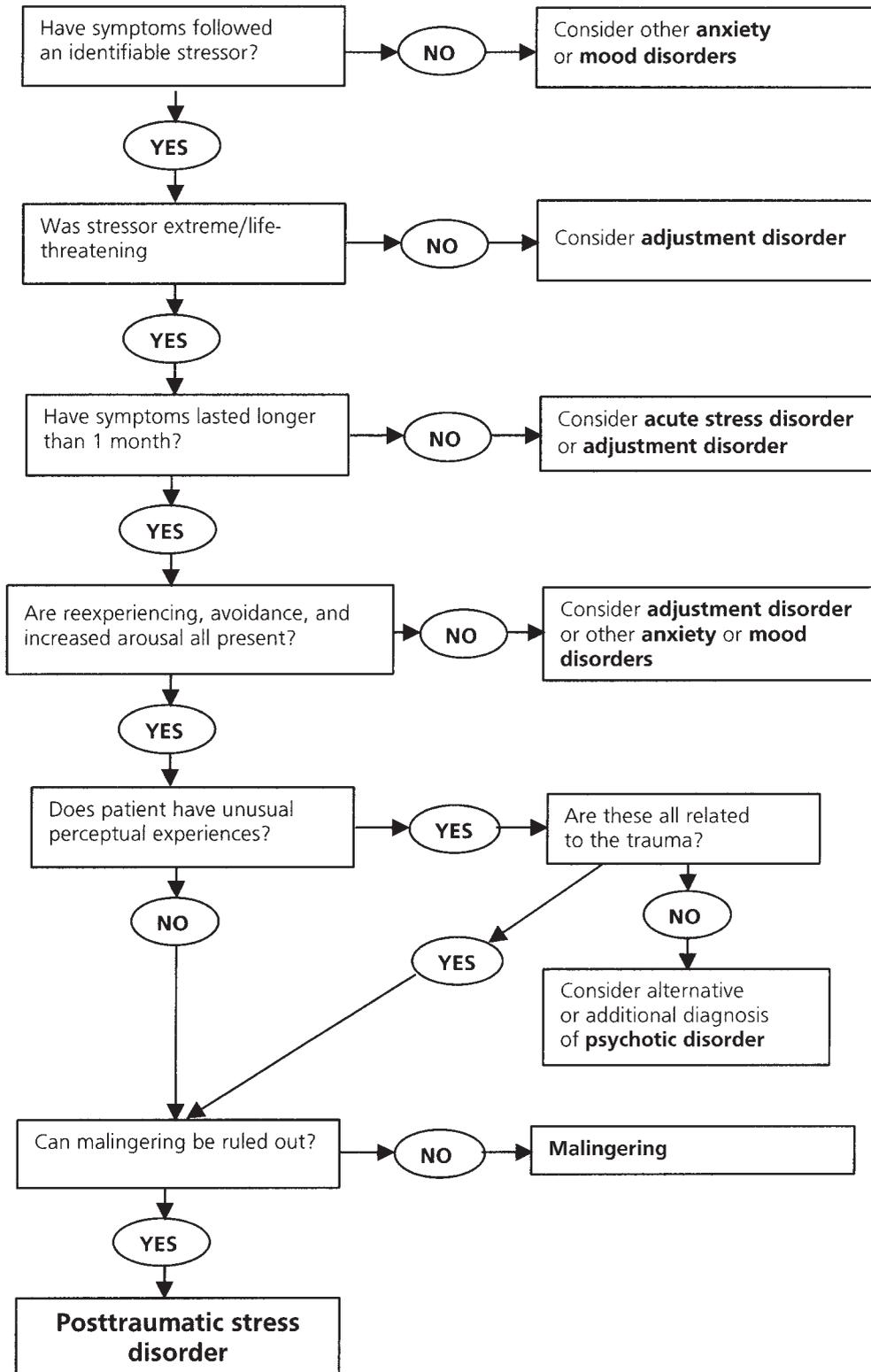


FIGURE 6.1. Diagnostic flow chart for posttraumatic stress disorder.

generalization, whereby cues that are similar to the original cue begin to evoke anxiety; and (2) higher-order conditioning, whereby a cue that was originally neutral comes to evoke anxiety because it has become associated with anxiety triggered by other cues. For example, a woman who was raped while walking home alone at night may begin to fear not only being out at night (the original cue), but also any dark place (generalization). She may also come to fear her therapist's office, where she has been discussing the rape (higher-order conditioning). It should be noted that anxiety-arousing cues can be external (places, sights, sounds) or internal (thoughts, memories, physical sensations, or emotional states).

The second part of the two-factor theory involves avoidance. Cues that remind the person of the event evoke anxiety, so he or she tries to avoid them. When a cue is avoided, the person's anxiety decreases. The reduction in anxiety serves as a reward that increases the likelihood of the person's avoiding the cue in the future. This is a form of operant conditioning. Thus avoidance becomes used increasingly often as a coping strategy. Because the cues that are avoided can be internal, such as thoughts or emotions, avoidance may lead to emotional numbing. Often alcohol or drugs are used as a way to avoid internal cues, and this leads to substance abuse or dependence.

Avoidance behaviors help maintain PTSD symptoms because, although they reduce anxiety in the short run, they prevent habituation to the cues that trigger traumatic memories and emotions. For this reason, substance abuse and other forms of avoidance interfere with the natural process of recovery.

Cognitive Factors

The behavioral model provides explanations for both the reexperiencing and avoidance symptoms of PTSD. However, it has been criticized as failing to account adequately for the repeated alternation between reexperiencing and avoidance/numbing that is commonly seen in the disorder, or for the persistent hyperarousal. It also fails to account for the altered sense of meaning reported by many patients with PTSD (Foa & Riggs, 1994).

Foa and her colleagues (Foa, Hembree, & Rothbaum, 2007; Foa & Riggs, 1994; Foa, Rothbaum, & Molnar, 1995; Foa, Stetekee, & Rothbaum, 1989) have proposed a cognitive model of PTSD that incorporates elements of the behavioral model. They propose that when a person experiences a trauma, a "fear structure" is formed in memory, consisting of three elements: (1) stimuli (the sights, sounds, and other sensations associated with the event); (2) responses (physiological and emotional reactions to the event); and (3) the meanings associated with the stimuli and responses. This fear structure forms a program for escaping from danger. Like the behavioral model, Foa's model proposes that cues associated with the trauma activate the fear structure—causing reexperiencing of the memories and responses, and leading to attempts to avoid such cues.

However, Foa's model also emphasizes the importance of the meaning element of the fear structure. Traumatic events often violate several commonly held assumptions and schemas: (1) "The world is safe," (2) "Events are predictable and controllable," (3) "Extreme negative events will not happen to me," and (4) "I can cope with whatever events arise." Foa proposes that when an event is experienced that contradicts such basic schemas, there is a natural push to make sense of the experience. If the meanings associated with the trauma (e.g., "Dangerous events can

happen without warning,” “They can happen to me,” and “I may be unable to cope”) cannot be assimilated into existing schemas, there will be a need to revise the schemas—a process referred to as “accommodation.”

The process of making sense of the trauma and revising existing schemas is difficult for a person with PTSD, because the activation of the meaning element of the fear structure also activates the response element. This leads to reexperiencing of the intense emotional responses associated with the trauma. Since the emotions feel overwhelming, the person tries to stop thinking about the memories. This avoidance blocks the process of integrating the meanings associated with the trauma with existing schemas. A pattern then develops of alternating between attempts to come to terms with what happened (which lead to reexperiencing), and attempts to avoid the memories and negative emotions. According to Foa’s model, the tension between the need to find meaning and the need for avoidance leaves the person in a persistent state of hyperarousal. Alternatively, for people with preexisting negative views of themselves and the world (often the result of prior traumas), a traumatic experience may serve to activate and reinforce negative schemas; the result is negative emotion, followed by avoidance that prevents the development of more adaptive beliefs.

Resick and Schnicke (1993) have proposed a further elaboration of the role of schema processing in PTSD. As Foa and her colleagues do, Resick and Schnicke suggest that traumatic events often violate commonly held schemas about safety and personal competence. When people cannot assimilate the traumatic experience into their existing schemas, they will tend to avoid or deny memories or meanings associated with the event. For example, a woman who was sexually assaulted by an acquaintance may say that what happened was not rape, because it does not fit with her model of rape as something done by a stranger to a woman who is out alone at night. Alternatively, people may overaccommodate their schemas to fit the traumatic experience, resulting in overgeneralized, all-or-nothing beliefs about issues such as safety, trust, power, control, self-esteem, self-blame, and intimacy. For example, the same woman may have believed before the rape that she is personally safe and competent to protect herself, but afterward she may come to believe that she is constantly at risk and unable to do anything to keep herself from harm; therefore, she may conclude that she should avoid any potentially dangerous situations, including any intimate contact with men.

Although the models of Foa et al. and Resick and Schnicke, with their emphasis on information processing, can account for many PTSD symptoms, some have suggested that they do not adequately explain the effects of PTSD on memory (Brewin & Holmes, 2003). Specifically, people with PTSD show the seemingly contradictory phenomenon of excessive access to trauma-related memories in the form of intrusive images and flashbacks, while simultaneously having difficulties retrieving full and coherent narratives of the traumatic event.

Brewin, Dalgleish, and Joseph (1996) have proposed a dual-representation theory of memory to account for the disturbances of memory that occur in PTSD. They suggest that two separate memory systems operate in parallel. “Verbally accessible memory” (VAM) includes narrative and conceptual memories that are coded in the context of other autobiographical information, and are therefore placed within the framework of a person’s past, present, and future. “Situationally activated memory” (SAM) consists of perceptual memories that are encoded without significant conscious processing and that are not placed in conceptual or narrative context. The emotional intensity of the trauma event inhibits full encoding in the VAM system, resulting in incom-

plete narrative memories. Flashbacks and other forms of reexperiencing result from activation of strongly encoded SAM memories. The process of recovery from PTSD is believed to involve the integration of SAM memories into the VAM system. Once this takes place, the trauma is primarily recalled through the VAM system. SAM memories are still present; however, recall through the VAM system inhibits access to the SAM system, thus reducing the occurrence of reexperiencing symptoms (Brewin & Holmes, 2003).

Ehlers and Clark (2000) have proposed a cognitive model of PTSD that integrates information-processing and memory models. They suggest that PTSD results when people process the trauma in ways that result in an on-going sense of current threat. Three factors are involved: (1) negative appraisals of the trauma and its sequelae; (2) poor elaboration and contextualization of the trauma memory, along with strong associative memory and perceptual priming; and (3) maladaptive behavioral strategies and cognitive processing styles that inhibit recovery. Specifically, people with PTSD tend to have negative thoughts about the fact that the trauma happened (e.g., “Nowhere is safe,” “I deserve bad things to happen to me”); about the initial symptoms of PTSD (e.g., “I’m going mad,” “I’m dead inside,” “I’ll never be able to relate to people again”); about other people’s reactions (e.g., “People think I’m weak,” “I can’t rely on anyone”); and about practical consequences of the trauma (e.g., “My body is ruined,” “I’ll never lead a normal life again”). The experience of “mental defeat” during the trauma (e.g., the belief that one has lost all personal control and autonomy) has been shown to be strongly predictive of PTSD (Kleim et al., 2007).

Similar to Brewin and Holmes’s (2003) model, Ehlers and Clark’s model suggests that strong associative memories of stimuli and responses from the trauma are not sufficiently integrated with autobiographical memory, resulting in an experience of “nowness” associated with trauma memories. Maladaptive coping strategies include thought suppression; avoidance of situations and other cues associated with the trauma (e.g., the site of the trauma, television shows with themes related to the trauma); dissociation; use of alcohol, illicit drugs, or medications; rumination; avoidance of previously rewarding activities; and safety behaviors (e.g., sleeping with a knife in the bed to prevent another attack). Although these coping strategies may result in short-term reductions in distress, they maintain the sense of current threat by exacerbating PTSD symptoms, preventing disconfirmation of negative beliefs, and inhibiting integration of trauma memories into autobiographical context in a way that would place the trauma in the past.

Jackson, Nissenson, and Cloitre (2009) have proposed a model of “complex” PTSD that can result from exposure to prolonged traumas, such as childhood abuse and being a prisoner of war. They suggest that for people subjected to these kinds of events, problems with emotional regulation, including anger, and problems with interpersonal relationships can contribute as much or more to functional impairment as the defining PTSD symptoms of reexperiencing, avoidance, and hyperarousal (Levitt & Cloitre, 2005).

Drawing on the conceptual models cited above, Leahy (2009) has suggested that PTSD can be seen as a set of maladaptive “rules” for interpreting and responding in the aftermath of trauma. Table 6.1, which can be discussed with patients, shows these “rules.” An overview of the origins, processes, and factors that maintain PTSD, based on the models outlined above, is shown in Form 6.1 (Leahy, 2009); this can be used as a handout for patients. Finally, examples of typical distorted automatic thoughts, maladaptive assumptions, and dysfunctional schemas for patients with PTSD are provided in Table 6.2.

TABLE 6.1. Maladaptive "Rules" in Posttraumatic Stress Disorder

-
1. Since something terrible happened, then terrible things will happen again.
 2. Images and sensations are a sign of danger.
 3. You have to stop having any memories of what happened.
 4. If you feel afraid, then it's happening again.
 5. Avoid anything that reminds you of the trauma.
 6. Try to numb yourself so you don't feel anything.
 7. Your life is changed forever.
-

Note. Adapted from Leahy (2009). Copyright 2009 by Robert L. Leahy. Reprinted by permission.

TABLE 6.2. Examples of the Three Types of Cognitive Distortions in Posttraumatic Stress Disorder

<u>Distorted automatic thoughts</u>
"What happened is my fault."
"I should have been able to prevent it."
"I should have been able to handle the situation."
"I should be over this by now."
"I am weak."
"I can't stand these feelings."
"Something terrible could happen at any minute."
"I'm in danger now."
"I can't let my guard down."
"I can't handle this situation."
"I'm helpless."
"You can't trust anyone."
"No one cares."
"No one will be there to help me if I need it."
<u>Maladaptive assumptions</u>
"Because I could not control what happened, there is no point in trying to control anything."
"Because I could be in danger at any time, I must maintain control at all times."
"I must always be on the alert."
"I'll be overwhelmed if I think about what happened."
"It is better to avoid any potentially dangerous situation than endure risk."
"All risk is bad."
"I wouldn't be able to stand another loss."
<u>Dysfunctional schemas</u>
"The world is inherently unpredictable and dangerous."
"Bad things can happen at any time."
"You can't trust anyone."
"I am powerless to prevent catastrophe."
"I am a bad person."
"Life is meaningless."
"The future is bleak."

OUTCOME STUDIES OF TREATMENTS FOR POSTTRAUMATIC STRESS DISORDER

A number of different cognitive-behavioral treatments for PTSD have been developed, based on the conceptualizations described above. These include the following:

- **Relaxation:** Patients are taught to reduce physical tension by using techniques such as progressive muscle relaxation, controlled breathing, and/or biofeedback.
- **Systematic desensitization:** Patients are repeatedly exposed to brief presentations of trauma cues in imagination while undergoing relaxation.
- **Stress inoculation training:** Patients are taught to manage anxiety symptoms by using techniques such as muscle relaxation, breathing retraining, guided self-dialogue, and thought stopping.
- **Prolonged exposure:** Patients are asked to expose themselves repeatedly and for prolonged periods to memories and other cues associated with the trauma, until those cues no longer evoke anxiety.
- **Eye movement desensitization and reprocessing (EMDR):** Patients are asked to recall aspects of the trauma in brief segments, and to report any spontaneous thoughts or images that arise, while engaging in side-to-side eye movements.
- **Cognitive restructuring:** Patients are taught to identify negative beliefs related to the trauma and to form more realistic appraisals of the implications of their experience.

Some treatment protocols have involved combinations of these techniques. Foa, Rothbaum, and Furr (2003) have tested various combinations of exposure, stress inoculation training, and cognitive restructuring. Cognitive processing therapy (Resick & Schnicke, 1993) involves written exposure exercises and cognitive restructuring. Smucker and Niederee (1995) developed a program for treating incest-related PTSD that combines imaginal exposure with imagery rescripting, a procedure in which a client reimagines traumatic events with the adult self intervening, first to protect and then to nurture the childhood self. Cloitre and colleagues (Cloitre, Cohen, & Koenen, 2006; Levitt & Cloitre, 2005) have developed a treatment program for complex PTSD that involves two stages: (1) training in affective regulation and interpersonal effectiveness, using skills adapted from stress inoculation training and dialectical behavior therapy (Linehan, 1993); and (2) imaginal exposure with cognitive interventions.

Results

In general, cognitive-behavioral therapy has been shown to be an effective treatment for PTSD. Bradley, Greene, Russ, Dutra, and Westen (2005), in a review of 26 studies, found that 67% of patients treated with some form of cognitive-behavioral therapy no longer met criteria for PTSD. Types of trauma successfully treated with such therapy included combat, sexual and physical assault, childhood sexual abuse, motor vehicle accidents, and political violence. Combat-related PTSD has been found to be the most difficult to treat, yielding the lowest remission rates of any group (Bradley et al., 2005; Foa, Keane, Friedman, & Cohen, 2009).

Prolonged exposure, cognitive restructuring, stress inoculation training, EMDR, and cognitive processing therapy have all been found to perform better than waiting-list controls, treatment as usual, and/or supportive counseling. Comparisons among these forms of cognitive-behavioral treatment have generally found equivalent outcomes (Benish et al., 2008; Bisson et al., 2007; Foa et al., 2009; Mendes et al., 2008). When compared directly, cognitive processing therapy and prolonged exposure have been found to be equally effective (Solomon & Johnson, 2002). Some studies have found slight differences in outcome between EMDR (Shapiro, 1999) and other forms of cognitive-behavioral treatment; however, the direction of the differences has been inconsistent (Lee, Gavriel, Drummond, Richards, & Greenwald, 2002; Taylor et al., 2003).

Foa et al. (2009) reviewed the quality of the evidence for various cognitive-behavioral treatments for PTSD. They found the strongest support, in the form of the largest number of high-quality controlled clinical trials, for exposure. Cognitive restructuring, cognitive processing therapy, and EMDR were also found to have good empirical support. Findings for stress inoculation training were inconsistent but generally positive. Relaxation has been used as a control condition in clinical trials for other forms of cognitive-behavioral treatment, and has generally resulted in a poorer outcome when used as a stand-alone treatment for PTSD. Systematic desensitization has less empirical support than other forms of cognitive-behavioral treatments. There is little evidence for the effectiveness of group cognitive-behavioral therapy for PTSD; individual therapy is considered the treatment of choice. The only exception to this is that imagery rescripting, combined with training in sleep hygiene, has been found to be effective as a group intervention when targeted to trauma-related nightmares. Virtual-reality recreations of traumatic events have been shown to be an effective form of exposure; however, to date there are no studies directly comparing virtual reality to other forms of exposure (Foa et al., 2009).

Dismantling Studies

Dismantling studies of EMDR have consistently found that the eye movements used in the treatment do not improve outcome, nor do other alternating stimuli such as finger taps. It has been argued that the effective component of EMDR is imaginal exposure (Benish et al., 2008).

Dismantling studies that have attempted to determine the relative contribution of exposure and cognitive restructuring have yielded inconsistent results. Foa's group has compared prolonged exposure alone to combinations of prolonged exposure with cognitive restructuring or stress inoculation training. Prolonged exposure performed as well as the combination treatments. Treatment that included imaginal and *in vivo* exposure resulted in better outcome than imaginal exposure alone. Both prolonged exposure and cognitive restructuring resulted in reductions in negative thoughts, which in turn predicted improvement in PTSD symptoms (Foa et al., 2003; Foa, Hembree, et al., 2005; Foa & Rauch, 2004).

As a result of these findings, Foa's treatment protocol now consists primarily of prolonged exposure, with a brief introduction to breathing retraining and no explicitly cognitive therapy component (Foa et al., 2007). It should be noted, however, that Bryant et al. (2008) found that cognitive restructuring combined with exposure yielded better outcome than exposure alone, even when *in vivo* exposure was included. They suggest that the reason their results differ from Foa et al.'s is that they limited discussion of the patients' thoughts and feelings in the exposure-

only conditions, whereas Foa's protocol allows time for such discussion after every exposure session.

Resick's group has done a dismantling study of cognitive processing therapy, in which the full protocol was compared to the written exposure component alone and the cognitive therapy component alone. All three conditions resulted in reductions in PTSD symptoms and depression. However, the full package and the cognitive-therapy-only condition were both superior to the written-exposure-only condition (Resick et al., 2008). This may be due in part to the fact that the exposure component of cognitive processing therapy does not include *in vivo* exposure.

Cloitre and colleagues compared their treatment program, combining skills training in affective and interpersonal regulation with modified prolonged exposure, to either treatment alone. They reported better outcome for the combined treatment, along with a reduced dropout rate (Jackson et al., 2009). As noted above, this program was designed as a treatment for complex PTSD. Foa et al. (2009) caution that although skills training may improve outcomes for some patients, there is insufficient evidence at this time to support application of affective and interpersonal skills training to all patients.

Taken as a whole, the current outcome literature suggests that cognitive-behavioral treatments employing imaginal and *in vivo* exposure, cognitive restructuring, or the combination of exposure and cognitive restructuring to target the core fear structures of people who have been exposed to trauma will provide the best outcomes. Training in affective and interpersonal regulation skills may be useful for some patients, particularly those with severe PTSD symptoms and difficulty in tolerating exposure.

ASSESSMENT AND TREATMENT RECOMMENDATIONS

Rationale and Plan for Treatment

In keeping with the findings of the current outcome literature, the treatment package described in this chapter emphasizes exposure and cognitive restructuring. Training in coping skills, including affect and interpersonal regulation, can be included as needed, but is not used for all patients. Since exposure alone will frequently result in significant cognitive change, cognitive restructuring is used to prepare patients for exposure and to deal with remaining dysfunctional beliefs after exposure. We also recommend using cognitive-behavioral techniques to help patients cope with life problems that may be related to their trauma experience.

Most studies of cognitive-behavioral treatment for PTSD have involved between 8 and 12 sessions, lasting from 60 to 90 minutes each, scheduled once to twice a week (Foa et al., 2009). We have found that the empirically supported techniques from these studies can be effectively delivered in 45-minute sessions, although we still typically allow 90 minutes for at least the first exposure session. The use of shorter sessions is consistent with the finding reported by van Minnen and Foa (2006) that 30-minute imaginal exposure sessions were as effective as 60-minute sessions. Using this approach, we have found that 12–20 sessions, the majority of which last 45 minutes, are sufficient for most patients. Patients who have severe or chronic PTSD, who have a history of multiple traumas, or who show substantial disturbance in life functioning may require longer treatment.

The general treatment plan for PTSD is outlined in Table 6.3.

TABLE 6.3. General Plan of Treatment for Posttraumatic Stress Disorder

-
- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
 - Socialization to treatment
 - Skills training (optional)
 - Emotional regulation
 - Interpersonal skills
 - Exposure
 - Imaginal exposure to trauma memory
 - Exposure to internal and external cues
 - *In vivo* exposure to avoided situations
 - Cognitive restructuring
 - Coping with life problems
 - Phasing out treatment
-

Assessment

Although some patients with PTSD will present for treatment describing their symptoms as a response to a specific traumatic event, many others will present complaining of anxiety, depression, substance abuse, or problems of living without revealing a history of trauma. This may be because they do not make the link between their symptoms and the event, or because they are reluctant to discuss the trauma.

Tests and Clinical Interviewing

Self-report questionnaires can be useful for assessing patients with possible PTSD. The PTSD Checklist—Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993; see Form 6.2) is a commonly used measure of patients' current symptom level. Scores of 44 or higher suggest a likely diagnosis of PTSD. Changes in PCL-C scores can be used to track progress in therapy.

Patients should also fill out the standard intake form (see Chapter 2, Form 2.1). Additional self-report and interview measures may be used as needed, including the BDI-II, BAI, MCMI-III, DAS, and GAF. Form 6.3 provides space for recording initial assessment information, including scores on questionnaires; medication, alcohol, and/or other drug use; and history of any previous traumatic episodes or other psychiatric episodes. It may also be used later in treatment to note progress, targets for continued work in therapy, and recommendations.

Given the high prevalence of PTSD in clinical populations, all patients, regardless of their presenting problems, should be screened in the initial clinical interview for a history of trauma. Questions that can be included in standard intake interviews include the following:

“What is the most upsetting thing that ever happened to you?”

“Have you ever felt your life was in danger?”

“Have you ever been attacked or assaulted?”

“Have you ever been physically or sexually abused?”

Even when patients reveal a recent trauma, clinicians should always inquire about any history of prior trauma.

Once a patient has disclosed a traumatic event, he or she should first be asked to describe the event in an open-ended manner. Even this process may be therapeutic, as it may be the first opportunity the patient has had to tell a neutral and sympathetic party about what happened.

After the patient has told his or her story, the clinician should inquire about any details of the event and its aftermath that have been omitted, including (1) physiological and emotional reactions at the time of the event; (2) choice points and actions taken before, during, and after the event; (3) meanings attached to the event, the patient's reactions, and his or her behaviors; (4) responses of others to the patient during and after the event; (5) cues that trigger memories; (6) the specific nature of reexperiencing symptoms; (7) all avoidance, including situations avoided, attempts to avoid memories, thoughts, and/or emotions, and psychic numbing; (8) symptoms of physiological arousal (insomnia, startle responses, etc.); and (9) any difficulties in interpersonal, academic, or work functioning that have developed since the trauma. The patient's current social supports should also be assessed. It will probably take more than one session to gather all of these details.

The patient should be asked to list all cues that trigger memories on the Patient's Trauma Trigger Record (Form 6.4). This can be used either to list cues that have triggered memories in the past, or to log any triggers and intrusive memories experienced between sessions.

Patients who have been diagnosed with PTSD should also be evaluated for comorbid conditions, including depression, other anxiety disorders, and substance abuse. If a patient is so depressed that he or she is suicidal or cannot actively participate in therapy, the depression may need to be treated before treatment for PTSD is undertaken. Patients who are currently abusing alcohol or other substances should be told that ongoing substance abuse impedes the process of recovery and will interfere with therapy. Although it is not necessary to establish total sobriety before beginning cognitive-behavioral treatment for PTSD, such patients should be encouraged to stop using substances as a coping strategy.

Any legal or financial issues related to the PTSD should be explored, and malingering should be ruled out. Inquiry should be made regarding the patient's premorbid level of functioning, including strengths and weaknesses, as well as developmental history. If the trauma included head injury, possible cognitive deficits need to be assessed.

Consideration of Medication

SSRIs are considered the first-line medications for PTSD. Paroxetine (Paxil) and sertraline (Zoloft) are FDA-approved as treatments for the disorder. Although SSRIs can be beneficial, the effect sizes found have been modest, and relapse rates are high when medication is discontinued. Other antidepressants may be helpful for patients who cannot tolerate or do not respond well to SSRIs (Davis, Frazier, Williford, & Newell, 2006; Schoenfeld et al., 2004). Benzodiazapines are

not considered effective treatments and can interfere with exposure therapy (Cooper, Carty, & Creamer, 2005).

There have been relatively few studies comparing medication to psychotherapy for PTSD. One study found that cognitive-behavioral therapy was superior at a 6-month follow-up (Frommberger et al., 2004). Another study found EMDR to be more effective than fluoxetine (Prozac) (Bandelow, Zohar, Hollander, Kasper, & Moller, 2008). Adding paroxetine to the treatment of patients who did not respond to exposure therapy did not improve outcome (Bandelow et al., 2008). However, adding cognitive-behavioral treatment for patients who did not fully respond to sertraline did result in greater reduction of symptoms (Otto et al., 2003).

These results suggest that all patients with PTSD should receive cognitive-behavioral therapy. Medication may be helpful in conjunction with therapy, particularly for patients with more severe symptoms or with comorbid conditions (such as severe depression) that might interfere with treatment. All patients should receive education about medication as a treatment option.

Socialization to Treatment

Once the diagnosis is established, patients should be educated regarding PTSD, the rationale for treatment, and treatment options (including medication). This often has a therapeutic effect, as it may be the first time many patients have had a way to understand their symptoms and may allay fears that they are “going crazy.” Patients can be told that PTSD is a common reaction to uncommon situations that probably has its roots in our evolutionary history (Leahy, 2009). Discussing the rationale for treatment and getting a patient’s specific consent before proceeding will help build and maintain motivation for the treatment phase. Form 6.5 is an educational handout about PTSD that can be given to patients, and Form 6.1 (see above) can be used to illustrate the development and maintenance of PTSD. Table 6.1 (the maladaptive “rules” for PTSD; see above) can also be discussed with patients. The handout about cognitive-behavioral therapy in general (Form 10.1 in Chapter 10) may be helpful as well.

Skills Training

As noted above, we do not offer extensive coping skills training to most patients. However, consistent with Foa et al.’s (2007) protocol, we do teach patients breathing relaxation. Patients are taught to inhale normally through the nose, to exhale slowly through the nose while saying “relax” to themselves, and then to pause for a count of four before inhaling again. They are instructed to practice this for 10 minutes at a time, three times a day.

Patients who present with complex or severe PTSD symptoms, and/or who have difficulty tolerating exposure exercises, may benefit from additional skills training. Emotional regulation skills may include emotional awareness, affective expression, progressive muscle relaxation, distraction, reward planning/activity scheduling, self-soothing, and mindfulness. For patients who experience dissociative symptoms, “grounding” exercises, in which a patient is asked to focus on immediate sensory experiences, may be helpful. For example, a patient may be asked to describe things he or she sees in the therapist’s office, or to touch various objects and describe how they feel.

The goal of training in emotional regulation skills is to give patients an increased sense of

self-efficacy in managing their feelings, which should make it easier for them to risk experiencing intense emotion during exposure. In the end, however, all patients must learn through exposure exercises that the anxiety and other emotions triggered by their memories are not dangerous and will subside without the use of any coping or avoidance behaviors.

Some patients will present with significant impairment in interpersonal relationships. Problems may include excessive anger, difficulty trusting others, difficulty asking for help, and inhibition in expressing needs and wishes. Such patients may benefit from training in communication and assertion skills, and from practice with applying emotional regulation skills in interpersonal contexts. Role plays of specific social interactions may be helpful.

Exposure

There are three primary targets for exposure: (1) the memory of the trauma; (2) other internal and external cues that trigger anxiety and reexperiencing; and (3) situations that are avoided. The best results will be obtained if exposure is completed to all three groups of targets.

Imaginal Exposure to the Trauma Memory

Exposure to the trauma memory is initiated in the therapist's office. The first exposure session is typically scheduled for 90 minutes, in order to allow enough time for habituation to occur. The patient is asked to relax in a comfortable position with eyes closed, and to tell the story of the trauma in the present tense while attempting to visualize it in his or her mind. This procedure is recorded. The therapist functions as a guide and asks questions, which serve two main functions: (1) to focus the patient on details (such as specific sights, sounds, smells, and other sensory experiences, as well as emotions and internal physical sensations) in order to help fully activate the memory; and (2) to ensure that all significant details of the story are included and nothing is avoided. Periodically during the retelling of the story, the patient is asked to rate the distress he or she is feeling on a scale from 0 to 10 (i.e., to use SUDs ratings, as described in earlier chapters).

The second step in the exposure session is to have the patient listen to the recording of the story, closing his or her eyes and attempting to "relive" the experience. During this process, the patient again gives SUDs ratings. The patient listens to the recording repeatedly until the SUDs levels begin to decrease. Ideally, exposure should continue until the SUDs ratings have dropped by at least half. When the trauma is complex or involves multiple events, it may be necessary to break the story into segments and to devote several sessions to the telling of the whole story.

It is crucial that exposure not be terminated until the patient has experienced some decrease in anxiety. This is important for two reasons. First, terminating exposure while the patient is highly distressed will only serve to strengthen the association between the memory and the emotional distress. Second, the first time a patient experiences a reduction in distress during exposure is usually a very powerful event. It contradicts the patient's belief that focusing on memories will make him or her feel ever more anxious, and it provides motivation to continue exposure work.

After the initial exposure session, the patient is assigned to listen to the recording of the trauma story as homework. He or she is told to set aside at least 45 minutes each day for this purpose and to listen repeatedly until the SUDs score for that day is reduced by half. As the patient progresses, it often takes less than 45 minutes for the SUDs level to decline. The results

of practice sessions can be recorded on the Patient's Imaginal Exposure Practice Record (Form 9.1 in Chapter 9).

After the initial session, if the patient is able to do the exposure homework successfully, exposure sessions are typically reduced to 45 minutes. The trauma memory should be re-recorded in subsequent sessions, as the patient's recall may become more detailed and nuanced over time. It is also useful to focus on "hot spots" in the patient's story. These are parts of the memory that trigger particularly strong emotion. The patient may be asked to listen to a "hot spot" segment of the trauma memory repeatedly, in both session and as homework. All "hot spots" should be targeted until the patient can tell the entire story of the trauma without experiencing significant anxiety at any point. Form 6.6 may be used by the patient to record "hot spots" and related emotions and cognitions.

In addition to telling the story out loud, exposure to trauma memories may be accomplished by having the patient write about the trauma, draw or paint images from the trauma, and/or look at pictures or movies containing images related to the trauma. Virtual-reality recreations may also be used.

Exposure to Internal and External Cues

Patients who have anxiety reactions to specific cues should be exposed to these during sessions. For example, patients whose anxiety is triggered by increased heart rate can be asked to run in place long enough to raise their pulse rate, and to do this repeatedly until their anxiety level decreases. Patients who experience faintness or dizziness may be asked to hyperventilate and/or spin in place. Patients who experience dissociative symptoms may be given exposure exercises that mimic these feelings. Staring at oneself in the mirror or at a spot on the wall for 2 minutes may create sensations of depersonalization. Looking at a fluorescent light for 1 minute and then trying to read can imitate the feeling of derealization.

Similarly, patients whose trauma memories are triggered by external cues, such as specific sights, sounds, and/or odors, may be exposed to those. For example, a combat veteran who gets anxious at the sound of helicopters can be exposed to a recording of helicopters in session. Exposure to internal and external cues should begin in session, with patients assigned to continue such exposure exercises as homework.

In Vivo Exposure to Avoided Situations

After the first few sessions of imaginal exposure, the patient should be assigned to begin *in vivo* exposure to avoided situations. *In vivo* exposure can proceed as homework while the patient continues imaginal exposure in session. Time should be left in each session to discuss the patient's experience with *in vivo* exposure and to set up the next week's practice. For example, a man who has avoided driving on limited-access highways since experiencing an automobile accident can be assigned to begin driving again. A woman who has avoided returning to her hometown since having been sexually assaulted can be assigned to go visit. As with imaginal exposure, *in vivo* exposures should be continued until the SUDs level drops by half and repeated until the previously avoided situation evokes minimal anxiety.

In vivo exposure can generally be done as homework without the therapist present, par-

ticularly once patients have experienced habituation to their trauma memory in session and understand the process of exposure. However, in cases where a patient is extremely anxious, it may be necessary to have another person (such as a supportive family member) present during early exposure trials, and in some instances it will be necessary to have the therapist or a trained adjunct accompany the patient.

In addition to overt situations that are avoided, patients should be instructed to note behaviors that they do in order to minimize their anxiety. As noted for other anxiety disorders in earlier chapters, these are known as “safety behaviors.” For example, a woman who was assaulted in her home began sleeping with furniture pushed against her bedroom door every night. Another patient, who had experienced a traumatic airplane flight, would never fly without listening to music to distract himself from his feelings of panic. Form 6.7 can be used to help patients identify the safety behaviors they use. Patients should be instructed to forgo safety behaviors and allow themselves to experience their anxiety directly during exposure exercises.

Patients with PTSD often develop extensive patterns of avoidance and safety behaviors. In such cases, it will be helpful to develop a hierarchy of feared situations ranked from least to most anxiety-producing and to have the patients work their way up the hierarchy. The patients should start with a situation that evokes moderate, but tolerable, anxiety. Once they have repeated that exposure sufficiently so that their anxiety response is substantially reduced, they move up to the next item on their hierarchy. A more complete description of exposure procedures can be found in Chapter 9. *In vivo* exposure practice should be recorded on Form 9.2 in Chapter 9.

Cognitive Restructuring

Cognitive restructuring for PTSD targets a patient’s distorted automatic thoughts, maladaptive assumptions, and dysfunctional schemas associated with the trauma. The most common categories of distorted automatic thoughts in PTSD are overgeneralization, all-or-nothing thinking, and personalization. These reflect underlying assumptions about how things “must” or “should” be, and core beliefs about the nature of the self and others. Faced with a traumatic event that contradicts commonly held assumptions about the safety of the world, the predictability and controllability of events, and the ability of the self to cope, people often overaccommodate their schemas—coming to see everything and everyone as dangerous, unpredictable, and malevolent, and themselves as weak and incompetent. It should be noted that patients with multiple prior traumas may have already developed negative assumptions and schemas. In such cases, the most recent trauma may have served to strengthen existing negative schemas, rather than to contradict positive ones.

The goal of cognitive restructuring for PTSD is to return the patient to a more balanced view, in which the world is seen as safe within limits, events are seen as generally predictable and controllable, and the self is seen as competent to cope with most situations. At the same time, there should be acknowledgment of the existential reality that sudden, unpredictable, and extreme negative events, including death, can and do happen. Table 6.4 lists some techniques that may be helpful in addressing typical cognitive distortions in PTSD.

It should be noted that exposure alone will often lead to cognitive change. This is because exposure reduces the anxiety and avoidance associated with the trauma memories, and allows the natural process of assimilation and accommodation to take place. Time should be allowed after all exposure sessions to discuss any feelings and thoughts that emerged during the exposure.

TABLE 6.4. Examples of Techniques for Addressing Trauma-Related Cognitive Distortions

Target belief	Techniques
“The world is dangerous.”	<ol style="list-style-type: none"> 1. Calculating probabilities of specific events. 2. Listing advantages/disadvantages of world view. 3. Doing a cost–benefit analysis of specific vigilance and avoidance behaviors. 4. Identifying reasonable precautions.
“Events are unpredictable and uncontrollable.”	<ol style="list-style-type: none"> 1. Listing advantages/disadvantages of belief. 2. Listing all areas of life in which patient has some control, and rating degree of control for each. 3. Doing a cost–benefit analysis of specific efforts at prediction/control. 4. Keeping a daily log of behaviors that produce predicted outcomes. 5. Engaging in behaviors with high probability of predictable outcome. 6. Accepting that some events are unpredictable.
“What happened was my fault.”	<ol style="list-style-type: none"> 1. Examining knowledge and choices available to patient at the time. Were any better choices actually available? Could patient reasonably have predicted outcomes? 2. Using double-standard technique: “Would you blame a friend in a similar situation?” 3. Constructing a “pie chart” assigning responsibility for event to all relevant parties. 4. Examining societal biases (e.g., men are sent to war, then blamed for killing; women are urged to look “sexy,” then blamed for being raped). 5. Practicing self-forgiveness—all humans make mistakes.
“I am incompetent.”	<ol style="list-style-type: none"> 1. Examining evidence for competence in daily life. 2. Examining unreasonable expectation of competence in extreme and unusual circumstances. 3. Keeping a daily log of competent coping. 4. Using graded task assignment (see Chapter 9).
“Other people cannot be trusted.”	<ol style="list-style-type: none"> 1. Listing known persons who are trustworthy, and listing specific ways in which each can be trusted. 2. Rating people on a continuum of trustworthiness. 3. Examining patient’s history of relationship choices. Are better alternatives available? 4. Carrying out behavioral experiments that involve trusting others in small ways. 5. Keeping a daily log of people who honor commitments.
“Life is meaningless.”	<ol style="list-style-type: none"> 1. Listing activities that formerly were rewarding (see Chapter 9). 2. Scheduling pleasurable/rewarding activities (see Chapter 9). 3. Recognizing feelings of loss as a way of confirming meaning. 4. Examining which goals and activities no longer seem meaningful and which now appear more important. 5. Working toward an acceptance of death. 6. Finding meaning in each day.

Formal cognitive restructuring can then be applied in subsequent sessions to any negative beliefs and problematic schemas that remain. It is often helpful to target specific cognitions associated with “hot spots” in the patient’s trauma story. Form 6.8 provides space for patients to record negative thoughts about specific aspects of the trauma and its aftermath, including thoughts related to images and sensations; beliefs about safety; and beliefs about the self, others, and the world.

Coping with Life Problems

People who present with PTSD often have problems of living that are related to the trauma. Depending on the severity of the trauma, the chronicity of the PTSD, and personality factors, these problems can range from relatively mild to complex and highly disruptive. In addition, the type of life problems faced varies with the type of traumatic event. The issues faced by a woman who has been raped are likely to be quite different from those encountered by a male combat veteran.

In general, any problem that has the potential to interfere with therapy needs to be addressed before exposure work can begin. Patients who are in crises, in unstable living situations, or in poor physical health may need to deal with these issues first. Interventions that help a patient locate and/or utilize social supports may be particularly important. In some cases, the therapist may need to act as an advocate on the patient’s behalf. Patients with problems of substance abuse or dependence should be encouraged to take steps to deal with these problems and commit to abstinence during PTSD treatment. Patients who are not able to do this may need to focus on their substance abuse/dependence first and establish a period of sobriety before beginning treatment of their PTSD symptoms.

For some patients, substantial therapeutic work must be done before they begin PTSD treatment. This may include training in affect regulation and interpersonal skills (see above). For many patients, however, this phase of therapy can be done after exposure has been completed. The full range of cognitive-behavioral techniques can be brought to bear on these life problems, including cognitive restructuring, exposure, problem solving, and skills training. It may be helpful to include a patient’s spouse or significant other in some sessions.

Phasing out Therapy

Four criteria should be met before a patient is considered ready to terminate treatment: (1) Symptoms have remitted sufficiently that the patient no longer meets criteria for PTSD; (2) the patient can discuss the trauma without significant emotional upset; (3) avoidance no longer interferes with the patient’s daily functioning; and (4) relevant cognitive distortions have been modified.

As with all disorders, we recommend emphasizing relapse prevention in the final phase of treatment for PTSD. The patient is asked to review the techniques he or she has found most helpful. The possibility that the patient may have a recurrence of symptoms when subject to life stress is discussed, and the patient is asked to envision which techniques he or she would use under those circumstances. Form 6.9 may be given to patients to help remind them of the range of techniques they have at their disposal. In order to build patients’ confidence in their ability to manage their symptoms, patients are encouraged to assign their own homework in later sessions, and the last several sessions are spaced 2 weeks to a month apart.

TROUBLESHOOTING PROBLEMS IN THERAPY

Several problems commonly arise when exposure-based treatment for PTSD is employed. These are described below, with recommendations for how to deal with each one.

Resistance to Doing Exposure Work

The patient's beliefs about doing exposure should be elicited. Usually they involve fear that the anxiety will be overwhelming and unbearable, that it will go on forever, and/or that exposure will not work. The patient's understanding of the rationale for exposure should be reviewed. The patient can be asked this question: "If you were to tell the story 10 times in a row, how upset do you think you would feel by the 10th telling? How upset by the 100th? How upset by the 1,000th?" Most patients are able to see that eventually they would become "bored" and their anxiety would decrease. Patients can also be told of the experience of others who have been through exposure.

When a patient continues to resist exposure, the therapist should try to find a cue that evokes a low enough level of anxiety that the patient would be willing to try exposure. If necessary, this can be a cue that is not directly related to the trauma. Alternatively, altering the format of exposure may be helpful. A patient who is afraid to tell the trauma story in session may be willing to write about it. Or a patient who is very afraid of *in vivo* exposure may be willing to engage in imaginal exposure to the feared situation first. The goal is to collaborate with the patient to figure out what feels tolerable enough to use for the first exposure. Once most patients have had a successful experience of exposure and habituation, they are better able to face more difficult cues.

For some patients who are very fearful, it may be helpful to teach emotional regulation skills, as noted above. Once they realize that they can take action that will produce a short-term reduction in anxiety, and that they do have some measure of control, such patients may become more willing to deliberately face their anxiety-provoking cues.

Failure to Become Anxious during Exposure

The most common causes for failure to become anxious during exposure are those: (1) The patient is distracting him- or herself from the anxiety-provoking cues; and (2) the cues being used in the exposure are not the ones that actually trigger anxiety. The patient should first be asked about anything he or she is doing to attempt to reduce anxiety during exposure. The need to experience anxiety temporarily in order to get better should be emphasized, and the patient should be asked to focus his or her full attention on the exposure task. The use of safety behaviors and other coping skills during exposure should be discouraged. If the patient continues to experience minimal anxiety, other cues should be tried.

Becoming Overwhelmed with Anxiety during Exposure

As patients tell the trauma story, they often move from cues that evoke mild or moderate anxiety to cues that evoke maximal anxiety. If a patient feels overwhelmed during an exposure session and has difficulty continuing, it may be helpful to return to an earlier part of the story and allow

the patient to habituate to that part before continuing with the most difficult memories. It is not advisable to terminate exposure while the patient is in a high state of anxiety, as this will strengthen rather than weaken the connection between the cues and the patient's emotional reaction. For some patients, it may be necessary to meet more than once a week during the initial phase of exposure, in order to help them cope with the strong emotions elicited. Although patients should be discouraged from using coping skills during exposure, in some cases where the patients become too anxious to continue, it may be helpful to employ a technique such as distraction to reduce anxiety quickly. Patients who begin to dissociate may be helped by a "grounding" exercise (see above) to return their attention to the present. The temporary use of such coping skills may provide enough of a sense of relief and control to allow the patients to resume exposure.

Failure to Habituate

The most common reason for failure to habituate is that exposure has not continued long enough or has not been repeated sufficiently. Some patients will require an hour or more before habituating, particularly during early exposures. Patients who complain of failure to habituate during homework are usually making their exposure sessions too short. An alternative explanation is that the patients are distracting themselves during exposure or using coping skills, thereby preventing habituation.

Noncompliance with Homework

Patients who do not complete homework assignments should be asked what kept them from doing the homework. Simple explanations, such as lack of time, should be explored first. A therapist can work with a patient in session to schedule time for exposure homework during the following week. If this fails, motivational factors should be explored. Further in-session exposure may be needed in order for the patient to experience sufficient habituation to feel motivated to continue independently. Advantages and disadvantages of doing exposure homework can be reviewed. Finally, the possibility of resistance from one or more members of the patient's social support system, or of secondary gains from the patient's symptoms, should be considered.

It is not uncommon for patients to engage faithfully in exposure in the early part of therapy, but then fail to complete the final items on their exposure hierarchy. Often the problem is that the patients have experienced enough relief that they no longer feel the pressure to do something immediately about their problem, and the final exposure items are the scariest and hardest to face. It is important to tell patients that they are at greater risk of relapse if they do not complete all items on their hierarchy.

DETAILED TREATMENT PLAN FOR POSTTRAUMATIC STRESS DISORDER

Treatment Reports

Tables 6.5 and 6.6 are designed to help in the writing of treatment plans, including requests for insurance authorization. Table 6.5 shows sample specific symptoms; select the symptoms that are appropriate for your patient. Be sure also to specify the nature of the patient's impairments,

TABLE 6.5. Sample Symptoms for Posttraumatic Stress Disorder

Specify traumatic event(s)	Derealization
Intrusive memories	Emotional numbness
Nightmares	Restricted affect
Flashbacks	Inability to imagine the future
Intense distress when exposed to memories or cues	Insomnia
Avoidance (specify what is avoided)	Irritability
Inability to recall parts of the trauma	Anger outbursts
Withdrawal from usual activities (specify)	Impaired concentration
Detachment	Hypervigilance
Dissociation	Exaggerated startle response
Depersonalization	

including any dysfunction in academic, work, family, or social functioning. Table 6.6 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

Sequence of Interventions

Table 6.7 shows the sequence of interventions for a 16-session course of treatment for PTSD. We have found this format to be useful in working with patients whose symptoms are responses to a single, discrete traumatic event. Patients who have suffered multiple traumas, who have serious

TABLE 6.6. Sample Treatment Goals and Interventions for Posttraumatic Stress Disorder

Treatment goals	Interventions
Reducing symptoms of hyperarousal	Relaxation training
Reducing distress associated with memories to 2 or less on a scale of 0–10	Imaginal exposure
Eliminating avoidance of memories	<i>In vivo</i> exposure
Engaging in previously avoided activities (specify)	<i>In vivo</i> exposure
Eliminating anger outbursts	Anger management training
Increasing range of affect	Exposure to emotional cues
Increasing social contacts to three times a week	Activity scheduling, support groups
Eliminating feelings of guilt	Cognitive restructuring
Stating reduced belief (10%) in schemas of danger, lack of predictability/control (or other schemas—specify)	Cognitive restructuring, developmental analysis
Eliminating intrusive memories (and/or flashbacks/nightmares)	Imaginal exposure
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Finding sources of meaning in life	Life review, activity scheduling/reward planning
Eliminating all anxiety symptoms (PCL-C scores in normal range)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

TABLE 6.7. Detailed Treatment Plan for Posttraumatic Stress Disorder**Sessions 1–2****Assessment**

Ascertain presenting problems
 Administer standard battery of intake measures (see Form 6.3)
 Inquire about history of trauma, including possible multiple traumas
 Inquire about reexperiencing, avoidance, and hyperarousal symptoms (Form 6.2), as well as triggers (Form 6.4)
 Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
 Assess need for medication
 Rule out contraindications for PTSD treatment (e.g., current substance abuse/dependence, current suicidal threat, unstable life circumstances)
 Rule out malingering
 Assess premorbid functioning (including strengths, weaknesses, prior treatment, etc.)
 Obtain developmental history
 Assess social supports

Socialization to Treatment

Inform patient of diagnosis
 Indicate that the symptoms are a common and understandable response to a traumatic event
 Inform patient that short-term treatment is available, with high probability of a significant reduction in distress
 Provide patient with information handouts on PTSD (Forms 6.1 and 6.5) and cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
 Discuss option of medication
 Explore and discuss any fears/reservations patient has regarding treatment

Homework

Have patient write out goals for therapy
 Have patient begin monitoring trauma related triggers during the week (using Form 6.4)

Session 3**Assessment**

Review homework
 Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)
 Assess automatic thoughts, assumptions, and schemas related to the trauma
 Assess patient's coping skills and need for possible skills training

Socialization to Treatment

Review cognitive-behavioral conceptualization of PTSD, treatment, and rationale
 Link treatment plan to patient goals
 Discuss advantages/disadvantages of proceeding with treatment

Coping with Life Problems

Discuss any current life problems that might interfere with treatment
 Teach patient to utilize cognitive-behavioral skills as needed

Homework

Have patient continue monitoring triggers
 Ask patient to list avoided situations

(cont.)

TABLE 6.7 (cont.)**Sessions 4–5****Assessment**

Review homework

Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Evaluate patient's readiness to proceed with exposure

Skills Training

Teach breathing relaxation

Teach additional affect regulation and interpersonal skills as necessary

Exposure

Explain rationale and procedures for imaginal exposure

Plan first exposure session

Cognitive Restructuring

Teach patient to identify automatic thoughts

Teach patient rational responding

Homework

Have patient continue monitoring triggers, avoided situations

Ask patient to write automatic thoughts and rational responses (using Form 6.8, or form 2.10 in Chapter 2)

Have patient practice breathing relaxation (and any other skills taught)

Session 6

Note: The first exposure session may be done earlier or later than Session 6, depending on the patient's readiness; allow 90 minutes for this session

Assessment

Review homework

Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Exposure

Create first imaginal exposure recording of trauma memory

Have patient listen to recording repeatedly in session

Homework

Have patient continue to practice relaxation and other coping skills (not during exposure)

Have patient listen to exposure recording repeatedly each day until SUDs level decreases by half

Sessions 7–8

Note: These sessions may be 45 or 90 minutes, depending on patient's needs

Assessment

Review homework and any problems completing exposure assignment

Assess patient's current SUDs level in response to trauma memory

Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Exposure

Have patient retell and re-record trauma story

Have patient continue imaginal exposure to trauma memory

Expose patient in session to other trauma-related cues

TABLE 6.7 (cont.)**Cognitive Restructuring**

Note cognitive distortions during discussions of patient's reaction to exposure
 If cognitive distortions do not spontaneously change with continued exposure, use cognitive techniques to challenge them (see Chapter 10 and Appendix B)

Homework

Have patient continue listening to exposure tape
 Have patient continue writing automatic thoughts and rational responses (see Form 6.8 or 2.10)
 Ask patient to construct hierarchy of avoided situations, safety behaviors

Sessions 9–13**Assessment**

Review homework and any problems
 Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Exposure

Continue imaginal exposure to remaining “hot spots” in trauma memory (see Form 6.6)
 Continue exposure to trauma cues
 Plan and review *in vivo* exposures

Cognitive Restructuring

Identify any problematic cognitions remaining and challenge these

Homework

Have patient continue imaginal exposure to “hot spots”
 Assign self-directed *in vivo* exposure, forgoing safety behaviors
 Have patient continue to identify and challenge cognitive distortions as they occur

Sessions 14–16 (Scheduled Biweekly or Monthly)**Assessment**

Review homework
 Note any trauma-related memories, cues, or situations that continue to be avoided or evoke anxiety
 Note any remaining maladaptive thoughts, assumptions, and/or schemas
 Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Exposure

Continue exposure to any cues that remain problematic

Cognitive Restructuring

Address any remaining problematic beliefs
 Modify maladaptive schemas

Coping with Life Problems

Discuss ways of coping with any remaining life problems

Phasing Out Treatment

Review techniques patient has found useful
 Discuss possible sources of stress in future, predict possibility of temporary renewal of symptoms, and discuss ways of coping with them

(cont.)

TABLE 6.7 (cont.)**Homework**

Have patient self-assign homework
 Encourage continued practice of affect and interpersonal regulation skills
 Encourage self-directed exposure to avoided situations
 Encourage continued practice of cognitive techniques
 Encourage continued practice of life-problem-related skills
 Write list of favorite techniques to be used after termination

impairment in life functioning, and/or who present with significant Axis II psychopathology may require more sessions, although the components of the treatment remain the same. This package can also be used as part of more complex treatment when PTSD is one, but not the only, presenting problem.

CASE EXAMPLE

The following example is based on a composite of cases.

Sessions 1–2

<i>Presenting problem</i>	Ralph was a 25-year-old single white male. He lived with his divorced mother and worked as a salesman. When asked what brought him in for treatment, he replied, “Death.”
<i>Trauma history</i>	Ralph reported that 3 years earlier he had been in an automobile accident in which his girlfriend of 5 years, Sara, had been killed. They had spent the day at the beach and waited until late evening to drive home in order to avoid traffic. Although they’d both had three or four beers during the day, Ralph denied that either of them had been drunk. Because Ralph was feeling sleepy, Sara had volunteered to drive. Ralph had no memory of what happened next, except that he knew from later reports that their car left the road and struck a tree. Sara was thrown from the car and killed instantly. Ralph sustained a broken leg. Ralph’s only memories of the accident were of looking up and seeing Sara’s body, and of himself being carried on a stretcher to the ambulance. Ralph was kept overnight in the hospital and released the next day. While he was in the hospital, he was informed of Sara’s death. Ralph attended Sara’s funeral and recalled being shocked at the sight of her body in the casket.
<i>Symptoms and impairment</i>	After the accident, Ralph became depressed and started drinking daily. He had previously been considered a good worker, but his work attendance and performance became erratic, and he was fired from two jobs. He also withdrew from friends and did not date. This pattern continued for 2 years. Eight months prior to intake, Ralph was threatened with being fired again and decided to seek help. He underwent a brief hospital detoxification and began attending Alcoholics Anonymous (AA) meetings. He also resumed going to church. He stayed sober until shortly before the intake and maintained stable employment during that time. However, he continued to be socially isolated.

A few weeks before the initial session, Ralph learned that a cousin, Kate, to whom he had been close as a child, was in the hospital with AIDS complications. Ralph reacted by becoming depressed and resuming his drinking. He went on a 4-day “bender,” missing several days of work. It was this event that prompted him to seek treatment.

Current symptoms

When asked how the accident affected him now, Ralph reported that he had nightmares about it and that he still thought about Sara “constantly.” He did not want to date, because “It’s not worth the trouble to get involved and have to go through hell like that again.” He also reported that he was unable to go to hospitals to visit sick relatives or friends, and that he avoided funerals. He reported difficulty sleeping, was often irritable, and frequently got into conflicts at work. Ralph reported automatic thoughts such as the following: “If I get close to someone else, they’ll die on me,” “If I have to say goodbye to people, I will have a nervous breakdown,” “Everything is a waste,” and “Why is the world so cruel?” Ralph also felt responsible for Sara’s death because he had asked her to drive that night.

Automatic thoughts

Socialization to treatment

The therapist told Ralph that his symptoms were common for someone who had been in an automobile accident and had seen someone die. Ralph was given assessment forms to complete—the Patient’s Trauma Trigger Record (Form 6.4) and standard symptom checklists, as well as information handouts about PTSD (Form 6.5) and cognitive-behavioral therapy (Form 10.1 in Chapter 10). He was assigned to write his goals for therapy as homework.

Assessment and homework

Session 3

Goals; assessment results; comorbid conditions

Ralph brought in the following goals: (1) being able to go to hospitals and funerals, and (2) staying sober. His assessment forms, combined with the clinical interview, indicated that he met criteria for major depression and alcohol dependence in addition to PTSD. He denied any thoughts of killing himself, but did say, “I’ll be glad when I’m dead.” The therapist explained that treatment could not proceed if Ralph resumed drinking. He agreed to remain abstinent and to attend AA meetings. At Ralph’s request, the therapist called his boss to confirm that Ralph was undergoing treatment, which was a condition of his return to work.

Coping with life problems

Developmental history

When asked about his family history, Ralph reported that his parents had separated when he was 8. His father had moved to another state and had since been largely uninvolved in Ralph’s life. Ralph’s mother had not remarried. She worked two jobs to support Ralph and his younger brother as they were growing up, and consequently she was often emotionally unavailable. Although Ralph was a poor student, he completed high school. He reported no prior history of trauma. He reported a history of heavy weekend drinking in high school, but denied having had any serious problems with alcohol prior to the accident.

Further socialization to treatment

The therapist and Ralph then further discussed the cognitive-behavioral model of PTSD and the nature of the treatment. Ralph agreed to proceed. He reported that just talking about the accident felt good, because he had never talked to anyone about it before.

Homework

For homework, Ralph was asked to list any cues that triggered memories of the accident. He quickly replied, “Just hospitals, funerals, and driving.” He was asked to notice anything else that triggered memories in the coming week and write it down, again using the Patient’s Trauma Trigger Record (Form 6.4).

Sessions 4–6

At the start of the next session, Ralph said that he was feeling somewhat better and that he understood the idea behind therapy, but he was very anxious about beginning exposure. In particular, he feared that he would be too upset by remembering what happened and would begin drinking again.

Reward planning/ activity scheduling

The therapist and Ralph decided to take a couple of sessions to focus on emotional regulation skills and preparing Ralph for exposure. Ralph was asked what activities he found relaxing or pleasurable. He listed taking walks, working in his mother’s garden, and calling old friends. He was assigned as homework to engage in these activities. When Ralph was asked what might keep him from reaching out to friends, he reported these automatic thoughts: “I am going to say something stupid,” and “Everyone is too busy.” These thoughts were used to teach Ralph rational responding.

*Cognitive restructuring**Skills training*

Next Ralph was taught several emotional regulation skills, including breathing relaxation, progressive muscle relaxation, and distraction. He was assigned to practice these between sessions.

Cognitive restructuring

In the sixth session, Ralph’s guilt about the accident was discussed. Using Socratic dialogue, the therapist helped Ralph see that the choice to have Sara drive was a rational one at the time. Because of his fatigue, it might not have been safe for him to drive. Sara had said she felt “OK” to drive. In fact, each of them had often driven while the other one slept. Finally, since the cause of the accident had never been determined, there was no way to know whether Ralph could have prevented it had he been driving.

By the end of the sixth session, Ralph said that he continued to feel somewhat better. He found the progressive muscle relaxation particularly helpful, and his sleep had improved. He was more active and felt less depressed.

Planning exposure

Ralph had not been able to add any triggers to his original list of funerals, hospitals, and driving. He continued to express anxiety about beginning exposure, so the therapist suggested beginning with something other than the actual memory of the accident. Ralph’s cousin Kate was out of the hospital and reportedly doing better, so it was decided to start with an imaginary scenario in which he visited Kate in the hospital. The next meeting, which would be the first exposure session, was scheduled for 90 minutes.

Session 7*Imaginal exposure*

After briefly explaining the imaginal exposure procedure, the therapist narrated an imaginary scenario for Ralph that included his arriving at the hospital, seeing other patients, seeing Kate, and then learning she had only a few weeks to live. Periodically throughout the scenario, Ralph was asked to describe what he was seeing, hearing, and feeling. All of this was audio-recorded.

Homework

During the initial exposure, Ralph's SUDs rating rose to 8. However, after he listened twice to the recorded scenario, his SUDs level dropped to 5. Ralph was pleased with this reduction in distress. He was assigned to listen to the recording daily as homework.

Sessions 8–11*Further imaginal exposure*

In the eighth session, Ralph reported that he had listened to the exposure recording several times and that his SUDs ratings had continued to decrease. Another imaginal exposure scenario was done, this time of Ralph's attending a funeral. Ralph's SUDs rating peaked at 7 and decreased minimally after he listened to the recording one time. Although the session was only scheduled for 45 minutes, Ralph was offered the option of continuing in order to have time to habituate. He declined and said he would rather work with the recording at home.

Exposure to trauma memory

The ninth session was scheduled for 90 minutes, in order to do exposure to the memory of the accident and Sara's funeral. Ralph told the story in detail, with prompting by the therapist, and then listened to the recording several times. His maximum SUDs ratings declined from 8 to 4. At the end of the session, he commented: "It doesn't feel as depressing. I still love her and would like to have her back. But I don't feel angry or too much alone. . . . I feel kind of rested. Like I've been carrying a lot of weight alone and I just put it down."

Cognitive effects of exposure

Ralph then expressed some fears about letting go of Sara, including that if he got married to someone else he wouldn't get to see her in heaven. He finally concluded, "I would like to put her down for a while. I don't want to lose her, either. I guess I already did."

Further exposure to the accident

The 10th session was again scheduled for 45 minutes. Ralph said that he had listened to the memory recording only twice. The therapist had Ralph retell the story of the accident in session and recorded it. In the process, Ralph recalled some additional details about the accident. He continued to express ambivalence about letting go of Sara emotionally, but indicated that he was beginning to imagine what it would be like to date again. He was assigned to listen to the new recording daily.

*Homework**In vivo exposure*

In the next session, Ralph reported that listening to the recording of the accident was "like a rerun now. Like I went to a movie and someone died. I feel sad, but not really upset." He reported a dream in which he met an attractive girl and started going out with her. He said he had been thinking more about dating someone else, and was starting to accept the idea. He also reported spending more time with friends. When the therapist commented that it sounded as though he was handling the pain of his loss, Ralph replied, "Everyone else does it. I know I can, too." Ralph also reported that Kate was back in the hospital. He was assigned as homework to go visit her.

Sessions 12–13*Coping with life problems*

In the 12th session, Ralph reported that he had not been able to see Kate, because her condition had worsened and she was no longer allowed to have visitors. He reported that he thought he would be able to handle going to her

funeral. He commented, "I can't believe I wasted all this time and missed seeing her. Now I'll be in a hurry to do everything so I can catch up." He also reported that he had met a woman while bicycling with friends. He had asked her out, but she already had a boyfriend.

Phasing out therapy

Ralph said that he was feeling much better and wanted to meet with the therapist less often. His negative automatic thoughts and other cognitive distortions associated with the accident had, in large part, spontaneously changed during exposure. Ralph was making progress in resuming his social life and had continued to be abstinent from alcohol. The therapist recommended meeting in 2 weeks.

Coping with life problems

In the next session, Ralph reported that Kate had died and that he had attended her funeral with no difficulty. He had been glad to see many family members there whom he had not seen in some time. He had also gone bicycling again with the woman he met several weeks earlier. In the session he talked about future plans, including traveling, buying a house, and eventually getting married. Since he was continuing to do well, Ralph and the therapist agreed to wait a month before meeting again.

Session 14

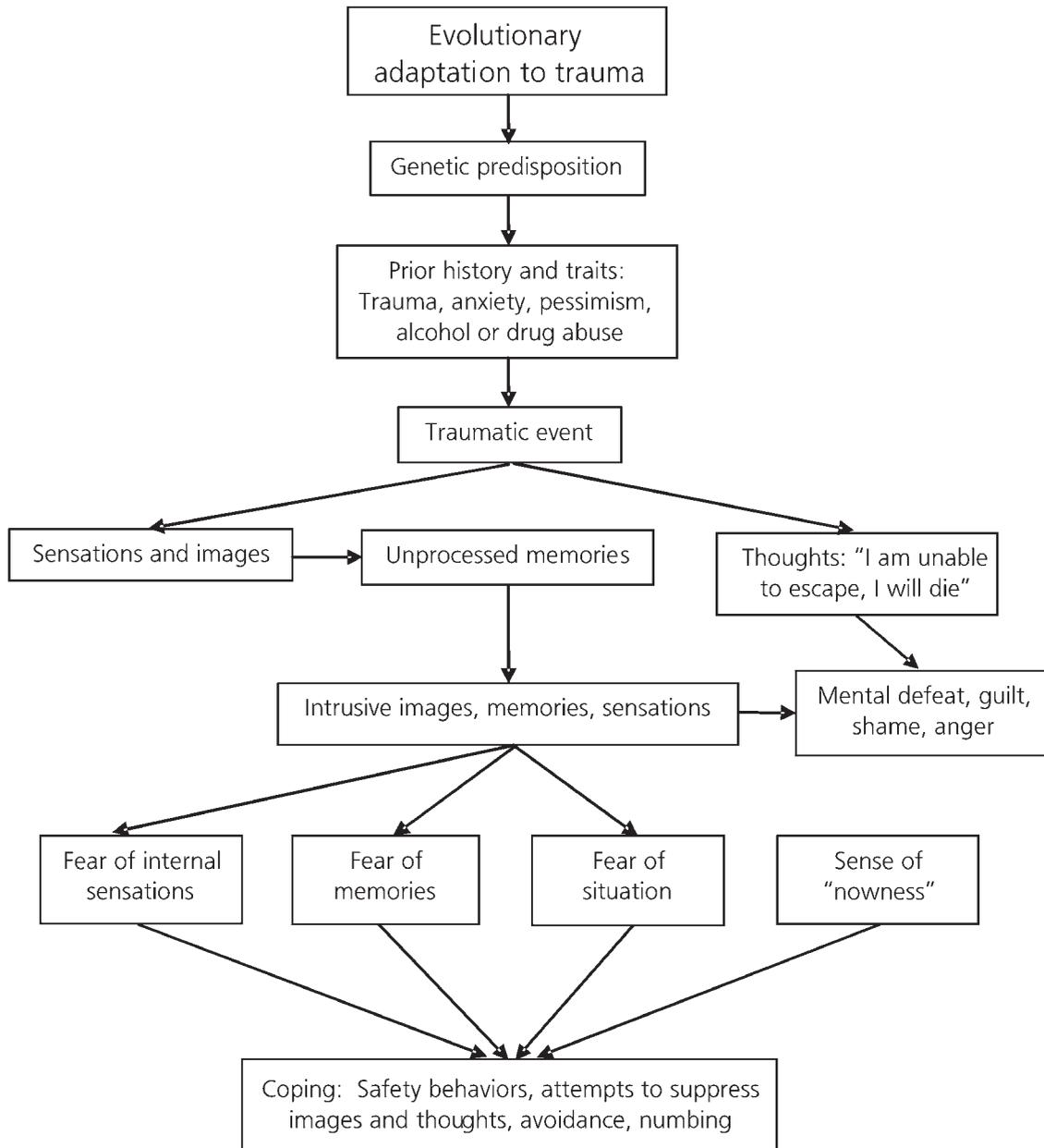
Phasing out therapy

In the final session, Ralph reported that he was feeling good and had no desire to drink. He had continued to attend AA meetings and church. He also said that he hardly ever thought about Sara. Although he was not yet dating anyone, he was socially active and meeting women he found attractive. He felt he had met his goals for therapy.

Termination

The therapist had Ralph review which techniques he had found helpful and what he would do if he found himself under stress in the future. The therapist reminded Ralph that he could always contact him if he had further problems, and therapy was terminated.

FORM 6.1. The Causes of Posttraumatic Stress Disorder



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FORM 6.2. PTSD Checklist—Civilian Version (PCL-C)

Patient's name: _____ Today's date: _____

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. In the column at the right, enter the number that best indicates how much you have been bothered by that problem *in the last month*.

1 = Not at all	2 = A little bit	3 = Moderately	4 = Quite a bit	5 = Extremely
Response				Rating
1. Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?				
2. Repeated, disturbing <i>dreams</i> of a stressful experience from the past?				
3. Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?				
4. Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?				
5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?				
6. Avoid <i>thinking about or talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?				
7. Avoid <i>activities or situations</i> because <i>they remind you</i> of a stressful experience from the past?				
8. Trouble <i>remembering important parts</i> of a stressful experience from the past?				
9. Loss of <i>interest in things that you used to enjoy</i> ?				
10. Feeling <i>distant or cut off</i> from other people?				
11. Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?				
12. Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?				
13. Trouble <i>falling or staying asleep</i> ?				
14. Feeling <i>irritable</i> or having <i>angry outbursts</i> ?				
15. Having <i>difficulty concentrating</i> ?				
16. Being <i>"super alert"</i> or watchful on guard?				
17. Feeling <i>jumpy</i> or easily startled?				

The PCL-C is a U.S. government document in the public domain.

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FORM 6.3. Evaluation of Posttraumatic Stress Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

PTSD Checklist for Civilians (PCL-C) _____ Beck Depression Inventory–II (BDI-II) _____

Beck Anxiety Inventory (BAI) _____ Dyadic Adjustment Scale (DAS) _____

Global Assessment of Functioning (GAF) _____

Other questionnaires (specify): _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous traumatic episodes (specify nature):

Onset	Duration	Precipitating events	Treatment
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(cont.)

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FORM 6.3. Evaluation of Posttraumatic Stress Disorder (p. 2 of 2)

Previous episodes of anxiety, depression, or other psychiatric disorder (specify nature):

Onset Duration Precipitating events Treatment

Treatment progress (later evaluations only)

Completed exposures: _____

Situations still avoided: _____

Remaining safety behaviors: _____

Cognitive distortions to be addressed: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 6.5. Information for Patients about Posttraumatic Stress Disorder

WHAT IS POSTTRAUMATIC STRESS DISORDER

Posttraumatic stress disorder (or PTSD) is a common reaction to very stressful or traumatic events. Many different kinds of events can lead to PTSD, including being in a car accident; being raped or being the victim of another crime; being physically or sexually abused; living through a disaster such as a flood or a bombing; or seeing someone else die.

People with PTSD have three main types of problems or symptoms

1. **Reliving the trauma.** This can include frequent memories, nightmares, and flashbacks that make people feel as if they are living the event all over again. Memories often come back when something people see or hear reminds them of the event.
2. **Avoiding.** Because it is upsetting to remember what happened, people with PTSD try not to think about it. They also stay away from people, places, or things that bring back memories. Often they feel numb or detached from other people. Some turn to alcohol or drugs to dull the pain.
3. **Signs of physical stress.** These can include trouble sleeping, feeling irritable or angry all the time, trouble concentrating, and feeling tense or on guard.

WHAT CAUSES POSTTRAUMATIC STRESS DISORDER?

When people live through a trauma, the memories of what happened get connected in their minds with what they saw, heard, smelled, or felt at the time. Later a similar sight, sound, smell, or other feeling can bring the memories and emotions flooding back.

A second reason memories come back is that people have a need to make sense of what happened to them. Traumatic events often make people question things they once believed—for example, that the world is basically safe or that bad things won't happen to them. To understand the trauma, they have to think about it. But thinking about it brings the memories and feelings back, so they try not to think about it. Instead of finding understanding and peace, people often end up going back and forth between remembering and trying to forget.

HOW DOES POSTTRAUMATIC STRESS DISORDER DEVELOP?

Most people begin to have symptoms of PTSD shortly after the trauma. For about half of these people, the symptoms get better on their own within 3 months. For others, the symptoms can last for years. Some people don't start to have symptoms until many years after the event.

HOW DOES COGNITIVE-BEHAVIORAL THERAPY FOR POSTTRAUMATIC STRESS DISORDER HELP?

Cognitive-behavioral therapy is designed to help reduce the upsetting memories and emotions from the trauma, and to help you make sense of what happened in a way that allows you to move on with your life. First, your

(cont.)

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therapist will give you some simple exercises to help reduce your anxiety. Then he or she will help you face the upsetting memories by retelling the story of what happened in a safe way. At first, you may find that some of the old feelings return. However, the more you do this, the more the emotions will begin to fade, allowing you to achieve a sense of peace. Your therapist will also help you think more realistically about what happened to you and what its implications are the future.

A number of studies have found that cognitive-behavioral therapy helps people with PTSD feel significantly better, and that about two-thirds of patients no longer have PTSD by the end of treatment. These studies have included combat veterans as well as victims of rape, assault, childhood abuse, political violence, and automobile accidents.

HOW LONG DOES THERAPY LAST?

How long treatment for PTSD lasts depends on how many traumas you suffered and how severe they were, how bad your symptoms are now, and how many other problems you are having in your life. For people who have been through a single traumatic event, 12–20 sessions are usually enough. Most of these sessions will be 45–50 minutes long, but a few may be as long as 90 minutes.

CAN MEDICATIONS HELP?

Medications by themselves are usually not enough for treating PTSD. However, they can be helpful for some people when combined with therapy. Your physician or a psychiatrist can suggest which medication might be best for you.

WHAT IS EXPECTED OF YOU AS A PATIENT?

It is best not to start treatment for PTSD if you are currently abusing drugs or alcohol, or if you have a major current crisis in your life. Your therapist can help you deal with these problems first, and then can help you begin working on your PTSD symptoms. Other than that, all you need to do is to be willing to try therapy and to spend some time each week practicing the things you learn.

FORM 6.6. "Hot Spots" in My Story

Image of the "hot spot"	What it makes me think and feel

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FORM 6.7. Safety Behaviors in Posttraumatic Stress Disorder

Typical safety behaviors	Examples of my safety behaviors	How I think these safety behaviors protect me
Continually looking for signs of danger		
Avoiding people, places, and things		
Looking away from sounds, images, or experiences that remind me of the trauma		
Seeking reassurance		
Repeating prayers or using superstitious behaviors		
Physical tensing (holding my body, holding my breath, walking a certain way, etc.)		
Using alcohol or drugs to make myself feel more calm		
Bingeing on food to take my mind off memories		
Other behaviors		

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FORM 6.8. Negative Thoughts and Realistic Responses in Posttraumatic Stress Disorder

Triggers: Sensations and images		
Triggers	Negative thoughts	Realistic thoughts

Why I am safe now	
Beliefs about danger	Why I am safe

Self, others, and the world	
Negative thoughts	Realistic thoughts
Self	
Others	
World	

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FORM 6.9. Possible Interventions for Posttraumatic Stress Disorder: A Self-Help Guide

1. **Practice relaxation.** Set aside time every day for deep muscle relaxation, mindful breathing, or a body scan.
2. **Examine the costs and benefits of changing.** Getting better will require doing some things that are uncomfortable. How will your life be better if you no longer have PTSD?
3. **Be an observer.** Rather than struggle against sensations, images, and thoughts, just stand back and watch them. Observe that they are temporary. They are mental events, not reality.
4. **Don't struggle; let it be.** Allow thoughts, sensations, and images to come and go like water flowing along a stream. Surrender to the moment.
5. **Evaluate your negative beliefs.** Challenge the negative thoughts that you have about helplessness, guilt, and the lack of meaning in life. What advice would you give a friend?
6. **Challenge your belief that you are still in danger.** It happened in the past, but it sometimes feels as if it is happening now. Remind yourself of how safe you really are.
7. **Retell the story in more detail.** Write out and tape-record your retelling of the story of your trauma. Pay attention to the details of sounds, sights, and smells. Try to recall the sequence of how things actually happened.
8. **Focus on the "hot spots" in your story.** Certain images and thoughts make you feel more anxious. Try to notice what they are and what they mean to you. Slow yourself down and examine the negative thoughts that are associated with these images.
9. **Restructure the image.** Create a new image in which you are triumphant, dominant, and strong. Imagine yourself as the victor and as more powerful than anything and anyone that has traumatized you.
10. **Eliminate safety behaviors.** Notice any superstitious things that you do to make yourself feel safer—like repeating reassurance to yourself, avoiding doing certain things at certain times or places, tensing your body, scanning for danger. Eliminate these behaviors.
11. **Be realistic about anxiety.** Realize that life includes anxiety, because anxiety is necessary for living. Don't think of your anxiety as awful or as a sign of weakness. Everyone has anxiety. It is temporary; it passes; it is part of getting better. You will do things that make you anxious to overcome your anxiety. Go through it to get past it.
12. **Expose yourself to your feared sensations.** You have been afraid of your internal sensations—dizziness, breathlessness, feeling spaced out. Practice the exercises to make yourself intentionally feel these sensations, to learn that they are temporary and not dangerous.
13. **Practice your fears.** The best way to overcome your PTSD is to practice the things that make you afraid:
 - Set up a hierarchy.
 - Imagine yourself in the situation.
 - Look at pictures that remind you of the trauma.
 - Answer your negative thoughts in the situation.
 - If possible, revisit the scene.
14. **Reward yourself.** Remind yourself that you are the one who is doing all this hard work. Give yourself credit. Praise yourself, cheer yourself on, and treat yourself to something special.

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Specific Phobia

DESCRIPTION AND DIAGNOSIS

Symptoms

Specific phobia is an unrealistic fear of a particular object or situation. When a person with a specific phobia either encounters the feared object/situation or anticipates encountering it, he or she will experience significant anxiety. In some cases, the person may become so anxious as to experience a panic attack. The fear must significantly interfere with the person's functioning, or the person must have strong distress about having the fear. Things that commonly trigger phobias include insects and other animals; environmental elements such as water, heights, and storms; blood, injections, or injuries; situations such as enclosed spaces, airplanes, tunnels, and bridges; and miscellaneous other stimuli (e.g., vomiting or choking).

For a detailed description of the current diagnostic criteria for specific phobia, refer to DSM-IV-TR (American Psychiatric Association, 2000, pp. 443–450).

Prevalence and Life Course

Phobic fears are common in the general population, with 60% of adults reporting some such fears. For most of these people, the levels of distress and impairment are not sufficient to qualify for a diagnosis of specific phobia. However, the National Comorbidity Survey Replication found that 12.5% of the respondents had experienced significant enough impairment to meet criteria for specific phobia at some point in their lifetimes, making specific phobia the third most common psychiatric diagnosis in the general population (Kessler, Berglund, et al., 2005). Using somewhat more restrictive diagnostic criteria, Stinson et al. (2007) found a lifetime prevalence of 9.4% and a 12-month prevalence of 7.1%.

Women are twice as likely as men to have specific phobia (15.7% vs. 6.7%) and tend to suffer most commonly from the animal subtype (Barlow et al., 2007; Choy, Fyer, & Lipsitz, 2007). However, these findings must be interpreted with caution, as research suggests that men may be likely to underreport fears, present less frequently for treatment, and deal with their fears differently (Barlow, 2002).

Specific phobia is more prevalent in lower-income groups. It also seems to be more prevalent in some ethnic groups, although the results for ethnicity are conflicting. Some studies show that African Americans are more likely to suffer from a diagnosis of specific phobia than are mem-

bers of other ethnic groups (Curtis, Magee, Eaton, Wittchen, & Kessler, 1998). A recent study indicates that Asians and Hispanics have a decreased risk of specific phobia compared to other groups (Stinson et al., 2007), whereas other studies show that being Hispanic may increase the risk for developing a specific phobia (Curtis et al., 1998). Again, these findings must be interpreted with caution, as few studies have examined cultural differences, and different cultures may be less likely to report or present with psychological symptoms.

Estimates of the median age of onset range from 7 to 11.2 years, with many individuals reporting their first symptoms as early as 5 (Kessler, Berglund, et al., 2005; Stinson et al., 2007). However, age of onset may vary across the different subtypes (Barlow, 2002). Although studies examining age of onset need to be replicated, current evidence suggests that animal and blood–injection–injury phobias may begin earlier in childhood, whereas situational phobias may not begin until later adolescence or adulthood. Although different fears may be more common in different age groups, in general, specific phobia tends to peak in young to middle adulthood and decline in later life (Barlow, 2002).

Specific phobia is a chronic condition. The mean duration of the disorder is over 19 years (Stinson et al., 2007), while the average time to treatment is over 22 years (Goisman et al., 1998). Only 8% of those who meet criteria for a principal diagnosis of specific phobia report getting treatment specifically for the disorder (Stinson et al., 2007).

The most common fears are of heights and animals, followed by fears of flying and being in enclosed spaces. Three-quarters of people with specific phobia report having more than one fear, and the average number of fears is 3.1 (Stinson et al., 2007). A greater number of fears is associated with increased impairment and comorbidity. Although specific phobia is often seen as a relatively benign condition, it is associated with a degree of disability comparable to that caused by substance use disorders and other anxiety disorders. In sum, specific phobia is a common condition that begins early, has a chronic course, and can result in significant impairment.

Genetic/Biological Factors

Although many psychologists and their clients may believe that all fears are established through learning, surveys indicate that only a very small percentage of patients with specific phobia can trace the onset of their fear to specific frightening events reflecting either classical conditioning or imitation (Menzies & Clarke, 1994, 1995). Most fears—such as fears of snakes, insects, water, animals, lightning, blood/injury, and heights—have biological value in primitive environments. A review provided by Marks (1987) illustrates that many phobias (e.g., fears of heights, open spaces, strangers, and other species) are manifested across a variety of species. The Darwinian explanation suggests that the cross-species manifestation of fear, its early onset (e.g., the visual cliff for infants), its universality across all human cultures, and the nonrandom nature of fears (i.e., the fact that certain stimuli are more likely to be feared than others) are all evidence of a strong evolutionary basis for fear. Genetic/biological models have a variety of expressions: arguments for innate releasing mechanisms or innate patterns of behavior (Eibl-Eibesfeldt, 1972; Lorenz, 1966; Tinbergen, 1951); arguments favoring strong genetic predisposition (Marks, 1987); models proposing “preparedness” for classical conditioning to single-trial learning (Seligman, 1971); and strict “learning theory” positions, such as Watson and Rayner’s (1920) argument for the primacy of experience.

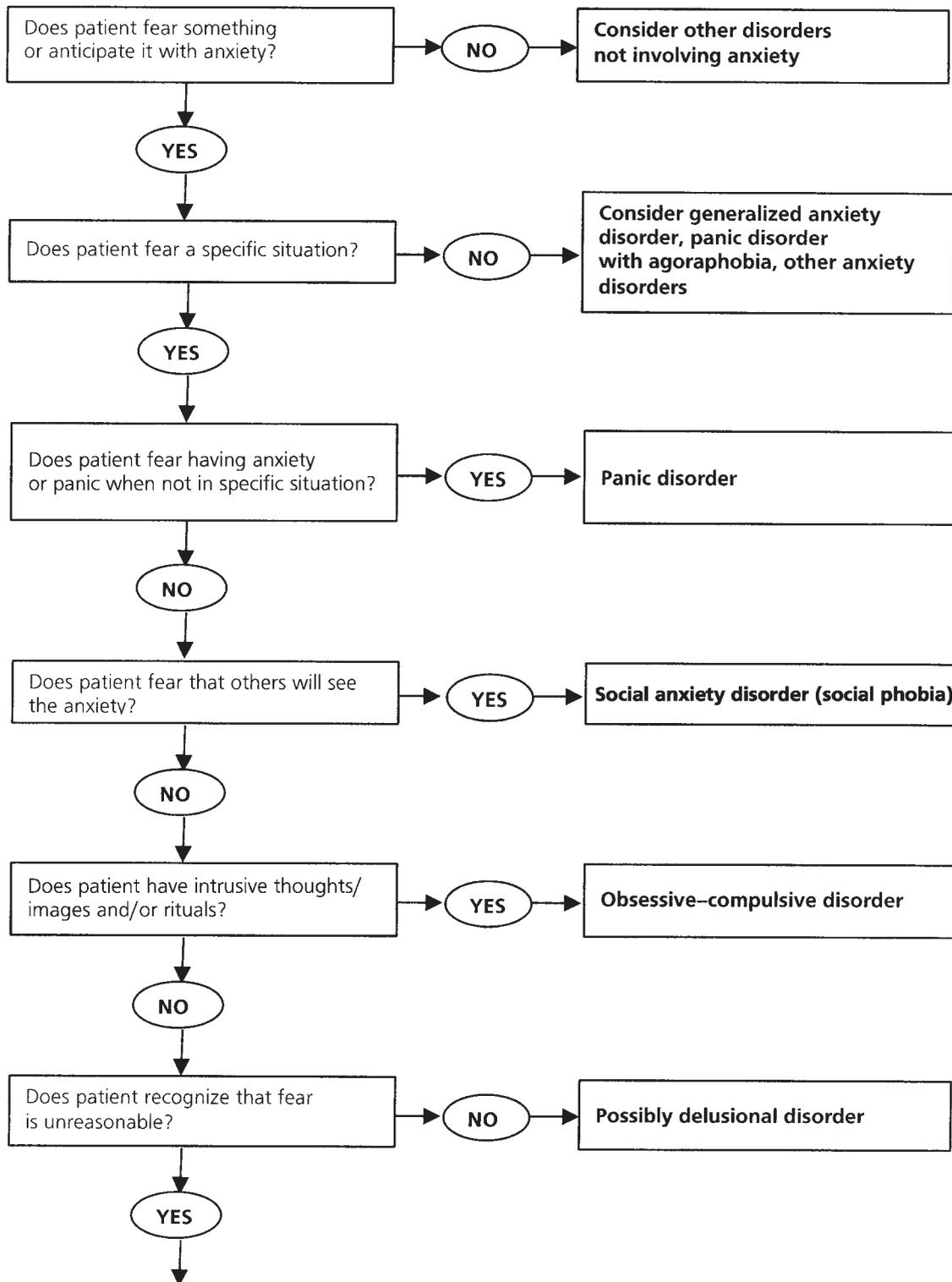
Further evidence for the importance of genetic factors in specific phobia is found in twin studies. Eley, Rijdsdijk, Perrin, O'Connor, and Bolton (2008) report a concordance for monozygotic twins of 74% compared to 48% for dizygotic twins, suggesting that 46% of the variance in the occurrence of specific phobia is explained by genes. In addition, subtypes of specific phobia run in families; for example, people who have animal phobia are more likely to have relatives with animal phobia than with other types of phobias. Blood–injury–injection phobia has the highest rate of familial transmission. It should be noted that the role of genetic and evolutionary factors in specific phobia does not preclude the use of exposure as an intervention.

Coexisting Conditions

As noted above, people with specific phobia usually tend to have more than one specific fear (Barlow et al., 2007). In addition, specific phobia occurs commonly as a comorbid diagnosis in the presence of other principal diagnoses, especially when the principal diagnosis is another anxiety disorder (Barlow, 2002). Comorbid conditions are also common in patients who present with a principal diagnosis of specific phobia (Stinson et al., 2007). Between 50% and 80% of people who meet criteria for specific phobia have at least one other psychiatric diagnosis (American Psychiatric Association, 2000). The most common comorbid conditions are anxiety disorders, mood disorders, and substance use disorders. The most common co-occurring Axis I diagnosis is panic disorder. However, people with a principal diagnosis of specific phobia are less likely to present with comorbid disorders than are people with other anxiety disorders (Barlow, 2002). Most people who present with specific phobia and a comorbid diagnosis are treated for the comorbid condition rather than the phobia. However, in some cases, the phobia is so pronounced as to cause problems in occupational and/or relationship functioning. The avoidance associated with blood–injury–injection phobia can lead to serious medical consequences. In such instances, the specific phobia is more likely to be identified and treated. When working with patients whose fears create problems in their significant relationships, the clinician may need to counsel all parties involved that phobias are seldom voluntary “choices” made to “punish” other people, and that cajoling the persons with the phobias only serves to exacerbate their fear.

Differential Diagnosis

Specific phobia is distinguished from other anxiety disorders by the fact that the fear is focused primarily on the consequences of exposure to a specific object or situation. While persons with specific phobia may also fear the consequences of the anxiety they experience in such situations, they do not generally feel anxious when they are not in contact with (or anticipating contact with) the object of their fear. In contrast, panic disorder is characterized by pervasive anxiety not specifically elicited by a single stimulus, and is characterized by a fear of the internal sensations of panic attacks. Persons with panic disorder also have uncued and many more panic attacks in a variety of situations, and are apprehensive about having panic attacks even when not directly confronted with a phobic situation. In social anxiety disorder, the fear is about the risk of negative social evaluation rather than about the dangers posed by an object or situation. Posttraumatic stress disorder is elicited by the experience of an actual traumatic event. It is characterized by additional symptoms that are present even when the patient is not in contact with a feared situa-



(cont.)

FIGURE 7.1. Diagnostic flow chart for specific phobia.

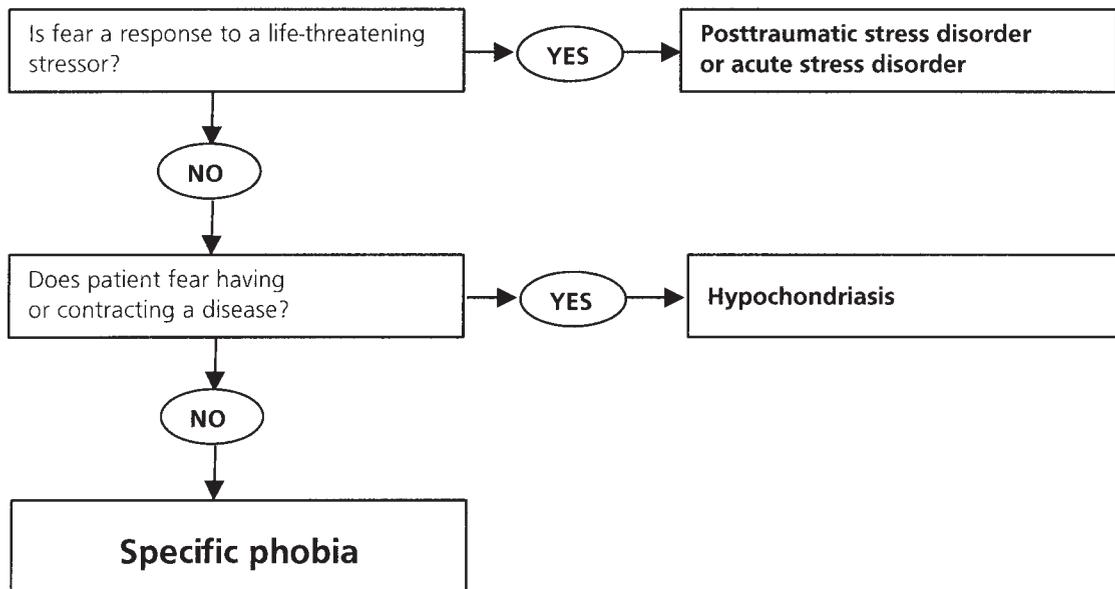


FIGURE 7.1 (cont.)

tion or object, including reexperiencing, numbing, and hyperarousal. With obsessive–compulsive disorder, the fear is of intrusive thoughts or images rather than of a phobic stimulus per se, and the patients typically engage in active rituals to control their anxiety.

Figure 7.1 is a flow chart that provides further guidance in the differential diagnosis of specific phobia.

UNDERSTANDING SPECIFIC PHOBIA IN COGNITIVE-BEHAVIORAL TERMS

Evolutionary Factors

Cognitive-behavioral models of fear stress ethological or evolutionary theory (see “Genetic/Biological Factors,” above) in explaining the development of specific phobia. According to this model, individuals are innately predisposed to fear some stimuli rather than others, because these stimuli represent danger in a primitive environment. Thus surveys of fears in the general population indicate that the most common fears are fears of snakes, rats, insects, water, darkness, animals, strangers, heights, lightning, and closed spaces—rather than fears of stimuli in the recent industrialized world, such as electricity. A variation of the ethological model has been proposed by Seligman (1971), who has suggested that individuals are innately prepared to acquire fears of certain stimuli more easily than fears of others, because of the adaptive value of these fears. This ethological/conditioning model helps account for both individual differences in fears and the nonrandom distribution of fears (i.e., the selectively higher frequency of certain fears). Form 7.1, which can be used as a handout for patients, outlines the development of phobias from an evolutionary perspective.

Leahy (2009) has proposed that people with specific phobia respond to possible threat based

on a set of beliefs or “rules.” These “rules” once served to protect our ancestors in the primitive environments in which we evolved. However, they now serve to maintain fears that are no longer adaptive in a modern environment. (The left column of Form 7.13, which can be given to patients as a self-help guide when treatment is being phased out, lists these maladaptive “rules.”)

Behavioral Factors

The behavioral model of specific phobia describes two stages in the learning and maintenance of phobia. The first phase of acquisition is based on contiguity or associationist learning (classical conditioning). According to this model, a previously neutral stimulus becomes conditioned to anxiety because it occurs in the presence of a stimulus that naturally produces anxiety. As a result, future contact with that stimulus evokes a conditioned response of anxiety. Other learning models of fear acquisition stress the effect of modeling and imitation, suggesting that fear may be acquired through watching others avoid or react with fear (Bandura, 1969; Rachman, 1978).

Once the fear is established, it is maintained through avoidance. This second phase is presumed to reflect operant conditioning; that is, avoidance of or escape from the feared stimulus is negatively reinforced by the reduction of fear (Mowrer, 1939, 1947). This two-factor model accounts for the fact that a fear may be acquired (through classical conditioning) and maintained over a long period of time through the negative reinforcement of avoidance and escape, resulting in the conservation of fear (Mowrer, 1939, 1947). An alternative model of fear maintenance proposed by cognitive theorists suggests that avoidance does not provide disconfirming information that would lead to the recognition that the initial pairing of the phobic stimulus and the negative consequence no longer holds (Arntz, Hildebrand, & van den Hout, 1994; Arntz, Rauner, & van den Hout, 1995).

Cognitive Factors

The cognitive model of specific phobia proposes that early developmental experiences may give rise to specific threat schemas that result in selective attention, evaluation, memory of, and strategies for dealing with feared stimuli. Since there are individual variations in the effects of negative experience in giving rise to phobias, the cognitive model attempts to explain these differences as a consequence of the meanings attached to the specific phobic stimulus and to the experience of anxiety (see Beck et al., 1985). Form 7.2, which can also be used as a patient handout, shows the role of cognitive factors in phobias.

OUTCOME STUDIES OF TREATMENTS FOR SPECIFIC PHOBIA

Types of Cognitive–Behavioral Treatment

Cognitive-behavioral treatment for specific phobia focuses on breaking the association between the conditioned stimuli and anxiety, as well as on breaking the association between avoidance or escape and the feelings of relief that serve as a powerful negative reinforcer. The fearful patient is helped to confront the feared stimulus in order to learn that it is not dangerous. Techniques that have been studied for treating specific phobia include exposure, cognitive restructuring, and

relaxation when it is included as part of reciprocal inhibition. However, exposure is the treatment of choice. In addition, applied muscle tension has been used in the treatment of blood–injection–injury phobia.

Exposure is the process of deliberate planned contact with stimuli that evoke anxiety. *In vivo* exposure involves contact with actual phobic objects or situations. Imaginal exposure involves having the patient imagine or visualize feared stimuli; representations of stimuli in pictures, stories, or movies may also be used. Exposure to interoceptive cues—that is, the internal physical sensations associated with anxiety—is useful for some patients. The cues typically targeted include rapid heart rate, dizziness, and/or hyperventilation. Virtual reality (i.e., computer-generated representations of feared situations) has also been used for exposure. In all forms of exposure, the patient is asked to stay in contact with the feared stimuli until his or her anxiety begins to decrease. This process is repeated until the stimuli evoke little or no anxiety.

Cognitive restructuring aims to identify and alter patients' maladaptive beliefs about the danger of phobic objects or situations and about their ability to cope with threat. Beck's cognitive therapy, with its emphasis on collaborative empiricism and guided discovery, has been used in a number of studies. Self-instructional training, which teaches patients to use positive coping statements, has also been studied.

Progressive muscle relaxation has been used to teach patients with specific phobia to substitute a relaxation response for their fear response. However, it is no longer used, given the accumulated body of evidence suggesting that exposure alone appears to be the active ingredient in reducing anxiety, and that adding relaxation to exposure does not produce results beyond those produced by exposure alone. Furthermore, relaxation exercises may induce feelings of safety in the presence of the feared stimulus, and thereby prevent individuals from learning that they can tolerate the feared object or situation even without the use of safety behaviors.

Applied muscle tension was developed specifically for the treatment of blood–injection–injury phobia (Öst & Sterner, 1987). Patients with this type of specific phobia have an initial anxiety response of increased heart rate and blood pressure. However, this is often followed by a rapid drop in heart rate and blood pressure that results in fainting. It is believed that this fainting response may have served the evolutionary purpose of decreasing bleeding after injury and/or of discouraging attack by making a person seem dead. To counteract this response, patients are taught to tense their muscles for 15 seconds at a time, followed by 15 seconds of relaxation. Tensing the muscles increases blood pressure and can prevent fainting.

A number of studies have looked at combinations of these techniques. Systematic desensitization combines imaginal exposure with relaxation training. Applied relaxation teaches patients to use relaxation during *in vivo* exposures. Applied muscle tension has been tested in combination with exposure. Various combinations of exposure and cognitive restructuring have also been examined. Most treatments studied have been brief, typically ranging from one to five sessions.

Results

Choy et al. (2007) did a qualitative review of studies of treatment for specific phobia published between 1960 and 2005. They found that *in vivo* exposure was the most effective treatment, with some studies reporting response rates of 80–90%. Treatment gains were found to be maintained at follow-up periods of up to a year. However, dropout rates for *in vivo* exposure were relatively

high. Virtual-reality therapy was found to be as effective as *in vivo* exposure and more effective than systematic desensitization. Exposure to interoceptive cues was effective in treating claustrophobia. Applied muscle tension was effective in treating blood–injection–injury phobia, alone and in combination with *in vivo* exposure. Cognitive therapy was found to be an effective stand-alone treatment for claustrophobia and to enhance the effectiveness of *in vivo* exposure. It was also found to be somewhat helpful as a solo treatment for flying and dental phobia. However, cognitive therapy did not enhance the effectiveness of *in vivo* exposure for flying or animal phobia. Cognitive treatments that used Beck’s model tended to have better outcome than those that used self-instructional training.

In general, medication has not been found to be effective for specific phobia (Choy et al., 2007). Benzodiazepines can reduce subjective anxiety when used acutely (e.g., to help a patient with fear of flying who must get on an airplane). However, in some studies, use of benzodiazepines resulted in increased anxiety when patients encountered phobic stimuli again without medication. The use of nitrous oxide for dental phobia was found to be effective in some studies. The use of D-cycloserine during exposure was found to enhance the effectiveness of exposure treatment.

Wolitzky-Taylor, Horowitz, Powers, and Telch (2008) performed a meta-analytic review of 33 controlled studies of treatment for specific phobia. They found the strongest support for treatments that involved some form of exposure. Patients treated with exposure (alone or in combination with other techniques) had better outcome on average than 84% of patients who received no treatment, 75% of patients who received a placebo treatment, and 64% of patients who had active treatment that did not include exposure. At the same time, cognitive-behavioral treatments that did not include exposure still produced a large effect size when compared to no treatment, indicating that these treatments do have some benefit. This is an important finding, since some studies show that 25% of patients with specific phobia will refuse exposure treatment. Treatments that involved *in vivo* exposure had better immediate posttreatment outcome than treatments that used other types of exposure. However, this benefit disappeared at follow-up, due largely to continued improvements in the groups that did not receive *in vivo* exposure. Thus *in vivo* exposure may achieve its effect more rapidly, but other forms of exposure may prepare patients to perform self-directed exposures and help them continue to improve after treatment has stopped. The addition of cognitive techniques did not appear to improve outcome over exposure alone; however, Wolitzky-Taylor et al. (2008) point out considerable variation in the findings of individual studies on this question and suggest further research. Treatments that used five sessions were found more effective than single-session treatments in some analyses. This somewhat contradicts previous findings that massing exposures in a single session produces better outcome. Wolitzky-Taylor et al. found no evidence for the specific effectiveness of different techniques for different subtypes of specific phobia.

Taken together, the current research findings suggest the following treatment guidelines:

- Exposure is the treatment of choice for specific phobia.
- Whenever possible, *in vivo* exposure should be included in treatment. Other forms of exposure may be helpful for preparing patients to undertake *in vivo* exposure or when the availability of *in vivo* situations is limited.
- Exposure to interoceptive cues associated with anxiety may help some patients, particularly those with claustrophobia.

- Applied muscle tension should be used in conjunction with exposure for blood–injection–injury phobia.
- The addition of cognitive techniques may be helpful for some patients. This may be particularly true for patients who are initially reluctant to engage in exposure exercises.
- Relaxation exercises are no longer recommended alone or in combination with exposure, and are only recommended for use as preparatory exercises to help reduce high levels of anxiety if patients are initially unwilling to engage in exposure exercises.
- Spreading exposure over several sessions may result in slightly better outcome than single-session treatment.
- Cognitive therapy may be used to disconfirm erroneous or maladaptive cognitions about the feared stimulus, or to prepare patients who initially cannot or will not engage in exposure. However, patients should be encouraged to undertake *in vivo* exposure eventually.

ASSESSMENT AND TREATMENT RECOMMENDATIONS

Rationale and Plan for Treatment

Although individuals with specific phobia rarely present for treatment, patients can be successfully treated relatively easily and quickly. Eighty to ninety percent of individuals with some phobias can achieve significant and enduring change in as little as one to five sessions of treatment. Table 7.1 shows the general treatment plan for specific phobia.

Following an initial assessment to diagnose specific phobia and comorbid conditions, the patient is socialized into treatment. Socialization stresses educating the patient on the “evolutionary adaptiveness” of phobia (in order to “depathologize” it for the patient), as well as on how avoidance maintains fears and how exposure is helpful in overcoming these fears. As noted in the research review above, exposure, particularly *in vivo* exposure, to feared objects and situations is the treatment of choice for specific phobia. Exposure not only reverses the processes of avoidance that maintains phobic anxiety, but gives patients access to information that disconfirms their fears. Imaginal or simulated exposure may be used to prepare patients for eventual *in vivo* exposure to a feared stimulus and may also be used when *in vivo* exposure is not feasible. Finally,

TABLE 7.1. General Plan of Treatment for Specific Phobia

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- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
 - Socialization to treatment
 - Behavioral interventions
 - Fear hierarchies and planned exposure
 - Adapting behavioral treatment for different types of phobias/fears
 - Eliminating avoidance, escape, and safety behaviors
 - Cognitive interventions
 - Phasing out therapy
-

cognitive interventions may be used supplementally to address information-processing errors such as selective availability to information, filtering, memory biases, exaggeration of threat and probability, and the tendency to “forget” events that disconfirm danger. Applied muscle tension may be used for patients with blood–injection–injury phobia. Relaxation should be employed only for patients who cannot or will not tolerate exposure alone.

Assessment

Based on the cognitive-behavioral model outlined above, the clinician must first diagnose specific phobia, differentiating it from the other anxiety disorders and assessing for comorbid conditions, including alcohol and other substance abuse. Since many patients with specific phobia have arranged their lives around their phobia, they may not initiate a discussion of it unless it presents new and difficult problems (e.g., a threat to employment or marital conflict). Hence the clinician should specifically inquire whether there are any situations or things that they avoid or tolerate only with anxiety and discomfort.

Tests and Clinical Interviewing

As described in Chapter 3 for panic disorder and agoraphobia, the ADIS-IV (Brown et al., 2005) and the SCID (First et al., 2002) are semistructured clinical interviews that may be used to assess specific phobia and to make differential and comorbid diagnoses. In addition, self-report questionnaires such as the Fear Questionnaire (Marks & Mathews, 1979) may be used to assess the exact nature of symptoms and the severity of illness. Patients should also fill out the standard intake form (see Form 2.1 in Chapter 2).

In conducting a differential diagnosis, the clinician should determine whether a patient fears a specific situation (specific phobia), fears that others will see the anxiety (social anxiety disorder), fears that an anxiety attack will lead to loss of control or threat to health (panic disorder), or fears that the object or situation will contaminate or harm the patient or others (obsessive–compulsive disorder). When specific phobia is present, the clinician should assess its specific content areas (e.g., animals, the natural environment, blood–injection–injury, etc.); more than one type of specific phobia may be present.

Once the assessment confirms a diagnosis of specific phobia, and the patient expresses interest in treatment for the phobia, the clinician can construct a fear hierarchy for the most important phobia, noting whether the fear is greater when exits are blocked or lesser if the patient is accompanied by someone. Both imaginal and *in vivo* situations should be described; that is, patients should be asked to rate the anxiety level for situations that they would only imagine versus situations that they would actually encounter (*in vivo*).

During the initial and ongoing assessment, the clinician also evaluates the patient for safety behaviors and determine the impact of the phobia on general functioning. Again, careful questioning should be conducted to identify situations that decrease or increase the fear (e.g., being accompanied vs. being alone). The therapist also closely assesses the situations in which individuals experience anxiety, as well as their thoughts, feelings, and behaviors before and after these situations, in order to understand how fear is being triggered and maintained.

Although initially patients are asked to provide a historical report in the initial assessment session, they are asked as treatment moves forward to monitor their thoughts, feelings,

and behaviors between sessions as and when their fears are triggered. A prospective, situational examination of their fears at the moment they are triggered not only assists in confirming the diagnosis, but provides a wealth of information that can be used to formulate a treatment plan, and may be used to modify their fear and avoidance hierarchy on an ongoing basis. Form 7.3 is used to record the results of the initial assessment, including test data/scores; use of psychiatric medications, alcohol, and other substances; history (at intake only) of previous anxiety episodes; treatment progress (on later evaluations only); and treatment recommendations. Form 7.4 may be used to assess the presence of various specific phobias.

Consideration of Medication

Given that exposure-based treatments are considered the gold standard for specific phobia, medication is not considered as a primary treatment for individuals with this disorder. A few case studies have demonstrated the efficacy of fluvoxamine (Luvox) and fluoxetine (Prozac) for a few patients with storm and flying phobias (Balon, 1999), and a small randomized double-blind trial provides preliminary evidence for the efficacy of paroxetine (Paxil) (Benjamin, Ben-Zion, Karbofsky, & Dannon, 2000) and escitalopram (Lexapro) (Connor, Varia, Zhang, & Davidson, 2006). Finally, results of a recent trial suggests that D-cycloserine may augment effects of exposure, purportedly by enhancing learning in patients (Ressler et al., 2004). Given these preliminary results, the adjunctive use of these medications may be considered for patients who are entirely unwilling to engage in exposure or those who are treatment-refractory.

Socialization to Treatment

During the socialization phase of therapy, we provide patients with handouts on the nature of fear (see Forms 7.1 and 7.2) and educate them on the evolutionary basis of many fears. Patients are helped to understand that they are “biologically prepared” to fear certain stimuli. Appreciating that their fears were in fact adaptive in a different, prehistoric environment (and could still be adaptive today in some contexts) creates significant relief for patients. Many patients immediately grasp that fearing stimuli such as heights, closed spaces, and animals allowed their ancestors to survive in environments when these stimuli were truly dangerous. We tell patients that their fears indicate that they have “the right response at the wrong time,” and that they are better adapted than most other people to survive in the natural environment. We often tell patients that their fears indicate that they are closer to human nature, and that the reason why the fears are so convincing to them is simply that they have worked for hundreds of thousands of years in preventing disaster.

Table 7.2 lists common fears and adaptations to these fears, which can be discussed with patients as their particular types of fears indicate. Form 7.5 provides patients with information about the causes and treatment of specific phobia.

Next, given that fleeing or avoiding danger is a natural response to truly dangerous situations, we also help patients understand that they are “biologically prepared” to avoid or escape their innate fears as well. Given that these stimuli are no longer dangerous today, these innate behaviors are ineffective at best, and help their fears persist at worst. Avoiding or escaping these stimuli creates immediate relief and hence begets further avoidance and escape, as individuals begin craving feelings of relief each time they encounter a phobic stimulus. Patients are helped

TABLE 7.2. Fears and Adaptations

Fear	Adaptation
Starvation	Binge eating, preference for sweet or high-calorie foods, carbohydrate craving, hoarding of food, excessive weight gain, somnolence, reduced metabolic rate/inactivity during winter months
Predators	Avoiding animals, avoiding crossing open fields, fear of the dark (night-time predators), grouping with others when crossing fields as protection against predators
Attack by strangers	Fear of strangers, protecting one's territory, allegiance to one's family and tribe, use of appeasement gestures to show that one is not hostile, submissiveness to stronger and more threatening figures
Natural danger	Fear of heights, water, lightning; hesitancy in moving forward
Death of children	Attachment of parent (especially mother) to child. Parent responds to infant's crying, clings to infant, soothes infant. Infant/young child maintains closeness to parents; fears being left alone, the dark, and animals.
Poison	Avoiding any smells or tastes associated with bacteria or toxins. Quickly learning that some foods are poisonous.

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to understand that although avoiding situations reduces anxiety in the short run, it strengthens anxiety in the long run by maintaining their sense that they are in danger. By avoiding these stimuli, individuals believe that they have “averted danger” each time, and hence continue to believe that these stimuli are truly dangerous. We also help patients appreciate that by always avoiding and escaping these stimuli, they have taught themselves to believe that they are unable to handle the feared situations, and thus have begun to feel less effective.

This socialization allows patients to appreciate why confronting phobic stimuli is critical for them to get better. By confronting these stimuli systematically over time, they learn that these stimuli are not truly dangerous, that anxiety subsides naturally without avoidance or escape, and that they are able to cope effectively with their fears. To address their concerns that they will be unable to confront these long-feared and avoided phobic stimuli, we tell patients that the exposure will be predictable, that it will remain within their control, and that they will learn strategies to cope with their fears.

Building motivation to engage in exposure is an important part of the socialization process. Patients should be helped to identify specific personally meaningful benefits to overcoming their fears. Anticipated costs should also be explored and addressed. Form 7.6 can be used to help patients consider the costs and benefits of treatment.

Behavioral Interventions

Fear Hierarchies and Planned Exposure

Exposure to the feared stimulus appears to be a critical ingredient for success in the treatment of specific phobia. *In vivo* exposure is seen as the treatment of choice and over the last few decades

has been successfully used to treat most types of phobias (Antony & Barlow, 2002), including animal, thunder–lightning, water, heights, flying, enclosed spaces, dental, choking, and blood–injection–injury phobias (Barlow et al., 2007). Although *in vivo* exposure is preferred, imaginal exposure may also be conducted as well—either in preparation for live exposure, or in the event that *in vivo* exposure is not practical. Although exposure to the most feared stimulus all at once (flooding) has shown to be as effective as graded exposure (Barlow, 2002), graded exposure is the treatment of choice, particularly in outpatient settings, since it is better tolerated by most patients.

DESIGNING GRADED EXPOSURE

The therapist works collaboratively with the patient to develop a hierarchy or “ladder” of fears, with each “rung” representing an increasingly difficult stimulus that the patient will ultimately confront. As described in earlier chapters, SUDs levels (from 0 = no discomfort to 10 = overwhelming anxiety or fear) are used to give the therapist and patient a common language to grade the hierarchy of fears and to track success in treatment when fears begin to diminish. For example, a lower rung may involve exposure to the feared stimulus in imagination or viewing photos or slides of the feared object before confronting it in real life. Patients may be confronted with a stimulus during the session (*in vitro*) before they are confronted with it in the natural environment (*in vivo*). The hierarchy can also be graded based on increasing proximity to the stimulus. For example, a patient with a fear of spiders may be asked initially to observe a spider in a box, next to observe the spider on the therapist’s hand, and then finally to allow it to crawl on the patient’s own hand. Form 7.7 allows patients to monitor their fears as they occur; Form 7.8 can be given to a patient to record his or her fear hierarchy.

Several factors have been shown to increase the success of exposure treatment (Barlow, 2002; Barlow et al., 2007) and should be incorporated into exposure sessions, if possible. Direct exposure appears to be more beneficial than indirect exposure, and therapist-directed exposure appears to offer an advantage over self-directed exposure (Öst, Salkovskis, & Helmström, 1991). Massed practice—for example, sessions lasting two or three hours—allows intense exposure and habituation to the stimulus. This “rapid treatment” of phobia often yields dramatic, immediate results, especially when the patient is encouraged to continue practicing self-directed exposure outside sessions (Öst, 1997). However, as noted above, there is some evidence that spacing exposures over several sessions may improve long-term outcome. Exposing patients to different types of the same stimuli (e.g., different types of dogs) and to stimuli in different contexts (e.g., different locations and situations) also appears to increase their resistance to relapse (Antony & Barlow, 2002).

TERMINATING AN EXPOSURE SESSION

Exposure to the feared stimulus during a given exposure session typically continues until the patient’s fear decreases substantially. Brief exposure or exposure sessions that do not allow the fear to lessen have been linked to increased sensitization to the feared stimulus, making the fear worse in some cases. Hence exposure sessions are typically terminated when habituation occurs. In the absence of enough habituation, the therapist may increase the length of the session; return

to a less feared stimulus during the session to facilitate habituation; identify and eliminate any “safety behaviors” (see below) that may be preventing full exposure to the stimulus; identify and modify any dysfunctional thoughts; or adjust the fear hierarchy so that more rungs are added.

However, recent studies indicate that complete habituation during sessions may not be necessary for successful treatment (Craske & Mystkowski, 2006; Eifert & Forsyth, 2005; Williams, 1992), and that tolerating fear (as opposed to eliminating fear) and experiencing self-efficacy during exposure sessions may be better predictors of overall outcome. Furthermore, both extinction of the conditioned emotional response and disconfirmation of misappraisals are now posited to be mechanisms through which change occurs during exposure (Barlow, 2002; Barlow et al., 2007). Hence exposure sessions may be terminated when patients’ misappraisals have been disconfirmed, when the urge to escape the situation has subsided, and when they have learned that they can tolerate feelings of anxiety and cope with being in the feared situation.

MOVING UP THE FEAR HIERARCHY

A patient is repeatedly confronted with a particular stimulus both in session and between sessions until the anxiety associated with the situation is minimal over two consecutive exposure sessions; this is done in order to generalize effects of exposure to the natural environment (Barlow, 2002; Barlow et al., 2007). Once the fear is reduced, the patient engages in exposure to the next feared stimulus. Throughout exposure, patients should be directly praised by the therapist for tolerating the feared stimulus, and should be encouraged to reward themselves with either self-praise or external rewards for accomplishing exposure goals.

Adapting Behavioral Treatment for Different Types of Phobias/Fears

BLOOD–INJECTION–INJURY PHOBIAS

As noted earlier, individuals with blood–injection–injury phobia often have a physiological reaction in the presence of their feared stimulus that triggers a fainting response (vasovagal syncope). Although their heart rate and blood pressure initially increase in the presence of the feared stimulus (as they do for patients with other phobias), these individuals experience a subsequent drop in their heart rate and blood pressure, which results in the fainting response. Hence exposure therapy for these individuals includes teaching them coping strategies to prevent this precipitous drop. Applied muscle tension consists of alternately tensing and releasing the large muscle groups of the body (arms, torso, and legs) for 15 seconds each. Once patients have learned this technique, they are first instructed to practice it in neutral situations until they have achieved mastery. Once the skill is mastered, patients are encouraged to use the technique during exposure to cues that tend to induce faintness. The goal is to counteract the behavior of fainting directly by teaching patients to tense their gross body muscles at the first signs of hypotension. Patients are instructed to perform five cycles of applied muscle tension before, during, and after they are confronted with their specific feared situation (blood, injections, or injuries). If they are not ready to encounter their feared situation, a hierarchy can be created to help them use applied tension in the presence of increasingly distressing stimuli. For example, they may begin practice their tensing exercises first while lying down and then standing up. They may begin by seeing photographs

of people giving blood, next watching videotapes, followed by watching someone else give blood in person, and then finally giving blood themselves.

FEARS OF ANXIETY SYMPTOMS

Although individuals with specific phobia are less likely to report fears of anxiety sensations than are individuals with other anxiety disorders, those who do may receive benefit from being exposed to interoceptive cues associated with anxiety. Individuals with height phobia and other situation-specific phobias, particularly those with claustrophobia, tend to have a greater fear of anxiety sensations (e.g., hyperventilation) than do patients with other specific phobias. Exposure to interoceptive cues may be used to help these patients habituate to these sensations and extinguish the association between the sensations and the feared stimulus.

OPEN-SPACE PHOBIAS

Some individuals tend to have a fear of falling when support is not nearby. These patients may anchor themselves to objects around them to stabilize themselves; they may even resort to crawling on hands and knees across an open space. This type of phobia is more common in older adults who have had a fall, and preliminary evidence suggests that these patients may have a mild disturbance in visual–perceptual–spatial functioning (Barlow, 1988). However, contrary to what may seem logical, exposure to open spaces is often not useful in such cases. Instead, exposure to audiovestibular cues or other sensory sensations of dizziness may be useful, along with neuropsychological rehabilitation procedures.

Eliminating Avoidance, Escape, and Safety Behaviors

As stated above, avoiding or escaping the feared stimulus maintains individuals' beliefs that the stimulus is dangerous, and hence prevents them from losing the associated anxiety and habituating to the stimulus over time. In addition, the relief experienced upon avoiding the stimulus become negatively reinforcing and leads to increased avoidance in the long run. Hence exposure to the object or situation patients have feared and avoided for so long enables them to learn that it is not truly dangerous. It also helps them learn that the anxiety associated with the feared stimulus naturally subsides as the association with danger is extinguished.

Patients should be encouraged to view avoidance and escape as bad habits that are self-reinforcing and hence difficult to give up. We like to tell patients that they are not making progress unless they often do things that make them uncomfortable. The therapist may troubleshoot with patients the urge to avoid or escape from uncomfortable situations by helping them come up with strategies to help overcome their temptation. For example, the therapist may help patients conceptualize the phobia as a “bully” that is preventing them from reaching their life goals, and their avoidance and escape behaviors as ways of “giving in to” the bully. Confronting the feared stimulus can then be seen as a way to stand up to the bully. Form 7.9 will help patients list and evaluate the costs of their avoidance or escape behaviors.

Many patients with specific phobia also utilize safety behaviors to tolerate being in the presence of the feared stimulus. These behaviors serve the same function as avoidance or escape,

because they prevent complete exposure to the stimulus and hence perpetuate their sense that the stimulus is dangerous. Many of these safety behaviors are covert, and must be identified and blocked during exposure. Otherwise, patients will often mistakenly attribute their success in confronting the stimulus to these behaviors; they may believe that without their use, catastrophic outcomes would occur (e.g., “If I had not held onto the railing, I might have fallen over the edge”) and/or that they would be unable to cope (e.g., “I would have lost my mind if I hadn’t taken the Xanax when I entered the elevator”). Examples of safety behaviors include holding onto a wall or a piece of furniture to prevent fainting, clenching muscles to establish readiness of response, scanning the environment for visual or auditory signs of danger, repeating prayers or self-reassurance statements, engaging in anxious tics, holding one’s breath, or trying to form images that distract one from the situation. In addition, some patients may self-medicate with alcohol or anxiolytics; others may simply carry anxiolytics around as a way of ensuring safety.

Patients should be encouraged to abandon any safety behaviors during exposure, since these responses may result in misattribution of positive results to the safety behaviors and/or may lead to distraction from the stimulus, thereby hindering habituation. Powers, Smits, and Telch (2004) found that just the availability of safety behaviors, even if they were not utilized, reduced the effectiveness of exposure. We find it helpful to ask patients directly about their safety behaviors (e.g., “Are there things you do or not do to make yourself feel less anxious when you are on a plane?”). We then explain that many people mistakenly believe that these safety behaviors protect them from danger, when in fact engaging in safety behaviors actually strengthens their fear and sense of being in danger. The patients are urged to watch for any signs of safety behaviors, examine the costs and benefits of these behaviors (Form 7.9), review the evidence for and against the idea that these behaviors actually provide safety, and begin slowly eliminating them. Form 7.10 enables patients to record their safety behaviors.

A therapist should inquire directly about anything that a patient does, says, imagines, or uses in order to create safety or reduce surprise. Once these safety behaviors are identified, the therapist may ask the patient to engage in an experiment in which these behaviors are temporarily relinquished or postponed to learn what will happen without their use. The therapist may examine the patient’s beliefs about the function of these safety behaviors, indicating how he or she may tend to attribute tolerance of the stimulus to the behaviors.

Cognitive Interventions

Many patients with specific phobia have distorted automatic thoughts that need to be submitted to evaluation. This examination may be done prior to conducting exposure, if patients are unwilling or too fearful to begin confronting their feared situations at the outset. Typical phobic automatic thoughts are “I will not survive,” “I’ll go crazy from the anxiety,” “I’ll never get over this,” “I must be a coward,” “I can’t do anything right,” “People will see I’m phobic,” and “No one else has this problem.”

Patients’ catastrophic ideas about danger—for example, that planes crash on a routine basis or that dogs will attack them—are identified and restructured by helping the patients examine the evidence (e.g., the odds of dying in a plane crash are 1 in 10.5 million) or helping them consider less threatening alternatives (e.g., a dog may be friendly). Direct education about feared situations can also be provided:

“The reason you feel faint when you see a needle is that your blood pressure drops. It is your body’s way of protecting you and is not a sign that you will die. I will be teaching you strategies to increase your blood pressure. For example, you will learn to tense and relax your muscles, which will serve as a pump for your blood flow, increasing your blood pressure. When your blood pressure goes up, you will feel less faint.”

Patients’ automatic thoughts regarding their ability to cope with their anxiety—that it will never subside, that they will not be able to handle it, or that experiencing anxiety is a sign that danger is imminent—may also be examined via cognitive restructuring: “Have you ever been in a situation where the anxiety did not subside? Can you explain how this meant that you did not handle it? Have you had an occasion where you felt anxious, but nothing bad happened?” Using Socratic questions such as these, a therapist can guide a patient to challenge the believability of such thoughts and consider more adaptive, less erroneous cognitions (e.g., “If I hold the snake, my anxiety will shoot up, but after I continue holding the snake for a while, my anxiety will go down”).

Other ways to challenge the believability of automatic thoughts may include helping patients place themselves in the position of an objective observer. For example, patients may be asked whether they know anyone else with a phobia—preferably a phobia that they do not share. What advice would they give this friend? How would they help their friend examine the situation objectively?

Cognitive restructuring may also be used to prepare patients for conducting exposure. Have they ever overcome a fear of anything else? What did they tell themselves about the feared situation before they confronted it, and what did they learn after they did? Patients can be guided to learn that exposure to a feared stimulus is difficult but not dangerous, and that it is the only means to overcome their fears (like taking a bitter medicine to get better). They are also helped to see that they are capable of handling the anxiety they will inevitably experience when they initially confront their fears. Form 7.11 can help patients compare their predictions before encounters with feared stimuli to their actual experience. Form 7.12 can be used to help patients challenge their negative automatic thoughts.

Phasing Out Therapy

Generalization of treatment effects is achieved by having patients engage in self-directed homework assignments. Self-directed exposure exercises are scheduled as frequently as possible between sessions. The goal is for patients to “overpractice” exposure (e.g., taking elevators twice as much as would be reasonable), so that the associated anxiety habituates over time.

Although therapist-guided exposure is helpful in increasing the efficacy of exposure exercises, therapists should begin fading their participation and direction as soon as patients are able to direct their own exposure exercises. This not only helps treatment effects generalize, but it helps patients attribute the exposure effects to their own efforts. If multiple phobias are present, patients are encouraged to begin creating and directing a therapeutic plan to overcome their other fears. This enables patients to serve as their own therapists, and allows the therapist to gauge skill areas that still need strengthening. Form 7.13, which is a “phobia-free rule book,” can be given to patients as a self-help guide at this stage.

Another way to build generalization is eventually to decrease patients' reliance on companions who may help reduce their anxiety when confronting feared situations or objects. If patients are unable to conduct exposure on their own, the fear hierarchy may be developed with initial rungs permitting individuals to face the feared stimulus with a companion. However, phasing out companions as soon as possible is essential in building the self-efficacy necessary for continued exposure.

TROUBLESHOOTING PROBLEMS IN THERAPY

Although the treatment of specific phobia may seem straightforward, various problems may arise during treatment, especially during exposure. The clinician needs to maintain both structure in pursuing exposure, and flexibility and warmth necessary to help patients confront their fears. In this section, we review some common problems in treatment.

Fear That Treatment Will Make Things Worse

Many patients believe that exposure treatment will become an ordeal that will increase their anxiety to such an extreme level that they will go insane or have a heart attack, or that their heightened anxiety will never dissipate. We indicate to patients that the outcome for exposure treatment is very favorable, and that they have already experienced the highest levels of anxiety in the past on their own. Via cognitive strategies, patients are helped to see that their catastrophic fears are unfounded, that their anxiety will decrease both during an exposure exercise and over time, and that they have the resources to handle high levels of anxiety. With the secure presence of the therapist, with the use of graduated exposure, and with clear explanations beforehand, a patient is usually more willing to experiment with exposure.

Some patients believe not only that they will be unable to control the levels of anxiety they face, but that their therapist will startle them with stimuli far more fearful than they can tolerate. Patients may be comforted by being informed that the hierarchy of fears they will confront and the exposure timeline are developed collaboratively between patient and therapist. Patients are also told that the therapist will explain everything that will happen in the sessions before anything is initiated and will obtain the patients' permission beforehand. Patients can also be told that in fact it is highly unlikely that the amount of anxiety that they will experience during exposure will exceed the anxiety that they have experienced on their own, since exposure will be gradual. Moreover, in the initial phases of treatment, the therapist will model exposure and assist the patients in confronting phobic stimuli.

Self-Criticism

Many patients believe that their fears are a sign of weakness or cowardice and that they should not be afraid. These judgments or stigmas about their phobic fears need to be modified in order for treatment to be successful. In the socialization phase of treatment, as described earlier, we explain to them that most fears conferred greater fitness in the natural environment of our early ancestors. Consequently, rather than viewing their fears as "weaknesses," patients may reframe

them as advantages in a different environment. We explain to patients that avoidance is “nature’s way” of assuring safety, and that they have been “quick learners” in knowing what to do. Rather than viewing fear as a “deficiency,” we reconstrue it as “more rapid learning of what was initially adaptive.”

Difficulties in Establishing a Fear Hierarchy

Some patients have difficulty in defining a range of feared situations, often focusing on the extreme points of the scale. A therapist can assist such a patient by using imagery induction; by suggesting to the patient intermediate points on the scale; by using comparatives (“somewhat frightening,” “very frightening”); by identifying points on the scale through behavior (“How much longer could you stay in the situation?” or “How often have you been willing to do that?”); by modifying the stimuli to determine “conditions” of approach (“Would you be more or less willing to approach the situation if someone were with you?” or “Would you be more or less willing if you were closer to an exit?”); and by allowing the patient to modify the hierarchy later in treatment.

Unwillingness to Engage in Exposure

As indicated above, some patients fear that exposure will produce too much discomfort. In such a case, the therapist might inquire about the patient’s definition of “too much anxiety”: “Exactly what do you predict will happen?” By identifying these specific fears (e.g., “I will go insane”), the therapist can guide the patient to see that anxiety does not have untoward effects (e.g., “You cannot go insane from too much anxiety”), and that the patient is capable of handling the experience of heightened anxiety. The therapist needs to explain that exposure is the only method of demonstrating without ambiguity that the stimulus is not dangerous, whereas avoidance maintains the continued misperception of the stimulus as unsafe.

As described earlier, the patient may also be asked to identify the costs and benefits of maintaining the cycle of avoidance versus performing exposure to eliminate the fears. Contrasting the satisfaction and freedom gained by overcoming the fears with living as a prisoner of the fears is often helpful for a patient whose fears have resulted in a reduced range of movement and quality of life. The therapist can indicate that there is a difference between “what you want to do and what you are willing to do,” and that “being willing to do what you do not want to do is the key to making progress in therapy.”

The therapist can also use past successful attempts at overcoming other minor fears to motivate patients to engage in exposure to their phobic fears. For example, the therapist can ask patients whether they have ever done anything that they were reluctant to do or frightened of doing in the past, how they overcame their fears, and what the benefits were once they did this.

Unwillingness to engage in exposure may also be addressed by adding more rungs to the hierarchy, so that the patient is able to take small, achievable steps. First, a patient may be more willing to engage in exposure if the therapist models the exposure, thus providing the patient with evidence that the stimulus is not dangerous. For example, a patient with a fear of dogs who is unwilling to interact with a dog may find it beneficial to observe the therapist petting a dog before trying it him- or herself. Second, imaginal exposure is often less anxiety-provoking than

in vivo exposure and may be used as a preparation for *in vivo* exposure if the patient is unwilling to try the latter. Exposing a patient to the least frightening stimuli may also be helpful in demonstrating that the patient is able to tolerate some anxiety and habituate during exposure. During these initial exposure sessions, the therapist can elicit the negative thoughts the patient is having (e.g., “I can’t stand it,” “It’s going to drive me crazy,” or “This will kill me”) and can test them to see if they come true. When feared predictions do not arise during exposure to the least feared stimulus, the patient may be more motivated to continue with stimuli that create a greater degree of fear.

Demands for Certainty

Some people with specific phobia are hesitant to pursue exposure because they demand to know with absolute certainty that there will be no risk involved in confronting their fears. Even though the therapist can provide certainty with regard to risks for certain catastrophic outcomes (e.g., having a heart attack or becoming psychotic during exposure), they cannot provide an absolute guarantee of zero risk for other feared outcomes (e.g., that a dog will never bite).

A therapist can ask a patient to examine the costs and benefits of demanding certainty and to examine prior behaviors in which the outcome could not be completely guaranteed. The therapist can examine how the patient was able to pursue such risky behaviors, and why he or she was able to make that choice. For example, since driving confers some risk of accident, how was the patient able to tolerate this degree of risk? Patients are then encouraged to frame their predictions in terms of probabilities rather than possibilities or certainties—for example, “I think that there’s a 10% chance that the elevator will crash,” rather than the unchallengeable “I think it’s possible that the elevator will crash” or “I know that the elevator will crash.” The goal of therapy is not to provide certainty, but to help patients take risks in the face of ambiguity by weighing probabilities versus possibilities of catastrophic outcomes. For example, the chances of being mugged in a dark alley are certainly greater than the chances of being struck by lightning on a sunny day.

Unavailability of Exposure Items

Therapists in private practice may not have access to the stimuli that some patients fear (such as spiders, rats, or other animals), and many therapists do not find it convenient to accompany patients for *in vivo* exposure on airplanes or other places. Obviously, this is less than ideal, since many of the outcome studies demonstrating efficacy for treatment are based on actual *in vivo* exposure. However, a therapist may often overcome these obstacles by using a variety of creative solutions. For example, the therapist may begin by conducting imaginal exposure exercises in the therapy sessions. The patient may then be instructed to listen to a recording of the therapy session in the presence of the feared stimulus; this can serve as a form of therapist participation.

Working collaboratively with patients, the therapist can also come up with creative ways of conducting live exposure when feared stimuli are not easily obtained. The therapist may begin by using photographs and videotapes of feared objects or situations, and then instruct the patients to confront the feared stimuli in a contained environment (e.g., a pet store), to use simulated

exercises (e.g., a flight simulator, virtual-reality machines), or to ask friends or relatives to bring stimuli to the therapy session (e.g., a friend's pet spider housed in a cage).

Noncompliance with Homework

There are many reasons why patients may not engage in exposure outside therapy sessions. Common reasons include therapists' lack of clarity and specificity about the importance of conducting homework assignments, combined with patients' long-standing habit of avoiding feared stimuli.

Compliance with homework is more likely to be achieved if a therapist emphasizes that homework is critical for treatment success and ensures that homework is given and checked during each session. Patients are informed at the outset of treatment that the treatment is unlikely to yield significant benefits if homework assignments are not conducted. The therapist gives homework at the very first session, and thereafter makes sure to give patients homework at the end of each session and to review the homework done at the start of each session.

In order to ensure compliance, therapists should also make it completely clear what they expect patients to do. Rather than tell a patient with an elevator phobia, "Take elevators this week," a therapist should specify exactly what the assignment is: "Ride up three floors and down three floors on an elevator every day. Write out your predictions before you get on the elevator, noting your anxiety level from 0 to 10, and then write out the actual outcome after you get off the elevator, noting what actually happened and what your anxiety level is." It is also helpful to ask patients to anticipate and schedule the exact days and times that the exposure is anticipated to occur.

The therapist may also ask patients about the costs and benefits of doing homework, and identify and restructure their fears or beliefs about completing assignments. We find it helpful to anticipate noncompliance with homework and to role-play this in session. The therapist can act out the reluctance (e.g., "There is no point in doing these assignments; I am never going to get better"), and patients can be taught to challenge the role-played negative thoughts (e.g., "I know it is tedious and anxiety-provoking, but it is important that you do it, because it will help you get better").

The homework may also be broken into smaller, more achievable steps. For example, patients may be asked to create their own homework and only do what they are sure they will be most likely to do (e.g., "Place the therapy logs on my desk," or "Call my friend Joe to inquire about borrowing his pet snake later").

The length of exposure to *in vivo* stimuli during sessions may also be increased to ensure that fear is not sensitized. This may help reduce the patient's subsequent anxiety outside of sessions. Fading therapist assistance may be accomplished by using flashcards with coping statements about fear, recording a session and playing it daily, and moving down the hierarchy to practice less fear-provoking stimuli.

Therapist Fears

Some therapists, particularly novices, may have fears of inducing anxiety in patients. These beliefs need to be examined before such therapists begin using exposure. Some typical beliefs are "I shouldn't make my patients anxious," "The patient will drop out of therapy," "The patient

won't like me," "The patient's anxiety will get out of control," "Maybe the stimulus really is dangerous," and "I can't stand to see people who are suffering."

A deeper understanding of the nature of fear and the cognitive-behavioral model of fear reduction may be needed before therapists begin working with patients who have specific phobia or other anxiety disorders. The only way that exposure can work is if a patient's fear schemas are activated (Foa & Kozak, 1991), so that habituation may occur and the patient may learn that the feared stimulus is tolerable. Patients do not acquire a sense of self-efficacy by dealing with trivial and unemotional situations. Our experience is that therapists who are directive and encourage patients to face their fears are far more successful and retain their patients, whereas therapists who appear apprehensive about exposure only reinforce the patients' belief that there really is something to fear. Therapists do not induce anxiety through exposure in order to satisfy sadistic needs, but rather to help the patients become liberated from their fears. Our experience is that patients may balk at the discomfort of exposure, but are soon able to relish their efforts and success in overcoming their fears.

DETAILED TREATMENT PLAN FOR SPECIFIC PHOBIA

Treatment Reports

Tables 7.3 and 7.4 are designed to help in writing managed care treatment reports for patients with specific phobia. Table 7.3 shows sample symptoms. Select the symptoms that are appropriate for your patient. Be sure also to specify the nature of the patient's impairments, including

TABLE 7.3. Sample Symptoms for Specific Phobia

Specify feared object or situation
Anxiety
Specify physical/cognitive symptoms of anxiety:
Panic attacks
Palpitations
Difficulty breathing
Chest pain
Nausea
Dizziness
Feeling faint
Sweating
Shaking
Mind going blank
Derealization
Depersonalization
Numbness
Tingling
Chills
Hot flashes
Avoidance, escape, and other safety behaviors (specify)

TABLE 7.4. Sample Treatment Goals and Interventions for Specific Phobia

Treatment goals	Interventions
Reducing physical symptoms of anxiety	Exposure
Stating reduced fear of phobic object/situation phobic object	Cognitive restructuring
Reporting anxiety <1/10 when encountering phobic object/situation	Exposure
Modifying schemas of danger and vulnerability (or other schemas—specify)	Cognitive restructuring, cost–benefit analysis
Eliminating all avoidance, escape, and safety behaviors	Exposure
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Eliminating all anxiety symptoms (test scores in normal range)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

any dysfunction in academic, work, family, or social functioning. Table 7.4 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

Sequence of Interventions

Table 7.5 shows the sequence of interventions for a six-session treatment of specific phobia. Patients with more severe symptoms may require longer treatment.

CASE EXAMPLE

Sessions 1–2

Presenting problem

The patient, Gail, was a 34-year-old unmarried woman who had had fears of flying for 12 years and fears of elevators for at least 15 years. Her fear of elevators was so intense that even though she lived in one of the largest cities in the United States, she would not visit people living above the 12th floor, since she refused to use an elevator and had to walk up and down the stairs. The therapist's office was on the 10th floor, so she walked up the stairs the entire distance. She presented for treatment because she had been offered a job in an office on the 38th floor and believed that the time had finally come for her to overcome her fear of elevators. However, this fear was so severe and chronic that she was almost certain that she would not be able to overcome it.

Assessment

During the initial evaluation, Gail completed the standard intake battery (see Form 7.3), but this indicated no diagnosis other than specific

TABLE 7.5. Detailed Treatment Plan for Specific Phobia**Session 1****Assessment**

Elicit objects or situations feared, as well as degree of avoidance and escape
 Note onset of fear, level of fear, duration, episodic nature
 Elicit beliefs about feared stimulus/response
 Identify safety behaviors
 Assess impairment in social, occupational, and educational functioning
 Administer standard battery of intake measures (see Form 7.3), plus additional questionnaires as appropriate
 Have patient complete Fear Evaluation for Patients (Form 7.4)
 Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
 Evaluate substance use; evaluate need for counseling or detoxification if patient has substance abuse or dependence
 Assess need for medication

Socialization to Treatment

Indicate that fears and phobias are common and that brief treatment is available
 Provide patient with information handouts on specific phobia (Forms 7.1, 7.2, 7.5) and on Cognitive/behavioral therapy in general (Form 10.1 in Chapter 10)

Session 2**Assessment**

Provide feedback on evaluation
 Explain costs-benefits of eliminating fears

Socialization to Treatment

Explain to patient the evolutionary, behavioral, and cognitive models of fear acquisition and of fear maintenance through avoidance
 Explain need for exposure treatment

Behavioral Interventions

Construct fear hierarchy (see Form 7.8) and train patient in use of SUDs

Cognitive Interventions

Begin identifying patient's distorted automatic thoughts

Homework

Have patient begin self-monitoring fears (see Form 7.7)

Sessions 3–4

Note: All sessions involving exposure may be double-length.

Assessment

Review homework

Behavioral Interventions

Elicit imagery of feared stimuli
 Review fear hierarchy
 Begin imaginal exposure in session
 Begin *in vivo* exposure in session, if possible (or therapist may model exposure)

(cont.)

TABLE 7.5 (cont.)

Identify safety behaviors during exposure
 Encourage patient to eliminate safety behaviors
 [Exposure may be concentrated in one session (massed exposure) or spaced over several sessions, with homework exposure in between sessions.]

Cognitive Interventions

Elicit patient's negative automatic thoughts during exposure
 Begin to challenge patient's automatic thoughts

Homework

Have patient engage in and self-monitor *in vivo* exposure experiences (using Form 7.7)
 Have patient identify and challenge automatic thoughts

Sessions 5–6**Assessment**

Review homework

Behavioral Interventions

Continue exposure (imaginal or *in vivo*) during session
 Encourage "overpractice" of exposure
 Encourage decreased reliance on companions
 Begin to phase out treatment; discuss possible future problems and ways of coping with them

Cognitive Interventions

Practice stress inoculation during session (develop coping cards, model arguing against negative thoughts, model making coping/self-reinforcing statements, have patient imitate therapist's coping statements, plan stress inoculation as homework)
 Examine patient's explanations for improvement (e.g., presence of therapist, exposure, disconfirmation of negative beliefs, safety behaviors, luck)
 Encourage self-efficacy statements
 Begin to phase out treatment; discuss possible future problems and ways of coping with them

Homework

Encourage patient to continue eliminating safety behaviors
 Have patient plan further *in vivo* exposure experiences, and encourage self-monitoring of these
 Encourage continuing work on automatic thoughts

Socialization to treatment

phobia. She was taking no psychiatric medications at present and denied use of other substances. Gail also filled out the Fear Evaluation for Patients (Form 7.4) and was asked about a number of situations that might provoke fear. This indicated that she had fears of elevators, flying, public speaking, authority, heights, snakes, rats, and fire. However, her fears of elevators and flying created the most distress for her. The final decision to focus on her phobia of elevators was based on the fact that these fears were interfering most significantly with her life.

The therapist presented the results of the evaluation and began socializing Gail into treatment by presenting a biological/cognitive-behavioral conceptualization of fear. Like many patients with specific phobia, Gail expressed

particular interest in the ethological model, so the therapist described it in some detail. He also provided some direct psychoeducation about elevators: “Did you know that Otis, the man who invented the elevator brake, actually had them suspend an elevator in a building and cut the cables, and the Otis brake held the elevator in place? And did you know that elevators are the safest means of transportation?” (At a later date, to treat her fear of flying, the clinician asked, “Did you know that 65 million passengers flew out of O’Hare airport in Chicago without a single death in one year?” and “Did you know that commercial airplanes can fly upside down and that their wings bend?”)

*Assessing
motivation to
change*

In order to examine and enhance Gail’s motivation to change, the therapist then told Gail about exposure treatment and indicated that about 85% of people with fears of elevators overcome their fears with exposure treatment. However, the exposure would necessarily make her anxious, so that she would learn that the things that make her anxious are in fact safe. She was asked to indicate the costs and benefits of doing the exposure treatment. She indicated that the costs (increased anxiety) were now outweighed by the benefits (getting over her fear, being able to take elevators to see her friends and pursue work, and feeling more like a normal person).

*Constructing a
fear hierarchy*

The therapist next indicated to Gail that she would need to construct a hierarchy of her feared situations related to elevators. The therapist explained to her that she could also rate how anxious she felt if she just had to imagine getting onto an elevator, rather than actually doing it. This yielded the following hierarchy of least to most feared situations:

<u>SUDs</u>	<u>Feared situation</u>
2	Sitting in therapist’s office thinking of elevator at home
2.5	Imagining standing outside an elevator
3	Imagining being in an elevator
4	Standing outside elevator thinking of getting in
6	Getting into elevator with therapist with door open, knowing I can get out
7.5	Being in the elevator, with therapist, as door closes
8.5	Going down on the elevator
9	Going up on the elevator
9.5	Going up to a very high floor on the elevator
10	Going up to the highest floor of the tallest building in town

*Eliciting
automatic
thoughts*

The therapist asked Gail to indicate what she thought would specifically happen if she got into the elevator. At this point, Gail indicated that she feared that the elevator would get stuck and that she would suffocate from lack of air. Again, psychoeducation proved to be useful: “Elevators are not hermetically sealed like tombs in the shaft. There are vents, the ceiling can be removed, and they contain a call box and an alarm.”

Psychoeducation

Challenging automatic thoughts

Gail was also asked whether she had heard of anyone suffocating in an elevator, and, if not, why did she think that she had not. With the help of psychoeducation and guided discovery, Gail was able to concur that suffocating in an elevator was highly unlikely. Next, she was asked to name the next worst thing that she could imagine happening. Gail indicated her fears that no one would know that she was stuck or that the elevator would crash. The therapist and Gail examined the possibility that no one would know that an elevator was stuck in an office or apartment building in a large city; she admitted that this was extremely improbable. Next, they examined why the elevator would crash. She could not identify any reason. She was helped to take note of the fact that elevators are unlikely to crash and don't crash to the basement even when the power is shut off for repairs.

Developing rational responses

Gail's catastrophic predictions were also elicited: "The elevator will get stuck, I'll choke from suffocation, my anxiety will make me go crazy, I can't stand my anxiety." Using Socratic questions, Gail was guided to develop rational responses to modify the believability of her catastrophic predictions. Gail's coping responses were then listed on an index card so she could read it in-between sessions.

"You've been anxious before. Fear doesn't kill you. You don't go crazy from anxiety. Elevators are safe. Remember that they are not sealed tombs. They don't crash. If you get stuck between floors, the elevator will start up again. There is an escape hatch in the ceiling of the elevator. There's a doorman downstairs, and there's an alarm button."

To facilitate Gail's use of these rational thoughts during moments of increased fear, the therapist indicated that she would need to learn how to challenge these negative thoughts on her own. Consequently, they engaged in a reverse role play, with the therapist playing the negative thoughts and Gail playing the rational responses. This helped Gail learn that she could adequately challenge her negative thoughts; she also learned that with continued use of this technique, her fear-inducing automatic thoughts would slowly be "drowned out" by her rational thoughts.

Imaginal exposure

Finally, because Gail seemed willing and able to begin engaging in it, exposure therapy was initiated. Gail was first asked to block any safety behaviors (e.g., distraction) during the exercise. The therapist indicated to Gail that she would begin with two items lower down in her hierarchy: imagining standing outside an elevator, and then being in an elevator. Beginning with the image of standing outside the elevator, Gail practiced imaginal exposure in the session until her SUDs level decreased to 1.5. She then moved on to imagining being in the elevator, with her fear level rising to 4.5; with repeated exposure to this image, however, her fear level dropped to 1.5 again. The exposure session was terminated when her fears subsided. The session was recorded, and Gail was required to conduct imaginal exposure on her own three times over the following week.

Sessions 3–4

In vivo exposure

The therapist decided at the beginning of Session 3 to have Gail engage in direct exposure to the stimulus—that is, *in vivo* exposure. Before the exposure session was initiated, her automatic thoughts were “I can’t stand it. I’m too anxious. I’ll go crazy. It’s dangerous. It’s going to crash.” The therapist challenged these thoughts, reminding her of the role plays and helped her use her rational responses.

The therapist next accompanied Gail to the elevator, and she was asked to stand outside the elevator and imagine herself getting in. She expressed a surge of anxiety (6) and broke out into a sweat. When her fear subsided to approximately 1.5–2, the therapist pressed the button for the elevator; when the door opened, the therapist got inside, holding the open button. Gail then got in, while the therapist got out, with the door still open. She got out and then back in. Her anxiety level spiked to about 9. She was asked to go in and out of the elevator multiple times until her fear level subsided.

The therapist then asked Gail whether she was ready to take a ride down to the first floor. She indicated that she was extremely anxious (10), but she knew she had to face her fears if she wanted to get better. The door closed, and she closed her eyes and held onto the side of the elevator. She was asked to give up both safety behaviors, and she reluctantly agreed. As the elevator descended to the first floor, she became considerably less anxious.

The therapist and Gail walked outside the building and stood on the sidewalk. Gail admitted that the experience was not as bad as she had thought it would be. The therapist asked her what she thought would happen if she went up the elevator again. She replied that she would be anxious, but less so because she had faced it once. They then got back onto the elevator, and she reported her SUDs level to be 6.5. By the time they arrived on the 10th floor, her SUDs level was 4.5. They got off and stood in the hall outside the elevator. Gail indicated that she was feeling better after having faced her fears, but felt a sense of unreality about what she had done. She said she could not quite believe that she had actually completed an elevator ride. Her sense of unreality was normalized, and Gail was informed that ideally the exposure exercises needed to continue until her fear and her urge to escape had subsided.

More in vivo exposure

At the start of Session 4, Gail’s SUDs level was 5 when she got into the elevator. Again she closed her eyes and held onto the side of the elevator, but she was able to open her eyes and not hold on, as requested. Her anxiety level increased to 7.5 in the elevator. The therapist and Gail got out again, got back on, and headed up to the 10th floor. This time her anxiety level dropped first to 4.5 and then to 3. This exercise was repeated four more times, until her anxiety upon entering the elevator was no higher than 3 and her urge to end the exercise had subsided.

Homework

As homework, Gail was asked to conduct at least three exposure sessions that involved her taking an elevator up and down with a family member or friend. She was asked to monitor her SUDs levels and to use the same indices as she had used during the session to end each exposure exercise.

Sessions 5–6

Moving up the fear hierarchy

Once Gail had conducted six exposure exercises while accompanied by someone and was able to experience minimal anxiety upon entering these sessions, the therapist decided to help her move up her hierarchy. She was able to acknowledge the importance of giving up the feeling of safety in the presence of someone, and was helped to take the elevator while the therapist waited outside the elevator. Although her SUDs level surged to 10 almost immediately, she reported that it declined faster than it had during her initial *in vivo* exposure exercise (when she had been accompanied). Before long, she experienced minimal anxiety even upon entering the elevator. However, she still reported a sense of unreality that she had finally managed to face something she had avoided for so long. She was told that this was an indication that exposure exercises needed to be continued until her success in conducting them felt completely real.

Homework

Gail's homework assignment was to take the elevator unaccompanied to the seventh floor, where she lived. The therapist urged her to try to note her predictions beforehand and compare them to actual outcomes. (For example, she had predicted before her first *in vivo* exposure that the elevator would get stuck or would crash—but, contrary to her predictions, the elevator had arrived at its destination each time.) She was urged to reward herself, through praise and tangible rewards, for conducting exposure exercises on her own.

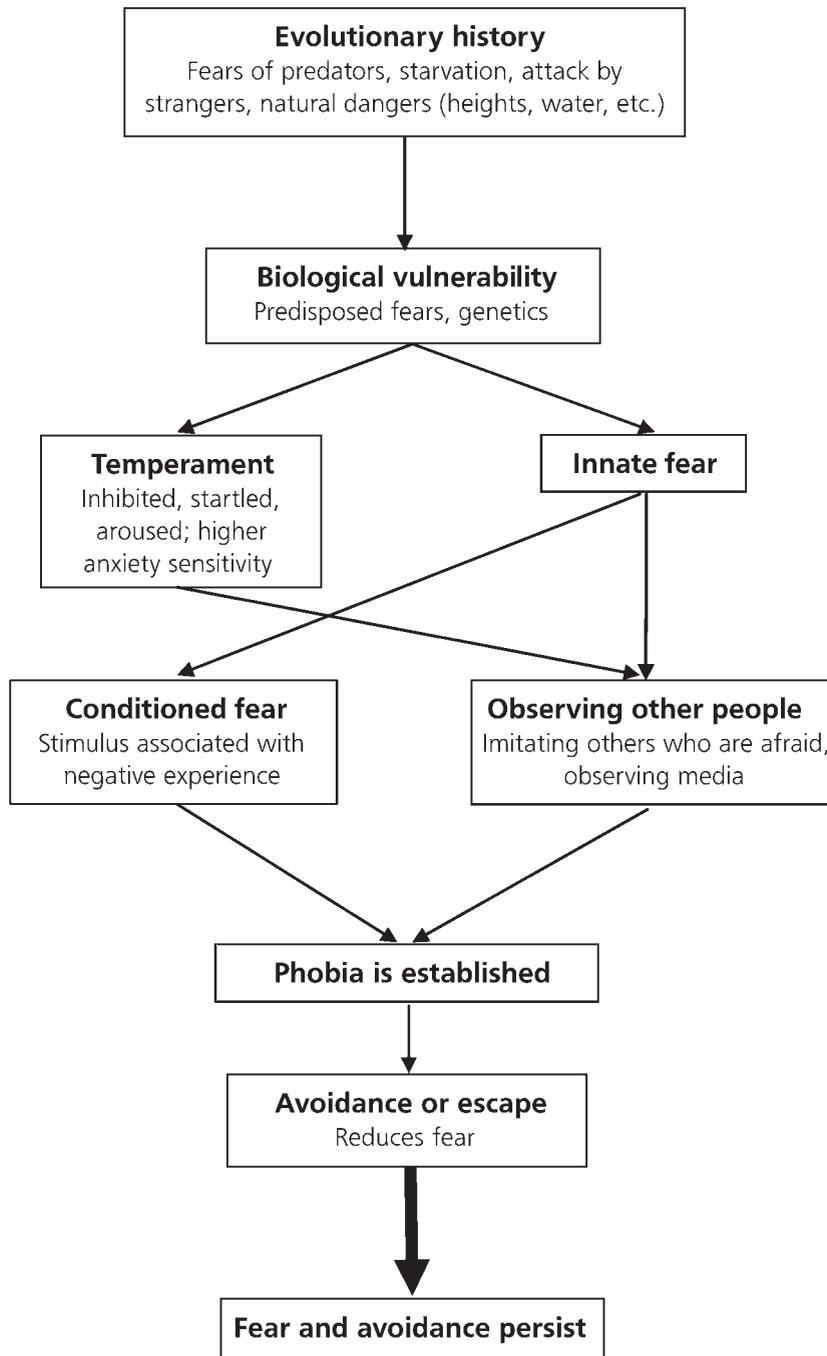
Treatment progress

After one more session of exposure and daily homework, Gail decided to take the elevator to the 38th floor of her office building. Much to her surprise and pleasure, she was able to do it without escape or avoidance, and without any feelings of unreality. Her final test was to take the elevator to the top of the tallest building in the city—which she was able to accomplish 3 weeks after she began exposure.

Termination

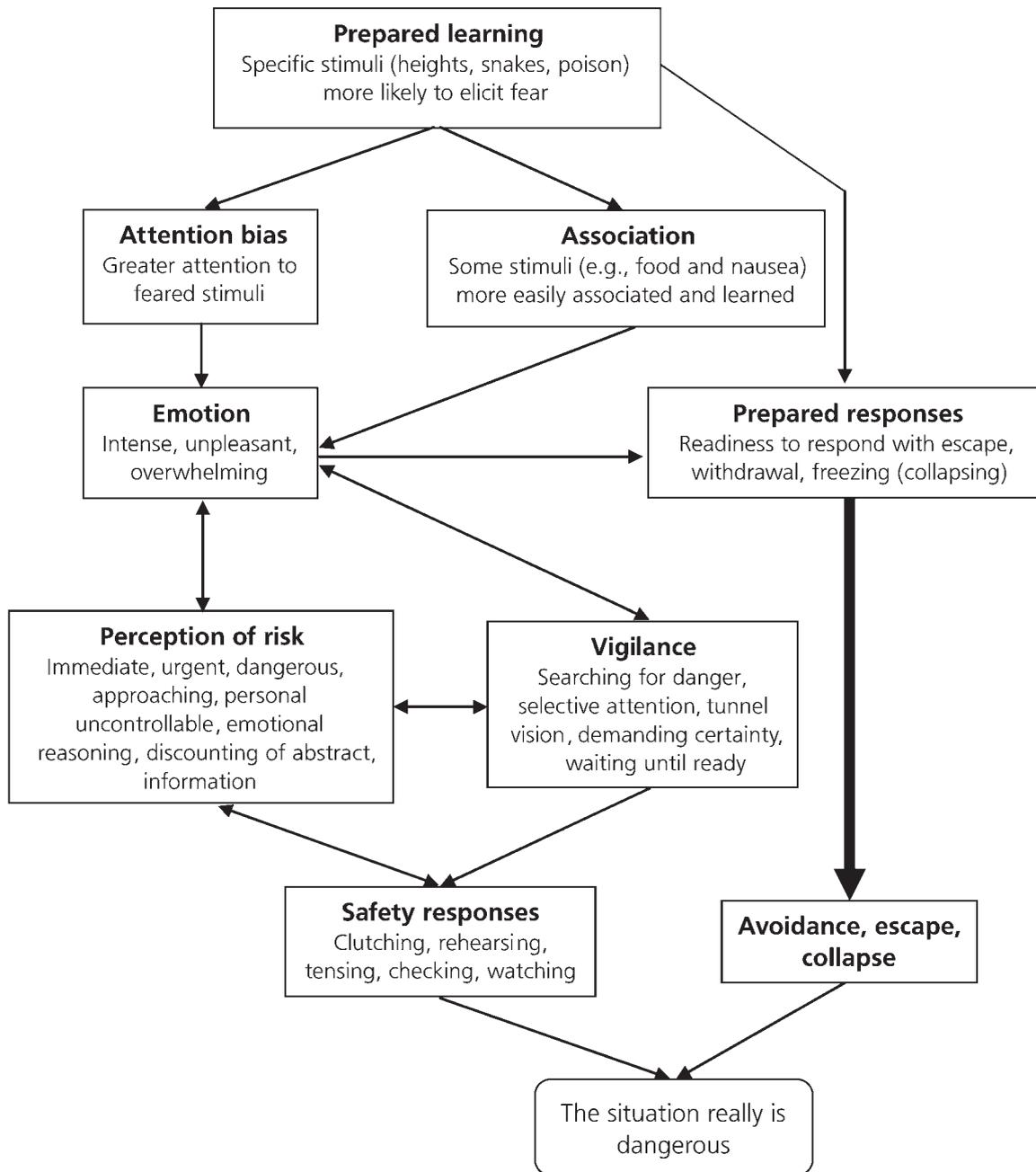
Regular sessions were then discontinued. Gail was asked to use elevators every day to maintain her therapy gains, and to continue working on challenging her catastrophic predictions.

FORM 7.1. Where Your Fear Comes From and Why It Persists



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FORM 7.2. Fearful Thinking



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FORM 7.3. Evaluation of Specific Phobia: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Beck Depression Inventory–II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Global Assessment of Functioning (GAF) _____ Dyadic Adjustment Scale (DAS) _____

Structured Clinical Interview for DSM-IV-TR, Axis I (SCID) _____

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) _____

Other questionnaires (specify) _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Treatment
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(cont.)

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Treatment progress (later evaluations only)

Situations in which stimulus is still avoided: _____

Situations in which stimulus is approached but was previously avoided: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 7.4. Fear Evaluation for Patients

Patient's name: _____ Today's date: _____

Therapist's name: _____

Choose a number from the scale below to show how much you fear each of the situations listed below, and write that number next to each fear.

0	25	50	75	100
None	Somewhat	Moderate	Very	Extreme

1. Flying	11. Meeting strangers	21. Traveling in a bus, train, or subway
2. Elevators	12. Speaking in public	22. Walking alone
3. Heights	13. Using a public bathroom	23. Being alone at home
4. Insects	14. Eating in public	24. Dirt or soiled things
5. Snakes	15. People seeing I'm nervous	25. Lightning or thunder
6. Animals	16. Crowded stores	26. Darkness or night
7. Blood or injections	17. Malls	27. Standing in line waiting
8. Rats and mice	18. Restaurants, churches, movies	28. Exercise
9. Water	19. Closed spaces	29. Increasing my heart rate
10. Hospitals	20. Open spaces	30. People criticizing me

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FORM 7.5. Information for Patients about Specific Phobia

WHAT IS SPECIFIC PHOBIA?

Specific phobia is a fear of a particular object, animal, or situation. The fear is great enough that you wish to avoid the situation or experience it only with considerable anxiety. Fears and phobias are very common. In a recent national survey, 60% of the people interviewed reported that they feared some situation or thing. The most common fears were fears of bugs, mice, snakes, bats, heights, water, public transportation, storms, closed spaces, tunnels, and bridges. Many people reported that they feared several things and that they consciously avoided them. In fact, over 12% of the people indicated that their fears qualified as specific phobias. That is, their fears were persistent and associated with intense anxiety; they avoided or wanted to avoid certain situations; they realized that their fears were excessive and unreasonable; and that their fears resulted in distress and difficulty in their normal lives.

WHAT ARE THE CAUSES OF SPECIFIC PHOBIA?

There are several causes of specific phobia. Cognitive-behavioral theorists make a distinction between how you learned to fear something and why you still fear that thing even years later.

Some theories suggest that people tend to develop phobias about objects, animals, or situations that were dangerous in prehistoric times. For example, bugs, mice, snakes, many other animals, heights, strangers, bridges, and water were all potentially dangerous for early humans. In a wild environment, these fears were very adaptive and useful. People with these fears were better prepared to avoid contamination, poisonous bites, falling off cliffs or bridges, being murdered by strangers, or drowning. But in today's technological world, these fears are no longer as accurate as they once were.

A second origin of phobias is through learning—either connecting a bad experience with the thing you are afraid of (for example, perhaps you were bitten by a dog and developed a fear of dogs) or observing someone who is afraid and learning from their fear (for example, perhaps other family members had a fear of flying and you learned that fear from them). A third reason for phobias may be distortions in thinking. For example, a phobia may be based on incorrect information, on a tendency to predict the worst, on a tendency not to use evidence that challenges the phobia, or on a belief that you cannot tolerate anxiety.

Once you learn a fear or phobia, it is maintained in a number of ways. The most important reason is that you avoid the situation you fear. If you fear flying, you feel less anxious every time you decide to avoid getting onto a plane. Each time you avoid flying, you teach yourself that “the way to reduce my fear is to avoid”—that is, you learn to avoid. This is like taking a drink every time that you are anxious—you learn to drink more because it temporarily reduces your anxiety. But by avoiding the thing you fear, you never learn that you can overcome your fear. Another way you may maintain your fear is by engaging in “safety behaviors.” These are things you do or say that you think will protect you. For example, in an elevator you may hold onto its side, or in an airplane you may hold onto your seat. Or you may repeat prayers or otherwise seek reassurance when you are in a feared situation. You can come to believe that these safety behaviors are necessary for you to overcome your fear.

HOW CAN COGNITIVE-BEHAVIORAL THERAPY HELP?

Your fear and anxiety will begin to fade when you learn, from experience, that your phobia is unfounded. Cognitive-behavioral therapy for specific phobia is about helping you face what you fear rather than avoiding it.

(cont.)

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In order to overcome your fear, your therapist will have you make a list of the objects or situations that you fear, describe how intense your fear is, and indicate what your beliefs are about each object or situation (for example, do you think that you will be contaminated, die, be attacked, or go insane?). Your therapist may ask you to form images in your mind about a feared situation and hold these images in mind until you feel less anxious. You may observe your therapist doing the things you fear, and later you may imitate him or her. Your exposure to the things that you fear will be gradual: Your therapist will explain everything before you do it; you are free to refuse to do anything; there will be no surprises sprung on you; and you will determine the pace at which you make progress. Most patients using these techniques find that they feel much less tense, become able to do things that they feared, and feel more effective in their lives. Many patients are able to improve rapidly with a few sessions. Depending on the fear, between 80% and 90% of patients improve when they use these techniques. Although some patients may use antidepressants or antianxiety medications for these fears, the treatments that we have described do not require these medications.

WHAT IS EXPECTED OF YOU AS A PATIENT?

Overcoming fears may require you to put yourself gradually into situations that make you anxious. You should let your therapist know which situations or things make you most anxious, what kinds of thoughts you have about those things, and whether you are willing to experience some anxiety in order to overcome your fears. Your therapist will help guide you through gradual exposure to these situations. You will have to carry out some self-help homework between therapy sessions, with which you will practice many of the same things that you are learning in the sessions with your therapist.

FORM 7.6. Costs and Benefits of Overcoming Your Fear

My specific fear is:

Costs	Benefits	What I will be able to do if I overcome this fear

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FORM 7.7. Patient's Self-Monitoring of Fears

Patient's name: _____ Today's date: _____

To collect information about your fears for treatment, please record the information below for times when you were in a feared situation. In the first column, write the date and time. In the next, describe the feared situation. Use a scale of 1-10, where 10 represents the greatest fear you can imagine. In the fourth column, describe the actual outcome: Did you avoid the situation, engage in the behavior, seek safety, etc.? What sensations and thoughts did you have? What happened? For example: "I was able to take the elevator. I thought I was going to panic, but I got up and down safely." In the last column, indicate the actual level of fear you felt in the situation, again using a scale of 0–10 where 10 represents the greatest fear you can imagine.

Date/time	Situation feared and my prediction	Expected fear level (0–10)	Actual outcome	Actual fear level (0–10)

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FORM 7.9. Costs and Benefits of Avoidance Behaviors in Specific Phobia

Examples of avoidance behaviors	Costs to me of avoiding	Benefits to me of avoiding

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FORM 7.10. Safety Behaviors in Specific Phobia

Categories of safety behaviors	My specific behavior	Yes/No
Tensing, clutching		
Scanning the environment		
Asking for reassurance		
Praying, repeating phrases		
Rehearsing distracting images or sounds (e.g., singing to myself)		
Breathing differently		
Moving in a different manner (slowly, quickly, rigidly, etc.)		
Other		

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FORM 7.12. Rational and Irrational Thoughts in Specific Phobia

Irrational automatic thought	What distorted thought category is this?	Rational response
The elevator will crash.	Fortunetelling Catastrophic thinking	The chances of the elevator falling and killing me are 398 million to 1. I have made these predictions before, and they have never come true.
Yeah—but this time it could happen. There is no guarantee.	Discounting the positive Perfectionism Demand for certainty	Of course, anything could happen—but life has to be lived with what is probable, not with what is possible.
I shouldn't get on the elevator until I feel comfortable.	Demand for certainty and the need to be ready	The only way to make progress is to do things when I am not ready—like exercise and facing my fears. In fact, I will need to feel the fear to get over it.
<p>Note: List any irrational negative thoughts that you have, and identify the categories of distorted thoughts that these fall into. Then give the most useful rational responses that you can give. You can go back over this form at later times and add to your rational responses.</p>		

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FORM 7.13. Your Phobia-Free Rule Book

Rules that make you afraid	Rules that overcome your fears
If you are afraid, then it must be dangerous.	Your fear does not mean the danger is real—emotions are not reality.
The danger is approaching rapidly.	The danger may be only in your head (it may not be approaching at all), or it may be slowly approaching.
Don't rely on probabilities. You could be "the one" who gets hurt.	Probabilities are reality—you "could" always be "the one"—but that's no way to live. There is no certainty in an uncertain world.
You must have absolute certainty, or it is dangerous.	There is no certainty. Uncertainty is neutral, not dangerous.
It will be catastrophic—it could kill you.	You probably have no evidence it is going to be catastrophic. You've had these beliefs before, and you are still alive.
Focus on the threat—this will save you.	You should recognize that there is always some evidence of a "threat"—but there is also evidence of safety.
Look for "clues" that it is dangerous.	Use all the information—not just the "signs" of threat.
You will not be able to cope—you are potentially helpless.	You may be stronger than you think.
Ignore anyone who tells you it's safe—you could get overconfident.	Use the information other people have. After all, phobia is not evidence of danger—it's evidence of your emotion.
You must get out of or avoid the situation immediately.	You might be better off staying as long as possible to find out that it is really safe.
Use safety behaviors to tolerate the discomfort.	Safety behaviors maintain your fears. Eliminate them as soon as possible.
If you survive, it's because your safety behaviors helped you.	If you survive, it has nothing to do with safety behaviors—it has more to do with the fact that the situation is safe.
Always avoid the things you fear.	Try to do the things that you fear doing.

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Obsessive–Compulsive Disorder

DESCRIPTION AND DIAGNOSIS

Symptoms

Obsessive–compulsive disorder (abbreviated OCD in the text of this chapter), one of the most debilitating of all anxiety disorders, is characterized by habitual thoughts, urges, or images that create apprehension or concern (“obsessions”), or behavioral or mental actions that the patient feels driven to undertake in a repetitive, systematic fashion in order to reduce apprehension or avoid some feared outcome (“compulsions”). Compulsions are usually performed in response to obsessions. OCD is diagnosed if obsessions and/or compulsions cause considerable anxiety or are time-consuming.

Typical obsessions include fears of being contaminated by germs or poison, fears of causing harm to oneself or others by not being careful enough, and fears of doing something unacceptable. Others include a discomfort with asymmetry or with discarding objects, as well as a range of superstitious fears or magical thoughts. Often a person’s obsessive thoughts are in direct contradiction to his or her value system (e.g., a highly religious woman fears she will commit blasphemy; a loving father fears he will kill his child) and are perceived as being outside his or her control.

Compulsions are also known as “rituals,” and may be either overt acts (such as repeatedly checking that a stove has been turned off) or mental acts (such as silently repeating a prayer). Typical compulsions include excessive or ritualized washing/cleaning and repeated checking, occurring in 53% and 50% of cases, respectively (Ball, Baer, & Otto, 1996). Other rituals include counting; mental rituals such as repeating words, phrases, or prayers; seeking reassurance; hoarding objects; and insisting that things be put in a specific order or pattern. Approximately 36% of individuals with OCD report counting rituals, 31% report a need to ask or confess, 28% report rituals involving symmetry, and 18% perform hoarding rituals. Multiple rituals are reported by 48% of people with OCD, while 60% report multiple obsessions (Ball et al., 1996).

Although OCD can be diagnosed in a person presenting with either obsessions or compulsions, the majority (over 90%) of patients with OCD have both obsessions and compulsions. Approximately 2% of individuals appear to suffer from only obsessions. However, clinicians need to inquire carefully in these cases to ensure that patients are not engaging in covert mental acts, intended to neutralize their obsessive thoughts.

Individuals with OCD commonly also exhibit passive avoidance or escape behaviors, as well as pathological doubt about whether they have performed tasks or actions correctly (or at

all), despite objective evidence to the contrary. Passive avoidance behaviors (e.g., avoiding using the stove) are seen across the range of anxiety disorders and are functionally similar to active avoidance behaviors such as compulsive rituals, in that both are aimed at reducing discomfort or anxiety. Although a fear of uncertainty is present in other anxiety disorders, pathological doubt about one's memory for actions performed (e.g., unreasonable doubt that one has adequately checked the stove to ensure that it is turned off) appears to be unique to OCD (Tolin, Abramowitz, Brigidi, & Foa, 2003).

People with OCD have some recognition that their obsessions and compulsions are exaggerated and unrealistic. However, this recognition waxes and wanes during the illness, and in some cases it may rarely be present. Even when individuals have insight into the senselessness of their obsessions and compulsions, they find themselves unable to stop the intrusive obsessive thoughts and feel driven to perform the rituals.

Individuals may suffer with OCD for years before they present for treatment. Some patients feel compelled to perform rituals for hours at a time, which interfere with their ability to fulfill social roles, such as work obligations (Koran, 2000; Leon, Portera, & Weissman, 1995) and marital or other interpersonal relationships (Emmelkamp, de Haan, & Hoogduin, 1990; Riggs, Hiss, & Foa, 1992). Many avoid situations that provoke obsessive thoughts, and some patients become homebound. Often patients involve other family members in their compulsive behaviors; for example, a mother may have her children engage in elaborate washing rituals before they are allowed in the house. As a result, OCD is associated with high rates of disability and a lowered quality of life. Approximately 38% of those with OCD are unable to work at some time, due to the severity of their disorder; 22% are unemployed, and 24% live in a substandard socioeconomic class (Mancebo et al., 2008). According to past epidemiological studies, the total costs of OCD may be as high as \$8.4 billion (Mancebo et al., 2008). Indirect costs associated with the illness, reflecting lost productivity of individuals suffering from or even dying from the disorder, were estimated at \$6.2 billion (Dupont, Rice, Shiraki, & Rowland, 1995).

For a detailed description of the current diagnostic criteria for OCD, refer to DSM-IV-TR (American Psychiatric Association, 2000, pp. 456–463).

Prevalence and Life Course

Although OCD was initially believed to be a rare disorder, recent epidemiological studies estimate annual prevalence rates of OCD at between 1% and 1.6% (Kessler, Berglund, et al., 2005; Kessler, Chiu, Demler, & Walters, 2005) and lifetime prevalence rates at between 1.9% and 3% (Karno, Golding, Sorenson, & Burnam, 1988; Kessler, Ruscio, Shear, & Wittchen, 2009). Community samples using children and adolescents suggest similar lifetime prevalence rates (Flament et al., 1988; Valleni-Basile et al., 1994).

Although earlier studies indicated that OCD is slightly more prevalent among women (Rasmussen & Tsuang, 1986), more recent studies suggest that OCD seems to be evenly divided between men and women (Lochner & Stein, 2001). However, among pediatric samples, OCD seems to be more frequently found in males, with several studies showing a 2:1 ratio (American Psychiatric Association, 2000; Hanna, 1995).

Rates of OCD appear to be consistent across many countries and cultures, including the United States, Canada, Korea, Puerto Rico, New Zealand, and Germany, with lifetime preva-

lence rates ranging from 1.9% to 2.5% and annual prevalence rates ranging from 1.1% to 1.8% (McGinn & Sanderson, 1999; Weissman et al., 1994). With a lifetime prevalence rate of 0.7% and an annual rate of 0.4%, Taiwan appears to have the lowest OCD rates of any culture studied. Some earlier studies suggest that OCD is less prevalent in minority groups (Karno et al., 1988); however, few studies have been conducted on minority populations, so it is premature to make definitive conclusions regarding prevalence by ethnicity. In addition, racial and ethnic differences may reflect differences in symptom reporting and in the utilization of mental health treatment (Abramowitz, Taylor, & McKay, 2009), and may also vary widely depending on the specific cultural populations being studied.

OCD's typical age of onset appears to be between early adolescence and young adulthood, although onset in childhood is sometimes seen. Males tend to develop OCD between the ages of 13 and 15, whereas females tend to develop symptoms between the ages of 20 and 24 (Rasmussen & Eisen, 1990).

Although the onset of the disorder is usually gradual, an acute onset has been documented in some individuals. A sudden onset in some pediatric cases (age 3 to puberty may indicate the presence of pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS). A positive throat culture for a strep infection and the presence of motoric hyperactivity or choreiform movements may aid in making a PANDAS diagnosis. Antibiotics are used to treat the infection, along with standard treatment for OCD; however, the infection can recur, leading to an exacerbation of symptoms.

The course of OCD is generally chronic, with waxing and waning of symptoms. However, episodic and progressively deteriorating courses have been observed in a minority of cases (American Psychiatric Association, 2000). Stress may precipitate the first onset of symptoms, as well as future exacerbations of the illness.

Genetic/Biological Factors

Several different lines of research point to a role for biological factors in the development of OCD. The fact that OCD aggregates in families points to the role of both genes and the environment in the development of the illness (Grisham, Anderson, & Perminder, 2008; Hettema et al., 2001). Twin studies suggest that OCD is partially heritable, with a 45–65% heritability estimate in children and a 27–47% estimate among adults (Steketee, 1993; van Grootheest, Cath, Beekman, & Boomsma, 2005). Although the influence of the environment is a confounding variable in family studies, the finding that monozygotic twins have a higher concordance rate for OCD than dizygotic twins (65% vs. 15%) indicates at least a partial role of genes in the etiology of OCD. Additional evidence comes from studies showing that first-degree relatives of patients with OCD also appear more likely to suffer from OCD (10.3–11.7%) than relatives of controls (1.9–2.7%) (Nestadt et al., 2000; Pauls, Alsobrook, Goodman, Rasmussen, & Leckman, 1995). However, the occurrence of the disorder in first-degree relatives is under 25%, and often obsessive or compulsive features are present rather than the full-blown disorder. Providing further support for a genetic basis, recent studies provide evidence of a linkage to markers on chromosome 9p and other chromosomes (Feng, Leckman, & Zhang, 2004; Hanna et al., 2002; Shugart et al., 2006; Willour et al., 2004).

Patients with OCD have higher-than-average rates of birth abnormalities, head trauma his-

tory, epilepsy, encephalitics, meningitis, and Sydenham's chorea, suggesting a possible role for early neurological trauma. A higher frequency of neurological "soft signs" has also been reported (Steketee, 1993).

Abnormalities in brain functioning have been observed in brain imaging studies of patients with OCD. Positron emission tomography and functional magnetic resonance imaging have shown that individuals with OCD have higher than normal glucose metabolic rates in the head of the caudate nucleus, as well as increased correlations in metabolic activity between elements of the orbital prefrontal cortex, caudate nucleus, and thalamus (Whiteside, Port, & Abramowitz, 2004). The caudate nucleus is believed to be involved in procedural learning and implicit memory. Interestingly, patients who have been successfully treated for OCD, either with fluoxetine (Prozac) or with behavior therapy, show a decrease in activity in the cortical–striatal–thalamic circuit (Hollander, Abramowitz, Koran, & Pallanti, 2008; Schwartz, Stoessel, Baxter, Martin, & Phelps, 1996).

Coexisting Conditions

Approximately 50–60% of individuals in the community with OCD have a comorbid Axis I or II disorder over their lifetimes, indicating that OCD commonly co-occurs with other illnesses (Matthews, 2009). The rate of lifetime comorbidity is even higher among clinic populations (Ledley, Pai, & Franklin, 2007). In most cases, OCD appears to be the principal diagnosis when it co-occurs with other illnesses (Antony, Downie, & Swinson, 1998).

Between 28% and 38% of patients diagnosed with OCD meet criteria for major depression, and 49% appear to have a comorbid anxiety disorder (Kessler et al., 2009; Weissman et al., 1994). A diagnosis of dysthymia is correspondingly less common, with a rate of approximately 10% (Wilhelm & Steketee, 2006). Bipolar disorders appear to occur more frequently in individuals with OCD than in the general population. Among the anxiety disorders, generalized anxiety disorder, specific phobia, and panic disorder appear to be most common (Brown, Campbell, Lehman, Grisham, & Mancill, 2005; Matthews, 2009; Steketee, 1993). When depression is present, it appears to follow the onset of OCD, suggesting that it may be a reaction to having the illness (Bellodi, Sciuto, Diaferia, Ronchi, & Smeraldi, 1992; Diniz et al., 2004).

Hypochondriasis (Neziroglu, McKay, & Yaryura-Tobias, 2000) and eating disorders (Sasson et al., 1997), are present in 10% and 17% of individuals with OCD, respectively. There also appears to be a relationship between OCD and Tourette's disorder. Between 35% and 50% of individuals with Tourette's disorder have OCD, while 5–7% of patients with OCD meet criteria for Tourette's disorder (Barlow, 2002). Furthermore, approximately 20–30% of patients with OCD report current or past tics (American Psychiatric Association, 2000). Substance use disorders are often found (American Psychiatric Association, 2000), with alcohol abuse present in 14–24% of patients with OCD and drug dependence in 16% over their lifetimes (Karno et al., 1988). Finally, comorbid schizophrenia is present in 12% of individuals with OCD (Karno et al., 1988).

Personality disorders also appear to coexist with OCD. Cluster C personality disorders (avoidant, dependent, and obsessive–compulsive) appear to be the most common (Barlow, 2002). Earlier studies found that obsessive–compulsive personality disorder occurs in fewer than 25% of patients with OCD (Steketee, 1993); however, recent estimates suggest that this personality disorder may be found in up to 30% of the population with OCD (Matthews, 2009).

Findings vary regarding the impact of comorbidity. Some studies suggest that a greater severity of illness is observed among individuals with OCD and comorbid conditions (Angst, 1993; Tükel, Polat, Ozdemir, Aksüt, & Türksoy, 2002), whereas others indicate that comorbid conditions do not exert a negative impact on severity of illness (Denys, Tenney, van Megen, de Geus, & Westenberg, 2004). However, there is a general consensus that as the number of comorbid conditions increase, the quality of life decreases substantially (Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2009; Lochner & Stein, 2003; Masellis, Rector, & Richter, 2003), with higher rates of disability and social dysfunction (e.g., marital distress) (Steketee, 1993).

Studies have also examined the impact of comorbidity on treatment outcome; the largest such studies to date have been conducted on the effects of depression. These studies generally show that major depression in the mild to moderate range does not negatively affect the outcome of standard cognitive-behavioral treatment for OCD. In fact, depression often improves as OCD symptoms decrease. However, studies show that severe depression exerts a negative impact on treatment outcome (Abramowitz, Franklin, Street, Kozak, & Foa, 2000) and leads to a greater risk of relapse (Abramowitz & Foa, 2000; Basoglu, Lax, Kasvikis, & Marks, 1998). Hence patients with severe depression may require medication and/or cognitive-behavioral therapy before being able to participate in treatment. Likewise, studies also show that comorbid substance abuse must be addressed before treatment for OCD can be initiated (Steketee, 1993). Although fewer studies have been conducted on personality disorders, existing research shows that patients with comorbid personality disorders generally have poorer outcome and may require longer treatment (Jenike, 1991). Little research exists on the impact of anxiety disorders, but the studies conducted show that comorbid anxiety disorders such as posttraumatic stress disorder and generalized anxiety disorder may attenuate the effects of treatment and/or lead to a higher dropout rate (Gershuny, Baer, Jenike, Minichiello, & Wilhelm, 2002; Steketee, Chambless, & Tran, 2001).

Differential Diagnosis

Although the presence or absence of rituals can help clinicians make an accurate diagnosis, other differences may also facilitate the diagnostic process. The type of obsessive thinking that characterizes OCD can be distinguished from the ruminations that are typical in depression and the worrying that marks generalized anxiety disorder. In depression, the ruminations are mood-congruent and ego-syntonic, and individuals do not attempt to suppress them. Furthermore, depressive concerns generally center on themes of failure and inadequacy, whereas obsessive concerns are typically characterized by beliefs about overresponsibility and vulnerability to harm. Worries are experienced as realistic concerns about actual life events; in contrast, the obsessions in OCD are unrealistic or magical, and they are experienced as ego-dystonic and therefore resisted. Even when obsessions center on realistic concerns, they are typically more exaggerated than worry thoughts (Franklin & Foa, 2008).

If obsessive thoughts are present but focus only on a specific content area, such as a preoccupation with an imagined defect or a health anxiety, then a diagnosis of body dysmorphic disorder or hypochondriasis may be considered. If additional obsessions or compulsions are present, OCD may also be diagnosed. A differential diagnosis between OCD and Tourette's disorder or other tic disorders may be based on the fact that tics are stereotyped motor or vocal behaviors that are involuntary and are not aimed at reducing distress, whereas rituals are voluntary actions undertaken to alleviate the discomfort associated with obsessions. Finally, if the obsessive thoughts are

not recognized as exaggerated or unrealistic and take on a bizarre quality, a diagnosis of delusional disorder should be considered. Stereotyped behaviors that are ego-syntonic and are not recognized as unrealistic may be manifestations of schizophrenia rather than OCD (American Psychiatric Association, 2000).

A diagnostic flow chart for OCD (Figure 8.1) illustrates the differential diagnosis of this disorder.

UNDERSTANDING OBSESSIVE–COMPULSIVE DISORDER IN COGNITIVE–BEHAVIORAL TERMS

Behavioral Factors

The behavioral conceptualization of OCD elaborated by Dollard and Miller (1950) emphasizes the role of conditioning in the development and maintenance of the disorder. This conceptualization, initially proposed by Mowrer (1939) to explain how anxiety disorders in general develop and are maintained, states that harmless and neutral objects, situations, thoughts, or images can begin to create discomfort or fear because they initially occur along with an event or stimulus that naturally produces anxiety. Through this association, normal, unbidden, intrusive thoughts, as well as neutral objects, situations, and so on, begin automatically producing anxiety on their own. Individuals thus begin to fear their own thoughts, as well as a variety of objects and so forth, which trigger these obsessive thoughts by becoming associated with it.

Mowrer's (1939) two-stage model also suggests that anxiety is maintained through conditioning. The individual tries to avoid or escape the thoughts, situations, objects, and so on that create anxiety and experiences relief from doing so, which in turn leads to more avoidance and escape behaviors (operant conditioning). According to Dollard and Miller (1950), because obsessions are intrusive, the passive avoidance and escape behaviors generally used by individuals with other anxiety disorders are insufficient in reducing this anxiety. As a result, individuals also develop active avoidance or escape behaviors (compulsions) in order to reduce the anxiety created by the conditioned stimulus (e.g., obsessive thoughts), and these behaviors are maintained because of their success in creating immediate relief (negative reinforcement).

Ironically, compulsions, passive avoidance, and escape lead to increased obsessional anxiety in the long run, as the individual is prevented from learning that the conditioned events, situations, thoughts, and so forth are not dangerous in and of themselves (i.e., that they are neutral), and that anxiety would abate on its own without the use of these avoidant behaviors. Hence anxiety continues despite the fact that these thoughts, situations, or objects are not dangerous and are no longer associated with naturally fear-producing events.

For example, a woman who fears being contaminated by chemicals may avoid or escape from stores where she thinks chemicals might be sold (e.g., supermarkets that sell cleaning supplies). Because she is afraid that the chemicals may contaminate her even if she has escaped from the store or even if she just thinks about the store, she may begin to wash her hands repeatedly to remove the perceived contamination. Many persons with OCD go to great lengths to avoid anxiety-provoking situations, often resulting in significant restriction of their lives. Such actions are rewarding to the individuals because they make them feel better for the moment, which makes it more likely that these actions will be repeated. The problem is that the reduction of distress is short-lived. When an obsessive thought occurs again, an action must be done repeat-

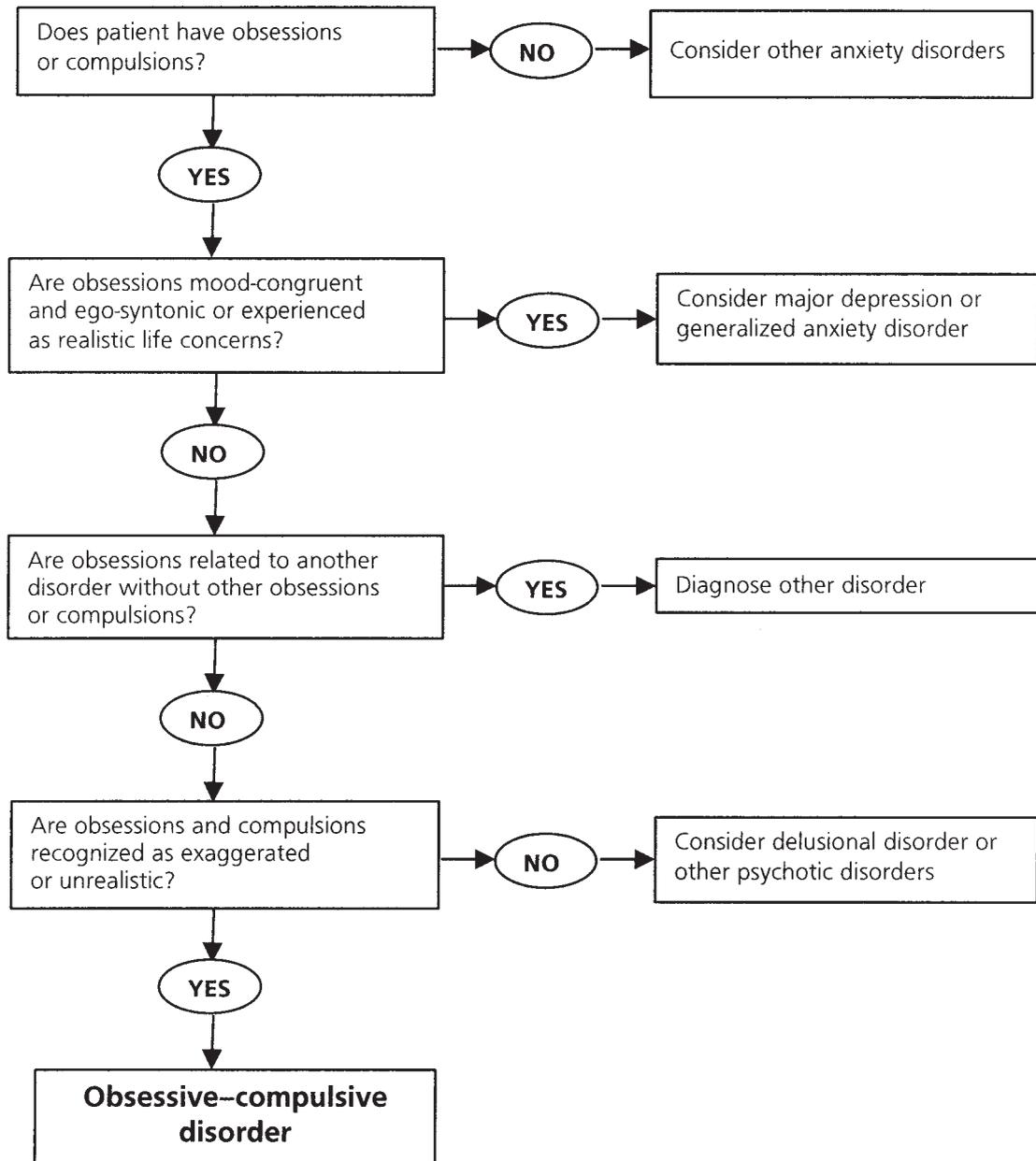


FIGURE 8.1. Diagnostic flow chart for obsessive-compulsive disorder.

edly, and before long it becomes a ritual. Although the individuals are generally distressed by their rituals, which can become time-consuming and often seem senseless, they feel compelled to continue to perform them because of the temporary relief they provide. This continued performance of rituals then prevents them from learning that in the long run they only serve to reinforce the anxiety arising from the obsessions. For example, by continuing to wash her hands, the woman who fears that she will be contaminated by chemicals does not learn that she would

not get contaminated even if she went into a store that contains chemicals *and* did not wash her hands; instead, her belief about the danger of chemicals continues unchanged.

Although the behavioral conceptualization explains the emergence of new triggers for obsessional thoughts, it appears to be insufficient in explaining how obsessional anxiety develops in the first place (McGinn & Sanderson, 1999). Not only do a majority of patients with anxiety disorders, including OCD, deny a link between symptom onset and specific traumatic events (Rachman & Wilson, 1980); this model does not take into account other ways of developing OCD, such as informational learning (e.g., becoming fearful of germs after hearing about a news report on a breakout of swine flu among school children) or observational learning (e.g., growing up with a parent who is constantly afraid of catching a disease) (Foa & Kozak, 1986). By contrast, there is greater support for the behavioral explanation for how fear is maintained once it develops (McGinn & Sanderson, 1999; Solomon & Wynne, 1954). Studies have demonstrated that environmental cues trigger anxiety (Hodgson & Rachman, 1972; Hornsveld, Kraaimaat, & Van Dam-Baggen, 1979), that obsessions increase distress (Boulougouris, Rabavilas, & Stefanis, 1977; Rabavilas & Boulougouris, 1974), and that compulsions lead to decreases in anxiety (Hodgson & Rachman, 1972; Hornsveld et al., 1979; Roper & Rachman, 1976; Roper, Rachman, & Hodgson, 1973).

Behavioral Treatments

For many years, OCD was considered to be resistant to treatment. Meyer (1966) reported successfully treating OCD with a procedure he called “exposure and response prevention” (ERP). The treatment consisted of repeatedly exposing patients to their obsessive thoughts while preventing them from carrying out rituals. In the years since Meyer’s paper was published, ERP has been extensively studied and is currently regarded as the gold standard of treatment for OCD.

The goal of ERP is to break the cycle of conditioning that maintains the disorder. Just as a person with a specific phobia of dogs needs to be exposed repeatedly to dogs without experiencing any negative consequences in order to reduce the association between dogs and fear, so a person with OCD must be exposed to his or her obsessive thoughts, as well as to the situations, events, objects, and so on that trigger the obsessive thoughts. If exposure is done repeatedly and frequently, the patient’s anxiety will decrease. In addition, the person will come to realize that he or she can tolerate the obsessive thoughts without resorting to avoidance, and that the obsessive thoughts (as well as the objects, situations, events, etc., that trigger them) are not inherently dangerous. In other words, exposure allows the person with OCD to confront the obsessive thought and the associated events, objects, and so forth; this allows the anxiety to decrease as the individual realizes that they are harmless.

For exposure to be effective, however, patients must be prevented from performing rituals and thereby experiencing the resulting relief from anxiety induced by their performance. Otherwise, the rituals used to manage their anxiety during exposure will prevent anxiety from spiraling upward and decreasing naturally. Instead, they will continue to perpetuate the cycle of relief, increased avoidance, and anxiety in the long run.

Cognitive Factors

Until recently, more attention has been paid to behavioral factors than to cognitive factors in the formulation and treatment of OCD. This is due to the fact that the efficacy of behavioral

interventions for OCD has been well established. However, in the past two decades there has been increasing interest in the role of cognition in the disorder, given that there is insufficient evidence for behavioral conceptualizations of how OCD develops. Moreover, some sufferers from OCD do not respond to behavioral treatments, and others are unwilling to engage in these.

On a theoretical level, cognitive factors may help explain why some people are more likely than others to react to intrusive thoughts with distress. On a practical level, it has been proposed that integrating cognitive techniques into the treatment of OCD may help decrease drop-out, improve compliance, increase the efficacy of standard behavioral treatment, and help those patients who do not respond to behavioral interventions (Salkovskis, 1989).

Several cognitive theories (Carr, 1974; Beck, 1976) have been used to explain the onset and maintenance of OCD. The most comprehensive cognitive conceptualization has been offered by Salkovskis and colleagues (Salkovskis, 1985, 1989; Salkovskis & Kirk, 1997), and van Oppen and Arntz (1994) have proposed a similar cognitive model of OCD. Both these models regard intrusive thoughts as normal phenomena. In support of this conceptualization, 90% of nonclinical subjects report some intrusive thoughts similar to those experienced in OCD (Salkovskis & Kirk, 1997). What distinguish patients with OCD, according to these models, are the individuals' evaluations and attempts to suppress or neutralize thoughts, which lead to an increase in obsessive thoughts and to even stronger urges to neutralize them in the long run. Supporting this conceptualization, research shows that using neutralization and distraction maneuvers in the presence of distressing intrusive thoughts leads to greater discomfort and increased neutralization/distraction urges, for patients with OCD and nonclinical subjects alike (Salkovskis, Thorpe, Wahl, Wroe, & Forrester, 2003; Salkovskis, Westbrook, Davis, Jeavons, & Gledhill, 1997).

Similar to patients with other anxiety disorders, individuals with OCD not only overestimate the likelihood that negative events will occur, the damage that would result if the event occurred, and their ability to tolerate the damage; they uniquely overestimate the degree of responsibility that they would bear if it occurred and the consequences of being held responsible. This sense of responsibility not only leads to anxiety, but also to tremendous shame or guilt, which these individuals find intolerable (McGinn & Sanderson, 1999). Accordingly, compulsions and avoidant behaviors are seen not merely as attempts to reduce danger, but as attempts to reduce their perceived sense of responsibility.

In other words, the cognitive conceptualization proposes that persons with OCD have belief systems or schemas characterized by danger, responsibility, and self-blame. Salkovskis and Kirk (1997) place particular emphasis on responsibility, pointing out that beliefs or schemas of danger, in the absence of perceived responsibility and self-blame, will lead to other forms of anxiety but not to OCD. In support of this conceptualization, patients with OCD have been found to have higher scores on two measures of perceived responsibility than either nondisordered controls or patients with nonobsessional anxiety disorders (Salkovskis & Kirk, 1997). Table 8.1 lists automatic thoughts, assumptions, and schemas that are typical for patients with OCD.

Salkovskis (1985, p. 579) outlines several dysfunctional assumptions that reflect the exaggerated beliefs of responsibility and self-blame found in OCD: (1) "Having a thought about an action is like performing the action," (2) "failing to prevent (or failing to try to prevent) harm to self or others is the same as having caused the harm in the first place," (3) "responsibility is not attenuated by other factors (e.g., low probability of occurrence)," (4) "not neutralizing when an

TABLE 8.1. Examples of Automatic Thoughts, Assumptions, and Schemas in Obsessive–Compulsive Disorder

<u>Distorted automatic thoughts</u>
<i>Danger</i>
“There are germs everywhere.”
“This object is dirty.”
“I’ve been contaminated.”
“I can’t stand my anxiety.”
“I have to clean this right now or I’ll go crazy.”
“What if I need this sometime in the future and I don’t have it?”
“Something terrible could happen to someone I love.”
“I could do or say something unacceptable without realizing it.”
 <i>Responsibility</i>
“If I don’t wash my hands I could spread germs to my whole family.”
“What if I forgot to lock the door? It will be my fault if we’re robbed.”
“I have to be sure.”
“I’d better check. Otherwise the house could burn down.”
“I’ll feel better if I do this.”
“Better safe than sorry.”
“I can’t let myself think that or I’ll lose control.”
“I’m a terrible person for having such thoughts.”
“If anything bad happens it’s my fault.”
“That horrible thought will come true unless I do something to stop it right now.”
“This has to be perfect.”
 <u>Maladaptive assumptions</u>
<i>Danger</i>
“All risk must be avoided.”
“You must be absolutely sure things are safe, otherwise you are in danger.”
“Anxiety is bad and must be avoided.”
“Thoughts are powerful and can cause bad things to happen.”
“Safety is the more important than anything else.”
“If there is even a small chance of danger, it must be avoided at all costs.”
 <i>Responsibility</i>
“I should be able to control my thoughts.”
“If I can’t control my thoughts, I won’t be able to control my actions.”
“If anything bad happens, it’s my fault.”
“I am to blame if I don’t take all possible precautions.”

(cont.)

TABLE 8.1 (cont.)

“Things must be perfect to be good enough.”

“I must work very hard to keep myself under control or I could do something terrible.”

Dysfunctional schemas

Danger

“The world is full of dangers (germs, contaminants, accidents, etc.)”

“The probability of something bad happening is high.”

“I’m a bad person with thoughts and impulses that are dangerous.”

Responsibility

“Other people cannot be relied on for safety.”

“I am the only one I can truly count on.”

“I am responsible for keeping myself and others safe.”

“I’m inherently irresponsible unless I try very hard.”

intrusion has occurred is similar or equivalent to seeking or wanting the harm involved in that intrusion to happen,” (5) “one should (and can) exercise control over one’s thoughts.”

According to this conceptualization, intrusive obsessional thoughts do not inherently lead to increased anxiety or distress (McGinn & Sanderson, 1999). However, in individuals with OCD, whose belief systems are characterized by responsibility and self-blame, such obsessive thoughts (e.g., the image of a loved one being harmed) trigger (secondary) negative automatic thoughts (e.g., “Only bad people have such obsessions”), which in turn lead to increased anxiety or distress. Secondary automatic thoughts (e.g., “I can prevent my mother from coming to harm if I repeatedly wash my hands”) also lead the individuals to perform compulsions, which reduce this inflated sense of responsibility and self-blame and the corresponding distress.

Research supports Salkovskis’s (1989) contention that individuals with OCD report an increased sense of responsibility and self-blame regarding harm. Studies show that perceiving greater responsibility for events is associated with higher distress, anxiety, vigilance, and checking behavior both in nonclinical participants (Ladouceur et al., 2000) and in patients with OCD (Lopatka & Rachman, 1995). Patients with OCD also appear to endorse beliefs about responsibility, particularly as related to intrusive thoughts and outcomes, to a greater extent than controls do (Freeston, Ladouceur, Gagnon, & Thibodeau, 1993; Obsessive Compulsive Cognitions Working Group, 2003; Salkovskis et al., 2000). Studies also show that individuals with OCD are less able than patients with other anxiety disorders to differentiate between responsibility related to harm they have actively caused (commission) and harm that they may have unintentionally caused by a failure to act (omission) (Wroe & Salkovskis, 2000)—a tendency that may explain their compulsion to neutralize all harm.

However, critics argue that appraisals and neutralizing behaviors do not, in and of themselves, explain why obsessions become abnormal. They further contend that the proposed themes of responsibility and self-blame explain some obsessive–compulsive themes (e.g., aggressive, sexual, blasphemous thoughts) better than others (e.g., contamination fears, cleaning rituals) (Jakes,

1996). Finally, critics also note that a successful intervention (e.g., reducing the sense of responsibility and self-blame) does not imply causation (i.e., that an increased sense of responsibility caused the obsessions to occur in the first place) (Jakes, 1996).

Other cognitive theorists have proposed other beliefs that characterize individuals with OCD. Rachman (1993) has suggested that individuals with OCD tend to equate thoughts (e.g., “If I have an obsession about killing my son . . .”) with action (e.g., “. . . it will lead to his death”), thus heightening their sense of responsibility, guilt, and shame.

Similarly, Guidano and Liotti (1983) emphasize that persons with OCD have a cognitive need for perfect certainty, which may also be seen as maintaining the schemas of danger and responsibility. Since it is almost impossible to rule out all risk or doubt, they are unable to decide that an event or situation is safe and tend to catastrophize about the consequences of making a wrong decision. Because they are never quite sure whether their conclusions are accurate, individuals with OCD perform compulsive behaviors (e.g., checking) or seek reassurance from others to relieve themselves of the discomfort of potentially being wrong. As a result, decision making becomes arduous if not impossible: Such individuals need an inordinate amount of information before they can make a decision, and constant reassurance that it is the right decision. Some research supports the notion that individuals with OCD tend to be filled with doubt and uncertainty; indeed, OCD is often referred to as the “doubting disease” (see McGinn & Sanderson, 1999).

Foa and Kozak (1991) cite several processing errors made by persons with OCD in their inferences about harm: (1) they tend to assume that in the absence of evidence for safety, events are dangerous; (2) they often have insufficient knowledge of the laws of probability; (3) they tend to make “availability” errors—that is, to judge events as dangerous on the basis of immediately available but limited information (such as sensational news stories) rather than complete information; (4) they exaggerate the risk of minute amounts of potentially dangerous substances; (5) they ignore the source of information about risk in evaluating its accuracy; and (6) they focus exclusively on reducing the risk of harm, and ignore the more likely losses associated with their avoidance and ritualistic behavior.

The belief system of individuals with OCD also appears to be characterized by a sense of perfectionism, rigidity, and moralism (McFall & Wollersheim, 1979; Steketee, Quay, & White, 1991). Such individuals believe that they must be perfect in all endeavors, tend to have rigid ideas of right and wrong, have a more “tender conscience” than others (Reed, 1983), and believe that failure to live up to these ideals could lead to punishment. Such beliefs create tremendous anxiety and lead to an overconcern with precision and control.

Cognitive Treatments

Two forms of cognitive therapy have been tested in the treatment of OCD: rational emotive therapy (Ellis, 1962) and Beckian cognitive therapy based on the work of Salkovskis (1989). Cognitive therapy targets the secondary automatic thoughts (e.g., “I am a bad person for having such thoughts”) that are triggered following obsessional images, thoughts, urges, or impulses (e.g., images of one’s mother being stabbed), as well as those triggering the urge to perform rituals (McGinn & Sanderson, 1999). Furthermore, it targets patients’ beliefs about their intrusive thoughts, rather than just addressing the thoughts themselves (Beck, 1976; Beck, 2011; Salkov-

skis & Kirk, 1997). Various techniques are aimed at modifying patients' schemas of responsibility, self-blame, and danger. Patients are encouraged to take an alternative view of their thoughts, so that rather than seeing them as inherently dangerous, they conclude that—however distressing they may be—the thoughts are irrelevant to further action, and that efforts to control them are unnecessary and counterproductive (Salkovskis & Kirk, 1997). To facilitate their seeing the thoughts as merely thoughts and not reflections of reality, patients are also encouraged to see them from the perspective of others, and to test conclusions derived from the thoughts.

As automatic thoughts are modified, along with the dysfunctional assumptions and beliefs on which they are based, the anxiety regarding the obsessions themselves is believed to decline. Ultimately, this leads to a decline in the occurrence of obsessions, because the resulting anxiety that fuels the obsessions has declined. In other words, as more rational beliefs and assumptions become internalized, the anxiety regarding the obsessions declines, and the obsessions themselves occur less frequently (McGinn & Sanderson, 1999).

Cognitive-Behavioral Therapy

Symptoms treated within a cognitive-behavioral framework include the obsessive thoughts, images, impulses, or urges; the compulsions, which may take the form of ritualized thoughts or behaviors; and, primarily, the secondary automatic thoughts that develop among patients with OCD (see above). Common to both cognitive and behavioral conceptualizations is the notion that OCD may be a phobia of certain thoughts, which, like all phobias, is maintained by cognitive and behavioral avoidance. Given that thoughts are difficult to avoid, individuals with OCD try to suppress the thought and perform compulsions and other avoidant behaviors to neutralize the thoughts.

For example, one approach commonly attempted by sufferers from OCD is to try not to think the obsessive thoughts. However, the more they try *not* to think about something, the more they wind up thinking about it (Wegner, 1989). This can easily be demonstrated to patients by asking them to try *not* thinking about a pink elephant. Of course, a pink elephant is the first thing that comes to mind. The result, therefore, of trying to avoid thinking obsessive thoughts is that patients wind up thinking them more, thereby exacerbating their distress. The association between the obsessive thoughts and emotional distress could be extinguished if patients allowed themselves to experience the thoughts without attempting to avoid them or neutralize them with rituals. However, patients are generally afraid to do this, because they fear that (1) their feelings of distress will continue unabated; (2) the distress will be unbearable; and/or (3) thinking the thoughts will cause them to perform some unacceptable action. The result is that they continue the endless cycle of obsessive thought and compulsive rituals.

Although cognitive and behavioral approaches to therapy differentially emphasize cognitive and behavioral strategies to treat OCD, both approaches intend to modify mistaken cognitions and change behavior, and emphasize accepting obsessive thoughts and emotional distress without attempting to avoid them or neutralize them with rituals and other avoidant behaviors. Cognitive therapy uses direct verbal Socratic dialogue and the process of guided discovery to disconfirm maladaptive beliefs, whereas exposure creates conditions that lead to the disconfirmation of maladaptive beliefs, suggesting that disconfirmation of erroneous associations and beliefs may be a crucial mechanism underlying the efficacy of cognitive-behavioral treatments (Abramowitz, 1997).

OUTCOME STUDIES OF TREATMENTS FOR OBSESSIVE–COMPULSIVE DISORDER

When compared with waiting-list or treatment control conditions, cognitive-behavioral therapy and pharmacotherapy (particularly SSRIs and venlafaxine) have been identified as effective treatments for OCD (Franklin, March, & Garcia, 2007; March, Frances, Kahn, & Carpenter, 1997).

Efficacy Studies of Cognitive and Behavioral Treatments

Behavior Therapy

Since the early trials showing the efficacy of ERP (Meyer, 1966; Meyer, Levy, & Schnurer, 1974), a large body of uncontrolled and controlled studies has now established ERP as a first-line treatment for OCD, with the bulk of these studies demonstrating that patients who complete ERP are significantly improved and maintain their gains over time. Behavior therapy has demonstrated greater efficacy than several credible placebo treatments, including placebo medication (Marks, Stern, & Mawson, 1980), relaxation (Fals-Stewart, Marks, & Schafer, 1993) and anxiety management training (Lindsay, Crino, & Andrews, 1997).

Foa and Kozak (1997) reviewed 13 controlled studies of ERP and found that an average of 83% of patients showed moderate to marked improvement (generally defined as a 30% or greater reduction in symptoms). Even patients who were much improved generally had some residual symptoms, however. When followed up at periods averaging over 2 years after termination, an average of 76% of patients continued to be improved (Foa & Kozak, 1997). In his meta-analysis of 24 studies performed between 1975 and 1995, Abramowitz (1997) found large mean effect sizes for behavior therapy at posttreatment and after follow-up.

The degree of improvement varies considerably and depends on whether nonresponders, dropouts, and those who refuse treatment are taken into account (Abramowitz, Franklin, & Foa, 2002; Kozak, Leibowitz, & Foa, 2000). Given the high dropout and refusal rates for ERP (20–30%), the inclusion or exclusion of this sample may considerably affect findings (Stanley & Turner, 1995). When these factors are taken into account, the average rate of positive outcome drops considerably (Salkovskis & Kirk, 1997).

Cognitive Therapy

Early uncontrolled studies indicated that cognitive therapy is an effective treatment for OCD (Headland & McDonald, 1987; Roth & Church, 1994; Salkovskis, 1983; Salkovskis & Westbrook, 1989), especially when used adjunctively with ERP (Freeston, 1994; Kearney & Silverman, 1990; Salkovskis & Warwick, 1985). More recently, controlled trials have confirmed that cognitive therapy is an effective treatment for OCD (Abramowitz, 1997; Emmelkamp & Beens, 1991; Emmelkamp, van der Helm, van Zanten, & Plochg, 1980; Emmelkamp, Visser, & Hoekstra, 1988; McLean et al., 2001; van Oppen et al., 1995; Whittal, Thorarsden, & McLean, 2005), and can be used to treat patients who are resistant to behavior therapy (Salkovskis & Kirk, 1997; Salkovskis & Warwick, 1985).

Behavior Therapy versus Cognitive Therapy

Comparisons between behavior therapy and cognitive therapy have found mixed results. Although early trials found few differences between behavior therapy and behavior therapy enhanced with cognitive therapy (Emmelkamp & Beens, 1991; Emmelkamp et al., 1988), later studies have demonstrated that cognitive strategies may be as effective as behavioral strategies when used alone (Abramowitz, 1997; Cottraux et al., 2001; Emmelkamp & Beens, 1991; Emmelkamp et al., 1988; McLean et al., 2001; van Balkom et al., 1998; van Oppen et al., 1995; Vogel, Stiles, & Gatestam, 2004; Whittal et al., 2005).

Some studies have found a slight advantage of cognitive therapy over ERP (Emmelkamp & Beens, 1991; Emmelkamp et al., 1988; van Oppen et al., 1995), whereas recent meta-analytic reviews have suggested that cognitive therapy plus ERP may be superior to cognitive therapy alone (Abramowitz et al., 2002). Still others have found that a combined approach may be superior to either one alone (Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008), especially in the treatment of pure obsessions (Freeston et al., 1997), and that adding cognitive therapy to behavior therapy may lead to fewer dropouts (Vogel et al., 2004) and reduce relapse (Hiss, Foa, & Kozak, 1994).

Comparing cognitive and behavioral approaches is inherently complicated, since each approach usually contains some unspecified elements of the other (Abramowitz, 1997). As noted earlier, both cognitive and behavioral approaches focus on helping patients accept and experience obsessional thoughts rather than trying to stop them. Furthermore, the behavioral experiments used by cognitive therapists to disconfirm maladaptive thoughts appear to add to the efficacy of cognitive therapy (Abramowitz et al., 2002) and may be seen as a form of exposure. By the same token, behavioral approaches tend to provide corrective information regarding the risks of obsessive thoughts, use cognitive restructuring to help patients attempt difficult exposure exercises (Steketee, 1993), and acknowledge that the goal of ERP is to restructure patients' cognitive appraisals of threat (Foa & Kozak, 1986).

Given the difficulties in separating the two approaches and the mixed results observed in studies, a combined approach may be both clinically indicated and practically suited for patients, particularly in the once-a-week, 45-minute session format employed by most clinicians. The only study that separated cognitive therapy and behavior therapy into its purest elements found that the two were equal in efficacy and were more efficacious than a waiting-list control, and that the combined group was comparable to cognitive therapy and behavior therapy alone (van Balkom et al., 1998).

Factors Predicting Positive Outcome of Cognitive–Behavioral Therapy

Demographic Factors

Although the bulk of studies have examined adult populations, similar efficacy rates have been observed with children and adolescents (Barrett, Healy-Farrell, & March, 2004). Cognitive-behavioral therapy appears to be similarly effective regardless of demographic factors such as patients' age, gender, or education level, indicating that it is an effective method of treatment for a variety of patient populations (Keeley, Storch, Merlow, & Geffken, 2008).

Relative Efficacy of Treatment Components

As may be expected, obsessions respond primarily to exposure (Foa, Steketee, Grayson, Turner, & Latimer, 1984; Foa, Steketee, & Milby 1980), and compulsions respond primarily to response prevention (Foa, Steketee, & Milby, 1980; Foa et al., 1984; Mills, Agras, Barlow, & Mills, 1973; Turner et al., 1980). Combining exposure and response prevention appears to be more effective than using either one alone (Foa & Kozak, 1997; Foa et al., 1984). When both are feasible and indicated, combining *in vivo* and imaginal exposure appears to be better at maintaining long-term gains (Foa & Kozak, 1997; Foa, Steketee, Turner, & Fischer, 1980). Graded exposure has demonstrated similar efficacy to abrupt exposure (Hodgson, Rachman, & Marks, 1972), and complete abstinence from rituals appears to have a greater benefit than partial response prevention (Abramowitz, 1996, 1997).

Frequency of Sessions

Less intensive treatment (sessions once or twice a week) appears to be as effective as more intensive treatment (daily sessions over 1 month) (Abramowitz, Foa, & Franklin, 2003; DeAraujo, Ito, Marks, & Doles, 1995; Foa, Kozak, Steketee, & McCarthy, 1992), even in pediatric cases (Storch et al., 2007).

Length of Treatment

Although the average length of treatment in the review by Foa and Kozak (1997) was 15 sessions, with a typical session lasting 2 hours, the relationship between length of treatment and outcome is unclear. What appears to be a more informative result is that patients who are able to guide their own therapy, who incorporate regular therapy practice in their daily lives, and whose symptoms and functioning are substantially improved at termination have been found to have lower relapse rates than patients who have significant residual symptoms (Braga, Cordioli, Niederauer, & Manfro, 2005).

Duration of Exposure

Prior studies indicate that prolonged, continuous exposure is more effective than short, intermittent exposure (Foa & Kozak, 1997; Rabavilas, Boulougouris, & Stefanis, 1976), and that reduction in anxiety across sessions is associated with better outcomes (Jaycox, Foa, & Morrel, 1998; Kozak, Foa, & Steketee, 1988; van Minnen & Hagenars, 2002). However, recent studies have found a weak link between in-session habituation and fear/symptom reduction over time (see Franklin & Foa, 2008, for a review), suggesting that repetition of exposure may be more critical than in-session habituation.

Treatment Format and Therapist/Family Involvement

Both individual and group versions of ERP appear to be equally effective at posttreatment and at a 6-month follow-up (Anderson & Rees, 2007; Barrett et al., 2004; Fals-Stewart et al., 1993),

although the individual format may be associated with a quicker response (Anderson & Rees, 2007). A recent study also found that whereas both cognitive therapy and behavior therapy were equally effective in an individual format, behavior therapy was superior to cognitive therapy in a group format (Whittal, Robichaud, Thordarson, & McLean, 2008).

Findings regarding therapist involvement in exposure and family involvement in treatment are equivocal: Some studies indicate that therapist-guided exposure has greater benefit than self-directed exposure (Abramowitz, 1996) and that family involvement is beneficial (Mehta, 1990), whereas other studies show no additional benefit of therapist-guided exposure (Emmelkamp & van Kraanen, 1977; Lovell et al., 2006; Marks et al., 1988) or family involvement in treatment (Emmelkamp et al., 1990). Although the findings regarding family involvement are equivocal, involving the family may be clinically indicated in the treatment of children and adolescents, in cases where family members are involved in a patient's rituals, and in cultures where family involvement in treatment is seen as advantageous.

Use of Medication

Clomipramine (Anafranil) and all the SSRIs are all FDA-approved for the treatment of OCD. The most extensively researched medication for OCD is clomipramine, a tricyclic antidepressant that selectively targets serotonin. Clomipramine has repeatedly been found to be more effective than placebo, with 51–60% of patients showing moderate to marked improvement. Other tricyclic antidepressants have been found to be minimally effective (Foa & Kozak, 1997). Studies have also provided evidence for the effectiveness of SSRIs, including fluoxetine (Prozac), fluvoxamine (Luvox), and sertraline (Zoloft), as well as for a serotonin–norepinephrine reuptake inhibitor, venlafaxine (Effexor).

Studies comparing the various SSRIs and venlafaxine suggest that they have similar rates of efficacy (Bergeron et al., 2002; Denys, van der Wee, van Megen, & Westenberg, 2003). Similarly, comparisons between these drugs and clomipramine have also found nonsignificant results (Albert, Aguglia, Maina, & Bogetto, 2002; Mundo, Maina, & Uslenghi, 2000; Mundo, Rouillon, Figuera, & Stigler, 2001), suggesting that all of these medications may have similar efficacy (Nathan & Gorman, 2007).

Therapeutic dosages for OCD generally tend to be higher than those used for other anxiety disorders and depression, and a therapeutic response may not be observed in patients before 8–10 weeks (Nathan & Gorman, 2007). Approximately 60% of patients appear to respond to SSRIs, although effects are moderate (Greist, 1990a, 1990b; Greist, Jefferson, Kobak, Katzelnick, & Serlin, 1995). Patients with OCD tend not to respond to pill placebos. Symptoms also tend to recur if medications are discontinued in up to 95% of patients (Catapano et al., 2006; Dougherty, Rauch, & Jenike, 2007; Pato, Zohar-Kadouch, Zohar, & Murphy, 1988), although a few recent studies suggest that relapse rates may be lower among patients taking SSRIs than previously thought (Nathan & Gorman, 2007).

Given that symptoms are not fully ameliorated and a subset do not respond to SSRIs, other medications such as haloperidol (Haldol), risperidone (Risperdal), clonazepam (Klonopin), glutamate agonists, lithium, and dopamine may be used either to augment treatment or to treat individuals who do not respond to first-line treatments (Hollander et al., 2008; Nathan & Gor-

man, 2007; Wilhelm et al., 2008). For example, venlafaxine and low doses of dopamine have shown to be effective when patients do not respond to first-line treatments (Hollander et al., 2003; Nathan & Gorman, 2007).

Cognitive–Behavioral Therapy versus Medications

Studies comparing behavior therapy and clomipramine have generally found behavior therapy to be equal or superior to medications, depending on the outcome and design used (Foa, Liebowitz, et al., 2005; Pediatric OCD Study Treatment Team, 2004). The addition of medication to behavior therapy has been found to improve compliance and short-term outcome in some studies (Cottraux et al., 1990; Marks et al., 1980). However, this improvement disappears once medication is stopped (Marks et al., 1988). Some studies suggest that the combination of medication and behavior therapy may be higher when intensive exposure is not used (Foa, Franklin, & Moser, 2002). The effects of behavior therapy also appear to target OCD symptoms specifically, unlike medications and cognitive therapy, which also benefit depression symptoms in patients with OCD (van Balkom et al., 1998). The combination treatments also appear to be more effective at reducing obsessions and depression over behavior therapy alone, but appear to be comparable to behavior therapy at reducing compulsions (Hohagen et al., 1998).

Recent studies have also obtained mixed results. A randomized, placebo-controlled, multicenter trial conducted to compare the relative and combined efficacy of behavior therapy and clomipramine found that active treatments were better than placebo, that behavior therapy was superior to clomipramine, that the combination of the two was not superior to behavior therapy alone, and that relapse was highest among patients receiving only clomipramine (Foa, Liebowitz, et al., 2005). However, given that the therapeutic effects of clomipramine were achieved well after the intensive portion of behavior therapy was completed, the true additive effects of adding clomipramine to behavior therapy could not be assessed. In another study, the combination treatment was superior to monotherapy, although differences among sites were observed (Pediatric OCD Treatment Study Team, 2004). Although the advantage of combining treatments remains unclear and further research is necessary, combination treatments do not appear to inhibit treatment and are often used in clinical practice, despite the inconclusive evidence (Franklin & Foa, 2008).

Effectiveness Studies of Cognitive–Behavioral Treatments

Cognitive-behavioral therapy also appears to be effective in “real-world” settings. By design, effectiveness studies are not as rigorously controlled as efficacy studies; the therapists may not be as well trained; and patients may have comorbid diagnoses, a higher severity of illness, and a past history of treatment failures. Despite this, effectiveness studies of cognitive and behavioral treatments for OCD have demonstrated improvements comparable to or only slightly less than those observed in randomized, controlled efficacy trials (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Friedman et al., 2003; Kirk, 1983; Warren & Thomas, 2001), suggesting that findings from efficacy trials are generalizable to clinical settings.

ASSESSMENT AND TREATMENT RECOMMENDATIONS

Rationale and Plan for Treatment

The treatment package outlined in this chapter emphasizes cognitive restructuring and ERP. Along with initial sessions that socialize patients into treatment and help build motivation, cognitive techniques provide corrective information about OCD and help patients overcome their shame about the illness. Cognitive strategies principally target the distress associated with the obsessions and the urge to neutralize or undo them. Overall, patients are helped to accept obsessions without trying to stop or neutralize them; such acceptance leads to a reduction in the anxiety, guilt, and sadness associated with obsessional thinking, and thereby leads to a reduction in obsessional thinking over time. By modifying patients' schemas of danger and overresponsibility, cognitive restructuring helps patients see that they are not responsible for their obsessive thoughts, and that their obsessive thoughts do not pose a threat and need not lead to action. Cognitive techniques also help patients identify stressful triggers that may exacerbate their OCD symptoms; moreover, by reducing overestimated appraisals of danger, personal responsibility, and the like, they increase the likelihood that patients will engage in ERP.

Exposure targets patients' obsessive thoughts and the distress they trigger, and aims to modify the erroneous appraisals of threat by offering disconfirming information, thereby promoting habituation (Franklin & Foa, 2008). Exposure weakens the link between the thoughts and the distress, so that patients are able to tolerate the discomfort associated with experiencing their obsessional thoughts. When patients allow themselves to think through their feared thoughts rather than attempting to push them away, they realize over time that their perceived threat does not occur; as a result, their thoughts decrease in frequency. Response prevention directly targets patients' compulsions. Patients are taught to reduce and finally eliminate compulsive behaviors, so they can discover that the anxiety associated with their obsessive thoughts will decrease without their use and that over time, their obsessions naturally subside.

The package provides 20 sessions of treatment, including assessment. Most of the sessions are 45 minutes, except for the first few exposure sessions, which are 90 minutes. This provides somewhat fewer hours of therapist contact than the average of the studies reviewed by Foa and Kozak (1997). However, for patients with mild to moderate symptoms, 20 sessions will often be sufficient. Patients with more severe symptoms are likely to require longer treatment.

The general treatment plan for OCD is outlined in Table 8.2.

Assessment

The goals of the initial assessment include making the differential diagnosis; ruling out comorbid conditions that require prior or additional treatment; exploring motivation for treatment; establishing a baseline level of distress and impairment that can be used in assessing progress; and identifying the specific obsessions, rituals, and avoided situations that will become the targets of treatment.

Tests and Clinical Interviewing

Several standardized measures may be helpful in the assessment of patients with OCD. Structured clinical interviews such as the SCID (First et al., 2002) or the ADIS-IV (Brown et al., 2005) may

TABLE 8.2. General Plan of Treatment for Obsessive–Compulsive Disorder

-
- Assessment
 - Tests and clinical interviewing
 - Considerations of medication
 - Socialization to treatment
 - Building motivation
 - Cognitive interventions
 - Behavioral interventions
 - Exposure
 - Response prevention
 - Phasing out therapy and preventing relapse
-

be used to diagnose OCD. The Yale–Brown Obsessive Compulsive Scale (Y-BOCS; Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1980; Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989) may be used to assess the severity of OCD and track treatment progress. The Y-BOCS is a clinician-rated, 10-item self-report measure that separately rates obsessions and compulsions for the amount of time a patient spends on them, the level of impairment or distress they create, and the patient’s resistance to and perceived control over them. Each item is rated from 0 (no symptoms) to 4 (extreme symptoms) with total scores indicating severity of illness as follows: 0–7 (subclinical), 8–15 (mild), 16–23 (moderate), 24–31 (severe), and 32–40 (very severe).

The Maudsley Obsessional–Compulsive Inventory (MOCI; Hodgson & Rachman, 1977) is a self-report measure that yields subscales for checking, cleaning, slowness, and doubting, as well as a total score. The MOCI is provided in Form 8.1. The Obsessive–Compulsive Questionnaire (OCQ) is a symptom checklist we have developed for assessing our patients. Patients’ responses to individual items can help in making a diagnosis, and when the scale is readministered later, they can be used to evaluate therapeutic progress. The OCQ is shown in Form 8.2. Form 8.3 provides space for recording scores on these questionnaires and the standard intake battery. It also enables the clinician to record information about medication and other substance use; the history of a patient’s disorder (at intake only); treatment progress (on later evaluations); and treatment recommendations. Finally, patients should also fill out the standard intake form (Form 2.1 in Chapter 2).

As always, however, the primary means of assessment is the clinical interview. The details of patients’ obsessive thoughts, the rituals they perform, and the situations they avoid should be obtained. In order to facilitate treatment, information is gathered on internal stimuli (e.g., bodily sensations) and external objects (e.g., a gas stove), situations (e.g., entering a public toilet), and people (e.g., their children) that trigger obsessional distress and the urge to neutralize. If patients are able to verbalize the threat associated with their obsessions at this stage (e.g., “My house will burn down if I don’t check the gas stove 15 times”), then these are noted in order to help the therapist make determinations about which treatment strategies may be clinically indicated. For example, imaginal exposure may not be clinically indicated for patients who are unable to express feared consequences, even after cognitive strategies are employed to identify them. The

ways in which patients' symptoms interfere with daily functioning should be explored, as well as the history and development of the symptoms.

Patients are often reluctant to reveal their obsessions. Because the thoughts are so distressing to them, they may assume that others will react with disgust or condemnation. They may even fear that if they reveal their thoughts, they will be hospitalized against their will or have their children taken away from them. Normalizing the obsessive thoughts will often help patients talk more freely. Among the techniques that can be useful are (1) informing patients that according to research, having some obsessive thoughts is normal, and most people have thoughts they cannot control and find very upsetting at times; (2) helping them understand that having obsessional thoughts is a symptoms of OCD, that obsessions are not under their control and do not reflect their values, and that discussing thoughts will not make them come true; (3) giving examples of thoughts that others have reported, and asking the patients if they have any similar thoughts; and (4) pointing out to the patients that most people are distressed by thoughts that run contrary to their values, and that their finding their thoughts so upsetting means it is less likely (not more likely) that they will act on them. If patients are unable to discuss their obsessive thoughts without using rituals to neutralize them at this stage, this is permitted to facilitate assessment.

It is also important to assess whether patients recognize that their obsessive thoughts are to some extent unrealistic. It is often helpful to ask patients how much they believe their fears will come true when they are not actually in the situation that provokes their fear—for example, "When you are not in a public restroom, how likely do you think it is that you will get AIDS from touching the faucet handle?" Alternatively, the patients may be asked how likely they think it is that their feared consequences would happen to someone else.

If patients cannot, on inquiry, express some recognition that their fears are exaggerated, this indicates the presence of "overvalued ideas." Patients with overvalued ideas generally do not respond well to ERP. In such cases, it is advisable to use cognitive techniques to reduce belief in the obsessive fears before proceeding (Steketee, 1993).

Another important source of information is self-monitoring by the patient. After the initial sessions, patients are asked to monitor their obsessive thoughts, rituals, and avoided situations on a daily basis. Self-monitoring provides detailed information that may not emerge during the initial assessment and can serve as a baseline measure to assess progress. Self-monitoring is also a preliminary intervention that often leads to some reduction in symptoms. Form 8.4 is a form for self-monitoring obsessions and rituals.

Consideration of Medication

Although OCD may be treated effectively without medication, all patients should be given the option of medication as part of their treatment. Serotonergic antidepressants (e.g., Prozac, Zoloft, Clomipramine) appear to provide the most benefit, and therapeutic dosages for OCD appear to be higher than those used for other anxiety and depressive disorders. Most tricyclic antidepressants are ineffective. The use of medications, however, should not preclude the use of cognitive-behavioral treatment.

Socialization to Treatment

Once the diagnosis is established, patients should be educated regarding the cognitive-behavioral model of OCD and the rationale for treatment. Having an explanation of the disorder will

reduce demoralization and increase motivation to undergo treatment. Form 8.5 is an informational handout that can be given to patients. The handout on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10) should also be provided. In addition, patients may be assigned to read one of the self-help books that are available for OCD, such as Leahy's (2009) *Anxiety Free*, Foa and Wilson's (2001) *Stop Obsessing!*, or Steketee and White's (1990) *When Once Is Not Enough*.

Several key points should be made in the process of educating patients: (1) It is normal to have unpleasant, intrusive thoughts; (2) the strategies patients are currently using (i.e., attempting to avoid thinking the thoughts or neutralizing them with rituals) actually make their anxiety worse; and (3) allowing themselves to have the thoughts without ritualizing will lead to a natural decrease in their anxiety, the frequency of the thoughts, and urges to ritualize. Patients should be told that cognitive-behavioral treatment for OCD provides substantial relief and improved quality of life for most patients, but that it is typical for patients to have some residual symptoms or experience symptom resurgences during increased periods of stress. This creates hope while also setting realistic expectations.

Building Motivation

Cognitive-behavioral treatment for OCD is demanding; it requires considerable time and the toleration of significant anxiety. Premature dropout and noncompliance are common problems, and are the biggest reasons for treatment failure. It is crucial, therefore, to establish strong motivation before initiating ERP. If motivation is initially low, extra time will be required for this step. Patients can be asked to list the advantages and disadvantages of undergoing treatment. Advantages may include activities they would be able to engage in with the time they now spend ritualizing; reduced anxiety; and improved relationships and occupational functioning. Disadvantages may include problems such as disruptions to family systems, as well as the need to face situations and decisions that the patients do not currently have to deal with because they are preoccupied with their OCD. Careful questioning may be necessary to help a patient make a complete list of advantages and disadvantages, and erroneous beliefs associated with them (e.g., "Doing rituals is helpful because otherwise I will have a nervous breakdown") should be addressed, so that the patient can weigh true advantages and disadvantages and (ideally) make a decision to begin. If motivation seems low after this procedure, it may be advisable to suggest that the patient seek other alternatives such as medication, either on its own or as a means to build motivation for undergoing cognitive-behavioral therapy in the future.

Cognitive Interventions

The overarching goal of cognitive techniques for OCD is to modify the distress associated with the obsessions (and the urge to neutralize or undo them) by disconfirming overestimated appraisals of threat and responsibility. Cognitive strategies also identify stressful triggers that may exacerbate OCD symptoms or lead to symptom recurrence. In addition, by reducing the threat associated with the obsessions, cognitive strategies not only reduce obsessions and compulsions, they also increase the likelihood that patients will engage in systematic ERP. Consequently, it is optimal for cognitive strategies to precede ERP in treatment, especially in outpatient settings where intensive, massed treatment is not feasible for most clinicians and most patients.

As indicated earlier, the cognitive model suggests that individuals with OCD develop repetitive intrusive obsessions because they have erroneous dysfunctional thoughts (e.g., “My obsessive thought will come true,” or “I am an evil person for having this obsession”) following the initial occurrence of spontaneous, normal intrusive obsessions (Rachman & de Silva, 1978). These secondary automatic thoughts are based on core assumptions and beliefs characterized by overestimations of danger, personal responsibility, and self-blame, as well as a high degree of perfectionism, rigidity, morality, superstition, uncertainty, and doubt. As a result, when these automatic thoughts are triggered, they create anxiety, guilt, and sadness, which in turn trigger the urge to ritualize. Compulsions or rituals are performed to neutralize or undo the threat perceived in the obsessions and create immediate relief when carried out. Ironically, this performance strengthens an individual’s beliefs that obsessions are dangerous and need to be avoided, hence perpetuating the obsessive–compulsive cycle.

Patients learn to become aware of their automatic thoughts by recording them when they occur. Patients are asked to write down any thoughts that immediately follow obsessional intrusions, precede the urge to ritualize, or occur during moments of increased anxiety. In addition, patients are asked to note down the exact situations when thoughts are triggered; to describe and rate the degree to which they experience anxiety or other negative emotions resulting from these thoughts; and to describe and rate the degree to which they believe these secondary automatic thoughts when they are triggered. Finally, patients are asked to record the avoidant or ritualized behaviors performed in consequence. Recording the thoughts allows patients to achieve distance from them and to observe their impact on their mood and behavior. The process of monitoring thoughts itself is believed to defuse the impact of both the obsessions and the automatic thoughts, as patients learn to consider systematically that they are just thoughts and not harbingers of doom (see Table 8.1).

Once patients become aware of their automatic thoughts, learn to observe them systematically when they occur, and understand their impact on mood and behavior, the next phase of cognitive restructuring begins. In this phase, the therapist helps patients disconfirm these thoughts by using one or more of the following strategies: (1) considering less threatening explanations for the occurrence of obsessions; (2) examining the objective evidence for their thoughts; (3) correctly estimating the worst outcomes, as well as their ability to cope with them if they occur; (4) developing more helpful ways of thinking; (5) and viewing the situation from the perspective of an objective observer. These strategies have the shared goal of helping patients widen their narrowed and extreme appraisals of danger, responsibility, self-blame, and the like.

Through a process of guided discovery, the therapist uses these strategies to help patients further recognize that their obsessions are normal experiences shared by a majority of people, and accept that both obsessional intrusions and automatic thoughts are just thoughts and do not represent current or future reality. They learn that obsessions do not reflect their value systems and are not indications of imminent harm. Cognitive restructuring helps patients accept obsessional intrusions without efforts to neutralize them and helps disconfirm the secondary automatic thoughts, as well as the assumptions and schemas on which they are based. Patients are helped to estimate danger correctly, reduce their overarching sense of personal responsibility, and take calculated risks; they are also helped to see that they can tolerate negative emotions as well as imperfect outcomes, ambiguity, uncertainty, and doubt. Their oversensitive “conscience” is “toughened,” and their tendency to confuse thoughts with actions is also modified.

Specifically, patients are helped to see that (1) experiencing obsessions does not cause harm

to themselves or others, and that neutralizing their obsessions will not prevent harm from occurring; (2) thoughts are not to be confused with actions; (3) controlling obsessions is unnecessary; (4) having obsessions is not a sign of immorality; (5) harm is unlikely to occur (they just worry that it is); (6) they need not be competent in all areas of their lives; and (7) they are capable of coping with the anxiety associated with their obsessions (Salkovskis, 1985; see Table 8.1).

Assumptions about the danger inherent in obsessive thoughts can be challenged in a number of ways. The occurrence of intrusive thoughts can be normalized by informing patients that the vast majority of people experience thoughts similar to those of people with OCD. Possible advantages of some intrusive thoughts—for example, creative ideas or pleasant fantasies—can be discussed, along with the difficulty of inhibiting some thoughts while allowing others.

Fears of catastrophe can be challenged by having patients compare their estimate of risk for themselves to how often the feared event actually occurs. For example, a patient who initially states that the chance of hitting a pedestrian while driving to work is 70% can be asked whether 7 out of 10 people have such accidents every morning. When patients are not aware of the base rates of feared events, such as a plane crash, they can be asked to research them. van Oppen and Arntz (1994) suggest having a patient list the probability that each step will lead to a feared outcome, and then calculating the cumulative probability. For example, if there are six steps between the patient's failing to unplug a toaster at night and the patient's house burning down (i.e., the toaster catches fire, the fire spreads, the fire alarm doesn't work, no one smells smoke, etc.) and each step has a 10% probability, the cumulative probability becomes one in a million.

Behavioral experiments can also be useful. Patients who fear that their obsessive thoughts will cause a catastrophe or lead them to commit some unacceptable action may be asked to make something happen just by thinking it—for example, "Try willing yourself to die right now." Patients can also be asked to experiment with trying to avoid and neutralize their obsessive thoughts on some days, allowing themselves to think them on others, and tracking how often they have thoughts and how distressed they feel on the different days. This will generally lead patients to realize that avoiding and neutralizing actually make their obsessions worse (Salkovskis & Kirk, 1997).

A number of techniques can also be used to challenge assumptions of responsibility. For example, patients can be asked to create a pie chart showing the portion of responsibility held by all relevant parties. If patients put in everyone else's responsibility first, they usually realize that very little of the pie is left for them. The double-standard technique may also be useful. For example, if a woman assumes that she will be held responsible if her mother dies in a plane crash after the two of them have had an argument, she can be asked what she would say to a friend in similar circumstances.

In the later stages of treatment, cognitive restructuring can be used to help patients cope with possible sources of stress or anxiety that might trigger OCD symptoms or lead to a relapse of OCD. It can also help patients overcome the anxiety associated with facing life challenges that have been avoided or put off because of their OCD symptoms.

Behavioral Interventions

Exposure

The purpose of exposure is to weaken the association between obsessive thoughts and emotional distress. Patients are helped to understand that if they systematically allow themselves to

think their obsessive thoughts and confront the stimuli that trigger obsessional distress without attempting to avoid or neutralize them through ritualizing, their anxiety will eventually decrease, as will their obsessions. As a result, exposure is used in conjunction with response prevention.

According to Mowrer's (1939) two-stage model of conditioning, obsessions create anxiety as a result of their initial pairing with stimuli that naturally produce anxiety (classical conditioning). By the same process, images, objects, situations, and people that become paired with obsessions also begin to produce anxiety. Hence the classic behavioral approach to treatment has stressed the importance of systematically and repeatedly confronting obsessions, as well as the myriad stimuli that have become associated with them, without any avoidance or rituals until the distress associated with them declines. The extinction of this association or habituation of fear has been emphasized as the mechanism through which the threat associated with the obsession declines. However, given the weak link between in-session habituation and the reduction of fear and symptoms over time, an alternative formulation—namely, that exposure works by modifying patients' cognitive appraisals—is now emphasized (Franklin & Foa, 2008).

The first step in conducting exposure is to create a hierarchy of a patient's obsessive thoughts. This is done by taking all of the obsessive thoughts collected during assessment through the clinical interview and through self-monitoring (Form 8.4), and having the patient rate how anxious each thought makes him or her (on the usual SUDs scale of 0–10). The thoughts are then listed in order from the least anxiety-provoking to the most. A second hierarchy should be created of objects (e.g., garbage cans), situations, people (e.g., spouse), and internal stimuli (e.g., image of God) that have become associated with obsessions and are avoided. Forms 8.6 and 8.7 are hierarchy forms for patients with OCD.

For some patients, the hierarchy of obsessive fears (Form 8.6) will be largely distinct from that of avoided situations, objects, and so on (Form 8.7). In such cases, exposure should start with the obsessive thoughts; the avoided situations and the like should then be added, either in sessions or as homework. For other patients, however, it may be difficult to distinguish between the obsessive fears and the stimuli that provoke them. For example, if a patient fears contamination from chemicals and avoids going to grocery stores, exposure may consist of having the patient go to a store and purchase cleaning supplies which will trigger the fear of contamination. Consequently, exposure to the situation and exposure to the obsessive thought occur simultaneously.

Once the hierarchies are constructed, exposure can begin. The patient is initially exposed to the lowest-ranking item on the hierarchy in the presence of the therapist, either in the office or in an actual situation. Throughout the exposure, the patient is asked to rate his or her anxiety or distress every 5 minutes or so on the 0–10 SUDs scale. Exposure is continued until the patient's anxiety is reduced substantially, ideally back to the baseline level (i.e., before exposure was initiated) or at least by half. Early exposure sessions should be scheduled for 90 minutes because anxiety may take an hour or more to diminish, especially during initial sessions. Even though in-session habituation is no longer seen as essential for success (see Barlow, 2008, for a review), reducing anxiety to the greatest extent possible is still recommended. However, recent studies show that repeated exposure, rather than the duration of any given exposure, appears to be the critical ingredient for reducing fears and symptoms. Patients are then assigned to repeat the exposure daily as homework until it evokes minimal anxiety. After the first item on the hierarchy has been mastered, exposure to the next item is begun. For exposure to be successful,

patients must be repeatedly confronted with the items highest in their hierarchies before treatment is completed. Detailed instructions for conducting exposure are included in Chapter 9 of this book. Forms 9.1 and 9.2 in Chapter 9 are forms for recording exposure homework.

Some obsessions are most easily addressed by using imaginal exposure. This will be true, for example, when the patient fears some catastrophe (e.g., a family member's being killed) or fears committing some unacceptable action (e.g., murdering a child). In such a case, a scenario can be created in which the patient's worst fears come true. This scenario is most practically created by using a narrative script of the obsessional image, but any other medium (film, photographs, etc.) that triggers the image may be used. This narrative scene or another medium is then introduced in the session, and the patient is helped to visualize it repeatedly until the anxiety associated with the image is substantially reduced. To ensure that exposure to the image is conducted repeatedly and generalizes to real life, the patient is required to continue confronting the image between therapy sessions. The in-session imaginal exposure session can be recorded, so that the patient can listen to it repeatedly at home until the anxiety associated with that image has diminished. The decision to move on to the next image is made when there is minimal anxiety at the outset on at least two consecutive sessions. For imaginal exposure to be successful, patients must be confronted with the obsessional images that hold the greatest fear, and every detailed aspect of the image must be experienced as realistically as possible. Imaginal exposure may also be used as preparation for *in vivo* exposure for other stimuli (e.g., imagining touching a toilet before actually touching it) and can be readily incorporated into the hierarchy for those items.

Other obsessions are most easily accessed with *in vivo* exposure. This is common when patients have fears of contamination or of failing to perform some action (e.g., locking a door), or when they have a range of external stimuli that trigger obsessional distress. In such cases, putting the patients in contact with a feared situation—for example, using a public restroom or walking away from the house without checking—will effectively activate their obsessional fears.

Whenever it is feasible to do so, it is important to include both *in vivo* and imaginal exposure in the treatment, as studies suggest that this leads to the best outcome. Patients whose obsessive fears can only be accessed in imagination should nonetheless be encouraged to do *in vivo* exposure to related situations that they avoid and that evoke obsessive fears. For example, if a mother has obsessive fears that her son will be stabbed by a knife, she may try to suppress the image and may avoid using knives to cook food. In this case, imaginal exposure to the scene can be used in conjunction with *in vivo* exposure to using knives.

Patients whose fears are activated by *in vivo* exposure should also be encouraged to imagine their worst fears coming true as a result of the action. For example, a woman whose exposure consists of leaving the house without checking the door can be asked to express what she fears would happen if she were to leave the door open, and then can be helped to confront that in her imagination. For example, she may imagine a burglar breaking into the house, stealing her most precious possessions, and burning the house down, and her husband then blaming her for the disaster and divorcing her.

Imaginal exposure is not feasible when patients are unable to voice any feared consequences; in these instances, *in vivo* exposure may be the only option. For example, a man may state that he would become anxious if his books weren't "just so," but may be unable to voice what he fears might happen if the books weren't placed symmetrically placed on his bookshelf. However, for

most patients, effective use of cognitive strategies can help patients identify their feared consequences so that both *in vivo* and imaginal exposure become feasible. The patient who needs his books to be symmetrical may discover through monitoring his cognitions at those instances that he is afraid that his anxiety will spiral upward and he will have a nervous breakdown if his books are not symmetrically aligned.

Patients whose obsessions consist of specific thoughts or images and whose rituals are covert mental acts present a special problem. Such patients did not traditionally respond to behavioral treatments, because covert rituals were not identified and/or because mental rituals were mistakenly treated as obsessions. However, effectively identifying covert rituals and correctly categorizing mental phenomena as rituals when they reduce distress (as opposed to increasing distress, as in the case of obsessions) can increase the efficacy of behavioral treatments. Effective exposure can also be accomplished by having patients record and listen to their obsessive thoughts repeatedly, without using mental rituals or covert rituals, until their anxiety habituates. If rituals are performed inadvertently, then patients are required to listen to the segment of the recording that triggered the obsession until they are able to listen to it without ritualizing.

Modeling may be useful early in treatment in order to facilitate exposure. Therapists can model the exposure behavior—for example, “contaminating” themselves with a feared substance—before asking patients to do so. This can encourage patients to begin exposure. However, modeling should be discontinued as soon as possible, as it may serve to reduce patients’ anxiety and therefore prevent full exposure.

Two additional notes regarding exposure for OCD are in order. First, exposure is generally carried further than a person might act in everyday life. For example, a person who has a fear of being contaminated by newspapers may be asked not only to read a newspaper, but to rub it over his or her clothes and kitchen countertops. Patients who question the rationale of performing activities that would violate norms for most people (e.g., not washing their hands after going to the toilet) should be helped to understand that OCD is a problem of overcautiousness and that taking calculated risks is essential for recovery. Second, therapists should avoid giving reassurance to patients during exposure. For many patients, seeking reassurance is one way of managing their anxiety and constitutes a form of ritualizing. It is also important as therapy progresses to have patients design and carry out their own exposure assignments. This will counteract their tendency to reduce anxiety by assigning responsibility to their therapists.

Response Prevention

Response prevention directly targets patients’ compulsions and other avoidant behaviors, and it is used in conjunction with exposure. Patients are taught to reduce and ultimately eliminate all avoidant behaviors while confronting obsessions, so that the anxiety associated with obsessive thoughts and their triggers naturally subsides of its own accord.

According to Mowrer’s (1939) two-stage model, obsessive anxiety is maintained by the performance of rituals and other avoidant behaviors. Individuals with OCD develop ways to avoid or escape the threat perceived in obsessions, and also develop active rituals to undo this harm. The immediate reduction of distress experienced when rituals or other avoidant behaviors are performed is rewarding to patients and increases the likelihood that more and more rituals will be performed in the future. Over the long run, obsessional anxiety continues to spiral upward as

individuals believe that the danger inherent in the obsessions is still present, but that they have merely circumvented it by performing rituals.

Hence, once exposure has begun, it is important to block the performance of rituals so that individuals learn that the performance of rituals is not helping them avoid danger; rather, the obsessions are not inherently dangerous. Patients should be prevented from ritualizing not only during exposure sessions, but throughout the day. Otherwise they may manage their anxiety during exposure by planning to ritualize later.

Prior to beginning formal exposure work, patients may be prepared for response prevention by instructing them to engage in behaviors that disrupt their rituals. Useful techniques include (1) performing a ritual very slowly (which interferes with the intensity of the ritual); (2) repeating the activity an unusual number of times (e.g., if the patient always does sets of four repetitions, have him or her try sets of three); and (3) postponing the ritual. With postponing, the patient starts by putting off ritualizing for a minute, and then gradually increases the time to up to several hours. After the specified time has elapsed, the patient is asked to decide either to perform the ritual or to postpone it again. Many patients are surprised to find that if they resist the initial impulse to ritualize, the urge will go away. Patients should be encouraged to experiment and find the technique that works best for them.

Once formal exposure is initiated, a therapist gives a patient the list of rituals that must be stopped, as well as rules for what constitutes response prevention. The preferred method of response prevention is to have the patient go “cold turkey” (i.e., give up all ritualizing at the beginning of the exposure phase of treatment). Although some patients may agree to stop rituals abruptly, for many patients it may be necessary to eliminate rituals gradually, especially if treatment is conducted in a weekly outpatient setting. Many strategies may be used, including reducing the time spent on rituals, reducing the frequency of rituals performed, or increasing the time interval between rituals. One of the more effective ways of gradually reducing rituals is to instruct patients to stop all rituals associated with obsessions to which they have already been exposed (or are currently being exposed), while still allowing ritualizing to items higher on the hierarchy.

Several strategies have been developed to help patients engage in response prevention (McGinn & Sanderson, 1999), and some may be used from the outset of treatment:

1. Building motivation for the procedure is the first step. This is often accomplished by discussing the rationale for ERP and the various ways in which performing rituals have impaired patients' lives and prevented them from accomplishing their goals. Reminders of the rationale may be then given to patients when response prevention is initiated or when the motivation to resist compulsions flags.

2. Increasing awareness of rituals that are often performed on “autopilot” is another easy way to reduce rituals. As indicated earlier, the process of monitoring creates self-awareness, which may lead to a reduction in rituals. Other creative ways of creating self-awareness (e.g., placing a red dot on a finger to remind a patient to resist the automatic urge to wash hands) may also be used.

3. In some cases, it may be helpful to engage family members to remind a patient to forgo rituals. Although all family members should be instructed to refuse to help the patient perform rituals and to avoid providing reassurance, enlisting a specific person to help the patient refrain

from performing rituals may be helpful, but this should only be done if the person is willing and able to serve as a coach. The coach is asked to be empathic and noncritical, yet firm; is given detailed guidelines for how he or she should supervise the patient; is asked to keep in regular touch with the therapist; and is requested to fade out his or her assistance as soon as the patient is able to refrain independently from performing rituals.

4. Finally, using behavioral modification strategies such as rewards when goals are met and response costs when rituals are not resisted may be useful in helping patients engage in ERP.

It is common for patients to have some lapses in response prevention during treatment. Patients should continue to log all rituals, and the therapist should enquire about any lapses in each session. Reasons for lapses should be explored, including the thoughts patients that led to a lapse (e.g., “I can’t stand the anxiety,” or “Just a little won’t hurt”). Advantages and disadvantages of having engaged in the ritual should be explored. Over time, patients generally come to realize that ritualizing increases the occurrence of obsessive thoughts, whereas response prevention actually decreases them. Reexposing patients to the obsessive thought or stimulus if they inadvertently ritualize can also be used as a way of “undoing” the ritual and may be used for both mental and behavioral rituals (McGinn & Sanderson, 1999). For example, patients with washing rituals may be asked to “contaminate” themselves again if they wash their hands or perform any other decontaminating ritual when they are exposed to a feared object. Above all, the therapist should caution patients against being self-critical or harsh if they inadvertently ritualize. The potential negative effects of self-criticizing statements (such as feelings of guilt, shame, and behavioral passivity) are outlined before ERP begins, and patients are given more constructive ways of talking to themselves when a slip occurs (McGinn & Sanderson, 1999).

Phasing Out Therapy and Preventing Relapse

Before ending treatment, it is important to help patients predict possible sources of stress that might lead to a relapse. This serves two functions: (1) It gives them tools to deal with such stressors; and (2) it helps them see a temporary return of symptoms not as an indication that treatment has failed, but as a natural occurrence that provides an opportunity to practice the skills they have learned. It is also important to deal with any stressors that may be related to the reduction in OCD symptoms, such as the need to fill extra time that is now available, or family conflict that had previously taken a back seat to the OCD symptoms.

Once possible stressors are identified, ways of coping with these stressors are reviewed, including relaxation and cognitive restructuring. Finally, the patient is asked to write out a list of procedures to follow if a relapse does occur, including self-directed ERP, as well as calling the therapist for booster sessions if the patient is not able to bring the symptoms under control.

Once acute treatment has ended, sessions should be scheduled at intervals of 2 weeks to a month. Sessions may also be further tapered (every 3 months, twice a year, etc.) as needed. In addition, patients are asked to design their own therapy homework and check in with themselves each week as they did with their therapist, to ensure that they are regularly practicing skills. This will give patients increased confidence in their ability to cope with their symptoms on their own.

TROUBLESHOOTING PROBLEMS IN THERAPY

The most common problems encountered in treating OCD are premature dropout and noncompliance. If the treatment is understood from a patient's point of view, this makes sense. The principles of ERP are counterintuitive. Therapists are, in fact, asking patients to do the very things that they most fear doing and have believed would lead to disaster.

The first step in preventing premature dropout is properly preparing a patient. The cognitive-behavioral conceptualization of OCD must be explained in a way the patient can understand. Any fears the patient has should be elicited and discussed. It may also be helpful to have the patient read stories by people who have successfully undergone treatment. *Stop Obsessing!* (Foa & Wilson, 2001) provides a number of such stories.

Ultimately, however, it is usually helpful to acknowledge that some doubt and anxiety are to be expected before treatment begins. If the patient continues to hesitate, behavioral experiments may be used before initiating full ERP. For example, the patient may be asked to try purposely thinking an obsessive thought and to observe the results. Similarly, the patient may be asked to attempt to postpone rather than forgo a ritual. If the patient continues to resist full exposure, adding medication to the treatment may be helpful.

Premature dropout sometimes happens after a patient has done enough ERP to get some relief, but before he or she has completed the exposure hierarchy. This too makes sense from the patient's point of view: The extreme distress that motivated the patient to seek treatment has subsided, but the fear associated with the highest items on the hierarchy still remains to be faced. It is helpful to warn patients about the risks of premature dropout and to inform them that, according to research, patients who have not confronted their most feared items or continue to have substantial symptoms are at greater risk of relapse. If a patient suddenly stops coming to sessions, it is important to establish contact and discuss his or her fears. If the patient does not return, the message should be conveyed that the therapist is available if the patient should desire further treatment at any point in the future. It has been our experience that a number of patients return after premature dropout because they have experienced a relapse; such patients will then have the motivation to complete treatment.

Noncompliance presents a more subtle problem. It is common for patients to engage in covert forms of avoidance during exposure. For example, they may distract themselves from the exposure cues; they may perform covert mental rituals; or they may promise themselves that they will ritualize later. The best way to detect covert avoidance is to monitor a patient's SUDs level throughout the exposure. If the patient fails to experience significant anxiety, inquiry should be made about any actions he or she may be taking to feel less anxious. The patient should then be reminded of the need for full exposure. In some cases, it may be necessary to contract with the patient to proceed more slowly with exposure, in exchange for a promise to forgo covert avoidance.

Failure to do homework is another problem. Simply asking patients to record their exposure practice on the forms provided in Chapter 9 (Forms 9.1 and 9.2) will increase compliance. If the patient fails to habituate over time to exposure items, noncompliance with homework should be suspected. Again, the patient's fears should be explored, and the patient should be encouraged to experiment independently to determine the results of doing or avoiding self-directed exposure.

Noncompliance with response prevention is also common. The patient should be encouraged to discuss any ritualizing he or she has engaged in during the week. Lapses should be approached nonjudgmentally as learning opportunities. The advantages and disadvantages of having ritualized can be explored, along with the automatic thoughts that led to the lapse. If the patient continues to have difficulty refraining from ritualizing, family members may be recruited to help remind the patient of the need to forgo rituals and to monitor any rituals that are performed. Patients with severe OCD who are incapable of response prevention may need to undergo treatment in an inpatient setting.

Finally, although cognitive restructuring is effective in disconfirming secondary automatic thoughts, therapists should be alert to the possibility that patients may begin to ritualistically repeat the restructured cognitions. In these cases, the anxiety decreases not through the true disconfirmation of the *content* of the erroneous thoughts, as intended, but instead through the ritualistic *process* of repeating key phrases. To prevent this from occurring, therapists should ensure that patients create new automatic thought logs each time, and should ask patients to vary the wording used to modify erroneous assumptions and thoughts. The “coping cards” used to restructure common thought patterns in other emotional conditions are not recommended for use by patients with OCD. When the restructuring phase is initiated, therapists should forewarn patients and request them to alert the therapists if the restructuring process itself becomes ritualized, so that the process of restructuring can be varied.

DETAILED TREATMENT PLAN FOR OBSESSIVE–COMPULSIVE DISORDER

Treatment Reports

Tables 8.3 and 8.4 are designed to help in writing treatment reports for patients with OCD. Table 8.3 shows sample symptoms. Select the symptoms that are appropriate for the patient. Be sure also to specify the nature of the patient’s impairments, including any dysfunction in academic, work, family, or social functioning. Table 8.4 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

Sequence of Interventions

Table 8.5 shows the sequence of interventions for a 20-session course of treatment for OCD. As noted above, patients with severe symptoms may require longer treatment.

CASE EXAMPLE

Sessions 1–2

Presenting problem Robert was a 25-year-old single white male. He presented in the first session specifically requesting treatment for OCD. He had been previously diagnosed by a psychiatrist, who had prescribed Prozac. Robert never took the medication, however; he had read that one of the side effects was nausea, and, as it turned out, vomiting was one of his obsessive fears.

TABLE 8.3. Sample Symptoms for Obsessive–Compulsive Disorder

Obsessions (specify)—for example:	Nausea
Fear of contracting disease (specify)	Dizziness
Fear of contamination (specify)	Feeling faint
Fear of hurting someone (specify)	Sweating
Fear of failure to do something (specify)	Shaking
Fear of losing control (specify)	Numbness
Compulsions (specify)—for example:	Tingling
Excessive washing or cleaning (specify)	Chills
Checking (specify)	Hot flashes
Repeating (specify)	Specify cognitive symptoms:
Hoarding (specify)	Mind going blank
Ordering (specify)	Difficulty speaking
Anxious mood	Loss of concentration
Specify physical symptoms of anxiety:	Derealization
Palpitations	Depersonalization
Difficulty breathing	Avoidance (specify)
Chest pain	

TABLE 8.4. Sample Treatment Goals and Interventions for Obsessive–Compulsive Disorder

Treatment goals	Interventions
Reducing physical anxiety symptoms	Imaginal exposure
Reporting obsession-related distress less than 2 on a scale of 0–10	Exposure
Eliminating compulsions (specify)	Response prevention
Stating belief that anxiety is not dangerous and can be tolerated	Cognitive restructuring, exposure
Stating understanding that seeking perfect certainty exacerbates symptoms	Cognitive restructuring
Modifying schemas of danger and responsibility (or other schemas—specify)	Cognitive restructuring, developmental analysis
Engaging in previously avoided behaviors (specify)	<i>In vivo</i> exposure
Reducing functional impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Reducing anxiety symptoms (MOCI and/or OCQ scores in normal range)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

TABLE 8.5. Detailed Treatment Plan for Obsessive–Compulsive Disorder**Sessions 1–2****Assessment**

Assess presenting problem
 Inquire regarding all symptoms
 Assess presence of obsessions and compulsions
 Assess avoidance behaviors
 Assess feared consequences
 Assess internal and external triggers of obsessional anxiety
 Assess impairment in social, educational, and occupational functioning
 Assess social supports and involvement of family members in rituals
 Have patient complete OCQ (Form 8.2)
 Administer standard battery of intake measures (see Form 8.3), plus other anxiety questionnaires as appropriate
 Evaluate for comorbid conditions
 Evaluate substance use; evaluate need for counseling or detoxification if patient has substance abuse or dependence

Socialization to Treatment

Inform patient of diagnosis and provide education on OCD
 Educate patient regarding treatment options, including medication
 Provide patient with handouts on OCD (Form 8.5) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)

Homework

Have patient write out goals for therapy
 Assign self-help reading material (*Anxiety Free, Stop Obsessing!, When Once Is Not Enough*)

Sessions 3–4**Assessment**

Evaluate homework
 Readminister self-report questionnaires to assess mood and track progress
 Review all obsessions, compulsions, and avoided situations
 Assess motivation for treatment

Socialization to Treatment

Build motivation
 Describe cognitive-behavioral conceptualization of OCD and describe cognitive-behavioral treatment
 Educate patient regarding outcome research
 Obtain patient's commitment to proceed with treatment
 Educate family members regarding diagnosis and their role in treatment, if appropriate

Cognitive Interventions

Introduce cognitive model
 Identify automatic thoughts, obsessional anxiety, compulsions or urge to ritualize, and triggering situations
 Evaluate automatic thoughts

Homework

Have patient list advantages and disadvantages of proceeding with treatment
 Have patient begin to log all obsessions and rituals (Form 8.4)

TABLE 8.5 (*cont.*)

Assign further chapters from selected self-help book(s)
 Have patient begin recording automatic thoughts, feelings, emotions, behaviors

Sessions 5–6**Assessment**

Evaluate homework
 Readminister self-report questionnaires to assess mood and track progress

Cognitive Interventions

Educate patient regarding intrusive thoughts as normal phenomena
 Evaluate validity of automatic thoughts
 Modify automatic thoughts, dysfunctional assumptions about danger; challenge magical thinking
 Identify and modify overresponsibility
 Help patient devise behavioral experiments (e.g., avoiding or not avoiding thoughts and tracking results; attempting to influence events by thoughts)

Behavioral Interventions

Help patient begin constructing hierarchies of obsessions and avoided situations/other stimuli

Homework

Have patient continue modifying automatic thoughts and assumptions
 Have patient continue to log obsessions/rituals
 Have patient conduct behavioral experiments
 Assign practice in disrupting rituals

Sessions 7–10**Assessment**

As in Sessions 5–6

Cognitive Interventions

Continue modifying automatic thoughts, dysfunctional assumptions, and personal schemas of responsibility, self-blame, and vulnerability to harm
 Continue helping patient devise behavioral experiments

Behavioral Interventions

Help patient complete exposure hierarchies
 Plan initial exposure sessions
 Conduct exposure to initial items on hierarchies of obsessions and avoided situations/other stimuli (imaginal and *in vivo*)

Note: Initial exposure sessions, particularly imaginal exposure, should be 90 minutes to allow for habituation; it may be advisable, after the first exposure session, to schedule a 45-minute session later in the week to monitor any problems with exposure homework

Teach postponing, slowing, and changing repetitions
 Help patient block all rituals (abstinence or near-abstinence), or block rituals associated with current exposure items (or use other ways to grade response prevention)

Homework

Have patient continue modifying automatic thoughts (not during exposure)

(*cont.*)

TABLE 8.5 (cont.)

Assign daily repetition of exposure
Have patient log and block rituals based on response prevention plan

Sessions 11–16**Assessment**

As in Sessions 5–6

Cognitive Interventions

Examine and challenge any thoughts related to avoidance of exposure
Examine and challenge any thoughts related to lapses in rituals
Help patient evaluate advantages/disadvantages of rituals
Continue modifying assumptions and schemas of danger, responsibility, and the like.

Behavioral Interventions

Complete exposure to items higher up hierarchies of obsessions and avoided situations/other stimuli
Monitor continuation of safety behaviors or any avoidance of exposure homework
Be sure to include both *in vivo* and imaginal exposure unless contraindicated
Continue to help patient block rituals
Examine any lapses in response prevention
Use behavior modification strategies to increase compliance with response prevention

Homework

Have patient continue logging obsessions/rituals
Have patient record automatic thoughts related to any lapses
Assign continued daily repetition of exposures
Have patient continue modifying dysfunctional thoughts, assumptions, and schemas

Sessions 17–20 (Schedule Biweekly or Monthly)**Assessment**

As in Sessions 5–6
Assess attainment of goals to determine whether treatment may be tapered
Track progress in identifying and modifying thoughts
Assess and address any residual symptoms
Assess any life problems related to OCD or patient improvement

Cognitive Interventions

Continue with cognitive challenges to schemas of danger, responsibility, and the like
Have patient apply cognitive skills to life stressors

Behavioral Interventions

Ensure that exposure is being performed to items highest on the hierarchy
Ensure that obsessional fear is decreasing
Continue helping patient block all rituals
Monitor any lapses

Relapse prevention

Educate patient regarding likelihood of residual symptoms and use of lapses as opportunity to practice skills
Evaluate possible future stressors
Review coping skills and develop strategies for future stressors

TABLE 8.5 (*cont.*)

Address current life problems
 Have patient prepare list of skills learned in therapy
 Encourage patient to call if booster sessions are needed

Homework

Have patient self-assign exposure homework
 Encourage patient to continue practicing all skills learned

<i>Rituals</i>	<p>Robert lived with his mother. His parents had divorced 5 years earlier. He was employed as the office manager of a small company. He aspired to be a photographer, but had yet to seek work in his chosen profession.</p> <p>When asked about his symptoms, Robert complained of a history of ritualizing since the age of 10. His rituals involved repeating actions, often hundreds of times. He reported that his condition had worsened in the last 3 years. He had rituals for dressing, showering, and shaving that often took several hours a day. Many of his rituals involved going from one part of a room to another, tapping objects. He often did this so rapidly and intensely that he would sweat. At his job, Robert would open and close computer files hundreds of times. He also often reprinted the same photograph repeatedly until he felt he had done the procedure without thinking any “bad” thoughts.</p>
<i>Obsessions</i>	<p>Robert’s obsessions included a fear of vomiting, especially in anxiety-provoking situations such as job interviews; fears of being injured or killed in a car or plane accident; and fears of family members’ dying. He was afraid that if he allowed himself to have one of these thoughts, the feared event might actually occur.</p>
<i>Avoidance</i>	<p>Robert avoided subways, buses, and airplanes, as well as walking down streets where he had once had an obsessive thought. He avoided buying books, DVDs, or CDs that he associated with vomiting or plane crashes. In addition, he sometimes avoided eating for fear of being nauseated; consequently, he was slightly underweight.</p>
<i>Impairment in functioning</i>	<p>When asked how his OCD had interfered with his life, Robert reported a number of problems. His college girlfriend had broken up with him because of his ritualizing, and he had not dated or been sexually active in almost 2 years. Although he did hold a job that was unstructured enough for him to hide most of his ritualizing, he was not functioning at his optimal level at work. He said he was afraid to pursue work as a photographer for fear he would become anxious and his OCD would get worse. He continued living at home, in spite of a stated desire to be on his own.</p>
<i>Family history</i>	<p>Robert reported that his mother had been treated for anxiety. He described her as overprotective and said that she actively discouraged him from moving out of the house. In spite of wishing for more independence, Robert was very close to his mother. Robert’s father, an attorney, was largely an absent figure.</p>
<i>Socialization to treatment</i>	<p>Robert was administered the OCQ (Form 8.2) and the standard intake battery (see Form 8.3). The therapist educated Robert about OCD and helped him to see that many others suffered from this illness. He was helped to understand</p>

that OCD was no different from a medical illness that could be treated, and that it was not a personality flaw or a sign of immorality. He was given information on the effectiveness of cognitive-behavioral therapy as a treatment for OCD. He was also provided with the information handouts on OCD (Form 8.5) and on cognitive-behavior therapy in general (Form 10.1 in Chapter 10). The option of combining therapy and medication was discussed, but Robert stated a strong preference to try therapy without medication.

Bibliotherapy

For his therapy homework, Robert was assigned to write out his goals for therapy and begin reading *Stop Obsessing!* When he expressed fear that reading the book would make his symptoms worse, he was helped to understand that although his anxiety could increase initially, this would be a temporary and natural result of finally facing his fears. The therapist explained that this anxiety increase was temporary and would subside naturally as he read on.

Sessions 3–4

Further socialization to treatment

In the third session, the therapist further described the cognitive-behavioral model of OCD and the steps involved in treatment. Robert was told that OCD was a chronic condition that waxes and wanes with stress, and although his chances for improvement were excellent, it was likely that some minor symptoms would remain.

Building motivation

In the session, Robert was asked to think about the ways his life would become better if his OCD symptoms improved, and to make a list of advantages and disadvantages of proceeding with treatment. When the advantages and disadvantages were reviewed, Robert expressed the desire to proceed, but he said he was afraid that exposure would make his anxiety worse. The therapist told Robert that prolonged exposure would actually lessen his anxiety, and suggested that Robert conduct a behavioral experiment in the coming week: He was asked to allow himself to visualize one of his obsessive thoughts instead of trying to suppress it. He was also asked to begin logging his rituals (Form 8.4).

Homework

Obsession/ritual log

The log Robert presented in the fourth session revealed almost constant obsessing and ritualizing. However, he reported that recording his rituals had made him more aware of what he was doing and had led to a decrease in the time he spent ritualizing. Robert was pleased, because he felt that this indicated he was already making progress. However, he reported being unable to visualize his thoughts and instead had suppressed them as usual.

Introducing cognitive model

Robert was then helped to identify and record his automatic thoughts during moments of obsessional anxiety:

“My obsessions (such as ‘I will vomit’) will come true.”

“It will be my fault if a file is lost from the drawer.”

“If I don’t ritualize, my mother will die, and it will be my fault.”

“If I don’t ritualize, it means I want bad things to happen.”

“I must control my thoughts at all times.”

“My anxiety will give me a nervous breakdown.”

“I am weak and immoral for having bad thoughts.”

He was helped to see how his automatic thoughts about his obsessions increased his anxiety, led to rituals and other avoidance behaviors, and served to reinforce his obsessions in the long run.

Identifying automatic thoughts

Robert was asked to record his automatic thoughts when his obsessional anxiety was triggered. Robert was again asked to allow himself to visualize one of his obsessive thoughts instead of trying to suppress it.

Sessions 5–6

Behavioral experiments

In the next session, Robert reported that his ritualizing had continued to decrease. He had tried allowing himself to think of one of his obsessive thoughts and was pleased to discover that, as the therapist had predicted, his anxiety had decreased.

In the sixth session, Robert reported that he had found postponing his rituals very helpful, and that when he did postpone them, his urge to ritualize went away, much to his surprise.

Cognitive restructuring: Evaluating validity of automatic thoughts

Although Robert was able to acknowledge that allowing his obsessive fears to unfold had reduced his anxiety, he continued to express fears that exposure would make his anxiety worse in the long run. The therapist used Socratic dialogue to help him continue challenging these thoughts. In addition, using the thought records Robert had filled out between sessions, the therapist helped him see that his obsessions were normal. Moreover, the more he tried to control his thoughts, the more they would come; the more he allowed himself to have these thoughts, the more they would simply dissipate.

Behavioral experiments

To test this, Robert was asked to read a story in a magazine in the waiting room about someone who had suffered a motor vehicle accident. After he had finished reading the story, he was asked to try his best not to think of the story and to suppress any thoughts related to the story. When Robert found that he couldn't stop thinking about the story no matter how hard he tried and began to feel anxious, he was asked to switch gears and visualize the story in his mind from beginning to end. He experienced an initial increase in anxiety, but was asked to continue imagining the story. To his surprise, not only did his anxiety decrease, but he found it hard to keep his mind focused on the story no matter how hard he tried.

Homework

For homework, Robert was assigned to continue altering his rituals and identifying and modifying his automatic thoughts.

Sessions 7–10

Exposure hierarchies

The next three sessions were devoted to preparing Robert to begin exposure. This involved developing hierarchies of obsessive thoughts and avoided situations, and continuing to respond to Robert's fears about exposure. This process took somewhat longer than expected because of the extensive nature of Robert's symptoms; for example, his logs reflected over 50 distinct rituals.

Plan for exposure

In the ninth session, Robert was presented with a schedule for the next 3 weeks, consisting of one 90-minute session each week for exposure. An additional 45-minute session was scheduled the first week for troubleshooting any

Response prevention problems that arose. Imaginal exposure would be used in sessions to target Robert's obsessive fears. Between sessions, Robert would repeat the imaginal exposure and would do self-directed *in vivo* exposure to situations he avoided. Robert was told to set aside an hour a day for homework. The options of either stopping his rituals "cold turkey" or phasing them out as he moved up his hierarchy were discussed. Robert was asked to think about which method he preferred prior to the next session. Robert's exposure hierarchies are shown in Figures 8.2 and 8.3.

Cognitive strategies: Understanding categories of distorted automatic thoughts Over time, as patterns in his thoughts became evident, Robert was helped to see that he was *overestimating the likelihood of negative outcomes* (e.g., that he would vomit) and *underestimating his ability to cope* with negative outcomes (e.g., "I will not be able to survive if I vomit," "I cannot handle experiencing anxiety"). He also learned in therapy that he was infusing his thoughts with *magical properties* (i.e., believing that thinking things would make them come true); *blaming himself* for having symptoms of OCD, and seeing OCD as a sign of personal weakness and immorality; and holding himself *responsible* for things not under his control (e.g., the death of his mother, his obsessions).

Patient's name: Robert Today's date: 10/15

Please list your feared thoughts, images, and impulses in order from least to most distressing. In the last column, note how upset each one makes you from 0 (no distress) to 10 (maximum distress).

Rank	Thought/image/impulse	Distress (0–10)
1	Car accident—face damaged	4
2	Getting sick—throwing up	5
3	The number 13	5
4	Throwing up at a job interview	8
5	Car accident—family member hurt	9
6	Helicopter accident—I'm killed	9.5
7	Plane accident—I'm killed	9.5
8	Family member dying	10

FIGURE 8.2. Patient's Hierarchy of Obsessions (Form 8.6), as completed by Robert.

Patient's name: Robert Today's date: 10/15

Please rank your anxiety-provoking and avoided situations, objects, persons, or internal stimuli in order from least to most distressing. In the last column, note how upset each one makes you, from 0 (no distress) to 10 (maximum distress).

Rank	Situation/object/person/internal stimulus	Avoided (Yes/No)	Distress (0–10)
1	Bus	No	3
2	Car	No	3
3	Touch something touched by someone sick	Yes	4
4	Walk down block after obsession	Yes	8
5	Print picture associated with obsession	Yes	8
6	The number 13	Yes	8
7	Complete layouts so things line up	Yes	8
8	Purchase and use items associated with obsession	Yes	8
9	Boats	Yes	9
10	Eat when I might vomit	Yes	9
11	Certain CDs	Yes	9.5

FIGURE 8.3. Patient's Hierarchy of Anxiety-Provoking/Avoided Situations and Other Stimuli (Form 8.7), as completed by Robert.

Homework

For homework, Robert was asked to conduct behavioral experiments to test many of his predictions. For example, he was asked to imagine a politician dying and then to test his predictions over the following weeks, to see whether he had been able to “cause” the politician's death simply by imagining it. Robert was also asked to record his automatic thoughts when his obsessional anxiety was triggered, and to evaluate his automatic thoughts on his own. Finally, he was asked to consider and try the method of response prevention that he felt worked best for him.

Imaginal exposure

At the start of the 10th session, Robert reported that he had gone “cold turkey” and had not ritualized for the past week. He was very pleased by this and said, “I don’t want to ritualize, and no one can make me.” He was praised for this, but was also warned that relapse was likely.

Imaginal exposure was then initiated to the first thought from Robert’s hierarchy (i.e., that his face would be disfigured in a car accident). His SUDs rating never increased above 4, and he habituated quickly. Therefore, exposure was begun for the second item (his fear of vomiting). The imaginal exposure used for Robert’s fear of vomiting is described below. It contains a number of specific elements that were taken from Robert’s hierarchy of avoided situations. For example, his fear of vomiting had increased following his becoming ill after eating scallops at age 12. He had avoided scallops ever since.

THERAPIST: You get a call from your friend Larry saying that there is a party a week from now at his house, and that he really wants you to come, because one of the guests is an agent who might be interested in your photographs. He also mentions that Sally [a woman Robert had worked with and liked] is going to be there. She just broke up with her boyfriend and said she’s looking forward to seeing you. What are you thinking and feeling?

ROBERT: I’m feeling anxious. Why did he have to call so far in advance? Now I’m going to be nervous all week. I want to call and cancel.

THERAPIST: What do you feel physically?

ROBERT: I feel a knot in my stomach and maybe, yes, I think a little nauseated.

THERAPIST: Good. And you have an urge to ritualize to control the anxiety, but you promised to go “cold turkey,” so you don’t. What are you feeling?

ROBERT: I’m really anxious, ‘cause I think that if I don’t ritualize, I might vomit when I get to the party.

THERAPIST: OK. Now it’s a week later. It’s the morning of the party, and you started feeling a little sick last night. There’s been a flu going around, and you think you might have it. How are you feeling?

ROBERT: Well, I’m a little light-headed. I feel just a bit queasy, and I’m really worried I’m going to get sick before this party.

THERAPIST: Now you go to get dressed and you realize that the only jacket you have that isn’t at the cleaners is the green one, the one you never wear because it reminds you of vomit. So you put it on. What’s going through your mind?

ROBERT: Why don’t I have anything else to wear? Maybe I can just wear a nice sweater.

THERAPIST: OK, but you decide that you have to look professional to meet this agent, so you put on the green jacket and go to work. [Note the attempted avoidance by Robert even in the fantasy, and the move by the therapist to block it.]

As the exposure continued, Robert was told that he went to work, but felt sicker as the day went on. He didn't have time to get lunch, and all that was available was someone's leftover chicken and cashews from the local Chinese restaurant. While he was eating it, he noticed the chicken looked slightly undercooked. When he left, it was raining, so he couldn't get a cab. He had to take a bus. It was very crowded, and the exhaust system didn't work, so it smelled. By the time he got to the party, he was feeling very nauseated. However, Sally greeted him warmly and said she was very glad he was there because she had cooked her special dish, scallops marinara, and wanted him to try it.

THERAPIST: What are you feeling now?

ROBERT: I'm really sick and I don't want to eat anything.

THERAPIST: But you really like this girl, and she's looking right at you as you sit there with the food in front of you. So you start to take a bite. What does it taste like?

ROBERT: The scallop is kind of rubbery, and it smells like seaweed. I don't like it. I try to swallow a little, but it feels like my throat is closing. I'm feeling really nauseated. I think I am going to vomit all over Larry's house, the vomit will get over all my clothes, and I will never be able to get rid of the vomit. I will also vomit all over Sally, and it will be my fault that she will not be able to get rid of the vomit. She will get sick, and I will have caused it.

Robert's SUDs rating, which had climbed slowly during this exposure, suddenly jumped to 8 when he was asked to imagine eating the scallop and when he finally faced some of his catastrophic fears about vomiting. His fear climbed to 9 when he faced his worrying about the resulting contamination and his feeling responsible for causing harm to Sally by vomiting. He reported a strong urge to leave the office and wash his hands during the exposure session, but he was asked to allow the anxiety to spiral upward and continue imagining the contamination he felt from visualizing himself vomit. Robert began trembling, but despite reporting that he "couldn't stay with the image" and that he was "going to have a nervous breakdown," he was able to stay present and visualize the scene repeatedly until his anxiety dissipated.

Homework

Robert was commended for continuing the imaginal exposure exercise despite his fears about doing it. The rationale for doing exposure was once again reiterated, and he was asked for feedback. His spontaneously reported automatic thoughts were examined and evaluated for their validity, and he was assigned to listen to the recording of the vomit exposure as homework.

Sessions 11–16

Cognitive strategies: Modifying

Robert slowly began to accept that he suffered from OCD. He was helped to distinguish between his obsessive fears (e.g., "My mother will die because I had an image of her dying") and reality (e.g., "I just had an obsession that she will

thoughts, assumptions, and personal schemas

die; that doesn't mean that she will die"). Over time, Robert was also able to see that he held himself responsible for a great many things. He began to see that his tendency to see the world as a dangerous place and his responsibility in creating danger was worsening his OCD symptoms. His belief in his automatic thoughts slowly decreased, as did the assumptions and schemas on which they were based. His schemas that he was immoral and responsible for negative outcomes slowly subsided as he realized that he was being critical and judgmental of himself for having symptoms of OCD.

As planned, the 11th session was held 2 days after the first exposure session. Robert reported that he had felt very anxious after the prior session and had begun ritualizing again. He had not listened to the recording. He also reported being afraid that he would become so anxious that he would vomit.

Cognitive restructuring: Further evaluation of maladaptive thoughts

The therapist asked whether he had ever vomited when he felt anxious. Robert answered, "No," and seemed surprised by his own answer. It had never occurred to him that although he constantly feared vomiting from anxiety, this had never happened. He was also helped to see that even if he did vomit, he could cope with it; that vomiting was one of his body's ways of ridding itself of waste; and that vomiting did not lead to contamination and sickness.

Resumption of imaginal exposure

Imaginal exposure was resumed. All the elements from the scenario were repeated, and new ones were added until Robert had imagined eating an entire bowl of scallops, vomiting in front of Sally, contaminating himself and her, and making her sick. Although his anxiety peaked at 5, Robert was amazed to find that as he continued thinking about it, his anxiety declined to minimal levels. Robert was assigned to listen to the recording of the exposure scenario every day, and to begin self-directed exposure to items on his hierarchy of avoided situations.

Homework

Further exposure

Sessions 12 and 13 were again 90 minutes long. Robert was exposed to the rest of his obsessive thoughts. In addition to imaginal exposure, he was asked to do things such as writing the thoughts "I will die in a plane crash," and "My mother will die," 13 times each (since he was also obsessed with the number 13). Robert habituated easily to these exposures. All future sessions were planned for 45 minutes.

Effects of exposure

In Session 14, Robert indicated that he was very pleased with his progress. He reported that he was now able to say the word "vomit" and to watch a TV show that involved vomiting without feeling anxious. He had exposed himself to a number of avoided situations that had not been on his original hierarchy (it was becoming apparent that both his rituals and his avoidance were even more extensive than he had reported). He stated, "If I challenge myself, nothing can bother me."

Response prevention

Robert did report some minor ritualizing, including a new ritualistic thought "Just let me do that." He usually followed these rituals with some new exposure. However, he also reported that he was avoiding listening to exposure recordings made during sessions because he didn't feel "clean" afterwards. The therapist pointed out that this was a form of avoidance, and the advantages and disadvantages of exposure were reviewed. Robert was assigned to listen to the recordings daily and was asked to refrain from performing both old and new rituals.

Homework

In vivo
exposure

The next two sessions were primarily spent planning and discussing self-directed *in vivo* exposure. Robert exposed himself to a variety of previously avoided situations. He also reported progress in areas that had not been direct targets of therapy. He said that he was expressing disagreement with his mother more often without feeling guilty. He also reported that he was apologizing less often at his job. In addition, he had begun putting together a portfolio so that he could solicit jobs as a free-lance photographer.

Sessions 17–20

Further
cognitive
restructuring

Work during the 17th–20th sessions focused on areas of functioning that had been problematic for Robert; various cognitive techniques were used. He was having trouble completing his portfolio, and his automatic thought was “It has to be perfect.” This belief was challenged, with the therapist emphasizing the impossibility of achieving perfection and the advantages of starting to show his work even if it was not yet perfect. The following week Robert reported that he had completed the portfolio and made some appointments to show it. Robert then stated that his goal was to feel no anxiety during these appointments. This led to a discussion of the advantages and disadvantages of trying to feel no anxiety versus accepting anxiety. Robert’s underlying assumption was that any anxiety was dangerous. The therapist pointed out that mild anxiety actually enhances performance.

Further
response
prevention

Robert reported some minor bouts of ritualizing, accompanied by the thought “Just one for safety.” The advantages and disadvantages of performing “just one” ritual were discussed, and Robert concluded that rather than making him less anxious, continued ritualizing only served to reinforce his obsessive fears.

Continuation
of therapy

By the 20th session, Robert was ritualizing minimally and was far less troubled by his obsessive thoughts. The possibility of terminating therapy was discussed. If Robert had opted to stop treatment at this point, three or four more sessions would have been held, spaced every other week, to focus on relapse prevention. However, Robert felt that there were several areas of life functioning that he wished to work on, including pursuing his career as a photographer, dating, and his conflict about moving out of his mother’s house. Therapy was therefore continued once a week on an open-ended basis.

FORM 8.1. Maudsley Obsessional–Compulsive Inventory (MOCI)

Patient's name: _____ Today's date: _____

Please answer each question by putting a circle around the "True" or the "False" following the question. There are no right or wrong answers, and no trick questions. Work quickly and do not think too long about the exact meaning of the question.

- | | | |
|---|------|-------|
| 1. I avoid using public telephones because of possible contamination. | True | False |
| 2. I frequently get nasty thoughts and have difficulty in getting rid of them. | True | False |
| 3. I am more concerned than most people about honesty. | True | False |
| 4. I am often late because I can't seem to get through everything on time. | True | False |
| 5. I don't worry unduly about contamination if I touch an animal. | True | False |
| 6. I frequently have to check things (e.g., gas or water taps, doors, etc.) several times. | True | False |
| 7. I have a very strict conscience. | True | False |
| 8. I find that almost every day I am upset by unpleasant thoughts that come into my mind against my will. | True | False |
| 9. I do not worry unduly if I accidentally bump into somebody. | True | False |
| 10. I usually have serious doubts about the simple everyday things I do. | True | False |
| 11. Neither of my parents was very strict during my childhood. | True | False |
| 12. I tend to get behind in my work because I repeat things over and over again. | True | False |
| 13. I use only an average amount of soap. | True | False |
| 14. Some numbers are extremely unlucky. | True | False |
| 15. I do not check letters over and over again before posting them. | True | False |
| 16. I do not take a long time to dress in a morning. | True | False |
| 17. I am not excessively concerned about cleanliness. | True | False |
| 18. One of my major problems is that I pay too much attention to detail. | True | False |
| 19. I can use well-kept toilets without any hesitation. | True | False |

(cont.)

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FORM 8.1. Maudsley Obsessional–Compulsive Inventory (p. 2 of 2)

20. My major problem is repeated checking.	True	False
21. I am not unduly concerned about germs and diseases.	True	False
22. I do not tend to check things more than once.	True	False
23. I do not stick to a very strict routine when doing ordinary things.	True	False
24. My hands do not feel dirty after touching money.	True	False
25. I do not usually count when doing a task.	True	False
26. I take rather a long time to complete my washing in the morning.	True	False
27. I do not use a great deal of antiseptics.	True	False
28. I spend a lot of time every day checking things over and over again.	True	False
29. Hanging and folding my clothes at night does not take up a lot of time.	True	False
30. Even when I do something very carefully I often feel that it is not quite right.	True	False

For each subscale, count the total number of answers that match those listed below.

Checking

6-T 22-F 15-F 28-T 20-T 26-T 14-T 8-T 2-T

Cleaning

17-F 21-F 24-F 1-T 19-F 9-F 5-F 13-F 27-F 4-T 26-T

Slowness

2*-F 16-F 8*-F 23-F 29-F 4-T 25-F

*Note: These two items load on this factor in the opposite direction from what would be expected.

Doubting

7-T 3-T 30-T 12-T 11-F 10-T 18-T

TOTAL

1-T 2-T 3-T 4-T 5-F 6-T 7-T 8-T 9-F 10-T 11-F 12-T 13-F 14-T 15-F 16-F 17-F 18-T 19-F 20-T 21-F 22-F 23-F
24-F 25-F 26-T 27-F 28-T 29-F 30-T

FORM 8.2. Obsessive–Compulsive Questionnaire (OCQ) for Patients

Patient's name: _____ Today's date: _____

Obsessions

Listed below are some common fears people have. Please check how much you have been bothered by each one in the past week. If you have additional fears that are not listed, please write them in and rate how much they bother you.

Fear	None (0)	A little (1)	Moder- ately (2)	A lot (3)
Fear of germs				
Fear of getting or having a disease				
Fear of contact with poisonous or dangerous substances				
Fear of dirt				
Fear of making a mistake or doing something wrong				
Fear of forgetting to do something (e.g., lock a door, turn off a stove)				
Fear of hurting or killing someone (in the past or future)				
Fear of someone being injured or dying				
Fear of being killed or injured				
Fear of doing or saying something bad, immoral, or embarrassing				
Fear of not having something available or on hand when you need it				
Fear of having things out of order				
Fear of things not being perfect				
Other obsessions:				

(cont.)

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Compulsions

Listed below are typical compulsions or rituals. An action is considered a compulsion if you do it more often than it is commonly done by others or if it is done to make you feel less anxious. Please check how much time or effort you have spent on each compulsion in the past week. If you have additional compulsions, please add them.

Compulsions	None (0)	A little (1)	Moderately (2)	A lot (3)
Washing hands, showering, or other personal cleansing				
Cleaning (objects, surfaces, rooms, etc.)				
Checking to make sure you did (or didn't do) something				
Checking to make sure things are right or perfect				
Repeating actions				
Hoarding or collecting things				
Putting or keeping things in a certain order				
Saying things to yourself repeatedly (such as prayers, lists, or other phrases)				
Asking for reassurance from others				
Other compulsions:				

FORM 8.3. Evaluation of Obsessive–Compulsive Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test/data scores

Structured Clinical Interview for DSM-IV-TR Axis I (SCID) _____

Anxiety Disorder Interview Schedule for DSM-IV (ADIS-IV) _____

Beck Depression Inventory–II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Yale–Brown Obsessive Compulsive Scale (Y-BOCS) _____

Maudsley Obsessional–Compulsive Inventory (MOCI) _____

Obsessive–Compulsive Questionnaire (OCQ) _____ Global Assessment of Functioning (GAF) _____

Other questionnaires (specify) _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Prior Treatments
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(cont.)

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Key symptoms

Obsessions: _____

Compulsions: _____

Other avoidance/escape and safety behaviors: _____

External triggers of anxiety: _____

Internal triggers of anxiety: _____

Feared consequences (if none reported, reevaluate after implementing cognitive strategies): _____

Treatment progress (later evaluations only)

Obsessions and compulsions still engaged in: _____

Obsessions and compulsions no longer engaged in: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 8.5. Information for Patients about Obsessive–Compulsive Disorder

WHAT IS OBSESSIVE–COMPULSIVE DISORDER?

People with obsessive–compulsive disorder (OCD) have obsessions, compulsions, or both. “Obsessions” are thoughts, mental pictures, or impulses that are upsetting but that keep coming back. “Compulsions” are actions that people feel they have to perform to keep from feeling anxious or to prevent something bad from happening. Most people with OCD suffer from both obsessions and compulsions.

Common obsessions include:

- **Fears of getting a disease**, such as AIDS or cancer.
- **Fears of touching poisons**, such as chemicals.
- **Fears of hurting or killing someone**, often a loved one.
- **Fears of forgetting to do something**, such as turn off a stove or lock a door.
- **Fears of doing something embarrassing or immoral**, such as shouting obscenities.

Compulsions are also called “rituals.” Common compulsions include the following:

- **Excessive washing or cleaning**, such as washing one’s hands many times a day.
- **Checking**, such as looking at a stove repeatedly to make sure it is off.
- **Repeating actions**, such as always turning a light switch on and off 16 times.
- **Hoarding or saving things**, such as keeping old newspapers or scraps of paper.
- **Putting objects in a set pattern**, such as making sure everything in a room is symmetrical.

Most people with OCD know that their fears are not completely realistic at least some of the time. They also feel that their compulsions do not make sense. However, they find themselves unable to stop.

OCD is a common problem. During any 6-month period, over 4 million people in the United States suffer from OCD. One person in every 40 will have OCD at some point during his or her life.

OCD can cause serious problems. People with OCD often spend hours a day doing rituals. This makes it hard to work or take care of a family. Many people with OCD also avoid places or situations that make them anxious. Some become homebound. Often they have family members help them perform their rituals.

WHAT ARE THE CAUSES OF OBSESSIVE–COMPULSIVE DISORDER?

The exact causes of OCD are not known. Genes play a role. Family members of people with OCD often have OCD and other anxiety problems. However, genes alone do not explain OCD; learning and life stress also appear to contribute to the disorder.

HOW DOES OBSESSIVE–COMPULSIVE DISORDER DEVELOP?

Studies show that 90% of people have thoughts similar to those that trouble people with OCD. However, people with OCD appear to be more upset by these thoughts than other people are. Often the thoughts that worry people with OCD go against their beliefs and values—for example, a very religious man fears that he will commit blasphemy, or a loving mother fears harming her child.

(cont.)

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Because people who develop OCD are upset by these thoughts, they try to avoid them. Often they try to force themselves to stop thinking the thoughts. The problem is that the more you try not to think about something, the more you end up thinking about it. You can try this yourself: Try *not* thinking about a pink elephant for the next 60 seconds. The chances are good that the first thing that comes to your mind will be just what you are trying to avoid thinking about—a pink elephant.

When people find that they cannot avoid upsetting thoughts, they often turn to other ways to feel less anxious. They may begin to perform some action, such as washing a lot or saying a silent prayer. This usually relieves their anxiety. The problem is that the relief is only *temporary*. Soon they must perform the action more often in order to feel better. Before long, the action has become a compulsion.

HOW DOES COGNITIVE-BEHAVIORAL TREATMENT FOR OBSESSIVE–COMPULSIVE DISORDER WORK?

People with OCD are afraid that if they let themselves think their feared thoughts without doing any compulsions, they will get more and more anxious, and they won't be able to stand it. They often worry that they might go crazy.

Cognitive-behavioral treatment is aimed at helping you learn that you can control your anxiety without compulsions. You will learn coping strategies such as ways of thinking that can help you feel less anxious. You will also learn that if you face your fears rather than avoid them, they will go away. This may be hard to believe, but it's true. Your therapist will help you gradually face the things that you fear most, until you are confident that you can handle your fears without compulsions.

Cognitive-behavioral treatment for OCD usually takes about 20 sessions. Treatment may take longer for people with severe symptoms.

HOW EFFECTIVE IS COGNITIVE-BEHAVIORAL TREATMENT FOR OBSESSIVE–COMPULSIVE DISORDER?

Studies show that over 80% of people who complete cognitive-behavioral treatment for OCD are moderately to greatly improved. It is common to have occasional obsessions and urges to ritualize, even after treatment. However, patients usually feel much more in control and able to enjoy their lives. The studies also show that most people continue to feel better after therapy has stopped.

CAN MEDICATIONS HELP?

The medications that work best for OCD increase the level of the chemical serotonin in the brain. Your physician or a psychiatrist can suggest the medication that would be best for you. Studies show that 50–60% of patients improve with these medications. However, most patients find that their symptoms return if the medication is stopped. For this reason, cognitive-behavioral therapy should always be used in addition to medication. For some patients, the combination of medication and therapy will give the best results.

WHAT IS EXPECTED OF YOU AS A PATIENT?

It is common to feel anxious at the beginning of therapy and to have doubts about whether you can be helped. All that is required is that you be willing to give therapy a try. Your therapist will teach you new ways of dealing with your anxiety and will help you begin to face the things you fear. You will be asked to practice these new skills between sessions. If you work on the exercises your therapist gives you and complete the treatment, your chances for feeling better are excellent.

Behavioral Techniques

This chapter describes the behavioral interventions that are referred to throughout Chapters 2–8 of this book and in several tables and forms on the CD-ROM. It is not intended as a comprehensive review of behavior therapy. Rather, the goal is to provide instructions for the various behavioral techniques that are used to treat depression and anxiety disorders. Techniques are presented below in alphabetical order, and are summarized in this order in Appendix A of this book.

ASSERTIVENESS TRAINING

“Assertive behavior” is defined as behavior that seeks to protect one’s rights and to obtain those things to which one is entitled. Examples of assertive behavior include making one’s desires and wishes known, expressing feelings and opinions, refusing requests that one does not wish to comply with, making requests of others, and not allowing oneself to be taken advantage of (Spiegler & Guevremont, 2010). There are six steps to teaching assertion skills: (1) assessment, (2) teaching the concept, (3) listing problematic situations, (4) modeling, (5) role play, and (6) practice.

1. *Assessment.* Patients’ knowledge of assertive behaviors must be assessed, along with the situations in which they are and are not assertive. Often patients are assertive in some situations and not in others. This indicates that they know how to be assertive, but are blocked from using their skills in certain situations because of negative beliefs about the possible consequences. Other patients will need to be trained in specific skills. Typically there will be a mixture of skills deficits and inhibitory beliefs. Skills a patient lacks can be taught as outlined below. Inhibitory beliefs should be addressed via standard cognitive techniques (see Chapter 10).

2. *Teaching the concept.* Patients should be taught to differentiate among assertive behavior, aggressive behavior, and nonassertive behavior. “Assertive behavior” seeks to preserve one’s rights while respecting the rights of others. “Aggressive behavior” may seek to preserve one’s rights, but also violates the rights of others. “Nonassertive behavior” is behavior that does not seek to maintain one’s rights.

3. *Listing problematic situations.* A list should be made of the situations in which a patient has difficulty with assertion. The degree of anxiety associated with each situation should be

rated, and the situations should then be arranged in a hierarchy, from least to most anxiety-provoking.

4. *Modeling.* Taking the first situation on the hierarchy, the therapist models appropriate assertive behavior.

5. *Role play.* The patient next role-plays the behavior with the therapist. The therapist then provides feedback, and the process is repeated until the patient is able to role-play effective behavior.

6. *Practice.* Finally, the patient is assigned to practice the new behavior in real-life situations. Once the first situation is mastered, the patient moves up the hierarchy until the entire hierarchy is completed. It is important that therapists praise patients and that patients be taught to praise themselves for assertive behavior, regardless of the outcome. Assertion will not always get patients what they want, but the more often they are assertive, the more often they will have their needs and wishes met.

BEHAVIORAL ACTIVATION (REWARD PLANNING AND ACTIVITY SCHEDULING)

Behavioral activation is used primarily in the treatment of depression, although it may also be used for some anxiety disorders, such as generalized anxiety disorder (see Chapter 6) and post-traumatic stress disorder (see Chapter 7). The goal is to increase behaviors that are likely to result in a patient's being rewarded in some way. Rewards may be internal (such as pleasure or a sense of accomplishment) or external (such as social attention). Increasing rewards helps to lift patients' moods. A secondary goal is to decrease depressive rumination by having patients focus on other activities (Beck et al., 1979).

There are four steps to implementing behavioral activation: (1) monitoring current activities, (2) developing a list of rewarding activities, (3) planning activities, and (4) completing these activities. Patients who believe they are incapable of completing tasks or feel overwhelmed by them may be helped by graded task assignment (see below).

1. *Monitoring.* The patient is asked to list all activities he or she engages in during the day on an hour-by-hour basis. The Patient's Weekly Activity Schedule (Chapter 2, Form 2.8) can be used for this. The patient rates each hour's activity on two dimensions: pleasure and mastery. Each dimension is rated from 0 (no pleasure/mastery) to 10 (maximum pleasure/mastery). "Mastery" is defined as a feeling of effectiveness or accomplishment. This monitoring typically reveals that the patient is engaging in very few rewarding activities. Often the patient spends hours in activities with low reward, such as watching television or sitting and ruminating. Alternatively, the patient may be engaging in some activities that seem likely to bring pleasure or mastery, but do not because he or she is having negative thoughts that interfere with enjoyment. These negative thoughts can be elicited and challenged by means of cognitive techniques (see Chapter 10).

2. *Developing a list of rewarding activities.* The next step is to list activities the patient can engage in that are likely to be rewarding. Included on the list should be activities the patient

currently enjoys, activities the patient has enjoyed in the past when not depressed, and activities the patient has thought about trying but never has.

3. *Planning rewarding activities.* Next, the patient is assigned to schedule some activities from the activity list each day. The patient may be asked to predict in advance how much he or she will enjoy or experience mastery from the activity, again using a 0–10 scale. The Patient's Weekly Planning Schedule (Chapter 2, Form 2.9) can be used for this purpose.

4. *Completing planned activities.* Finally, the patient engages in the planned activities according to schedule, and records the actual ratings for mastery and pleasure. The Patient's Weekly Activity Schedule (Form 2.8) can again be used for this.

This assignment can lead to several cognitive tasks. First, the patient may be asked to note the difference in pleasure and mastery ratings between low-energy activities (such as watching TV, surfing the Internet, or ruminating) and more active pursuits. Typically patients will see that, contrary to their negative predictions, they actually get more satisfaction from being active.

Patients may have negative thoughts that keep them from enjoying the activities they have planned, such as "I'm not doing this right," or "I'm doing this by myself, so I must be a loser." Such thoughts should be challenged via standard cognitive techniques (see Chapter 10).

If a patient fails to engage in planned activities, the thoughts that led the patient to choose to avoid the activities can be elicited and challenged. Often patients assume that they should wait until they feel "motivated" before doing an activity. They should be told that this is a common mistake. In fact, they are more likely to feel "motivated" once they start doing an activity. Patients should be warned that when they first resume activities they have been avoiding, they may not enjoy them as much as they used to. Nonetheless, the activities are still more likely to give some degree of pleasure than doing nothing is. In addition, as patients continue to be active and their depression or anxiety lessens, they will again experience fuller enjoyment.

COMMUNICATION SKILLS TRAINING

When communication goes awry, there are two possible sources of the problem: the speaker and the listener. Communication skills training seeks to teach skills for both speaking and listening (Guerney, 1977).

Speaking Skills

When presenting their point of view, patients are taught to use "I" statements. These are sentences where "I" is the subject, as in "I think . . .," "I feel . . .," "I want . . .," and so on. The classic form of this is "I feel X when you do Y, because I think Z." Consider this example: "I feel angry when you don't wash the dishes, because I think you don't care about what's important to me."

The advantage of "I" statements is that they explicitly acknowledge that the speaker's point of view is subjective. They are contrasted with "you" statements, such as "You did . . .," "You didn't . . .," "You should . . .," "You are . . . [negative label]." Such statements are generally accusatory in tone and likely to encourage a defensive reaction from the person being spoken to.

Speakers can also enhance the likelihood that their message will be heard by expressing positives, even when they are offering a criticism—for example, “I realize you work hard all day and I really appreciate that, but it would really help me if you could wash the dishes.” In addition, requests for change should be specific and understandable, rather than global and vague—for example, “I’d like you to wash the dishes after dinner,” rather than “You should stop being so messy.”

Listening Skills

In addition to effective speaking, patients are taught active listening. Active listening implies more than hearing the other person. It requires interacting with him or her in such a way as to make sure that the listener truly understands the message and the speaker feels understood.

Skills of active listening include the following:

- *Attending*: Turning toward the speaker, making eye contact, and giving other nonverbal indicators of listening (such as nodding or saying “Uh-huh”).
- *Rephrasing*: Repeating back to the speaker what has been said and asking whether the listener has understood correctly.
- *Empathizing*: Reflecting the speaker’s emotion and expressing understanding of his or her feelings.
- *Validating*: Expressing agreement with the part of the speaker’s message that the listener does agree with; taking responsibility for part of the problem.
- *Inquiring*: Requesting further information and clarification of any part of the speaker’s message the listener does not understand.

The listener is discouraged from interrupting the speaker or judging the speaker’s message. When communication skills are taught in individual therapy (as opposed to couple therapy), the therapist first models effective skills and then has the patient practice them in role play, followed by feedback from the therapist. The patient is assigned to practice communication skills in specific situations as homework.

DISTRACTION

The purpose of distraction is temporarily to interrupt the flow of negative thoughts that leads to patients’ feelings of anxiety or depression. It can be used before patients have learned rational responding, when thoughts and emotions are so overwhelming that a patient is unable to cope by other means, or when a patient is flooded with intrusive memories or images (as in posttraumatic stress disorder) and is not in a situation where exposure is appropriate. We emphasize that distraction should be used only as a temporary solution. Eventually the negative thoughts or intrusive memories or images must be dealt with via other techniques.

Any activity that absorbs a patient’s attention can be useful for distraction. Patients should be encouraged to experiment and find what works for them. Doing crossword puzzles, reading a book, seeing a movie, talking to a friend, daydreaming about pleasurable times in the past, or

playing a sport all may be helpful. Activities that are routine and do not require mental concentration, such as doing household chores or watching television, may not be effective.

Distraction can be demonstrated in a session by first having a patient think about an upsetting thought or image until it begins to evoke emotion, and then asking him or her to engage in some mentally absorbing activity, such as counting backward by 3 from 1,000 out loud, or counting the number of objects of a certain color in the therapist's office. Patients are often surprised to find that their distress level decreases rapidly.

Patients should be told that when they first attempt distraction, they may find that the negative thoughts or emotions continue to intrude. However, if they persist in returning their attention to the distracting activity, they will eventually become absorbed in it. Like all skills, distraction takes practice, and the more often the patient uses it the better it will work.

One contraindication for distraction should be noted: It should not be used for the obsessive thoughts of patients with obsessive–compulsive disorder, as it could become another ritual.

EXPOSURE

Exposure is the most important behavioral technique for the treatment of anxiety disorders. It is based on the assumption that anxiety is maintained by avoidance of the thing feared. The essence of exposure is for patients to come deliberately into contact with the cues that evoke their anxiety, and to remain in contact with those cues until they begin to realize that the negative consequences they expect do not occur and their anxiety diminishes. The process of diminishing anxiety is referred to as “habituation.”

The types of cues that evoke anxiety vary from disorder to disorder. For specific phobia, the cue is the feared object. For social anxiety disorder, the cues are various social situations. For posttraumatic stress disorder, the cues are memories of the traumatic event and stimuli that remind the patient of the event. For panic disorder, the cues are bodily sensations that trigger panic attacks. For agoraphobia, the cues are situations that the patient avoids. For obsessive–compulsive disorder, the cues may be the patient's thoughts or mental images, and/or situations that trigger obsessive fears.

Types of Exposure

There are two main types of exposure: *in vivo* and imaginal. *In vivo* exposure consists of patients' coming into contact with cues in real-life situations. In imaginal exposure, patients come into contact with cues in their imagination.

In Vivo Exposure

Whenever possible, *in vivo* exposure should be used. Unless the cue is portable (e.g., a specific object, a bodily sensation), this means that exposure will generally have to take place outside the therapist's office. The therapist may accompany the patient during the exposure, or the patient may be assigned to do exposure on his or her own as homework. In practice, we find that most patients are able to do self-directed *in vivo* exposure outside sessions once they have had at least

one experience of habituation in a session with the therapist present. When patients are too anxious to do *in vivo* exposure away from the therapist's office, the therapist may need to accompany them. However, therapist involvement should be quickly faded out, and patients should be encouraged to repeat *in vivo* exposure on their own as homework.

With an extremely anxious patient, it may be helpful for the therapist to model exposure before asking the patient to do it. Thus the therapist will first contact the feared cue (e.g., getting on an elevator) while the patient watches. Then the patient is asked to do the same. Again, modeling should be quickly discontinued, with the patient then doing the exposure entirely on his or her own.

Imaginal Exposure

Sometimes *in vivo* exposure is not practical. This may be because the cues are internal (e.g., memories, thoughts), are not immediately available (e.g., public performance), or cannot practically be evoked (e.g., catastrophic fears such as the death of a family member). In addition, some patients may be too anxious to start with *in vivo* exposure. In such cases, imaginal exposure may be used. Imaginal exposure involves having patients imagine themselves coming in contact with external cues, or, in cases where the cues are memories or thoughts, having patients deliberately evoke internal cues. This is typically done with a patient sitting in a relaxed position with eyes closed, speaking into a voice recorder while attempting to visualize the cues.

When doing exposure to a memory, the patient is asked to narrate the sequence of events. In order to help the patient contact the relevant anxiety-provoking cues, the therapist may prompt the patient by asking about specific sensations and emotions experienced at the time. In the case of an imagined scenario (e.g., the house has burned down because the patient forget to check that the stove was off), the therapist narrates the scenario while periodically asking the patient what he or she would be thinking, feeling, sensing, or doing, as a way to help the patient visualize. Such a scenario should include all of the patient's catastrophic fears. Patients who fear specific thoughts may be asked to make a recording of themselves saying the thoughts out loud over and over for 30–60 seconds, and then to listen to the recording repeatedly.

Forms of imaginal exposure other than recorded scenarios include having the patient write about a feared cue or memory, or draw or paint something related to the cue. Another form of imaginal exposure, particularly useful for patients with social anxiety disorder, is role playing. The therapist and the patient can act out imaginary social interactions that are similar to the social situations that the patient fears.

Steps in Conducting Exposure

There are four steps in doing either imaginal or *in vivo* exposure with patients: (1) preparation, (2) creation of an exposure hierarchy, (3) initial exposure, and (4) repeated exposure.

1. *Preparation.* Exposure is a demanding treatment that requires patients to tolerate fairly high initial levels of anxiety. Patients need to be prepared before exposure is initiated. The rationale for exposure and its procedures should be clearly explained. Any concerns patients have should be discussed. Advantages and disadvantages of doing exposure may be reviewed. Finally,

a commitment to proceed with exposure should be obtained. For some patients, this process may be brief; for more fearful patients, it may extend over several sessions.

2. *Creation of an exposure hierarchy.* The patient is asked to describe all of the cues that evoke anxiety. The patient is then taught to rate his or her anxiety on a scale from 0 (no anxiety) to 10 (the most anxiety the patient has ever felt). These are called “subjective units of distress” or “SUDs” ratings. The patient assigns a SUDs rating to each cue based on the anxiety he or she feels when encountering the cue, or, if it is a cue that is always avoided, the anxiety the patient imagines he or she would feel upon coming in contact with it. The cues are then listed and ranked from least to most anxiety-provoking. Such a list is referred to as an “exposure hierarchy.” Several chapters of this book provide forms that enable patients with different anxiety disorders to develop exposure hierarchies.

The cues on an exposure hierarchy may be different but related to a central theme. For example, a man with social anxiety disorder may have diverse items on his hierarchy all related to his fears of being judged or rejected, such as calling a friend to make plans, attending a party with strangers, and asking someone for a date. Alternatively, a hierarchy may consist of progressively closer approaches to a single highly feared situation. For example, a woman with a specific phobia of elevators may have a hierarchy consisting of imagining being on an elevator, standing in front of an elevator, getting on an elevator with the doors open, riding the elevator one floor, and riding an elevator to the top of a tall building.

3. *Initial exposure.* If all of the items on a patient’s hierarchy evoke substantial fear, the least anxiety-provoking item is chosen for the initial exposure. If some items provoke only minimal fear (SUDs ratings of 3 or less), it is best to start with an item that evokes moderate anxiety (SUDs rating of 4 or greater).

The initial exposure should take place during a therapy session. Because patients can take an hour or more to habituate to a new cue, the first exposure session should be scheduled for at least 90 minutes. If patients habituate more quickly, as they often do once they are used to the procedure, subsequent exposure sessions may be shortened to 45 minutes.

During the initial exposure, a patient is introduced to an anxiety-provoking cue and asked to remain in contact with it. If the cue is an object, the patient stays in contact with the object until he or she habituates. If the cue is a situation, memory, or scenario that lasts a discrete period of time, the cue is repeated until the patient habituates. For memories or imagined scenarios, it is often useful to focus on a “hot spot” in the story (i.e., a segment of a few minutes that evokes particularly strong emotion) and repeat just that segment.

The patient is asked for SUDs ratings periodically during the exposure. Typically, patients’ SUDs ratings will rise initially, plateau, and then begin to decline. Exposure should continue until the SUDs rating has dropped by at least half. It is important that exposure not be terminated before a patient’s anxiety has dropped; otherwise, the connection between the cue and the anxiety response will be strengthened rather than weakened.

4. *Repeated exposure.* After the initial exposure, the patient is assigned to repeat the exposure on his or her own as homework, usually daily. The patient tracks his or her own SUDs ratings and continues each exposure session until the SUDs rating decreases by half. The Patient’s Imaginal Exposure Practice Record (Form 9.1) and the Patient’s *In Vivo* Exposure Practice Record (Form 9.2) can be given to patients for tracking exposure practice, both in sessions and as homework. With repetition, the peak SUDs rating obtained during each exposure exercise will decline.

Exposure should be repeated until the cue evokes minimal anxiety. An exposure that the patient has been practicing at home may be repeated in the next therapy session to assess the degree to which the patient has habituated. Once the cue no longer evokes significant anxiety, the patient moves up to the next item on the exposure hierarchy.

Problems with Exposure

Exposure is most effective when it consists of clearly specified tasks that (1) evoke anxiety, (2) are prolonged until habituation takes place, and (3) are repeated until the fear response decreases across repetitions (Foa & Kozak, 1986). When exposure is not effective, it is usually because one or more of these criteria have not been met.

An initial exposure may fail to evoke anxiety for one of two reasons: (1) The exposure task does not include the relevant anxiety-provoking cues; or (2) the patient is engaging in some subtle form of avoidance, such as attempts at distraction (e.g., daydreaming), not fully engaging with the cues (e.g., attending a party but avoiding talking to anyone), or employing safety behaviors (e.g., drinking before a party to reduce anxiety). Patients should be encouraged to focus fully on the exposure task and to forgo any safety behaviors. If the exposure still fails to evoke anxiety, other cues should be tried.

If patients' SUDs rating do not drop during exposure, it is generally because exposure has not continued long enough. Even when the therapist extends exposure sessions to allow time for habituation, patients will often fail to allow enough time during exposure homework. Patients should be told to continue exposures until their SUDs ratings decline by half, regardless of the time taken.

Finally, when patients fail to show a reduction of anxiety in response to a cue over time, it is likely that exposure has not been repeated sufficiently. Exposure should continue until the peak anxiety evoked by the cue on any given day is minimal. (See Chapters 3, 5, 6, 7, and 8 for case examples using exposure.)

GRADED TASK ASSIGNMENT

Graded task assignment may be used when a patient feels too depressed and hopeless or too anxious to begin a complex or demanding task (Beck et al., 1979). The therapist helps the patient break the task into smaller components. The patient is then asked to attempt only one small step at a time. For example, a patient who feels paralyzed at the thought of writing a résumé can be asked to write down the name of one company he or she used to work for. When that is done, the patient can be asked next to write down as many others as he or she can remember. Then he or she can write down approximate dates of employment. After succeeding at these very simple tasks, the patient can be given greater challenges, such as writing a rough draft of the résumé. These activities start in a session (especially for very depressed patients), but are then extended as homework. Typically patients feel less hopeless/overwhelmed and more motivated as they discover they can succeed with small steps. Often they will proceed to complete the task on their own.

MINDFULNESS

“Mindfulness” is defined as the process of focusing attention on immediate experience without attempting to avoid, prolong, or change whatever is being experienced. Mindfulness is typically practiced first in meditation exercises. It can then be applied to activities and experiences in daily life.

Mindfulness exercises can serve several purposes. They can help to break patterns of worry and rumination by teaching patients to focus their attention on other aspects of experience, or to regard their thoughts as passing phenomena rather than as things they need to engage actively with. They can also increase tolerance for normally avoided experiences (e.g., negative emotions or physical pain) by allowing patients to focus on such experiences without trying to alter or avoid them. Finally, they can promote relaxation through the practice of stillness while observing.

There are three steps to teaching patients mindfulness: (1) educating patients about the concept, (2) teaching breathing meditation, and (3) teaching variations of mindfulness.

1. *Educating patients about mindfulness.* Patients should be given basic information about the concept of mindfulness and how it may be useful for them. This explanation should be tied to their specific problems.

2. *Teaching breathing meditation.* This is the most basic mindfulness exercise and the one that is typically used first with patients. The patients are instructed to focus their attention on their breathing. They are told simply to observe the sensations associated with each breath they take. They do not attempt to control their breathing; rather, they should breathe normally (i.e., “Let the long breaths be long and the short breaths be short”). It is best to do the exercise in a position where the back can be kept straight (e.g., sitting in a straight-backed chair or on a cushion on the floor). Typically patients are instructed to do the exercise with their eyes open, gazing at the floor. However, the meditation may also be done with eyes closed. In order to help maintain their focus on breathing, patients are instructed to count each exhalation silently. When they reach 10, they should start over again at 1. If they lose track of the count, this is an indication that their minds have wandered, and they should start the count over again at 1.

Patients should be told to expect that thoughts will come into their minds during the meditation exercise and that they will get distracted from their breathing. It is important to predict this, because otherwise patients may have the expectation that they should be able to sit down, focus on their breathing, and have their minds become “blank.” When this doesn’t happen, they may become discouraged. Instead, patients should be told that the goal of the meditation is simply to notice when their minds do wander and to bring their attention gently back to their breathing. The metaphor of weight lifting can be used to explain this: Each time they get distracted and return to focused attention is like a “rep” that strengthens their ability to focus.

Breathing meditation should first be demonstrated in session, with the therapist also doing the exercise. Patients should then be instructed to practice meditation daily, starting with brief meditations of 5 minutes, and gradually expanding to longer periods of time. Patients should be told that there is a direct linear relationship between the amount of time they practice and the benefit they will receive: Practicing 5 minutes a day is better than nothing, practicing 15 minutes

is better than 5, practicing 30 minutes is better than 15, and so on. Most important is regular practice.

3. *Teaching variations of mindfulness.* Once patients have some experience with breathing meditation, they can begin using other sensations as the central focus. Common variants are as follows:

- a. *Bodily sensations.* Patients are instructed to focus attention on any sensations they feel in their bodies, whether pleasant or unpleasant. The goal is not to change the sensations, but rather just to observe them, including noticing whether the sensations change on their own. Patients may be instructed to systematically scan different parts of their bodies to observe sensations, or may focus on their whole bodies and simply notice any sensations that come to attention. When their minds wander to thoughts or other distractions, they simply return to observing their bodies.
- b. *Emotions.* Patients are instructed to focus their attention on any emotions they may feel, including any physical sensations that accompany the emotions. Again, the idea is to observe whatever they feel without trying to change it. When their minds wander to thoughts, they should return to focusing on their emotions and accompanying physical sensations. This exercise can be particularly helpful for patients who have difficulty tolerating negative feelings.
- c. *Thoughts.* Patients are instructed to observe any thoughts that come into their minds. As with other mindfulness meditations, the goal is not to change the thoughts, but rather simply to observe them as passing phenomena, like clouds drifting by or leaves floating down a stream.
- d. *Activities.* Patients are instructed to focus their attention on the physical sensations (including sights, sounds, and smells) associated with common activities, such as walking or washing dishes. When their minds wander, they return their attention to the activities.
- e. *Daily life.* Finally, patients can be encouraged to apply mindfulness to experiences that spontaneously occur in daily life. In other words, patients are instructed to practice noticing immediate sensations and emotions as they occur, without trying to avoid or change them. This can be particularly helpful in dealing with recurring experiences that they find unpleasant but have no way to change, such as intrusive thoughts, uncomfortable emotions, or pain.

MODELING

Modeling is a technique of teaching by example. It relies on the principles of observational learning (Bandura, 1977). In the treatments described in Chapters 2–8, the therapist most often serves as the model. However, other members of a treatment group, characters in movies, and other people encountered in everyday life may also be used as models.

Two common uses of modeling are seen in skills training and exposure. In skills training, a therapist first demonstrates effective behavior and then asks a patient to imitate the behavior. In exposure, the therapist first puts him- or herself in contact with a feared situation (e.g., riding an elevator) while the patient watches. The patient is then encouraged to perform the same behav-

ior. Modeling should be used only in the early phases of exposure with patients who are initially too afraid to do an exposure task by themselves. It should be rapidly faded out, so that patients gain a sense of self-efficacy in conducting their own exposures.

PROBLEM SOLVING

Problem-solving techniques are useful for helping patients get “unstuck” when they face tasks or problems that appear to overwhelm them. The steps involved in problem solving are (1) defining the problem, (2) setting goals, (3) brainstorming, (4) evaluating possible solutions, (5) selecting a solution, (6) working out the steps to attempt the solution, (7) cognitive rehearsal, (8) implementing the solution, and (9) evaluating the outcome.

1. *Defining the problem.* Problems should be defined in concrete terms. For example, rather than “I’m unhappy and lonely,” a patient’s problem might be defined as “I have no one I can call to make plans with.”

2. *Setting goals.* Goals should be concrete—for example, “Make two new friends I can do things with.”

3. *Brainstorming.* Patients often limit themselves by failing to consider a range of possible solutions, or by immediately discarding alternatives as soon as they think of any potential problems. To help overcome this tendency, patients are asked to write as many possible solutions as they can think of, without prejudging them. They should be encouraged to include extreme and outlandish solutions, as this will free them to think of more options.

4. *Evaluating possible solutions.* Each possible solution should be considered. Lists of pros and cons can be made for each option. Cognitive distortions on these lists should be challenged via standard cognitive techniques (see Chapter 10).

5. *Selecting a solution.* A patient is next asked to select the solution that appears to have the most advantages relative to disadvantages.

6. *Working out steps needed to attempt the solution.* If the proposed solution requires multiple steps, these should be specified. Patients should be encouraged to attempt one step at a time, in order not to feel overwhelmed (see “Graded Task Assignment,” above).

7. *Cognitive rehearsal.* Patients may be asked to rehearse in imagery the steps involved in completing the task. Any possible problems that could be encountered should be discussed. Cognitive distortions that might interfere can be challenged. If the proposed solution involves interaction with other people, role playing with the therapist may be useful.

8. *Implementing the solution.* The patient is assigned to complete the specified task(s) as homework.

9. *Evaluating the outcome.* Was the goal achieved? If not, why not? If the patient failed to perform the task as specified, reasons for this should be explored. Possible solutions for any roadblocks encountered should be discussed. Any cognitive distortions that arose should be challenged. If the patient completed the task, but it failed to produce the desired outcome, the patient should return to step 5 and select another alternative solution. This cycle should continue until the problem is solved. In some cases, no solution may work; in these cases, alternative goals may need to be considered.

REBREATHING

Rebreathing is used for patients with panic disorder who hyperventilate when they are anxious. Since many of their symptoms are the result of increased oxygen intake, the purpose of rebreathing is to decrease oxygen and increase CO₂. Patients are taught to “rebreathe” air they have already exhaled. This is accomplished by having the patients cup their hands over their mouths and breathe into their hands. Alternatively, patients may be asked to breathe into a paper lunch bag. Rebreathing is continued until the symptoms of hyperventilation, such as light-headedness, decrease. The technique should be practiced first in a session, by having a patient deliberately hyperventilate and then use rebreathing. The technique is then practiced as homework.

Rhythmic breathing, described below under “Breathing Relaxation,” may also be used to restore oxygen balance. When used for this purpose, the exhalation should be made slightly longer than the inhalation (e.g., a patient may inhale to a count of 4 and exhale to a count of 5 or 6).

RELAXATION

Almost any form of relaxation can benefit patients—from commercially prepared relaxation programs, to mindfulness meditation (see above) and visualization (see below). Most research-based relaxation treatments have been based on variations of progressive muscle relaxation, which was first developed by Jacobson (1938). Typically patients are taught a series of progressively shorter exercises designed to condition a relaxation response that can ultimately be evoked in a matter of seconds. The full sequence of progressive muscle relaxation exercises is described below, followed by a description of breathing relaxation exercises, which can be taught in less time and may be used when teaching the entire progressive muscle sequence does not appear necessary or practical.

It should be noted that while relaxation training has been shown to reduce symptoms of anxiety, it is not as effective as treatments that include exposure and cognitive restructuring. In addition, use of relaxation during exposure exercises can actually decrease the effectiveness of exposure. When patients control their anxiety through the use of relaxation they do not have the opportunity to fully experience their anxiety and, therefore, do not learn from experience that their anxiety is tolerable and not dangerous. For these reasons, relaxation training is not as central to standard cognitive behavioral treatments as it once was. Nonetheless, it may be helpful for some patients who lack coping skills. For that reason, we provide detailed descriptions of the procedures here.

Progressive Muscle Relaxation

Relaxation training should start with providing the patient with a rationale for the treatment. Relaxation is presented as a method for counteracting the patient’s physiological responses to anxiety. This should be tied to the symptoms that most concern the patient (e.g., palpitations, sweating, insomnia, etc.). Relaxation should be described as a skill that the patient can learn to gain greater control of his or her own bodily responses. Like all skills, relaxation requires practice

to master. The patient should be told that the goal is to provide him or her with a rapid, reliable, and portable means for coping with anxiety. The sequence of exercises described below is based on that of Öst (1987), Barlow and Cerny (1988), and Clark (1989).

Twelve-Muscle-Group Relaxation

Before starting the exercise, you, the therapist, should explain to the patient that you will be asking him or her first to tense and then to relax different groups of muscles. The purpose is to help the patient notice the difference between tension and relaxation. Describe the full exercise, and demonstrate the 12 muscle groups as follows:

1. Lower arms: Tightening the fists and pulling them up.
2. Upper arms: Tensing the arms by the side of the body.
3. Lower legs: Extending the legs and pointing the feet up.
4. Thighs: Pushing the legs together.
5. Stomach: Pushing it back toward the spine.
6. Upper chest and back: Inhaling into the upper lungs and holding for a count of 10.
7. Shoulders: Picking them up toward the ears.
8. Back of the neck: Pushing the head back.
9. Lips: Pursing the lips without clenching the teeth.
10. Eyes: Squinting with eyes closed.
11. Eyebrows: Pushing them together.
12. Upper forehead and scalp: Raising the eyebrows.

Next have the patient assume a comfortable seated position, with both legs on the floor, while you narrate the relaxation exercise. This should be recorded so that the patient can practice the exercise at home. The patient may keep his or her eyes open during the training in order to follow you, but should close the eyes when practicing.

Tell the patient to focus on his or her breathing. After two or three breaths, begin the instructions for tensing each muscle group. Name the muscle group, instruct the patient to tense it while you count to 5, and then say, "Release." You can demonstrate by doing the exercise along with the patient. There should be a pause of 15–20 seconds between each muscle group, during which time you should give suggestions for relaxation, such as the following:

- "Notice the difference between the tension and the relaxation."
- "Feel the muscles grow more relaxed."
- "Let the muscles grow soft and warm."
- "Continue breathing easily."

After completing all 12 muscle groups, instruct the patient to focus again on his or her breathing. Then say, "I am now going to count you down from 5 to 1. With each count, you will grow more relaxed." Begin counting, timing each count with an exhalation if possible, and allowing one or two breaths between each count. Between each count, give further suggestions for relaxation, such as these:

“Feel the relaxation spreading down from the top of your head, through your face and neck.”

“Feel it spreading down through your shoulders and your arms, down through your torso.”

“Feel it going down through your legs and feet.”

“Feel the relaxation spreading through your whole body. You are growing more and more deeply relaxed.”

After reaching the count of 1, instruct the patient to focus again on breathing and to say “Relax” to him- or herself with each exhalation. After a minute or two, tell the patient, “I am now going to count you up from 1 to 5. With each count you will become a little more alert, while staying very relaxed, until on 5 you open your eyes.” Then count the patient up from 1 to 5, again timing the count with the patient’s breathing. On 5, instruct the patient to open his or her eyes.

The patient should be assigned to practice relaxation twice a day. Practice at first should *not* take place during stressful situations. Emphasize that relaxation is a skill, and that as with any skill, it takes time to get good at it. The patient may not feel much relaxation at first, but will find that over time he or she is able to become deeply relaxed.

Some patients have difficulty with this exercise, because they become so focused on trying to relax that they make themselves more tense. These patients should be told that their goal is not to relax; rather, it is simply to follow the instructions on the recording. Other patients report muscle soreness after trying the exercise. They are usually applying too much tension. They should be instructed to use only three-quarters tension when tightening their muscles. Patients with abuse histories sometimes have difficulty letting go of enough control to relax. They can be assigned to practice a few muscle groups for a week in order to get used to the exercise, and then to build up to all 12 muscle groups.

After practicing for a week with the recording, a patient should be instructed to begin doing the exercise without the recording, and to practice it in various positions and at various times of day (e.g., sitting with feet up, lying in bed, sitting in an office chair).

Eight-Muscle-Group Relaxation

Once a patient has mastered the full-length muscle relaxation procedure described above (generally 1–3 weeks), eight-muscle-group relaxation can be taught. The patient is told that the goal is to help him or her achieve the same level of relaxation in a briefer time. The instructions are the same as for 12-muscle-group relaxation, except that only the groups listed below are used.

1. Whole arms: Slightly extended, elbows bent, fists tightened and pulled back.
2. Whole legs: Extended, toes pointed up.
3. Stomach: Pushing it back toward the spine.
4. Upper chest and back: Inhaling into the upper lungs and holding for a count of 10.
5. Shoulders: Picking them up toward the ears.
6. Back of the neck: Pushing the head back.
7. Face: Squinting eyes, scrunching features toward tip of the nose.
8. Forehead and scalp: Raising eyebrows.

The time between tensing each muscle group should be lengthened to a minimum of 30 seconds. The rest of the exercise (i.e., counting down, breathing while saying “Relax,” counting up) remains the same. This exercise may be recorded, but patients should be encouraged to practice without listening to the instructions as soon as they have learned the sequence.

Four-Muscle-Group Relaxation

Relaxation with just four muscle groups further shortens the time needed to relax. Proceed as with the eight-muscle-group relaxation, but use only the following muscle groups:

1. Whole arms: Slightly extended, elbows bent, fists tightened and pulled back.
2. Upper chest and back: Inhaling into the upper lungs and holding for a count of 10.
3. Shoulders and neck: Slightly hunching the shoulders and pushing the head back.
4. Face: Squinting eyes, scrunching features toward tip of the nose.

For homework, have the patient practice this exercise in a variety of positions and settings (e.g., waiting for a bus, walking, sitting at a desk).

Release-Only Relaxation

The purpose of the release-only exercise is to have patients begin to relax without first using tension. The same four muscle groups are used as in the prior exercise. The patient is asked to focus on the first muscle group, noticing any tension that is present. He or she is then asked to recall the sensation of relaxation and to relax the muscles. Allow 30–45 seconds and give relaxation suggestions, as before. Then ask the patient to signal if the muscles are not fully relaxed by raising one finger. If they are fully relaxed, proceed to the next muscle group. If not, repeat the instructions. If a muscle group is still not fully relaxed, have the patient tense and then release that muscle group. After all four muscle groups are relaxed, follow the usual procedure for counting down, repeating “Relax,” and counting up.

If the patient is able to relax all four muscle groups without first tensing, have him or her practice this exercise during the next week. If not, have the patient continue to practice the four-muscle-group relaxation, occasionally trying release-only relaxation until he or she is able to master it.

Cue-Controlled Relaxation

Cue-controlled relaxation is the final exercise in progressive muscle relaxation. To teach it, have the patient do release-only relaxation and signal when he or she is fully relaxed. Then instruct the patient to take one to three deep breaths and think “Relax” with each exhalation, while scanning the body for any tension and releasing it. “Relax” becomes the cue to signal the patient’s body to relax. Once the patient has learned this exercise, it should be repeated in session without being preceded by the release-only procedure. Patients are then instructed to practice cue-controlled relaxation 10–15 times each day, in a variety of settings. Certain cues may be established as reminders to relax (e.g., looking at a watch, stopping at a red light, hearing the

phone ring, etc.). Patients may also stick small colored dots in various places (on a mirror, on a desk, on the phone, etc.) as prompts for relaxation.

Application Practice

At each stage of training, patients are instructed to practice relaxation in non-anxiety-provoking situations. Once they are able to achieve some degree of relaxation, the techniques may be applied when they are anxious. However, relaxation should not be used during planned exposure exercises, as this will interfere with the process of the patients' learning that they can tolerate their own anxiety.

Breathing Relaxation

Breathing relaxation exercises are brief and may be used when the more extensive muscle relaxation training described above is not practical. These exercises may also be particularly helpful for patients whose anxiety manifests itself as difficulty breathing. For some patients, a combination of progressive muscle relaxation (with 12 or 8 muscle groups) plus one or two breathing relaxation exercises can be very effective.

Before patients are taught any of the breathing exercises, they should be taught diaphragmatic breathing. Often patients are used to breathing only into their upper chests, sucking their abdomens in as they breathe. This can lead to hyperventilation and other breathing difficulties. In diaphragmatic breathing, the diaphragm at the base of the lungs is distended, which pushes the abdomen out and draws air into the lower lungs. You should first model diaphragmatic breathing for a patient by placing your hand on your own abdomen, and then pushing it in as you exhale and out as you inhale. The patient is then asked to do the same, continuing breathing in and out for approximately 2 minutes. Patients should be instructed to take normal-size breaths while doing this, rather than unusually large breaths, in order to avoid hyperventilation. Some patients will need to practice diaphragmatic breathing for a week before they can be taught the relaxation exercises. Once taught, the exercises should be practiced several times a day.

Holding the Breath

Instruct a patient to inhale through the nose for a count of 3, drawing air into the lower lungs. Have the patient hold the breath for a count of 3. Then tell the patient to release the breath through pursed lips, while saying "Relax" to him- or herself.

Rhythmic Breathing

Have the patient inhale through the nose for a count of between 3 and 6, depending on what feels comfortable to him or her. Instruct the patient to exhale through the nose for the same count, without holding the breath in between. Encourage the patient to continue breathing in this rhythm for up to several minutes.

SELF-REWARD

Many depressed or anxious patients fail to reward themselves for positive behaviors, with predictable consequences: low motivation and depressed or anxious mood. They often believe that they should punish themselves (e.g., with self-critical thoughts) for failures, rather than rewarding themselves for successes. Providing them with information about basic principles of reinforcement can be helpful. In addition, patients should be told that it is important to administer rewards to themselves as soon after positive behaviors as possible. The steps in teaching self-reward are (1) listing possible rewards, (2) setting criteria for rewards, and (3) administering rewards.

1. *Listing rewards.* Patients are asked to make a list of possible rewards. One of the most effective rewards, of course, is self-praise. Tangible rewards may also be used, such as having a pleasurable snack, watching a favorite TV program, time on the computer, or talking on the phone to a friend. Larger rewards for greater accomplishments may also be used, such as getting a massage or going out to a fancy dinner. (If a patient is also engaging in behavioral activation, the list of rewarding activities developed for that purpose can be used, and other rewards that are not activities per se can be added to it. See “Behavioral Activation,” above.)

2. *Setting criteria for rewards.* Next, patients should list positive behaviors with specific, identifiable criteria to be met in order to earn a reward. Patients should be encouraged to reward themselves for steps toward larger goals, rather than waiting until an entire task is complete. Thus a patient might decide to reward him- or herself with a 10-minute break for every hour worked on a paper, and then with seeing a movie once the paper is done.

3. *Administering rewards.* Finally, patients are asked to write down the rewards they give themselves. Patients should also be encouraged to reward themselves, especially with self-praise, for unplanned tasks or accomplishments.

Although self-reward is most often used with depressed patients, anxious patients can use self-reward to provide motivation for accomplishing treatment goals, such as facing a particularly difficult exposure task or going for a week without ritualizing.

SOCIAL SKILLS TRAINING

Although assertion and communication may be thought of as social skills, “social skills training” here refers specifically to those skills involved in meeting other people, carrying on conversations, acting appropriately in social situations such as parties or interviews, and initiating relationships. The steps in social skills training are (1) assessment, (2) modeling, (3) role play, and (4) practice.

1. *Assessment.* The first step in social skills training is to assess a patient’s deficits. Many patients know appropriate social skills, but are inhibited by anxiety from using them. Role-playing imaginary social situations with the patient is a good way to assess the patient’s skill level. Some patients will require training in basic skills. These are usually taught in a sequence, starting with

making eye contact and progressing through saying hello, making a passing comment, complimenting the other person, making a request for information, and initiating a conversation. Once these basic skills are mastered, work can begin on more complex skills, such as how to behave in an interview, how to ask someone out on a date, and how to initiate a friendship.

2. *Modeling.* Social skills are first taught by the therapist's performing the skill with the patient in role play.

3. *Role play.* For each skill taught, the patient is next asked to role-play the skill with the therapist. The therapist provides feedback, and the role play is repeated until the patient masters the skill.

4. *Practice.* The final, crucial step is to have the patient practice the skill in real-life situations. Basic skills should be practiced and mastered before more complex skills are taught.

VISUALIZATION

Visualization combines elements of relaxation and distraction. During visualization, patients imagine themselves in a place or situation they find pleasant and relaxing. It may be a place they have really been (such as a favorite vacation spot or a place they loved in childhood), or it may be an imaginary scene. The steps in teaching visualization are (1) description of the technique, (2) demonstration, and (3) practice.

1. *Description of the technique.* The therapist first explains the procedure. The patient is then asked to choose a place or image to use.

2. *Demonstration.* The therapist next has the patient engage in either progressive muscle relaxation or breathing relaxation. Relaxation is deepened by counting the patient down from 5 to 1 while the patient focuses on his or her breathing. During this count, suggestions may be given for relaxation, or the patient may be asked to imagine him- or herself descending a flight of stairs. When 1 is reached, the patient is asked to imagine that he or she is in the scene. The therapist may give prompts to aid visualization, such as "Imagine what you smell, what feelings you have on your skin, what you see," and so on. After several minutes, the therapist counts the patient up from 1 to 5 and has the patient open his or her eyes. This procedure may be recorded for use by the patient in practice.

3. *Practice.* Patients are assigned to practice visualization as homework. At first, they may listen to the recording made by the therapist. Eventually they should practice the technique without the recording, doing relaxation and counting themselves down before entering the image. They may then continue the image as long as they like.

FORM 9.1. Patient's Imaginal Exposure Practice Record

Patient's name: _____ Week: _____

Each day that you do exposure, please note the imagined situation practiced. Then note the highest level of distress you feel for each trial (repetition) of the exposure. Repeat the exposure until the highest distress on the last trial is less than half the highest distress on the first trial for that day.

Date: _____ Exposure: _____		Date: _____ Exposure: _____		Date: _____ Exposure: _____	
<u>Trial</u>	<u>Maximum distress (0-10)</u>	<u>Trial</u>	<u>Maximum distress (0-10)</u>	<u>Trial</u>	<u>Maximum distress (0-10)</u>
1		1		1	
2		2		2	
3		3		3	
4		4		4	
5		5		5	
6		6		6	
7		7		7	
8		8		8	
9		9		9	
10		10		10	
Date: _____ Exposure: _____		Date: _____ Exposure: _____		Date: _____ Exposure: _____	
<u>Trial</u>	<u>Maximum distress (0-10)</u>	<u>Trial</u>	<u>Maximum distress (0-10)</u>	<u>Trial</u>	<u>Maximum distress (0-10)</u>
1		1		1	
2		2		2	
3		3		3	
4		4		4	
5		5		5	
6		6		6	
7		7		7	
8		8		8	
9		9		9	
10		10		10	

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FORM 9.2. Patient's *In Vivo* Exposure Practice Record

Patient's name: _____ Week: _____

Each day that you practice exposure, please note the trigger or situation you are working on. Then note the level of distress when you feel when you first begin the exposure and every 5 minutes after that. Continue the exposure until the distress level has dropped by at least half.

Date: _____ Exposure: _____		Date: _____ Exposure: _____		Date: _____ Exposure: _____	
<u>Trial</u>	<u>Distress (0–10)</u>	<u>Trial</u>	<u>Distress (0–10)</u>	<u>Trial</u>	<u>Distress (0–10)</u>
Initial		Initial		Initial	
:05		:05		:05	
:10		:10		:10	
:15		:15		:15	
:20		:20		:20	
:25		:25		:25	
:30		:30		:30	
:35		:35		:35	
:40		:40		:40	
:45		:45		:45	
:50		:50		:50	
:55		:55		:55	
:60		:60		:60	
Date: _____ Exposure: _____		Date: _____ Exposure: _____		Date: _____ Exposure: _____	
<u>Trial</u>	<u>Distress (0–10)</u>	<u>Trial</u>	<u>Distress (0–10)</u>	<u>Trial</u>	<u>Distress (0–10)</u>
Initial		Initial		Initial	
:05		:05		:05	
:10		:10		:10	
:15		:15		:15	
:20		:20		:20	
:25		:25		:25	
:30		:30		:30	
:35		:35		:35	
:40		:40		:40	
:45		:45		:45	
:50		:50		:50	
:55		:55		:55	
:60		:60		:60	

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Cognitive Concepts and Techniques

INTRODUCTION TO COGNITIVE AND COGNITIVE-BEHAVIORAL THERAPY

Readers familiar with the work of Aaron T. Beck, Albert Ellis, Donald Meichenbaum, Lynn P. Rehm, Michael Mahoney, Vittorio Guidano, and Giovanni Liotti will recognize that there are numerous cognitive-behavioral models for a variety of disorders. In the separate chapters of the book on depression and anxiety disorders (Chapters 2–8), we review the more common cognitive-behavioral models, indicating how specific models are adapted to each disorder. For example, Beck’s use of cognitive therapy for depression differs from his use of cognitive therapy for panic disorder. Moreover, we utilize more than one cognitive-behavioral model for each disorder, in order to provide the clinician with a range of tools and conceptualizations and with the opportunity to provide integrative therapy. We draw on earlier cognitive models (such as Beck’s) and expansions and elaborations of cognitive models (such as those of David M. Clark, David A. Clark, Paul Salkovskis, and others). In addition, we indicate how the metacognitive model advanced by Adrian Wells and his colleagues can be helpful for understanding and treating a variety of disorders.

In this chapter, however, we describe some of the fundamental concepts and techniques of the major cognitive therapies. The basic premise of cognitive approaches to therapy is that dysfunctional or distorted ways of thinking can cause or exacerbate dysfunctional emotions and behaviors. Cognitive interventions identify and target specific distorted automatic thoughts, maladaptive assumptions, and negative or otherwise dysfunctional schemas. The cognitive-behavioral therapist also utilizes behavioral interventions (e.g., behavioral activation and exposure) to assist the patient in testing and challenging cognitive distortions. An information hand-out for patients about cognitive-behavioral therapy is provided in Form 10.1.

THE THREE LEVELS OF COGNITIVE DISTORTIONS

Beck identifies cognitive distortions at three levels of thinking: “automatic thoughts,” “assumptions,” and “schemas.” Automatic thoughts are thoughts that come spontaneously and seem plausible to a person, but they may become distorted in depressed or anxious patients. Distorted

automatic thoughts can be associated with negative affect or dysfunctional behavior. They can be arranged into specific categories (see Form 10.2, which is also a handout for patients).

Assumptions are at a deeper cognitive level than automatic thoughts; they are more abstract and generalized. In depressed or anxious patients, assumptions can become maladaptive: They take the form of a set of rules, “shoulds,” imperatives, or “if–then” statements that can have disabling effects. Examples of some maladaptive assumptions are provided in Form 10.3 (another patient handout).

Schemas exist at a still more fundamental level than assumptions; they reflect deep-seated models of the self and others. Depressed or anxious patients may have a selective focus on certain schemas that mark their vulnerability. Beck et al. (1990, 2004) have identified a variety of negative or otherwise dysfunctional schemas that characterize the various personality disorders (see Table 10.1), as well as various types of attempts to avoid or compensate for these schemas. For example, patients with obsessive–compulsive personality disorder (which, incidentally, is *not* the same thing as the anxiety disorder called obsessive–compulsive disorder) attempt to compensate for their problems by trying to achieve perfection; or, in some cases, they may avoid any tasks in which mistakes appear probable. These compensatory and avoidant strategies are also targets for cognitive therapy.

These three levels of cognitive distortions are related in a hierarchical fashion, such that distorted automatic thoughts are the most directly and easily accessible, followed by maladaptive assumptions and then dysfunctional schemas. For example, consider a female patient who goes to a party and thinks of approaching a man. Her automatic thought might be “He’ll reject me.” The underlying assumption could be “I need to be approved of by men in order to like myself.” The patient’s schema about herself might be “I’m unlovable,” and her schema about men might be “Men are rejecting.” These different levels are depicted in Table 10.2.

In therapy with a depressed or anxious patient, the therapist may elicit cognitive distortions at any level and intervene at any level. For example, the therapist may challenge automatic thoughts or focus on underlying assumptions or schemas. Or, if the therapist takes a more behavioral approach, he or she may wish to help the patient modify the environment so as to avoid specific “activating events.”

IDENTIFYING AND CHALLENGING COGNITIVE DISTORTIONS

As just indicated, the essence of cognitive therapy is intervening with a patient’s cognitive distortions at any level required. The therapist takes an active role in inquiring about and challenging the patient’s thinking. The usual procedure in practice is to begin by working with the patient’s distorted automatic thoughts, and then to do the same with maladaptive assumptions and dysfunctional schemas as needed.

Once the therapist has educated the patient about the nature of automatic thoughts and the various categories into which distorted thoughts can be classified (Form 10.2 is helpful in this regard), the patient is told that moods (such as sadness or anxiety) are related to the thoughts he or she is having at the time. The patient is therefore asked to keep regular records of events in his or her life and the moods and thoughts related to them, as well as to rate the intensity of these moods. The Patient’s Event–Mood–Thought Record (Form 10.4) can be used for this purpose.

TABLE 10.1. Dysfunctional Schemas in Personality Disorders

Personality disorder	View of self	View of others	Main beliefs	Main compensatory/avoidant strategies
Avoidant	Vulnerable to depreciation, rejection Socially inept Incompetent	Critical Demeaning Superior	“It’s terrible to be rejected [put down].” “If people know the real me, they will reject me.” “I can’t tolerate unpleasant feelings.”	Avoid evaluative situations Avoid unpleasant feelings or thoughts
Dependent	Needy Weak Helpless Incompetent	Idealized Nurturant Supportive Competent	“I need people to survive [be happy].” “I need a steady flow of support and encouragement.”	Cultivate dependent relationships
Passive–aggressive	Self-sufficient Vulnerable to control, interference	Intrusive Demanding Interfering Controlling Dominating	“Others interfere with my freedom of action.” “Control by others is intolerable.” “I have to do things my own way.”	Passive resistance Surface submissiveness Evade, circumvent rules
Obsessive–compulsive	Responsible Accountable Fastidious Competent	Irresponsible Casual Incompetent Self-indulgent	“I know what’s best.” “Details are crucial.” “People should be better [try harder].”	Apply rules Perfectionism Evaluate, control Use “shoulds,” criticize, punish
Paranoid	Righteous Innocent, noble Vulnerable	Interfering Malicious Discriminatory Abusive motives	“Motives are suspect.” “Be on guard.” “Don’t trust.”	Be wary Look for hidden motives Accuse Counterattack

(cont.)

TABLE 10.1 (cont.)

Personality disorder	View of self	View of others	Main beliefs	Main compensatory/avoidant strategies
Antisocial	Loner Autonomous Strong	Vulnerable Exploitative	"I'm entitled to break rules." "Others are patsies [wimps]." "Others are exploitative."	Attack, rob Deceive Manipulate
Narcissistic	Special, unique Deserving special rules, superior Above the rules	Inferior Admirers	"Since I'm special, I deserve special rules." "I'm above the rules." "I'm better than others."	Use others Transcend rules Be manipulative Be competitive
Histrionic	Glamorous Impressive	Seducible Receptive Admirers	"People are there to serve or admire me." "They have no right to deny me my just deserts."	Use dramatics, charm Throw temper tantrums, cry Make suicide gestures
Schizoid	Self-sufficient Loner	Intrusive	"Others are unrewarding." "Relationships are messy [undesirable]."	Stay away

Note. Adapted from Beck, Freeman, and Associates (1990). Copyright 1990 by The Guilford Press. Adapted by permission.

TABLE 10.2. Relationship between Cognitive Levels

Event	Automatic thought	Maladaptive assumption	Schema (self and other)
Approaching man at a party.	He'll reject me.	I need the approval of men to like myself.	I'm unlovable. Men are rejecting.

Either the Patient's Form for Categorizing and Responding to Automatic Thoughts (Form 10.5) or the Patient's Daily Record of Dysfunctional Automatic Thoughts (see Form 2.10 in Chapter 2) can also be used, once the patient has received some coaching in methods of developing rational responses to automatic thoughts (see below). The identification of maladaptive assumptions and dysfunctional schemas is usually not as easy for a patient as the identification of distorted automatic thoughts; therefore, these two types of cognitive distortions are usually identified by the patient and therapist working together in sessions.

Once a patient's automatic thoughts, assumptions, or schemas have been identified, they are subjected to any of a wide variety of cognitive (and sometimes behavioral) challenges. In each case, the ultimate goal of this process of challenging is the production of a "rational response"—that is, a new, more logical, more realistic, and more adaptive version of the original thought, assumption, or schema. For example, the maladaptive assumption "Something is wrong with me if I am anxious" can be replaced by the rational response "Anxiety is normal; everyone has anxiety."

Appendix B of this book summarizes the cognitive techniques that can be used to identify and challenge cognitive distortions. For further descriptions of these techniques, the reader is referred to several books on cognitive therapy: *Cognitive Therapy of Depression* (Beck et al., 1979), *Anxiety Disorders and Phobias* (Beck et al., 1985), *Cognitive Therapy: Basics and Beyond* (J. S. Beck, 2011), *Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work* (J. S. Beck, 2005), *Cognitive Therapy: Basic Principles and Applications* (Leahy, 1996), *Practicing Cognitive Therapy* (Leahy, 1997), *Cognitive Therapy Techniques* (Leahy, 2003), and *Handbook of Cognitive-Behavioral Therapies* (Dobson, 2010). Bennett-Levy et al. (2004) have provided an excellent guide to implementing behavioral techniques in examining and testing thoughts and assumptions in the *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. The schema-focused approach is represented by Young et al. (2003) in *Schema Therapy: A Practitioner's Guide*. Wells (2009) has advanced an innovative cognitive-behavioral model of depression, anxiety disorders, and psychotic disorders in *Metacognitive Therapy for Anxiety and Depression*. In addition, Gilbert (2010) has incorporated "compassionate mind" principles from Buddhist practices into an intriguing new approach, described in *Compassion Focused Therapy: Distinctive Features*. Finally, Leahy, Tirch, and Napolitano (2011) have advanced a cognitive-experiential model of emotion regulation that can be incorporated into a variety of other cognitive-behavioral models in *Emotion Regulation in Psychotherapy: A Practitioner's Guide*.

These approaches and techniques are not specific to any single disorder and may be used for depression, anxiety disorders, anger, substance use disorders, relationship conflict, and a variety of other problems. In the chapters on specific disorders in our book, we demonstrate how many of these techniques can be adapted to each disorder. The interested reader will wish to

review these techniques and determine which are the most relevant to his or her style of doing therapy.

EXAMPLES OF CHALLENGES TO SPECIFIC DISTORTED AUTOMATIC THOUGHTS

In this section, we provide several examples of how a therapist might use some of the cognitive techniques described in Appendix B to respond to a patient's distorted automatic thoughts in therapy sessions. In later sections, we provide similar examples of responses to maladaptive assumptions and to dysfunctional schemas.

Catastrophizing

Here are examples of how a therapist might challenge this catastrophic thought: "It's awful that I had that argument with my boyfriend."

"Exactly what will happen that is awful? Describe in detail exactly what you expect will occur. What is the probability that this will happen? How often does this happen to people? How often does this not happen? If this event occurs, what will you no longer be able to do? What will you still be able to do? List all the behaviors that you will still be able to do in the event that this does happen. If you can still engage in all these behaviors, then how is it awful?"

"What is the evidence for and against the idea that it's awful?"

"How will you feel about this a week (a month, a year, 10 years) from now? Have you experienced other events that you thought were awful and found that they weren't as bad as you thought they were? What made you change your evaluation?"

"If you had to make a scale of negative events, with 0 corresponding to the absence of negative consequences and 100 corresponding to a nuclear holocaust, where would you place this argument? How would you fill in every 10 points on this scale? How is this argument not as bad as other things that could happen?" (Figure 10.1 illustrates how this patient might actually construct such a scale or continuum.)

"Would everyone think that this argument is as bad as you think it is? Why? Why not? If you knew someone who had gone through a life-threatening illness, would you be able to convince him or her that this is as bad as you think it is? How would you feel about doing this?"

"Have other people gone through this before? How have they survived?"

Personalizing

The following are examples of possible challenges to this personalizing thought: "It's my fault that this problem happened."

"What are the costs and benefits of personalizing this problem?"

"What behaviors did you and others engage in that contributed to the problem?"

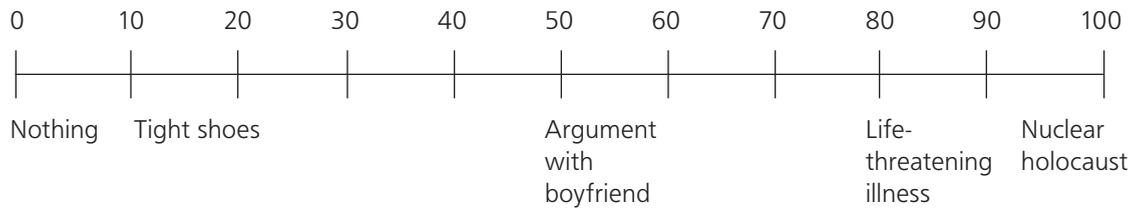


FIGURE 10.1. Example of how a patient might construct a continuum of negative events.

“Make a pie chart. Divide up the causes, assigning percentages of responsibility as follows: self, other(s), luck, task difficulty, and unknown causes.”

“Are you confusing an event with the whole person? Doesn’t your behavior vary across different situations? Across different times? Did these problems in this situation exist before you came on the scene?”

“Even if the event did not work out, did you learn anything, experience any pleasure, or grow in any way? Was there anything good about the event?”

“Is there some way that this can be corrected? Can you learn anything from this that you can use in the future? Can you engage in self-correction rather than self-criticism?”

“Are you blaming yourself because you tend to take an inordinate amount of credit for events? Do you always think that you are that important or that powerful? Are you the kind of person who thinks he or she has to control everything?”

Labeling

Here are instances of how a therapist might respond to this distorted labeling: “I’m a jerk for making that mistake.”

“How do you define ‘jerk’?”

“What are the costs and benefits of labeling yourself in this way?”

“Are all of your behaviors jerk-like, or just some? Does your behavior vary across situations? Across time? Are you looking at things in all-or-nothing terms? Do you ever do anything that is competent?”

“Are there extenuating circumstances? Other causes (such as provocation, lack of knowledge, duress, early history, lack of ability, or lack of effort)?”

“Would you label everyone in the world a ‘jerk’ if they made this mistake? Would you label your best friend (or a loved family member) in this way if he or she made a mistake? Don’t we all make mistakes at times?”

“Do you think of yourself as the biggest jerk in the world? Have other people made worse mistakes? If you’re a jerk, what are they?”

“If you think that you’re a jerk, when did you become a jerk? Were you born a jerk? If someone makes a mistake, does that mean that that person is a jerk? Would that mean that everyone is a jerk? Why not?”

“If you had a successful experience, would you stop being a jerk? If you made another mistake later, would you then become a jerk again?”

“Would you be better off thinking of this as a mistake? A difference of opinion? A different style?”

“Would you be better off or worse off accepting limitations in yourself? Are you applying perfectionistic standards? If you changed these standards, what would happen?”

Fortunetelling

Here are various ways in which a therapist might challenge this fortunetelling thought: “I’ll be rejected and fail if I do this.”

“What are the costs and benefits of this prediction?”

“Describe in detail exactly what will happen. Can you form a visual image of your prediction?”

“Do certain situations generally elicit negative predictions from you—for example, interacting with strangers, going to the doctor, or taking an exam?”

“What is the evidence for and against your prediction? What is the quality of the evidence? Are you basing your prediction on emotional reasoning? Are you focusing on just one negative and exaggerating its importance? Are you discounting your positives in the situation?”

“Would everyone make your prediction, given the current facts? Why not?”

“What are five less negative predictions that you could make? What is the best possible outcome?”

“Even if the worst possible outcome occurred, would there still be some positive aspects to it?”

“Have you made other predictions that have not come true? Are you prone to making bad predictions? What do you learn when you make false alarms? Do you tend to forget your false alarms?”

“If your prediction came true, what would it mean to you? Do you have to be approved of by everyone or perfect all the time?”

“Are you assuming that because it’s possible that something negative can happen, then it will happen?”

“Do you assume that if you don’t know something for sure, then it’s a negative?”

“Are you using all the evidence, or are you relying on your feelings to guide you?”

“If what you are predicting were to occur, what resources could you draw on to deal with it? What problem would you have to solve if it occurred? How would you solve the problem?”

“How would you feel about this 1 week, 2 weeks, 2 months, and 1 year later? Would it become less negative over time? Why would it become less negative over time?”

“Do you tend to act as if your predictions will come true? For example, do you avoid situations when you have a negative prediction? Have you ever acted against your negative predictions? What actually happened?”

“Would you be willing to test out your negative prediction by collecting more information or acting against your prediction?”

EXAMINING MALADAPTIVE ASSUMPTIONS

Many depressed, anxious, or angry people have maladaptive assumptions—sets of rules or guidelines that make them more vulnerable. Below, we give examples of how a therapist might respond to this “should” assumption by a patient: “I should be approved of by everyone.”

“What are the costs and benefits of this assumption?”

“Are you confusing a preference or desire with a moral imperative—that is, with the idea that you *must* or *should* have or do what you would *prefer* to have or do?”

“Why should you be approved of by everyone? What is the evidence or logic that leads you to conclude this?”

“How do you measure approval? Do you demand or require intense, lavish approval? Would you be willing to settle for less than 100%?”

“What does it mean to you if you are not approved of by someone?”

“What would you do with all that approval? Would you have time for everyone? If you didn’t have time for everyone, would you then have to ‘reject’ some people? Would that then make them worthless? Why not?”

“Are you getting yourself upset because you have other rigid and unrealistic rules and assumptions? Are you saying, ‘I should, must, have to . . . ,’ ‘about other things? Do you have rules like ‘If I don’t succeed, then I’m a failure,’ ‘I have to be liked by everyone,’ ‘I have to be sure before I try,’ or ‘I have to feel like doing something before I do it’?”

“What are some of your other assumptions? What are your ‘shoulds,’ ‘if-then’ statements, ‘must’ statements, ‘have-to’ thoughts?”

The following are illustrations of how a therapist might respond to this distorted assumption reflecting perfectionism: “I’ve got to do a perfect job.”

“How would you know what ‘perfect’ is if you saw it? If there are different standards, then what do you make of the fact that your criteria are different from those of others?”

“What are the costs and benefits of perfectionism? Of imperfectionism?”

“What would happen—what would it mean—if you did less than perfectly? Specify the exact consequences of doing imperfectly. If you did imperfectly on something, what would you still be able to do?”

“Have you ever achieved perfection? If not, how did you manage in the past?”

“Does everything have to be measured? Can’t some things be enjoyed for their own sake? Can’t you learn from experience?”

“Would you apply this standard to everyone? Why/why not?”

“Perfectionism means that you compare yourself to 100%. What would happen if you compared yourself to 0% or 50% or 75%?”

“What would happen if you rewarded yourself and took pride in achieving less than perfection? Would your work become mediocre?”

“Do you think that perfectionism motivates you? If so, then does it ever lead to procrastination? Are you afraid to take risks because you’re a perfectionist? Are there some

potentially enjoyable, growth-enhancing experiences that you avoid because of your perfectionism?”

“How would you be able to start learning something if you’re a perfectionist, since learning implies imperfection?”

“Are there some things that you are not a perfectionist about? What are they? What is rewarding about those activities?”

“What should we do about all the people who are not perfect?”

“What’s the advantage of accepting less than perfection? If you did less than perfectly, wouldn’t that be progress? Does perfectionism make you angry, self-critical, or impatient?”

“Describe five people you know well and think highly of. Are they perfect in everything? Ask them. Do you accept imperfection in your friends?”

“Ask your best friends whether they believe that you have to be perfect to be worthwhile or acceptable.”

“What if you replaced perfection with growth, progress, learning, and appreciation? What would happen?”

“If you think that perfectionism is so great, then would you think that a self-help book would sell if it were entitled *How to Criticize Yourself into Perfectionism*?”

“Why is it that other people can be happy if they are not perfectionists?”

“Would you be willing to carry out an experiment in imperfection? For example, what would happen if you purposely wrote every check for \$1 more than needed—that is, if you consistently made the same ‘mistake’ on your checks for a month?”

“Does anyone except you expect perfection from you?”

EXAMINING THE CONTENT OF DYSFUNCTIONAL SCHEMAS

As Table 10.1 indicates, patients’ dysfunctional schemas (deep-seated models of self and others) may reflect underlying concerns or issues with any of the following: entitlement, dependence, unrelenting standards, deficiency, biological threat, trust, betrayal, control, autonomy, dominance, self-sacrifice, punishment (of others or self), dramatic display, impressing others, obtaining admiration/tribute, abandonment, humiliation, or embarrassment (and these are only some of the possibilities). In this section, we provide examples of how a therapist might challenge a patient’s schema of unrelenting standards for the self.

“Identify some examples of when your standards are very demanding and difficult to live up to.”

“Specify a situation where your standards seemed to be unrelenting and almost impossible. What thoughts and feelings did you have? What did you do to try to live up to these standards? Specifically, what were your standards for success? What was acceptable? Unacceptable?”

“What are the costs and benefits of your standards?”

“What would you still be able to do if you did not have these high standards?”

“Draw a continuum from 0 to 100, with 0 corresponding to no standards and 100 corre-

sponding to absolute perfection. Where do you put yourself? Others? Identify people at each 10 points on the continuum.”

“Do you expect others to live up to your standards? Why/why not?”

“Are there certain areas where you allow yourself to lower your standards? What happens then?”

“Use vertical descent: ‘If I don’t live up to my standards, then it means . . .’ ‘Do your conclusions follow logically? Are other, less negative conclusions possible?’”

“Does anyone except you expect perfection?”

“What would happen if you aimed for growth and acceptance rather than perfection?”

“How have you been trying to live up to these standards during your life? Who taught you that you had to be perfect? What behaviors have you avoided? How has it affected your relationships, work, health, and ability to relax?”

“Can you remember an incident in your childhood that reminds you of these demanding standards? Close your eyes and try to recall the details—the feelings you had, how you felt in different parts of your body, your sensations. What was going on? Who was talking? What were you (and others) thinking?”

“Now try to rewrite this script so that you challenge the demand for perfect standards. Assert yourself in this image. Get angry at the demand for high standards. Tell the characters in the scene that you are going to accept yourself even if you are not perfect.”

“Identify an area in your life in which you will intentionally try to practice imperfection. When you begin feeling guilty or inferior because you are not perfect, vigorously argue back against your demanding standards.”

“Write out a ‘bill of rights’ for yourself that states your right to be human, to make mistakes, and to accept yourself.”

SELF-INSTRUCTION AND SELF-CONTROL

Many patients’ problems may be consequences of insufficient self-direction (Meichenbaum, 1977; Novaco, 1978; Rehm, 1990). Rather than being driven by emotions or situational determinants, such patients may be prepared for handling difficult situations through “self-instruction.” Self-instructional training requires a patient to engage in the following components or steps:

1. Identify signs of anger, anxiety, sadness, or unwanted desires (e.g., hunger for junk food).
2. List and describe situations that elicit the unwanted feelings.
3. List all maladaptive behaviors in the situation.
4. Examine the consequences—both short-term and long-term.
5. Determine the costs and benefits of the unwanted feelings/behaviors.
6. Think of alternatives that are available to reduce these (e.g., leaving the situation, avoiding contact, responsible assertion, problem solving, rational responding, etc.).
7. Determine the costs and benefits of these alternatives.
8. Generate some “coping thoughts” for use in the situation (to cool the patient down or make him or her feel better or more in control).

9. Develop an image of the troubling situation and how you could handle it more effectively.
10. Practice “inoculation” with the therapist, who can play the role of someone provoking the patient, while the patient plays the role of someone coping effectively.
11. Reverse roles with the therapist in the inoculation practice.
12. Make a list of situations in which to practice the coping thoughts.
13. Practice these skills outside therapy, writing down predictions and outcomes.
14. Revise the script and the coping statements as necessary, and keep practicing.
15. Engage in a self-reward after each attempt at self-instructional training.

For example, consider the following use of self-instruction with an angry husband who is easily provoked by his wife and who acts out his aggression. The therapist asks the patient the following questions:

THERAPIST: What is it your wife says or does that bothers you?

PATIENT: She nags me, tells me to do things over and over.

THERAPIST: Any other situations?

PATIENT: She questions me about our finances.

THERAPIST: What are the signs of your anger?

PATIENT: I can feel my heart racing. I get tense. Initially I get quiet, and then when I talk, I'm loud. I clench my fists. I tell her to leave me alone. Sometimes I'll call her names.

THERAPIST: What is the goal? The target you are aiming for in this situation?

PATIENT: I don't know if I have a goal. I guess I'm trying to get back at her.

THERAPIST: What are the costs and benefits of this goal?

PATIENT: The costs are that I feel guilty, she gets upset, and we have a lot of tension. The benefits are that I can feel like she's not controlling me.

THERAPIST: What are the alternatives?

PATIENT: I could use the time-out procedure that you told me about, and tell her that I need to go in the other room until I cool off.

THERAPIST: What are the costs and benefits of this alternative?

PATIENT: The costs are minimal. I don't get to strike back at her. The benefits are that we can avoid a fight and I can feel more in control.

THERAPIST: What are some cooling thoughts that you can tell yourself when you're in that situation?

PATIENT: I can tell myself that it's better to control myself, that I can remain cool. That I don't have to fight back to prove that I'm a man. That I never feel better if I fight.

THERAPIST: What can you tell yourself to reinforce this?

PATIENT: I can tell myself that I'm more in control than I thought. I did a good job. I'm making progress. [The therapist and patient then agree to practice “inoculation” with role plays, and the therapist and patient develop a “coping card” that the patient reads several times a day.]

The following “coping card” may serve as self-instruction for this patient:

COPING CARD

Don't get provoked. Remain cool.

I'm in charge of my feelings.

There's no problem if she makes requests or even nags me. It can't hurt me.

If I get upset, I can always ask for time out and go in the other room to calm down.

I'm much better off staying cool. Easy does it.

We recommend the Patient's Self-Instruction Script (Form 10.6) for patients working on self-direction and self-control.

CASE CONCEPTUALIZATION

A frequent criticism of cognitive therapy is that it appears too “technique-oriented”—that is, too focused on a nontheoretical, or nonconceptual approach to the individual patient. In fact, Beck (1976) gave an early warning against the “trial-and-error” approach of technique-oriented cognitive therapy, urging clinicians to develop a treatment plan and conceptualization for each patient. More recently, Persons (2008), in *The Case Formulation Approach to Cognitive-Behavior Therapy*, has encouraged cognitive therapists to guide their therapy by “case conceptualization” rather than a “shotgun” approach to using techniques. There is no one kind of case conceptualization—and, indeed, each cognitive-behavioral approach will lead to its own model of conceptualizing. For example, a more traditional behavioral approach will emphasize the role of contingencies, learning history, role models, and problematic coping (e.g., isolation, passivity, rumination, complaining). In contrast, a more traditional cognitive approach will emphasize the role of core beliefs or schemas and their relationship to other levels of cognitive functioning (such as automatic thoughts and maladaptive assumptions). These are then linked to the developmental precursors and socialization experiences that gave rise to these problematic schemas. A metacognitive model will emphasize the beliefs about the function of thinking in regulating functioning and problematic strategies, such as worry and rumination. A compassion-focused approach will emphasize significant experiences of shame and humiliation that gave rise to self-loathing and the unwillingness to experience positive self-regard or emotion. An emotional schema model will focus on socialization of beliefs about emotion in the patient's earlier developmental history, as well as the patient's ongoing negative beliefs and coping styles for emotion regulation.

Here we provide a more traditional cognitive example of case conceptualization, to provide the reader with a sense of how this may be utilized. Consider the following schemas evident in a patient's history, as well as the “scripts” by which the patient, Bill, compensates for these schemas.

Schema: “I am weak and vulnerable physically.”

Scripts of compensation: Bill becomes proficient in the martial arts, places himself in dangerous situations, and demonstrates counterphobic behavior. He is also compulsive about

checking his weight and his health, and is constantly hypervigilant about any physical problem.

Schema: “I am inferior.”

Scripts of compensation: Bill compulsively achieves—conspicuously displaying his wealth, living beyond his means at times, and socializing with the rich and famous. He surrounds himself with people who “depend” on him: His father works for him, and his brothers need his financial support. He tries to prove to his girlfriend that he can make enough money to provide her with the lavish lifestyle she wants.

Schema: “I will be abandoned.”

Scripts of compensation: Bill insists that others need him and that he will take care of them financially. If they need him, they won’t leave him. Furthermore, some “friends” who have befriended him for his investment savvy cannot truly “abandon” him, because he knows that he will never get attached to them.

The developmental analysis reveals that Bill’s father suffered significant business failures during Bill’s early adolescence. In addition, his sense of physical vulnerability can be traced to physical abuse and threats of abandonment by his mother. The therapist is able to develop a case conceptualization to assist Bill in recognizing the early origins of these highly powerful schemas—and the ways in which they were relevant and adaptive to a different time in his life. This simple case conceptualization links current automatic thoughts, assumptions, schemas, and compensatory functioning to a developmental analysis. Using experiential techniques (the empty-chair technique, imagery rescripting), behavioral techniques (assertion training, activity scheduling), the double-standard technique, and examination of the evidence for and against these schemas should be helpful. In addition, patients whose current schemas are traceable to individual experiences with parents or others (as Bill’s schemas are) can be helped by engaging in role plays challenging these figures and by writing assertive letters to the sources of the schemas.

CONCLUSION

We have outlined a wide range of cognitive therapy techniques that are applicable to almost any mood or anxiety disorder that clinicians will confront. Therapists need not limit themselves to the techniques covered here, however. In several chapters of this volume, we have suggested that patients may benefit from the use of schematic diagrams tracing the relationship between their current problem (e.g., panic disorder) and evolutionary models of psychopathology, genetics, earlier socialization experiences, coping strategies (e.g., avoidance, reassurance seeking), core beliefs or schemas, automatic thoughts and assumptions, and self-confirmation biases. Throughout this volume we have emphasized an integrative cognitive-behavioral approach, drawing on the wide range of techniques, conceptualizations, and strategies now available. Indeed, the exciting quality of cognitive therapy is the continuing development of new approaches and conceptualizations. The interested reader should consult the many volumes mentioned earlier in this chapter that describe the application of these techniques in more detail.

FORM 10.1. General Information for Patients about Cognitive–Behavioral Therapy

Issues	Answers
General description	Cognitive-behavioral therapy is a relatively short-term, focused psychotherapy for a wide range of psychological problems, including depression, anxiety, anger, marital conflict, fears, and substance abuse/dependence. The focus of therapy is on how you are thinking (your “cognitions”), behaving, and communicating <i>today</i> , rather than on your early childhood experiences. Numerous studies have demonstrated that cognitive-behavioral therapy is as effective as medication for depression, anxiety, obsessions, and other fears. Furthermore, because patients learn self-help in therapy, they are often able to maintain their improvement after therapy has been completed.
Evaluation of patients	When you begin cognitive-behavioral therapy, your therapist will ask you to fill out several self-report forms that assess a range of symptoms and problems. These forms evaluate depression, anxiety, anger, fears, physical complaints, personality, and relationships. The purpose of this evaluation is to gather as much information on you as possible, so that you and your therapist can learn quickly what kinds of problems you do (or do not) have and the extent of your problems.
Treatment plans	You and your therapist will work together to develop a plan of therapy. This might include how often you need to come; the relevance of medication; your diagnosis; your goals; skill acquisition; needed changes in the way you think, behave, and communicate; and other factors.
What are therapy sessions like?	Some other forms of therapy are unstructured, but in cognitive-behavioral therapy you and your therapist will set an agenda for each meeting. The agenda might include a review of your experience in the previous session, your homework, one or two current problems, a review of what you’ve accomplished in this session, and homework for the next week. The goal is to solve problems, not just complain about them.
Self-help homework	If you went to a personal trainer at a health club, you would expect to get guidance on how to exercise when the trainer is not there. The same thing is true in cognitive-behavioral therapy. What you learn in therapy is what you practice <i>outside</i> of therapy on your own. Research demonstrates that patients who carry out homework assignments get better faster and stay better longer. Your self-help homework might include keeping track of your moods, thoughts, and behaviors; scheduling activities; developing goals; challenging your negative thoughts; collecting information; changing the way you communicate with others; and other assignments.
Aren’t my problems due to my childhood experiences?	<i>Part</i> of your problems may be due to how your parents, siblings, and peers treated you, but your solutions to your problems lie in what you are thinking and doing <i>today</i> . However, with many people we do find it useful at times to review the sources of your problems and help you learn how to change the way you think about them now.

(cont.)

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FORM 10.1. General Information for Patients about Cognitive–Behavioral Therapy (p. 2 of 2)

Issues	Answers
Aren't my problems due to biochemistry?	<i>Part</i> of your problems may be due to biochemistry, but many other factors—such as the way you think, behave, and relate, as well as current and past life events—are important. Using cognitive-behavioral therapy does not rule out the use of medication. For most psychiatric disorders, there is considerable evidence that cognitive-behavioral therapy is as effective as medication. For very serious levels of depression and anxiety, we believe that it may be best to combine medication with therapy. An advantage of cognitive-behavioral therapy is that you also learn ways to solve your problems on your own.
How will I know if I'm getting better?	You and your therapist can identify specific goals at the beginning of therapy—and you can modify these goals as you continue. Then you can evaluate whether you are becoming less depressed, anxious, angry, or the like. You should feel free to give your therapist feedback on your progress. This feedback from you is useful in order to figure out what works and what doesn't work.
How can I learn more about cognitive-behavioral therapy?	Depending on the problems that you want to solve, your therapist can recommend a number of books or other readings for you. We believe that the more you know about yourself, the better off you will be. We hope that you can learn to become your own therapist.

FORM 10.2. Categories of Distorted Automatic Thoughts: A Guide for Patients

1. **Mind reading:** You assume that you know what people think without having sufficient evidence of their thoughts. "He thinks I'm a loser."
2. **Fortunetelling:** You predict the future negatively: Things will get worse, or there is danger ahead. "I'll fail that exam," or "I won't get the job."
3. **Catastrophizing:** You believe that what has happened or will happen will be so awful and unbearable that you won't be able to stand it. "It would be terrible if I failed."
4. **Labeling:** You assign global negative traits to yourself and others. "I'm undesirable," or "He's a rotten person."
5. **Discounting positives:** You claim that the positive things you or others do are trivial. "That's what wives are supposed to do—so it doesn't count when she's nice to me," or "Those successes were easy, so they don't matter."
6. **Negative filtering:** You focus almost exclusively on the negatives and seldom notice the positives. "Look at all of the people who don't like me."
7. **Overyeneralizing:** You perceive a global pattern of negatives on the basis of a single incident. "This generally happens to me. I seem to fail at a lot of things."
8. **Dichotomous thinking:** You view events or people in all-or-nothing terms. "I get rejected by everyone," or "It was a complete waste of time."
9. **Shoulds:** You interpret events in terms of how things should be, rather than simply focusing on what is. "I should do well. If I don't, then I'm a failure."
10. **Personalizing:** You attribute a disproportionate amount of the blame to yourself for negative events, and you fail to see that certain events are also caused by others. "The marriage ended because I failed."
11. **Blaming:** You focus on the other person as the *source* of your negative feelings, and you refuse to take responsibility for changing yourself. "She's to blame for the way I feel now," or "My parents caused all my problems."
12. **Unfair comparisons:** You interpret events in terms of standards that are unrealistic—for example, you focus primarily on others who do better than you and find yourself inferior in the comparison. "She's more successful than I am," or "Others did better than I did on the test."
13. **Regret orientation:** You focus on the idea that you could have done better in the past, rather on what you can do better now. "I could have had a better job if I had tried," or "I shouldn't have said that."
14. **What if?:** You keep asking a series of questions about "what if" something happens, and you fail to be satisfied with any of the answers. "Yeah, but what if I get anxious?" or "What if I can't catch my breath?"
15. **Emotional reasoning:** You let your feelings guide your interpretation of reality. "I feel depressed; therefore, my marriage is not working out."
16. **Inability to disconfirm:** You reject any evidence or arguments that might contradict your negative thoughts. For example, when you have the thought "I'm unlovable," you reject as *irrelevant* any evidence that people like you. Consequently, your thought cannot be refuted. "That's not the real issue. There are deeper problems. There are other factors."
17. **Judgment focus:** You view yourself, others, and events in terms of evaluations as good–bad or superior–inferior, rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards, and finding that you and others fall short. You are focused on the judgments of others as well as your own judgments of yourself. "I didn't perform well in college," or "If I take up tennis, I won't do well," or "Look how successful she is. I'm not successful."

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FORM 10.3. Examples of Maladaptive Assumptions: A Guide for Patients

"I should be successful at everything I try."

"If I am not successful, then I am a failure."

"If I fail, then I'm worthless [I'm unlovable, life is not worth living, etc]."

"Failure is intolerable and unacceptable."

"I should get the approval of everyone."

"If I am not approved of, then I am unlovable [ugly, worthless, hopeless, alone, etc]."

"I should be certain before I try something."

"If I am not certain, then the outcome will be negative."

"I should never be anxious [depressed, selfish, confused, uncertain, unhappy with my partner, etc]."

"I should always keep my eye out for any anxiety."

"If I let my guard down, something bad will happen."

"If people see that I am anxious, they will think less of me [reject me, humiliate me, etc]."

"My sex life [feelings, behaviors, relationships, etc.] should be wonderful and easy at all times."

FORM 10.4. Patient's Event–Mood–Thought Record

Patient's name: _____

Date/time	Event: Describe what happened. What were you doing at the time?	Mood: Describe your feelings (sad, anxious, angry, hopeless, etc.), and rate their intensity on a 0–100% scale.	Thought: Write down your automatic thoughts at the time.

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FORM 10.5. Patient's Form for Categorizing and Responding to Automatic Thoughts

Automatic thoughts: Write your negative thoughts and estimate your confidence in the accuracy of each one (0–100%).	Distortions: Identify the category into which each automatic thought falls (see “Categories of Distorted Automatic Thoughts: A Guide for Patients”).	Rational responses: Substitute more realistic thoughts and estimate your confidence in the accuracy of each one (0–100%).

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FORM 10.6. Patient's Self-Instruction Script

Questions to ask myself	Answers and solutions
What is the behavior I am trying to change?	
In what situations am I most likely to have this problem?	
What sensations and emotions are signs of this behavior?	
What are the costs and benefits to me of this behavior?	
What are some better alternatives?	
What are the costs and benefits of these alternatives?	
What are some more reasonable things I can say to myself to make me less upset?	
What plans can I make to carry out this new behavior?	
What are some rewarding things I can do for myself when I carry out my new behavior?	

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APPENDIX A

Summary of Behavioral Techniques

Technique	Description
Assertiveness training	Training patients to use behaviors that protect their rights while respecting the rights of others.
Behavioral activation (reward planning and activity scheduling)	Helping patients to increase activities that are likely to bring feelings of pleasure and/or mastery.
Communication skills training	Training patients in skills that will make them more effective as both speakers and listeners.
Distraction	Teaching patients to use mentally absorbing activities to prevent themselves from dwelling on negative thoughts.
Exposure—Imaginal	Using guided imagery to expose patients to feared cues in their imaginations.
Exposure— <i>In vivo</i>	Exposing patients to actual anxiety-provoking cues in real-life situations.
Graded task assignment	Helping patients to break tasks they find overwhelming into small steps, and to start with the easiest step; as they gain confidence, patients are encouraged to try more difficult steps.
Mindfulness	Teaching patients to focus attention on immediate experience in order to break patterns of negative thinking, increase tolerance for avoided experience, and promote a sense of calmness.
Modeling	Demonstrating adaptive behavior so that patients may imitate it. Used in skills training and exposure, for example.
Problem solving	Training patients to generate, evaluate, and implement possible solutions to problems they face.

(cont.)

Technique	Description
Rebreathing	A technique for patients with panic disorder who hyperventilate; involves teaching patients to breathe in air they have already exhaled, in order to restore proper oxygen balance.
Relaxation	Training patients in various techniques to induce physical relaxation as a means of coping with anxiety.
Breathing relaxation	Teaching patients breathing exercises to induce a relaxation response.
Progressive muscle relaxation	Teaching patients a set of techniques in which different muscle groups are first tensed and then relaxed, in order to induce a relaxation response.
Self-reward	Teaching patients to reward themselves for positive behaviors.
Social skills training	Training patients in skills necessary for common social activities, such as meeting new people, initiating conversations, going on job interviews, and dating.
Visualization	Teaching patients to use pleasant imagery in order to distract themselves from negative thinking and to induce relaxation.

APPENDIX B

Summary of Cognitive Techniques

Technique	Description or example
	<u>Socializing patient</u>
Establishing therapeutic contract	Directly ask the patient about commitment to therapy, such as willingness to come regularly and do homework.
Bibliotherapy	Assign readings, such as patient information handouts or books (e.g., Leahy's <i>Anxiety Free</i> or <i>Beat the Blues before They Beat You</i>).
Indicating how thoughts create feelings	Example: "I feel anxious [mood] because I think I'll fail [thought]."
Distinguishing thoughts from facts	Example: "I can believe that it is raining outside, but that doesn't mean it's a fact. I need to collect evidence—go outside—to see whether it's raining."
	<u>Identifying and categorizing distorted automatic thoughts</u>
Identifying negative thoughts that come spontaneously and seem plausible	Examples: "I think I'll fail," "I always fail," "It's awful to fail."
Identifying the emotions these thoughts create	Examples: Sadness, anxiety.
Rating confidence in accuracy of thoughts, as well as intensity of feelings	Example: "I feel anxious [80%] because I think I'll fail [95%]."
Categorizing thoughts (see Form 10.2 for complete list of categories)	Examples: "I think I'll fail" (fortunetelling), "I always fail" (dichotomous/all-or-nothing thinking), "It's awful to fail" (catastrophizing).

(cont.)

Technique	Description or example
<u>Challenging distorted automatic thoughts</u>	
Providing direct psychoeducation	Example: Give information about elevator safety to a patient with a specific phobia of elevators.
Defining the terms (semantic analysis)	Example: Ask patient, "How would you define 'failure' and 'success'?"
Examining testability of thoughts	Can patient make any real-world observations that will confirm or refute thoughts?
Examining logic of thoughts	Is patient jumping to conclusions that don't follow logically from premises (e.g., "I'm a failure because I did poorly on that test")?
Examining limits on patient's information	Is patient jumping to conclusions without sufficient information? Is patient only looking for evidence that supports his or her thoughts, not evidence that might refute them?
Vertical descent	Ask, "What would it mean [what would happen, why would it be a problem] if X occurred? What would happen next? And what would that mean [what would happen, why would it be a problem]?"
Double standard	Ask, "Would you apply the same thought [interpretation, standard] to others as you do to yourself? Why/why not?"
Challenging recursive self-criticism	Is patient locked in a loop of self-criticism for being self-critical (e.g., "I think I'm a loser because I'm depressed, and I'm depressed because I think I'm a loser")?
Examining internal contradictions	Does patient have contradictory thoughts (e.g., "I'd like to meet as many people as possible, but I never want to be rejected")?
Reductio ad absurdum	Are implications of patient's thought absurd (e.g., "If I'm single, I'm unlovable; all people who are married were once single; therefore, all married people are unlovable")?
Distinguishing behaviors from persons	Example: Indicate how failing on an exam is different from being a failure as a person.
Challenging reification	In self-criticisms, is patient making "real" something that is abstract/unobservable (e.g., worthlessness)? Can patient change reifications into "preferences" (e.g., "I prefer doing better at exams")?
Examining variability/degrees of behavior	Help patient examine evidence that his or her behavior varies across time, situations, and persons, and that it occurs to varying degrees (not in all-or-nothing ways).
Weighing the evidence for and against a thought	Example of thought: "I'll get rejected."

Technique	Description or example
	<p>Evidence in favor: "I'm anxious [emotional reasoning]," "Sometimes people don't like me."</p> <p>Evidence against: "I'm a decent person," "Some people like me," "There's nothing rude or awful about saying hello to someone," "People are here at the party to meet other people."</p> <p>For: 25%. Against: 75%.</p> <p>Conclusion: "I don't have much convincing evidence that I'll get rejected. Nothing ventured, nothing gained."</p>
Examining quality of evidence	<p>Would patient's evidence stand up to scrutiny by others? Is patient using emotional reasoning and selective information to support arguments?</p>
Keeping a daily log	<p>Have patient keep a daily log of behaviors/events that confirm or disprove a thought.</p>
Surveying others' opinions	<p>Have patient survey others for their opinions and see whether these confirm or disprove a thought.</p>
Cost–benefit analysis	<p>Example of thought: "I need people's approval."</p> <p>Costs: "This thought makes me shy and anxious around people, and lowers my self-esteem."</p> <p>Benefits: "Maybe I'll try hard to get people's approval."</p> <p>Costs: 85%. Benefits: 15%.</p>
Alternative interpretations	<p>Example: Ask patient, "If someone doesn't like you, might it simply be that the two of you are different? Or perhaps the other person is in a bad mood, or shy, or involved with someone else? Or perhaps there are many other people who can and do like you?"</p>
Negation of problems	<p>Have patient list all the reasons why the current situation is not a problem, rather than all the reasons why it is a problem.</p>
Defense attorney	<p>Tell patient, "Imagine that you have hired yourself as an attorney to defend yourself. Write out the strongest case you can in favor of yourself, even if you don't believe it."</p>
Carrying out an experiment	<p>Have patient test a thought by engaging in behavior that challenges the thought (e.g., for the thought "I'll be rejected," approaching 10 people at a party).</p>
Continuum technique	<p>Have patient place current situation or event on a 0–100 continuum of negative outcomes and examine what would be better and worse than this situation/event.</p>

(cont.)

Technique	Description or example
Putting situation/event into perspective	What would patient still be able to do even if a negative thought were true? Or how does patient's situation compare to that of someone with, say, a life-threatening illness?
"Pie" technique	Have patient draw a "pie chart" and divide up responsibility for situation/event.
Examining mitigating factors; reattribution	Are there other causes for a situation/event that should be considered (e.g., provocation, duress, lack of knowledge or preparation, lack of intention, failure on others' part, task difficulty, lack of clear guidelines)? If so, can patient reattribute some of the responsibility for the situation/event to these causes?
Externalizing both sides of a thought through role play	Take the "con" aspects of a thought while patient takes the "pro" aspects, and engage in a role-play argument (e.g., say, "You'll fail the exam"; patient replies, "There's no evidence that I'll fail"; and continue in this manner).
Using role play to apply a negative thought to a friend	Take the role of a friend to whom patient applies a negative thought. How does it sound?
Acting "as if"	First in role play and then in actual situations, have patient act as if he or she does not believe negative thoughts.
Challenging absolutistic thinking	Example: Ask patient, "If you believe that no one will like you, is it plausible that no one in the whole world will?"
Setting a zero point for comparisons; depolarizing comparisons	If patient always compares him- or herself to the best, how does he or she compare to the worst? And how does patient compare to people in the middle of the distribution?
Positive reframing (finding positives in negatives)	Is there a more positive way of interpreting patient's behavior or situation (e.g., instead of saying, "I really bombed on the exam," can patient say, "I learned I can't procrastinate," or "Thank God that course is over")?
Decatastrophizing	Ask patient, "Why would X not be so awful after all?"
Examining the "feared fantasy"	Ask patient, "Imagine the worst possible outcome of X. How would you handle it? What behaviors could you control even if it happened?"
Anticipating future reactions	Ask patient, "How will you [or others] feel about X 2 days, a week, a month, and a year from now?"
Examining past predictions, failure to learn from false predictions, and self-fulfilling prophecies	Has patient generally made negative predictions in the past that have not come true? If so, has patient failed to learn that these predictions have been distorted and biased? Have these predictions turned into self-fulfilling prophecies (i.e., has patient behaved as if they will come true and thus ensured that they will come true)?

Technique	Description or example
Testing predictions	Have patient make a list of specific predictions for the next week and keep track of the outcomes.
Examining past worries	Has patient worried about things in the past that he or she no longer thinks about? If so, have him or her list as many of these as possible and ask, "Why are these no longer important to me?"
Examining future distractions	What are all the other events (unrelated to current event) that will transpire over the next day, week, month, and year and that will cause patient not to care as much about the current event?
Distinguishing possibility from probability	Example: Ask patient, "It may be possible that you will have a heart attack if you are anxious, but what is the probability?"
Calculating sequential probabilities	Have patient multiply the probabilities of a predicted sequence of negative events.
Fighting overgeneralization	Ask patient, "Just because X happened once, does that mean it will inevitably happen?"
Challenging the need for certainty	Tell patient, "You can't have certainty in an uncertain world. If you are trying to rule out absolutely all possibility of negative outcomes, you will be unable to act."
Advocating acceptance	Suggest to patient, "Rather than trying to control and change everything, perhaps there are some things you can learn to accept and make the best of. For example, perhaps you won't be perfect in your job, but perhaps you can learn to appreciate what you can do."
Using "point-counterpoint" with difficult thoughts	For difficult thoughts that are resistant to other techniques, engage in "point-counterpoint" role play with patient.
Reexamining original negative thought and emotion, confidence in accuracy of thought, and intensity of emotion	Example: "I feel anxious [15%] because I think I'll fail [20%]."
Developing rational response to thought (new, more realistic, more adaptive thought)	Example: "There isn't much actual evidence that I'll fail; therefore, there's no real reason for me to think I'll fail, and no real reason for me to be anxious."
<u>Identifying maladaptive assumptions</u>	
Determining contents of patient's "rule book" ("shoulds," "musts," "if-then" statements underlying distorted automatic thoughts)	Examples: "I should succeed at everything I do," "If people don't like me, it means there's something wrong with me," "I must be approved by everyone."

(cont.)

Technique	Description or example
<u>Challenging maladaptive assumptions</u>	
Using techniques for challenging distorted automatic thoughts	See above.
Evaluating patient's standards	Ask patient, "Are you setting unrealistic expectations for yourself? Are your standards too high? Too low? Too vague? Do your standards give you room for a learning curve?"
Examining patient's value system	Ask patient, "What is your hierarchy of values? For example, do you place success above everything else? Are you trying to accomplish everything simultaneously?"
Examining social standards	Ask patient, "Are you trying too hard to measure up to society's standards—for example, beauty and thinness for women, or power and status for men? If you don't exactly meet these standards, do you think this makes you a bad or worthless person?"
Distinguishing progress from perfection	Help patient examine the advantages of trying to improve, rather than trying to be perfect.
Challenging idealization of others	Have patient try to list all the people he or she knows who are completely perfect. Since it's unlikely that there will be any, what does this mean about patient's achieving perfection? Or have patient ask an admired person whether he or she has ever made any mistakes or had any problems, and consider what this person's response implies about patient's idealization of others and devaluation of self.
Advocating adaptive flexibility	Help patient examine the benefits of being more flexible in standards and behaviors.
Borrowing someone else's perspective	Ask patient, "Instead of getting trapped by your way of reacting, try to think of someone you know who you think is highly adaptive. How would this person think and act under these circumstances?"
Emphasizing curiosity, challenge, and growth rather than perfection	Example: Suggest to patient, "If you do poorly on an exam, work on how you can develop curiosity about the subject matter or feel challenged to do better in the future, rather than focusing on your grade as a final measure of your worth."
Reexamining maladaptive assumptions and substituting new, more adaptive assumptions	Example: "I'm worthwhile regardless of what others think of me," instead of "If people don't like me, it means there's something wrong with me."
Examining costs and benefits of more adaptive assumptions	Example of more adaptive assumption: "I'm worthwhile regardless of what others think of me." Costs: "Maybe I'll get conceited and alienate people."

Technique	Description or example
	<p>Benefits: "Increased self-confidence, less shyness, less dependence on others, more assertiveness."</p> <p>Costs: 5%. Benefits: 95%.</p> <p>Conclusion: "This new assumption is better than the one that I have to get other people to like me in order to like myself."</p>
	<p><u>Identifying dysfunctional schemas</u></p>
Identifying negative or otherwise dysfunctional views of self and others underlying distorted automatic thoughts and maladaptive assumptions	Examples: "I'm incompetent," "I'm no good," "I must be admired," "Others are rejecting," "Others are all-powerful," "Others must pay tribute to me."
Explaining schematic processing	Indicate how dysfunctional schemas are formed and how they systematically bias the ways events are attended and responded to.
Identifying strategies of avoiding/compensating for schemas	Help patient determine how he or she avoids challenging a schema (e.g., "If you think that you are unlovable, do you avoid getting involved with people?") or compensates for a schema (e.g., "If you believe you are inferior to others, do you attempt to become perfect in order to overcome your 'inferiority'?").
	<p><u>Challenging dysfunctional schemas</u></p>
Using techniques for challenging distorted automatic thoughts and maladaptive assumptions	See above.
Activating early memories to identify sources of schemas	Ask patient, "Who taught you to think in this dysfunctional way? Was it your parents? Teachers? Friends? Do you think that their teaching was valid? Were they poor role models?"
Challenging the sources of schemas through role play	Have patient role-play him- or herself challenging the source of a schema and arguing vigorously against this person.
Imagery restructuring; rewriting life scripts	Have patient imagine going back in time and confronting a schema's source. Or have patient revise his or her negative life script so that it has a positive outcome (e.g. for a negative early image of humiliation, have patient write a script in which he or she rejects or criticizes the person responsible for the humiliation).
Writing letters to the source	Have patient write letters to a schema's source (which need not be sent) expressing his or her anger and frustration.

(cont.)

Technique	Description or example
Imagery and emotion	Have patient close eyes, evoke a negative feeling (e.g., loneliness), and then associate a visual image with this feeling. Ask patient to complete this sentence: "This image bothers me because it makes me think . . ."
Coping imagery	Help patient to develop an image of him- or herself coping competently with a feared person or situation.
Miniaturizing the frightening image	Help patient to develop an image of a feared person or thing as much smaller and weaker, instead of bigger and more powerful than the patient.
Desensitizing images	Have patient engage in repeated exposure to a feared image or situation, in order to diminish its capacity to elicit fear.
Nurturant self-statements	Have patient imagine him- or herself as a child and make nurturing statements to the child of the kind he or she wishes had actually been made.
"Bill of rights"	Help patient compose a personal "bill of rights" (e.g., the right to make mistakes, to be human, etc.).
Reexamining original schemas and developing new, more adaptive schemas	Examples: "I am competent" and "Others are only human," instead of "I am incompetent" and "Others are all-powerful."
<u>Problem solving and self-control</u>	
Identifying a problem	Is there a problem that needs to be solved? For example, if patient does poorly on an exam, perhaps he or she needs to study more.
Accepting the problem	Help patient to accept the existence of the problem and begin working toward its solution, instead of being self-critical or catastrophizing.
Examining the goal; generating alternative goals	What is patient's goal in the situation? If one goal has not worked, can patient modify the goal or generate alternative goals (e.g., replace "to be liked by everyone" with "to meet some new people" or "to learn how well I can do")?
Anti-procrastination steps	Guide patient through a series of steps to minimize procrastination (specifying a goal; breaking it down into smaller steps; examining costs and benefits of first step vs. an alternative; scheduling a specific time, place, and duration for the activity; role-playing resistance to engaging in the activity; carrying out the activity).
Self-correction	Encourage patient to learn from any mistakes instead of engaging in self-criticism.

Technique	Description or example
Developing self-instructional statements; creating a “coping card”	Have patient develop self-instructions for use in times of difficulty (e.g., “Don’t worry about my anxious arousal. It’s arousal. It’s not dangerous. Anxiety doesn’t mean I’m going crazy. I can tolerate it”). Put these statements, along with reminders and so on, on a “coping card” that patient can refer to easily.
Delaying a decision	For an impulsive patient, it may be useful to delay making a decision on a thought until a certain amount of time has passed or until the patient has had two good nights’ sleep.
Canvassing friends	To reduce compulsiveness, a patient can be asked to survey five friends for their advice on the intended thought or action.
Anticipating problems	Have patient list the kinds of problems that might come up and develop rational responses to these.
Inoculation	With the patient, role-play the worst negative thoughts and problems that might come up, and have patient indicate how he or she would challenge them.
Self-reward statements	Encourage patient to list positive thoughts about him- or herself after doing something positive.
Problem solution review	Have patient review past problems and the solutions he or she has used.

Overview of Contents of Companion CD-ROM

The CD-ROM is designed to provide a quick reference to key clinical tools and guidelines from the book. The disk allows users to print the various forms and handouts that they will use with their patients. In addition, it includes lists of behavioral techniques and of cognitive concepts and techniques, along with a chart of medications often used for anxiety and depression.

CLINICAL TOOLS AND GUIDELINES

For each of the seven disorders covered in the book, the accompanying CD-ROM provides a brief outline of treatment; sample symptoms, goals, and interventions; specific therapy techniques; forms; and handouts. They are organized into sections by disorder, corresponding to the structure of the book:

- Depression
- Panic disorder and agoraphobia
- Generalized anxiety disorder
- Social anxiety disorder (social phobia)
- Posttraumatic stress disorder
- Specific phobia
- Obsessive–compulsive disorder

In addition, the CD-ROM includes clinical forms applicable across all the disorders, as well as summaries of behavioral and cognitive techniques (Appendices A and B from the book).

MEDICATIONS

The CD-ROM also includes a table listing medications that are frequently prescribed in the treatment of depression and anxiety disorders, grouped by the major drug classes:

- Antidepressants—monoamine oxidase inhibitors (MAO)
- Antidepressants—tricyclics

Antidepressants—selective serotonin reuptake inhibitors (SSRIs)
Antidepressants—miscellaneous
Anxiolytics—benzodiazepines
Anxiolytics—miscellaneous
Stimulants
Antipsychotics—phenothiazines
Antipsychotics—miscellaneous
Antimanics
Hypnotics

USING THE CD-ROM

To read the files, users must have Adobe Reader 9 or higher, which can be downloaded for free at <http://get.adobe.com/reader/>.

To use the CD-ROM, insert it into your CD-ROM drive and open the file called Trmt_Plans_CD.PDF in Adobe Reader. From here you can access all of the content. If you prefer, you can copy the file called Trmt_Plans_CD.PDF in a convenient place on your local hard drive, so that you can access the contents from there in the future.

The CD-ROM is designed to allow you to view the files you want in three ways:

1. Use the hyperlinks included in the table of contents. Roll your mouse over the title. When you see the hand icon, click and you will go to that item.
2. Use the bookmarks provided. By hitting the plus sign next to a topic, you can see all of the items in that section. Click the bookmark to navigate to the form. If the bookmarks are not displayed, click on the bookmark icon.
3. Search the disk by using the Find function.. You can enter search terms in the box on the Adobe Reader toolbar (use CTRL + F to go directly to the box). Adobe Reader has a very good search function. If you are unfamiliar with it, consult the Help menu in your program.

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Treatment Plans and Interventions for Depression and Anxiety Disorders

SECOND EDITION

CD-ROM

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MEDICATIONS FOR DEPRESSIVE AND ANXIETY DISORDERS

Antidepressants—monoamine oxidase inhibitors (MAO)

Antidepressants—tricyclics

Antidepressants—selective serotonin reuptake inhibitors (SSRIs)

Antidepressants—miscellaneous

Anxiolytics—benzodiazepines

Anxiolytics—miscellaneous

Stimulants

Antipsychotics—phenothiazines

Antipsychotics—miscellaneous

Antimanics

Hypnotics

Intake

FORM 2.1. Intake Form

Patient's name: _____ Today's date: _____

Age: _____ Date of birth: _____ Sex: (Circle one) F M

Address: _____

City: _____ State: _____ Zip: _____

Home telephone: _____ Work telephone: _____

Other telephone: _____

Occupation: _____

Employer: _____

Education: _____

Social Security #: _____

Referred by: _____

Next of kin: _____ Telephone: _____

Emergency contact (if different from above):

Name: _____ Telephone: _____

Marital status: (Circle one) Single Married Separated Divorced Widowed Cohabiting

Spouse's (partner's) name: _____

Spouse's (partner's) occupation: _____

Children (names and ages):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Religious denomination (if any): _____

Do you have insurance coverage? (Circle one) Yes No

Policy #: _____ Percentage coverage per session: _____%

Are you presently seeing another therapist? (Circle one) Yes No

If yes, then therapist's name: _____

Names of previous therapists, and dates seen: (Use back of form if necessary)

Name: _____ Dates: _____ to _____

Name: _____ Dates: _____ to _____

(cont.)

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FORM 2.1. Intake Form (p. 2 of 9)

Name: _____ Dates: _____ to _____

Name: _____ Dates: _____ to _____

Are you currently taking, or have you ever taken, medications for a psychiatric problem? (Circle one) Yes No

If yes, please list the name, dosage, and dates of each medication: (Use back of form if necessary)

Please list the name, address, and telephone number of your prescribing psychiatrist:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office telephone: _____

Have you ever been hospitalized for a psychiatric problem? (Circle one) Yes No

If yes, please list the hospital(s), date(s), and reason(s):

When was the last time you had a physical examination by a doctor, and what was the outcome?

Physician's name: _____ Office telephone: _____

Are there any medical problems that have resulted in a significant impact on you? (Circle one) Yes No

If yes, please describe:

(cont.)

FORM 2.1. Intake Form (p. 3 of 9)

Are you currently taking any medications for medical problems? (Circle one) Yes No

If yes, please list the name and dosage of each medication: (Use back of form if necessary)

Please circle *each* problem below for which you would like help:

- | | | | |
|------------------|-------------------------------|---------------------|--------------------|
| Anxiety | Suicidality | Anger | Decision making |
| Depression | Assertion | Aggression | Violence |
| Fear | Loneliness | Low energy | Hopelessness |
| Headaches | Irritable bowel | Problem solving | Work |
| Inactivity | Shyness | Social skills | Friendships |
| Mood swings | Impulsivity | Meeting people | Overweight |
| Regrets | Sexual problems | Insomnia | Underweight |
| Self-esteem | Physical complaints | Self-criticism | Agitation |
| Marital problems | Difficulty controlling eating | Procrastination | Panic |
| Alcohol abuse | Other substance abuse | Conflict resolution | Obsessive thoughts |

Other (please specify):

Have you experienced any sources of stress in the past year? (Circle one) Yes No

If yes, please describe:

(cont.)

FORM 2.1. Intake Form (p. 4 of 9)

Have you ever experienced a trauma? (Circle one) Yes No

If yes, please describe:

Are there any situations or people you avoid because they make you feel anxious? (Circle one) Yes No

If yes, please describe:

Do you exercise? (Circle one) Yes No

If yes, please describe:

Do you consider your exercise excessive? (Circle one) Yes No

If yes, please describe:

What are your typical recreational activities?

(cont.)

FORM 2.1. Intake Form (p. 5 of 9)

Please describe your eating habits:

How much coffee, tea, or other forms of caffeine do you consume daily?

Have you ever had a problem with eating disorders? (Circle one) Yes No

If yes, which disorder and when?

Overweight: _____

Underweight: _____

Anorexia: _____

Bulimia: _____

Other: _____

Have you ever had, or do you have, a problem with substance abuse? (Circle one) Yes No

If yes, please indicate substance(s) (alcohol, medication, illicit drugs) and dates of use:

Have you ever had a period of 2 days or more when you experienced any of the following? (Circle each one that applies)

Decreased need for sleep

Very talkative

Racing thoughts

Unusually high self-esteem

Unusual desire to spend money

Driving very fast

Easily distracted

Very irritable or angry

(cont.)

FORM 2.1. Intake Form (p. 6 of 9)

Have you ever experienced any of the following? (Circle each one that applies)

Consuming more than five drinks in one day

Feeling an overwhelming need to drink

Driving while intoxicated

Not able to recall events the night after you drink

People close to you thinking you have a drinking problem

Drinking to reduce your anxiety

Is there anything else you would like your therapist to know about you?

FAMILY HISTORY

Mother: (Circle one) Living? Deceased? If deceased, year and cause of death: _____

Marital status: (Circle one) Single Married Separated Divorced Widowed Cohabiting

Occupations: (List past and present)

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

(cont.)

FORM 2.1. Intake Form (p. 7 of 9)

Father: (Circle one) Living? Deceased? If deceased, year and cause of death: _____

Marital status: (Circle one) Single Married Separated Divorced Widowed Cohabiting

Occupations: (List past and present)

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

Siblings: Names, ages, and occupations:

Psychiatric problems? If so, please describe:

FORM 2.1. Intake Form (p. 8 of 9)

Substance abuse? If so, please describe:

Other relatives: Any psychiatric history among your grandparents, aunts, or uncles? If so, please describe:

Stepmother: (Circle one) Living? Deceased? If deceased, year and cause of death: _____

Occupations: (List past and present)

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

Stepfather: (Circle one) Living? Deceased? If deceased, year and cause of death: _____

Occupations: (List past and present)

(cont.)

FORM 2.1. Intake Form (p. 9 of 9)

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

Stepsiblings: Names, ages, and occupations:

Psychiatric problems? If so, please describe:

Substance abuse? If so, please describe:

Depression

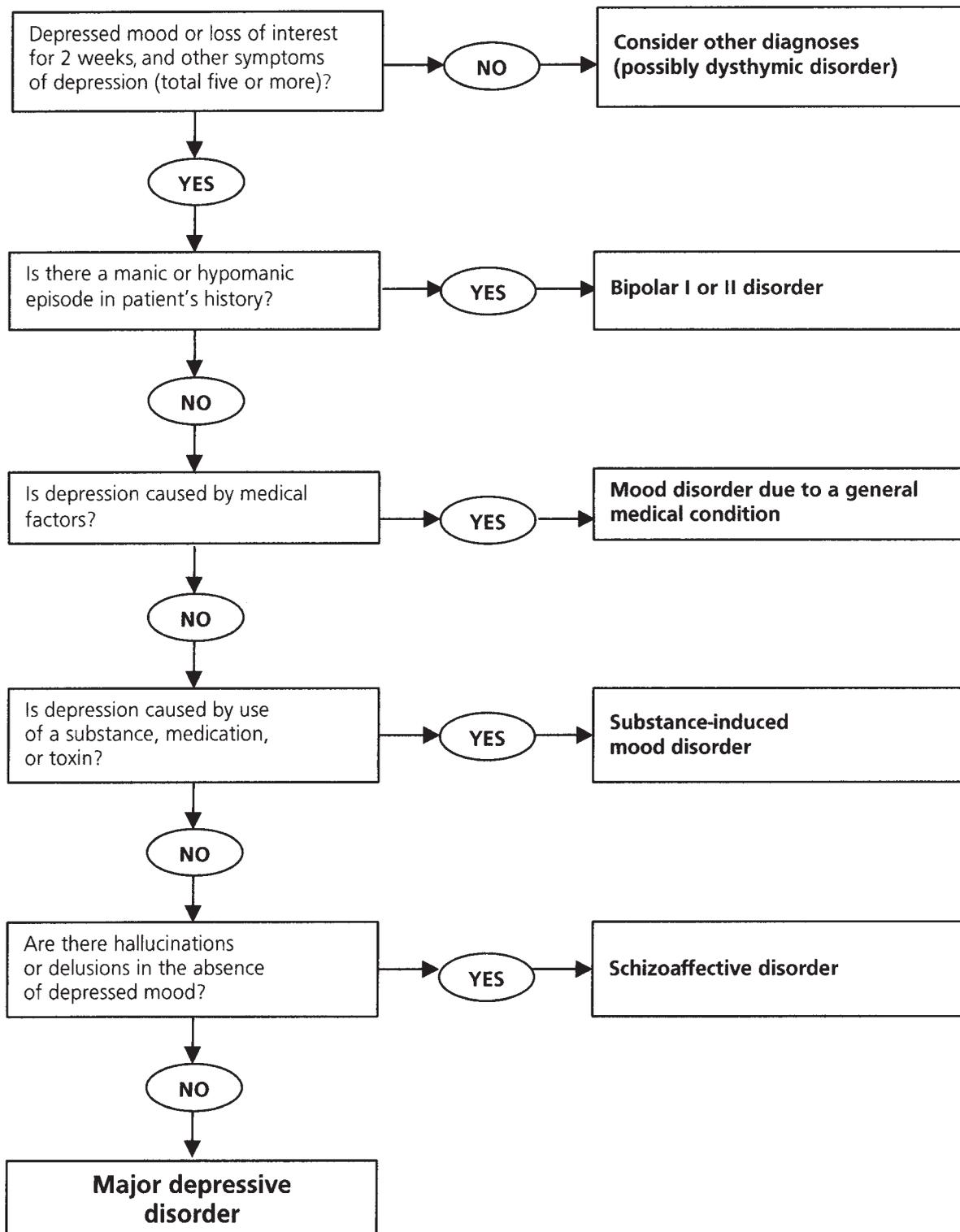


FIGURE 2.1. Diagnostic Flow Chart for Major Depression

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TABLE 2.5. General Plan of Treatment for Depression

- Assessment
 - Tests and clinical interviewing
 - Evaluation of suicidal risk
 - Consideration of medication
 - Socialization to treatment
 - Establishing goals
 - Behavioral activation and other behavioral interventions
 - Cognitive interventions
 - Inoculation against future depressive episodes
 - Phasing out therapy
 - Maintenance treatment
-

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TABLE 2.15. Sample Symptoms for Major Depression

Affective Symptoms

Depressed mood
Irritable mood
Anhedonia
Low motivation

Vegetative Symptoms

Lack of interest in usual activities
Loss of appetite or increased appetite
Weight loss or gain
Insomnia or hypersomnia
Psychomotor agitation or retardation
Fatigue
Low energy

Cognitive Symptoms

Feelings of worthlessness
Excessive guilt
Rumination
Pessimism
Hopelessness
Impaired concentration
Difficulty making decisions

Other Symptoms

Suicidal ideation (specify whether plan is present and whether there have been prior attempts)
Thoughts of death
Specify how long symptoms have been present
Specify whether there have been prior depressive episodes

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TABLE 2.16. Sample Treatment Goals and Interventions for Depression

Treatment goals	Interventions
Eliminating suicidal ideation	Cognitive restructuring, removing access to means, setting up a contract to contact therapist, developing coping strategies for suicidal impulses; developing short-term and long-term goals
Reducing hopelessness	Examining reasons for hopelessness, examining evidence for and against it, behavioral experiments, activity scheduling
Engaging in one rewarding activity/day	Reward planning, activity scheduling, graded task assignment
Reducing negative automatic thoughts	Cognitive restructuring, distraction
Sleeping 7–8 hours/night	Relaxation, insomnia treatment plan
Reducing rumination	Antirumination interventions, metacognitive therapy techniques
Engaging in one assertive behavior/day	Assertion training
Increasing social contacts (three/week)	Social skills training, reward planning, activity scheduling
Increasing self-reward for positive behaviors (one/day)	Reward planning, self-reward
Modifying maladaptive assumptions	Cognitive restructuring, behavioral experiments
Modifying schema of worthlessness (or other schemas—specify)	Cognitive restructuring, developmental analysis, schema work, empty-chair technique, writing letters to origins of schemas, developing adaptive schemas
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Eliminating most or all depressive symptoms (BDI-II < 10 for 1 month)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

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TABLE 2.17. Detailed Treatment Plan for Depression

Sessions 1–3

Assessment

Ascertain presenting problem
Inquire regarding all symptoms
Assess impairment in social, educational, and occupational functioning
Administer standard battery of intake measures (see Form 2.3)
Assess for cognitive, behavioral, and interpersonal deficits (Form 2.4)
Evaluate for comorbid conditions, especially substance abuse
Evaluate for suicidal risk (Form 2.5)
Assess need for medication

Socialization

Inform patient of diagnosis
Develop list of treatment goals
Explain cognitive-behavioral therapy
Provide patient with information handouts on depression (Form 2.7) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
Assign Leahy's (2010) *Beat the Blues Before They Beat You: How to Overcome Depression*

Behavioral Interventions

Identify behavioral targets (behavioral deficits and excesses)
Instruct patient in reward planning and activity scheduling
Encourage client to increase self-reward
Encourage patient to decrease rumination time and passive/socially isolating behavior
Evaluate need for patient to modify personal hygiene, grooming, diet, bingeing, etc.
Evaluate/treat insomnia (provide patient with handout—Form 2.11)

Cognitive Interventions

Train patient in relationship between automatic thoughts and feelings
Train patient in categorizing distorted automatic thoughts (see Form 10.2)
Elicit and challenge automatic thoughts in session
Evaluate reasons for and challenge hopelessness
Establish no-suicide contract (Form 2.6)
Challenge antipleasure thoughts

Medication

Consider medication
Evaluate side effects
Evaluate need to increase dosage

Homework

Have patient continue reading Leahy (2010), record thoughts and moods, categorize automatic thoughts, begin self-directed reward planning and activity scheduling, increase self-reward, assign worry or rumination time, and use graded task assignment

Sessions 4–6

Assessment

Evaluate homework
Evaluate depression (QIDS-SR16, BDI-II) and anxiety (BAI)

(cont.)

TABLE 2.17 (cont.)

Evaluate suicidality
Evaluate any side effects from medication

Behavioral Interventions

Teach and practice assertion skills in session
Encourage patient to increase rewarding behavior toward others
Encourage patient to increase positive social contacts—initiating contact, building support network
Evaluate self-reward
Introduce problem-solving skills

Cognitive Interventions

Identify specific targets: hopelessness, helplessness, indecision, self-criticism, rumination, lack of energy, lack of pleasure
Have patient use Patient's Daily Record of Dysfunctional Automatic Thoughts (Form 2.10)
Use specific cognitive techniques to help patient challenge negative automatic thoughts (see Chapter 10 and Appendix B)
Identify and challenge underlying maladaptive assumptions (again, see Chapter 10 and Appendix B)

Medication

Evaluate side effects
Evaluate need to increase dosage
If no improvement, either increase dosage, add another medication, or change class of medication (consider the need to taper or discontinue one class of medication when adding another class of medication)

Homework

Have patient use Form 2.10; assign specific cognitive techniques for challenging automatic thoughts and assumptions; continue with graded task assignment, social skills training, reward planning, activity scheduling, problem solving

Sessions 7–10

Assessment

As in Sessions 4–6

Behavioral Interventions

Continue to teach and practice problem-solving skills
Train patient in communication skills (active listening, editing communication, empathy)
Continue graded task assignment
Continue assertion and social skills training

Cognitive Interventions

Identify and challenge automatic thoughts that are particularly difficult for patient
Continue identifying and challenging underlying assumptions
Begin to examine personal schemas

Medication

As in Sessions 4–6

Homework

Have patient practice using various techniques to challenge assumptions and schemas; continue graded task assignment, assertiveness, self-reward; and continue practicing communication and problem-solving skills

TABLE 2.17 (*cont.*)

Sessions 11–14

Assessment

As in Sessions 4–6

Behavioral Interventions

Continue to teach and practice problem-solving skills

Continue to train patient in communication skills (active listening, editing communication, empathy)

Continue graded task assignment

Continue assertion and social skills training

Cognitive Interventions

Continue identifying and challenging difficult automatic thoughts and assumptions

Review old automatic thoughts (from previous sessions) and see if they still make sense to patient

Examine origins of schemas and evaluate how schemas have affected important experiences throughout life

Use empty-chair role plays to challenge negative schemas and people who have been the sources of negative schemas

Help patient develop more realistic assumptions and schemas

Help patient develop positive self-statements and “bill of rights”

Medication

As in Sessions 4–6

Homework

Have patient continue identifying and challenging automatic thoughts, assumptions, and schemas; develop list of new, adaptive assumptions and schemas; write out “bill of rights”; continue graded task assignment, assertiveness, and self-reward; and continue practicing communication and problem-solving skills

Sessions 15–18

Assessment

As in Sessions 4–6

Behavioral Interventions

Continue to teach and practice problem-solving skills

Continue graded task assignment

Continue assertion and social skills training

Cognitive Interventions

Help patient continue to develop more realistic assumptions and schemas

Help patient continue work on positive self-statements and “bill of rights”

Review old automatic thoughts (from previous sessions and from homework assignments) and continue challenging them

Plan phase-out of therapy

Have patient identify which interventions were helpful and which were not

Have patient examine previous episodes of depression and describe how he or she will handle depression in the future

Use mindfulness-based cognitive therapy (MBCT)

Emphasize antirumination treatment

Consider maintenance medication

(*cont.*)

TABLE 2.17 (*cont.*)

Homework

Develop plans for how problems can be handled in future

Have patient assign own homework

Have patient indicate which problems he or she will work on once therapy ends

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FORM 2.2. Quick Inventory of Depressive Symptomatology— Self-Report (QIDS-SR₁₆)

Patient's name: _____ Today's date: _____

Please check the one response to each item that best describes you for the past 7 days.

1. Falling Asleep:

- I never take longer than 30 minutes to fall asleep
- I take at least 30 minutes to fall asleep, less than half the time
- I take at least 30 minutes to fall asleep, more than half the time
- I take at least 60 minutes to fall asleep, more than half the time

2. Sleep During the Night:

- I do not wake up at night
- I have a restless, light sleep with a few brief awakenings each night
- I wake up at least once a night, but I go back to sleep easily
- I awaken more than once a night and stay awake for 20 minutes or more, more than half the time

3. Waking Up Too Early:

- Most of the time, I awaken no more than 30 minutes before I need to get up
- More than half the time, I awaken more than 30 minutes before I need to get up
- I almost always awaken at least 1 hour or so before I need to, but I go back to sleep eventually
- I awaken at least 1 hour before I need to, and can't go back to sleep

4. Sleeping Too Much:

- I sleep no longer than 7–8 hours/night, without napping during the day
- I sleep no longer than 10 hours in a 24-hour period, including naps
- I sleep no longer than 12 hours in a 24-hour period, including naps
- I sleep longer than 12 hours in a 24-hour period, including naps

5. Feeling Sad:

- I do not feel sad
- I feel sad less than half the time
- I feel sad more than half the time
- I feel sad nearly all the time

(cont.)

6. Decreased Appetite:

- My usual appetite has not decreased
- I eat somewhat less often or lesser amounts of food than usual
- I eat much less than usual and only with personal effort
- I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat

7. Increased Appetite:

- My usual appetite has not increased
- I feel a need to eat more frequently than usual
- I regularly eat more often and/or greater amounts of food than usual
- I feel driven to overeat both at mealtime and between meals

8. Decreased Weight (Within the Last 2 Weeks):

- My weight has not decreased
- I feel as if I've had a slight weight loss
- I have lost 2 pounds or more
- I have lost 5 pounds or more

9. Increased Weight (Within the Last 2 Weeks):

- My weight has not increased
- I feel as if I've had a slight weight gain
- I have gained 2 pounds or more
- I have gained 5 pounds or more

10. Concentration/Decision Making:

- There is no change in my usual capacity to concentrate or make decisions
- I occasionally feel indecisive or find that my attention wanders
- Most of the time, I struggle to focus my attention or to make decisions
- I cannot concentrate well enough to read or cannot make even minor decisions

11. View of Myself:

- I see myself as equally worthwhile and deserving as other people
- I am more self-blaming than usual
- I largely believe that I cause problems for others
- I think almost constantly about major and minor defects in myself

12. Thoughts of Death or Suicide:

- I do not think of suicide or death
- I feel that life is empty or wonder if it's worth living
- I think of suicide or death several times a week for several minutes
- I think of suicide or death several times a day in some detail, or have actually tried to take my life

13. General Interest:

- There is no change from usual in how interested I am in other people or activities
- I notice that I am less interested in people or activities
- I find I have interest in only one or two of my formerly pursued activities
- I have virtually no interest in formerly pursued activities

14. Energy Level:

- There is no change in my usual level of energy
- I get tired more easily than usual
- I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking, or going to work)
- I really cannot carry out most of my usual daily activities because I just don't have the energy

15. Feeling Slowed Down:

- I think, speak, and move at my usual rate of speed
- I find that my thinking is slowed down or my voice sounds dull or flat
- It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed
- I am often unable to respond to questions without extreme effort

16. Feeling Restless:

- I do not feel restless
- I'm often fidgety, wringing my hands, or need to shift how I am sitting
- I have impulses to move about and am quite restless
- At times, I am unable to stay seated and need to pace around

Total scores can range from 0 to 27. The key to scoring the QIDS-SR₁₆ is as follows:

- Enter the highest score on any one of the four sleep items (items 1–4).
- Enter score on item 5.
- Enter the highest score on any one of the four weight-related items (items 6–9).
- Enter sum of scores for items 10–14.
- Enter the highest score on either of the two psychomotor items (15 and 16).
- Sum the item scores for a total score.

Severity ranges on the QIDS-SR₁₆ are the following: mild depression (6–10), moderate (11–15), severe (16–20), very severe (21–27).

FORM 2.3. Evaluation of Depression: Test Scores, Substance Use, History, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Beck Depression Inventory–II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Global Assessment of Functioning (GAF) _____ Beck Hopelessness Scale _____

Quick Inventory of Depressive Symptomatology–Self-Report (QIDS-SR¹⁶) _____

Dyadic Adjustment Scale (DAS) _____

Elevations on Millon Clinical Multiaxial Inventory–III (MCMI-III): _____

Other questionnaires (specify): _____

Substance use

Current use of psychiatric medications (include dosage): _____

Who prescribes? _____

Past medications (include dosage): _____

Use of alcohol/other drugs (kind and amount): _____

Past substance abuse: _____

(cont.)

History (intake only)

Previous episodes of depression:

Onset	Duration	Precipitating events	Treatment
-------	----------	----------------------	-----------

Previous manic/hypomanic episodes (if any):

Onset	Duration	Precipitating events	Treatment
-------	----------	----------------------	-----------

Suicidal intent: None Weak Moderate Strong

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 2.4. Cognitive, Behavioral, and Interpersonal Assessment of Depression

Patient's name: _____ Today's date: _____

COGNITIVE ASSESSMENT

Describe a situation in which you feel sad or depressed: _____

Complete the following sentence: "I would feel sad because I am thinking ... ": _____

"And this would bother me because it would mean ... ": _____

"I would feel less depressed if ... ": _____

Typical distorted automatic thoughts of this patient:

Mind reading:

Fortunetelling:

Catastrophizing:

Labeling:

Discounting positives:

Negative filtering:

Overgeneralizing:

Dichotomous thinking:

Personalizing:

Blaming:

(cont.)

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Unfair comparisons:

Regret orientation:

What if?:

Emotional reasoning:

Inability to disconfirm:

Judgment focus:

Low frustration tolerance:

Underlying maladaptive assumptions of this patient:

Underlying negative schemas (specify):

Hypothesized earlier childhood or life events:

Compensatory strategies:

Avoidant strategies:

(cont.)

BEHAVIORAL ASSESSMENT

People mean different things when they talk about depression. When you feel sad or you are feeling down, what are you typically doing?

Are there situations that you avoid when you are depressed?

What are some things that you try to do to become less depressed?

Do you find yourself getting stuck on negative thoughts that keep going through your mind?

What do you do to cope with those thoughts and feelings?

Specify examples of each that apply, indicating, if possible, frequency, duration, intensity, and situational determinants:

Low level of behavior:

Withdrawal from others:

Rumination:

(cont.)

Social skill deficits:

Inadequate self-reward:

Inadequate reward in environment:

Exposure to aversive situations:

Inadequate challenge and novelty:

Poor problem-solving ability:

Lack of resources (e.g., financial):

Loss of past rewarding activities:

INTERPERSONAL ASSESSMENT

Specify examples of each that apply:

Frequent arguments:

Loss of relationships:

Lack of assertion:

Not rewarding to others:

Punitive to others:

Frequent complaining:

Rejects support from others:

Few contacts with others:

Deficient or inappropriate appearance/grooming:

FORM 2.5. Evaluation of Suicidal Risk

Patient's name: _____ Today's date: _____

Therapist's name: _____

Evaluate for current suicidal ideation and behavior and for any past incidence of suicidal plans, intentions, or behavior.

Question	Current	Past
Do you have any thoughts of harming yourself? [If yes:] Describe.		
Have you ever felt indifferent about whether something dangerous would happen to you and you took a lot of risk—like you really didn't care if you died or hurt yourself? [If yes:] Describe.		
Have you ever threatened that you would hurt yourself? [If yes:] Whom did you say this to? Why?		
Have you ever tried to hurt yourself on purpose? [If no, go on to p. 3 of form]		
Exactly what did you do to try to hurt yourself?		
How many times have you tried this? When? Describe.		
Did you tell anyone before or after your attempt? Had you threatened to hurt yourself or talked about it before? [If yes:] Describe.		

(cont.)

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FORM 2.5. Evaluation of Suicidal Risk (p. 2 of 5)

Question	Current	Past
Had you planned to hurt yourself, or was it spontaneous?		
What was your state of mind when you attempted to hurt yourself? Were you depressed, spaced out, anxious, relieved, angry, excited? Were you using alcohol, medication, other drugs?		
Did you call someone at that time, or were you discovered by someone? What happened?		
Did you go to a doctor or to the hospital? [If yes:] Which doctor/hospital? [Obtain release of information.]		
Did you feel glad that you were alive? Embarrassed? Guilty? Sorry you didn't kill yourself?		
Did you want to hurt yourself soon after your attempt?		
Was there any event that triggered your attempt? [If yes:] Describe. [If no, go to next page of form]		
What were you thinking after this event that made you want to hurt yourself?		
If something like that happened again, how would you handle it?		

(cont.)

FORM 2.5. Evaluation of Suicidal Risk (p. 3 of 5)

Question	Current	Past
Has any family member or close friend ever hurt him or herself?		
How would you describe your current [past] desire to live? None, weak, moderate, or strong?		
How would you describe your current [past] desire to die? None, weak, moderate, or strong?		
[If current or past desire to die:] What would be the reason for wanting to die or harm yourself? Hopelessness, depression, revenge, getting rid of anxiety, being with a lost loved one again, other reasons?		
[If current or past desire to die:] Have you ever planned to hurt yourself? What was that plan? Why did you [did you not] carry it out?		
Are there any reasons why you would not harm yourself? Explain.		
Do you have more reasons to live than reasons to die?		
[If not:] What would have to change so that you would want to live more?		
Do you own a weapon?		

(cont.)

FORM 2.5. Evaluation of Suicidal Risk (p. 4 of 5)

Question	Current	Past
Do you live on a high floor or near a high bridge?		
Are you saving medications for a future attempt to hurt yourself?		
Do you drive excessively fast?		
Do you ever space out, not knowing what is going on around you? [If yes:] Describe.		
Do you drink more than three glasses of liquor or beer a day? Do you use any medications? Other drugs? Do these substances affect your mood? [If yes:] How?		
Have you written a suicide note? Have you recently written out a will?		
Do you feel there is any hope that things can get better?		
What are the reasons why things could be hopeful?		
Why would things seem hopeless?		
Would you be willing to promise me that you would not do anything to harm yourself until you have called me and spoken with me?		

(cont.)

FORM 2.5. Evaluation of Suicidal Risk (p. 5 of 5)

Question	Current	Past
Is your promise a solemn promise that I can rely on, or do you have doubts about whether you can keep this promise? [If doubts:] What are these doubts?		
Can I speak with [loved ones or a close friend] to be sure that we have all the support that we need?		
[Does this patient need to be hospitalized? Increase frequency of treatment contact and level or type of medication? ECT?]		

Therapist: Summarize dates, precipitating factors, and nature of the patient's previous suicide attempts, if any:

FORM 2.6. No-Suicide Contract

I, _____ [patient's name], agree to contact my therapist and speak with him or her rather than cause any physical harm to myself or commit suicide. If there is an emergency and I am not able to contact my therapist or his or her colleagues, I promise that I will call 911 and/or go to the emergency room for evaluation and help.

Patient's name: _____ Today's date: _____

Signature: _____

Name of witness: _____

Signature: _____

FORM 2.7. Information for Patients about Depression

WHAT IS DEPRESSION?

Many of us have changes in mood, and sometimes we need help. But sometimes we can get stuck in a “down” mood and need help. Depression has a variety of symptoms, such as loss of energy, loss of interest in activities and in life, sadness, loss of appetite and weight, difficulty concentrating, self-criticism, feelings of hopelessness, physical complaints, withdrawal from other people, irritability, difficulty making decisions, and suicidal thinking. Many depressed people feel anxious as well. They often feel worried, nauseated, or dizzy, and sometimes have hot and cold flashes, blurred vision, racing heartbeat, and sweating.

Clinical depression varies from mild to severe. For example, some people complain of a few symptoms that occur some of the time. Other people, suffering from severe depression, may complain of a large number of symptoms that are frequent, long-lasting, and quite disturbing.

Clinical depression is not the same as grieving after the loss of a loved one through death, separation, or divorce. Feelings of sadness, emptiness, low energy, and lack of interest are normal during grief; anger and anxiety can also be part of the normal grief process. Clinical depression differs from normal grief, however, in that clinical depression sometimes may occur without a significant loss. In addition, depression may last longer than grief and includes feelings of self-criticism, hopelessness, and despair.

It would be an unusual person who said that he or she never felt “depressed.” Mood fluctuations are normal and help inform us that something is missing in our lives and that we should consider changing things. But clinical depression is worse than simple fluctuations in mood. Because there are various degrees of depression, the severely depressed patient may wish to consider a number of treatments in combination.

WHO GETS DEPRESSED?

Depression is not something that happens to people who are “unusual” or “crazy.” It is everywhere. Along with anxiety (which occurs more frequently than depression), it is the common cold of emotional problems. During any given year, a large number of people will suffer from major depression: 25% of women and 12% of men will suffer a major depressive episode during their lifetime. The chances of recurrence of another episode after the initial episode are high. Fortunately, there are highly effective treatments that can significantly reduce the likelihood of a relapse.

The reason for the sex difference in prevalence of depression is not entirely clear. Possible reasons may be that women are more willing to acknowledge feelings of sadness and self-criticism openly, whereas men may “mask” or hide their depression behind other problems, such as alcohol and drug abuse. In addition, women are often taught from an early age to be helpless and dependent. Women may also control fewer sources of rewards than men do, and their achievements may be more often discounted.

WHAT ARE THE CAUSES OF DEPRESSION?

There is no one cause of depression. We view depression as “multidetermined”—that is, a number of different factors can cause it. These factors can be biochemical, interpersonal, behavioral, or cognitive. Depression may be caused in some people by factors in one of these areas, but it is just as likely to be caused by a combination of factors from all these areas. Biochemical factors can include your family’s genetic predisposition and your current brain chemistry. Conflicts and losses in interpersonal relationships can be factors in causing depression, as can

(cont.)

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behavioral factors, such as increases in stress and decreases in positive, enjoyable experiences. Cognitive factors include various distorted and maladaptive ways of thinking. Let us look at the behavioral and cognitive factors in a little more detail.

HOW DOES BEHAVIOR AFFECT DEPRESSION?

The following is a more specific list of behavioral factors involved in depression.

1. **Loss of rewards.** Have you experienced significant losses in your life recently—for example, loss of work, friendships, or intimacy? There is considerable research evidence that people who suffer significant life stresses are more likely to become depressed—especially if they lack or do not use appropriate coping skills.

2. **Decrease of rewarding behavior.** Are you engaged in fewer activities that were rewarding for you in the past? Depression is characterized by inactivity and withdrawal. For example, depressed people report spending a lot of time in passive and unrewarding behaviors, such as watching television, lying in bed, brooding over problems, and complaining to friends. They spend less time engaged in challenging and rewarding behaviors, such as positive social interactions, exercise, recreation, learning, and productive work.

3. **Lack of self-reward.** Many depressed people fail to reward themselves for positive behavior. For example, they seldom praise themselves, or they are hesitant to spend money on themselves. Many times depressed people think that they are so unworthy that they should never praise themselves. Some depressed people think that if they praise themselves, they will become lazy and settle for less.

4. **Not using skills.** Are there any social skills or problem-solving skills that you are not using? Depressed people may have difficulty asserting themselves, maintaining friendships, or solving problems with their spouses, friends, or work colleagues. Because they either lack these skills or do not use the skills they have, they have greater interpersonal conflict and fewer opportunities to make rewarding things happen for them.

5. **New demands.** Are there new demands for which you feel ill prepared? Moving to a new city, starting a new job, becoming a parent, or ending a relationship and trying to find new friends can cause significant stress for many people.

6. **Being in a situation where you feel helpless.** Depression may result from continuing to stay in a situation in which you cannot control rewards and punishments. You feel sad or tired, lose interest, and feel hopeless because you believe that no matter what you do, you cannot make things better. Unrewarding jobs or dead-end relationships can lead to these feelings.

7. **Being in a situation of continual punishment.** This is a special kind of helplessness: Not only are you unable to get rewards, but you find yourself criticized by others and rejected. For example, many depressed people may spend time with people who criticize them or hurt them in various ways.

8. **Avoidance and passivity.** You may tend to avoid difficult or unpleasant experiences or feelings. This leads to fewer rewards and a greater sense of helplessness.

Although each of the factors of stress and loss described above may make you prone to depression, they do not necessarily have to result in depression. (For instance, a person may experience a loss but deal with it by increasing rewarding behaviors, learning new skills, redirecting attention and energy toward new goals, and using self-assertion.) Certain ways of thinking can increase your chances of becoming depressed, however. You are more likely to become depressed if you think that you are entirely to blame, that nothing can change, and that you should be perfect at everything. These *interpretations* of stress and loss are the “cognitions” or thoughts that you have about yourself and your environment. Cognitive therapy is specifically focused at identifying, testing, challenging, and changing these excessively negative views of life.

(cont.)

HOW DOES THINKING AFFECT DEPRESSION?

Certain ways you think (your cognitions) can cause depression. Some of these are described below:

1. **Dysfunctional automatic thoughts.** These are thoughts that come spontaneously and seem plausible; however, they reflect distorted perceptions and are associated with negative feelings such as sadness, anxiety, anger, and hopelessness. Examples of some types of these thoughts are the following:

Mind reading: "He thinks I'm a loser."

Labeling: "I'm a failure," "He's a jerk."

Fortunetelling: "I'll get rejected," "I'll make a fool of myself."

Catastrophizing: "It's awful if I get rejected," "I can't stand being anxious."

Dichotomous (all-or-nothing) thinking: "I fail at everything," "I don't enjoy anything," "Nothing works out for me."

Discounting positives: "That doesn't count because anyone could do that."

2. **Maladaptive assumptions.** These include ideas about what you think you *should* be doing. They are the rules by which depressed people think they have to live. Examples include the following:

"I should get the approval of everyone."

"If someone doesn't like me, that means I'm unlovable."

"I can never be happy doing things on my own."

"If I fail at something, then I'm a failure."

"I should criticize myself for my failures."

"If I've had a problem for a long time, then I can't change."

"I shouldn't be depressed."

3. **Negative self-concepts.** People who are depressed often focus on their shortcomings, exaggerate them, and minimize any positive qualities they may have. They may see themselves as unlovable, ugly, stupid, weak, or even evil.

4. **Negative preoccupation with thinking.** Many people get stuck on their negative thoughts and feelings, leading to greater passivity and avoidance.

WHAT IS COGNITIVE-BEHAVIORAL TREATMENT OF DEPRESSION?

The cognitive-behavioral treatment of depression is a highly structured, practical, and effective intervention for patients suffering from depression. This type of therapy treats depression by identifying and addressing the behaviors and thinking patterns that cause and maintain depression. This therapy focuses on your present, here-and-now thoughts and behaviors. You and your therapist will look at how actions, or lack of actions, contribute to your feeling bad or good. There are actions you can take to start feeling better. You and your therapist will also look at the negative and unrealistic ways of thinking that may make you feel depressed. Therapy can give you the tools to think more realistically and feel better.

In cognitive-behavioral therapy, you and your therapist will first identify your symptoms and how mild or severe they are. You will be asked to fill out forms or standardized questionnaires that can scientifically measure your symptoms. These may include the Beck Depression Inventory–II, the Quick Inventory of Depressive Symptomatology–Self-Report, the Global Assessment of Functioning, or other questionnaires. In the initial meetings, you will be asked to select goals you wish to attain—such as increasing self-esteem, improving

(cont.)

communication, reducing shyness, or decreasing hopelessness and loneliness. You and your therapist will monitor your progress in therapy by referring to your initial measures of symptoms and your movement toward the goals that you establish.

HOW EFFECTIVE IS COGNITIVE-BEHAVIORAL THERAPY FOR DEPRESSION?

Numerous research studies conducted at major universities throughout the world have consistently demonstrated that cognitive-behavioral therapy is as effective as antidepressant medication in the treatment of major depression. Moreover, most patients in cognitive-behavioral therapy maintain their improved mood when checked 2 years after ending therapy. In cognitive-behavioral therapy, we hope not only to reduce your symptoms, but to help you learn how to keep those symptoms from coming back.

ARE MEDICATIONS USEFUL?

Various medications have been found to be effective in the treatment of depression. It takes 2 to 4 weeks for you to build up a therapeutic level of the medication in your system. Some medications may have negative side effects. Some of these side effects may be temporary and decrease over time, or they may be handled with combinations of other medications.

WHAT IS EXPECTED OF YOU AS A PATIENT?

Cognitive-behavioral treatment of depression requires your active participation. During the initial phase of therapy, your therapist may request that you come to therapy twice per week until your depression has decreased. You will be asked to fill out forms evaluating your depression, anxiety, and other problems, and to read materials specifically addressing the treatment of depression. In addition, your therapist may ask you at later points, or on a weekly basis, to fill out forms evaluating your depression and other problems that are the focus of therapy. Your therapist may also give you homework exercises to assist you in modifying your behavior, your thoughts, and your relationships. Although many patients suffering from depression feel hopeless about improvement, there is an excellent chance that your depression may be substantially reduced with this treatment.

FORM 2.8. Patient's Weekly Activity Schedule

Patient's name: _____ Today's date: _____

For each hour of the week, fill in what you *actually did* and ratings for how much pleasure and mastery you *actually experienced*. To rate pleasure, use a scale where 0 = "no pleasure" and 10 = "the most pleasure you can imagine," with 5 indicating a moderate amount of pleasure. For example, fill in "talked with friend, 6" in the box for Tuesday at 10 A.M. if you rate yourself as experiencing that amount of pleasure from talking with a friend at that day and hour. To rate mastery (the feeling of effectiveness or accomplishment you get from an activity), use a similar 0–10 scale, and write the rating as the second number after the activity (e.g., "talked with friend, 6/5").

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6 A.M.							
7							
8							
9							
10							

(cont.)

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FORM 2.8. Patient's Weekly Activity Schedule (p. 2 of 3)

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
11							
12 noon							
1 P.M.							
2							
3							
4							
5							
6							

(cont.)

FORM 2.8. Patient's Weekly Activity Schedule (p. 3 of 3)

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7							
8							
9							
10							
11							
12 midnight							
1-6 A.M.							

FORM 2.9. Patient's Weekly Planning Schedule: Predicting Pleasure and Mastery

Patient's name: _____ Date: _____

For each hour of the week, fill in what you *plan to do* and how much pleasure and mastery you *think you will experience*. To rate pleasure, use a scale where 0 = "no pleasure" and 10 = "the most pleasure you can imagine," with 5 indicating a moderate amount of pleasure. For example, if you predict that you will derive a pleasure rating of 6 if you exercise at 8 A.M. on Monday, then write "exercise, 6" in the box for Monday at 8 A.M. To rate mastery (the feeling of effectiveness or accomplishment you get from an activity), use a similar 0–10 scale, and write the rating as the second number after the activity (e.g., "exercise, 6/8").

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6 A.M.							
7							
8							
9							
10							

(cont.)

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FORM 2.9. Patient's Weekly Planning Schedule (p. 2 of 3)

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
11							
12 noon							
1 P.M.							
2							
3							
4							
5							
6							

(cont.)

FORM 2.9. Patient's Weekly Planning Schedule (p. 3 of 3)

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7							
8							
9							
10							
11							
12 midnight							
1-6 A.M.							

FORM 2.10. Patient's Daily Record of Dysfunctional Automatic Thoughts

Patient's name: _____ Date: _____

Time	Situation: Specify what happened, where, and who was involved.	Emotions: Specify emotion and rate its intensity (0–100%).	Automatic thoughts: Write automatic thoughts that preceded emotions; rate each for confidence in accuracy (0–100%).	Rational response: Write rational responses to automatic thoughts; rate each for confidence in accuracy (0–100%).	Outcome: Now rate present confidence in accuracy of original thought, and present intensity of emotion (0–100%).	
					Thought	Emotion

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FORM 2.11. Information for Patients about Insomnia

One of the most troubling consequences of anxiety and depression is insomnia. Some people experience difficulty falling asleep (“onset insomnia,” which is usually linked to anxiety), while others tend to wake prematurely (“early-morning insomnia,” linked to both anxiety and depression). Usually when anxiety and depression lift as a result of treatment, insomnia decreases and sleep becomes more restful. However, several cognitive-behavioral interventions may be used to address your insomnia directly. This handout will outline some of these interventions. However, before undertaking any of them, you should record some baseline information concerning your sleep patterns. You can then compare any changes in these patterns with the baseline measures.

An issue to be addressed at the outset is sleep medication. In general, your sleep problems are related to how various factors affect your “circadian rhythms.” These are the daily hormonal changes that influence when you feel sleepy and when you feel awake. It’s important to let those natural rhythms assert themselves. Therefore, in order for the cognitive-behavioral approach to have its proper effect, you may want to consider getting off whatever sleeping pills you may be taking. Sleeping pills artificially alter your circadian rhythms; they will interfere with the techniques outlined here. Actually, research shows that cognitive-behavioral therapy is far more effective than sleeping pills in reversing insomnia. (Pills rarely work other than in the short term.) Before you make any changes in medication, consult your physician.

It takes a certain amount of time for progress to be felt—perhaps weeks. Because your disturbed sleep patterns have taken a long time to learn, it may take you a while to unlearn them. Do not expect immediate results.

HOW TO OVERCOME YOUR INSOMNIA

1. **Develop regular sleep times.** Try to arrange your life so that you go to bed and get up at about the same times. This may mean sometimes retiring or rising regardless of how tired you are.
2. **Avoid naps.** Naps may feel good and make you feel as if you’re catching up on sleep, but they can throw off your circadian rhythms. You need to retrain your brain to fall asleep and wake up at certain consistent times. So eliminate naps.
3. **Use the bed only for sleep (or sex).** Insomnia is often stimulated by increased arousal just before bedtime or while you are lying in bed awake. Many people with insomnia use their beds for reading, watching television, phone calls, or just plain worrying. As a result, the bed becomes associated with arousal and anxiety. It’s important that the bed be used only for sleep (or sex). Read or talk on the phone in another room. Discourage friends from calling after you are in bed.
4. **Avoid anxiety arousal during the hour before bedtime.** Avoid arguments and challenging tasks before you go to bed. You don’t want to be revved up. Have a wind-down time for the hour before bed. Do something relaxing or boring. Don’t exercise before going to bed.
5. **Get your “worry time” and “to do lists” over with earlier.** Most insomnia is due to excessive mental activity. You are simply thinking too much before you go to bed. You may be lying in bed thinking about what you have to do tomorrow. Or you may be thinking about what happened today. *This is too much thinking.* Set aside a worry time *3 hours or more before* you go to bed. Write out your worries; ask yourself if there is some productive action you need to take; make up a to-do list; plan what you will do tomorrow or this week; accept some limitations (you won’t get everything done, it will be imperfect); and accept some uncertainty. If you are lying in bed at night worrying about something, get out of bed, write down the worry, and set it aside for tomorrow morning. You don’t need to know the answer right now.

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6. **Discharge your feelings.** Sometimes insomnia is due to harboring emotions and feelings that are bothering you. It is useful to set aside “feeling time” several hours before you go to bed and write out your feelings—for example, “I was really anxious and angry when Bill said that to me,” or “I really got depressed after I had lunch with Joan.” Try to mention as many feelings as you can in your writing. Try to make sense of your feelings. Have compassion for yourself, validate your right to have feelings, and recognize that it is OK to feel anxious or depressed some of the time. Then set this aside. Do this 3 hours or more before you go to bed.
7. **Reduce or eliminate intake of liquids and some foods in the evening.** Sleep is often disturbed by urinary or digestive urgency. Avoid liquids in general (especially alcohol), caffeine products, heavy foods, fats, and sugar in the evening. If necessary, consult a nutritionist to plan a diet that encourages sound sleep.
8. **Get out of bed if you’re not sleeping.** If you are lying awake at night for more than 15 minutes, get up and go in the other room. Write down your negative thoughts and challenge them. Typical negative automatic thoughts are “I’ll never get to sleep,” “If I don’t get enough sleep, I won’t be able to function,” “I need to get to sleep immediately,” and “I’ll get sick from not getting enough sleep.” The most likely consequence of not getting enough sleep is that you will feel tired and irritable. Although these are uncomfortable inconveniences, they are not catastrophic.
9. **Don’t try to force yourself to fall asleep.** This will only increase your frustration, and in turn will increase your depression or anxiety. A more effective attitude is to let go of the attempt to fall asleep. Paradoxically, a very effective way of increasing sleep is to practice *giving up* trying to fall asleep. You can say to yourself, “I’ll give up trying to get to sleep and just concentrate on some relaxing feelings in my body.”
10. **Practice repeating your depressed or anxious thoughts.** Like any feared situation or thought, if you repeat it long enough, it becomes boring. You can practice this thought slowly: Stand back in your mind as if you are just “observing the thought,” and repeat it slowly and silently in your mind hundreds of times. Imagine that you are almost a zombie repeating this thought. Don’t try to reassure yourself; just stay with the thought and go slowly.
11. **Eliminate safety behaviors.** To combat your sleep anxiety, you may have been resorting to superstitious behaviors, such as checking the clock, counting, keeping your body motionless, or repeating injunctions to yourself like “Stop worrying.” Try and become aware of these, and give them up. You can, for example, turn the clock away from your bed. Or you can just allow whatever comes into your mind to be there, without trying to control it.
12. **Challenge your negative thoughts.** The whole process of going to sleep is complicated by the fact that your mind develops a whole range of negative thoughts about it. These thoughts then prevent you from sleeping. If you question their validity, they will have less power to cause you anxiety. Here are some typical negative thoughts of people with insomnia, together with what a reasonable response to each one might look like:

Negative thought: “I’ve got to fall asleep right now, or I won’t be able to function tomorrow.”

Rational response: “Actually, there’s no urgency. You’ve done without sleep before. You’ll be a little tired, which is uncomfortable and inconvenient, but hardly the end of the world.”

Negative thought: “It isn’t normal to have this kind of insomnia. It means there’s something wrong with me.”

Rational response: “Unfortunately, insomnia is quite common. Almost everyone experiences it sometimes. No one will think less of you for having it.”

(cont.)

Negative thought: "I could will myself to go to sleep if I tried hard enough."

Rational response: "Trying to force yourself to sleep never works. It increases anxiety, which only fuels your insomnia. It's better to let go of the attempt, and give in to *not* sleeping. Then you can relax a little."

Negative thought: "I need to remember all the things I'm lying awake thinking about."

Rational response: "If something is worth remembering, get out of bed, write it down, and go back to bed. There's plenty of opportunity to plan things tomorrow."

Negative thought: "I never get enough sleep."

Rational response: "This is probably true for most people, but it's simply uncomfortable and inconvenient. It's not the end of the world."

SLEEP RESTRICTION THERAPY: A POWERFUL ALTERNATIVE

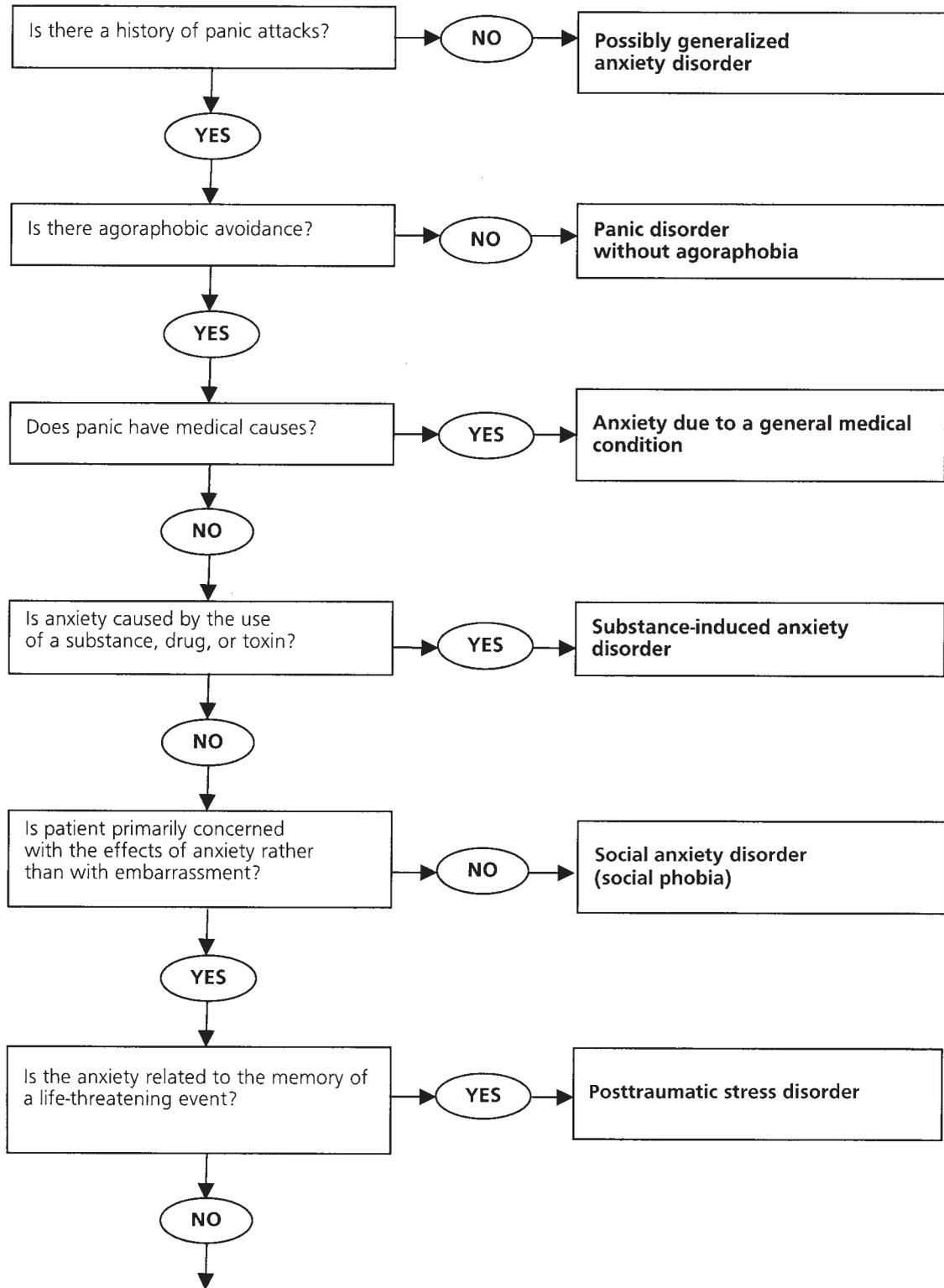
There's a more dramatic treatment for insomnia that is sometimes effective. It's called "sleep restriction therapy." It's based on the idea that you need to retrain your brain to adjust to a circadian rhythm. This is more challenging than the program outlined above, but sometimes it's what works best. It may involve the use of special "bright light" to establish a regular pattern of light and darkness. This can come from sunlight (if controlled by shades or blinds), high-intensity lamps, or certain commercially produced bright lights designed for this purpose. (Lights of this last type are available from Apollo Light, at www.apollolight.com, or Sunbox, at www.sunbox.com, as well as other manufacturers.)

The steps involved in sleep restriction therapy are as follows:

1. **Go without sleep for 24 hours.** This is quite a difficult first step, and many people will feel quite exhausted from it. But it may help you reestablish your circadian rhythms. If you cannot bring yourself to go without sleep for 24 hours, then you can start with the second step.
2. **Start with your minimum sleep time.** Look at your baseline information. What's the minimum amount of sleep you've had over the preceding week? If it's 4 hours, plan to begin by sleeping only 4 hours, no matter how tired you are. If you plan to get up at 7 A.M., then go to bed at 3 A.M.
3. **Increase sleep time gradually.** Add 15 minutes per night to your sleep. Go to bed 15 minutes earlier each night. For example, if you went to bed at 3 A.M., then go to bed at 2:45 A.M. the next night and 2:30 A.M. the night after.
4. **Don't demand 8 hours.** Many of us don't really need a full 8 hours of sleep. See if you're developing less fatigue and more alertness during the day before leveling off.

Although sleep restriction therapy seems quite difficult to many people, it can be highly effective. After you have completed sleep restriction therapy, you may use the 12 steps outlined earlier for healthy sleep. An occasional night of insomnia is to be expected for all of us, but developing the proper sleep habits is quite important. Improving your sleep can have a significant impact on your anxiety and depression.

Panic Disorder and Agoraphobia



(cont.)

FIGURE 3.1. Diagnostic Flow Chart for Panic Disorder with Agoraphobia

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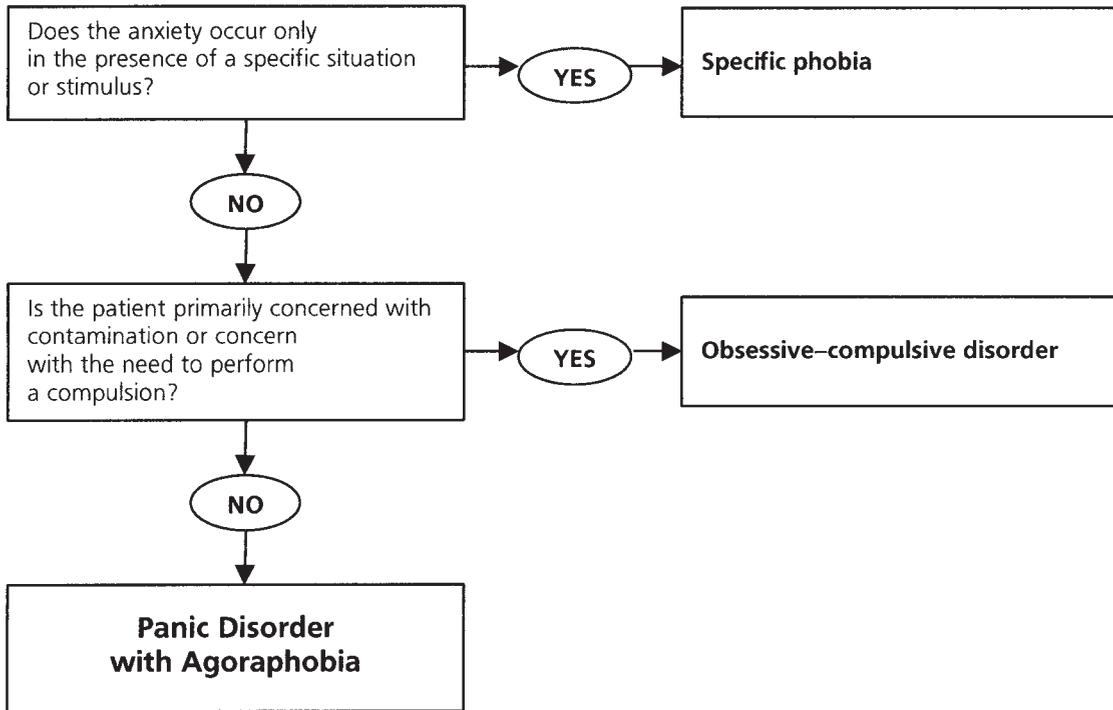


FIGURE 3.1 (cont.)

TABLE 3.2. General Plan of Treatment for Panic Disorder and Agoraphobia

- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
- Socialization to treatment
- Construction of a fear hierarchy
- Breathing retraining
- Relaxation training (only if chronic somatic tension is present)
- Cognitive interventions
 - Identifying and modifying automatic thoughts
 - Identifying and modifying maladaptive assumptions
 - Identifying and modifying personal schemas
- Behavioral interventions
 - Panic induction
 - Construction of a fear hierarchy
 - Exposure to fear hierarchy
- Coping with life stress
- Phasing out treatment

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TABLE 3.3. Sample Symptoms for Panic Disorder and Agoraphobia

<u>Panic disorder</u>	Fear of dying
Panic attacks (specify frequency)	Fear of going crazy
Heart racing	Fear of having future panic attacks
Palpitations	Specify any change in behavior as a result of panic attacks
Sweating	
Shaking	
Difficulty breathing	<u>Agoraphobia</u>
Chest pain	Specify situations feared—examples:
Tightness in chest	Fear of being alone
Nausea	Fear of crowded places
Dizziness	Fear of being in public
Feeling faint	Fear of bus, subway, car, train, plane
Derealization	Fear of having a panic attack
Depersonalization	Unable to go places without a companion
Numbness	Specify which feared situations are avoided
Tingling	
Chills	
Hot flashes	
Fear of losing control	

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TABLE 3.4. Sample Treatment Goals and Interventions for Panic Disorder and Agoraphobia

Treatment goals	Interventions
Reducing physical symptoms of anxiety/panic	Muscle and breathing relaxation training
Acquiring breathing skills	Breathing relaxation and rebreathing training
Eliminating conditioned anxiety response to physical sensations	Exposure
Stating belief that physical anxiety symptoms are not harmful	Cognitive restructuring, behavioral experiments
Engaging in all previously avoided activities	Exposure
Eliminating safety behaviors	Exposure
Modifying schemas of vulnerability and need for control (or other schemas—specify)	Cognitive restructuring, developmental analysis
Reporting that fear of future panic attacks has been reduced to less than 1 on a scale of 0–10	Cognitive restructuring, skills review, and practice
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
No panic attacks for 1 month	All of the above
Eliminating all avoidance behavior	All of the above
Scores on anxiety tests (BAI, PDSS, etc.) in normal range	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

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TABLE 3.5. Detailed Treatment Plan for Panic Disorder and Agoraphobia

Session 1

Assessment

- Inquire regarding all symptoms
- Administer standard battery of intake measures (see Form 3.2), plus additional anxiety questionnaires as appropriate
- Administer Evaluation of Anxiety and Avoidance for Patients (Form 3.3)
- Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
- Assess motivation and eligibility for treatment
- Evaluate patient's ability to induce relaxation in session
- Refer for evaluation of, or evaluate, need for medication
- Evaluate need for substance abuse counseling or detoxification
- Evaluate reliance on safety behaviors or safety persons

Homework

- Have patient begin self-monitoring of panic and anxiety symptoms (Form 3.4)
- Have patient begin identifying automatic thoughts and emotions in feared situations (Form 3.6)
- Have patient construct a list of feared and avoided situations

Session 2

Assessment

- Examine patient's typical thoughts and feelings in feared situations
- Examine panic and anxiety symptoms listed in self-monitoring

Socialization to treatment

- Inform patient of diagnosis
- Describe panic disorder and agoraphobia
- Provide patient with information handouts on panic disorder and agoraphobia (Form 3.5) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
- Develop list of treatment goals

Medication

- Consider medication (if patient is not already using it) and review side effects and efficacy

Homework

- Assign self-help material: Wilson's (2009) *Don't Panic* or Leahy's (2009) *Anxiety Free*
- Have patient continue self-monitoring with Forms 3.4 and 3.6

Session 3

Assessment

- Readminister self-report questionnaires to assess mood and track progress
- Review panic symptoms, avoidance/escape/safety behaviors

Interventions

- Teach breathing retraining (caution against using it as a safety behavior)
- Teach progressive muscle relaxation (only if chronic overarousal is present; caution against using it as a safety behavior)

Medication

- Evaluate side effects
- Evaluate need to adjust dosage

(cont.)

TABLE 3.5 (*cont.*)

If no improvement, either increase dosage, add another medication, or change class of medication (consider the need to taper or discontinue one class when adding another class)

Homework

Have patient practice breathing exercises (assigned each week except during exposure and unless used as a safety behavior)

Have patient continue self-monitoring as above

Session 4

Assessment

Readminister self-report questionnaires to assess mood and track progress

Review panic symptoms, avoidance/escape/safety behaviors

Behavioral Interventions

Prove rationale for exposure

Have patient begin constructing a fear hierarchy of items from least to most feared (Form 3.8)

Introduce patient to panic induction, imaginal exposure, and/or *in vivo* exposure (as deemed appropriate)

Medication

As in Session 3

Homework

Have patient engage in panic induction, *in vivo* exposure, and/or imaginal exposure (as appropriate) at home

Have patient continue self-monitoring as above

Sessions 5–8

Assessment

Readminister self-report questionnaires to assess mood and track progress

Have patient complete and modify fear hierarchy if needed

Cognitive Interventions

Elicit patient's automatic thoughts associated with anxiety/panic

Identify patient's misappraisals about panic and modify/challenge as appropriate (see Chapter 10 and Appendix B)

Other Interventions

Introduce stress management

Medication

As in Session 3

Homework

Have patient continue panic induction, *in vivo* exposure, and/or imaginal exposure (as appropriate) exercises at home

Have patient identify and modify automatic thoughts

Sessions 9–10

Assessment

Readminister self-report questionnaires to assess mood and track progress

Track progress in identifying and modifying thoughts and in conducting panic induction/exposure

TABLE 3.5 (*cont.*)

Cognitive Interventions

Help patient identify underlying themes evident in automatic thoughts (i.e., maladaptive assumptions)
Examine advantages/disadvantages of assumptions, evidence for/against assumptions
Help patient generate new, adaptive assumptions
Help patient continue modifying automatic thoughts (focus on self-instruction to decatastrophize panic symptoms)
Help patient develop self-instructions for anxiety and stress

Behavioral Interventions

Help patient plan and conduct exposure to situations higher in fear hierarchy

Medication

As in Session 3

Homework

Have patient continue modifying automatics thoughts and maladaptive assumptions
Have patient continue *in vivo* exposure, imaginal exposure, and/or panic induction (as appropriate)
Have patient test appraisals (write down predictions before exposure, and test outcome of predictions after exposure session is over)

Sessions 11–12

Assessment

Readminister self-report questionnaires to assess mood and track progress
Assess attainment of goals to determine whether treatment may be tapered off
Track progress in identifying and modifying automatic thoughts and maladaptive assumptions
Track progress in conducting exposure/panic induction
Assess and address any residual symptoms (including symptoms of comorbid disorders)
Assess any residual life problems related to panic/agoraphobia

Cognitive Interventions

Help patient identify schemas
Examine schema maintenance behaviors, origins of schemas
Help patient modify schemas
Help patient continue modifying automatic thoughts and assumptions
Review past negative predictions and outcomes

Behavioral Interventions

Continue with panic induction, imaginal exposure, and/or *in vivo* exposure (as necessary/appropriate)

Other Interventions

Stress management: Help patient develop self-instructions for anxiety and stress
Begin planning phase-out of treatment
Evaluate need for assertion training, relationship enhancement skills, mutual problem solving, ability to construct alternatives

Homework

Have patient develop own homework
Assign continued exposure to anxiety-provoking situations/panic induction (as necessary/appropriate)

(*cont.*)

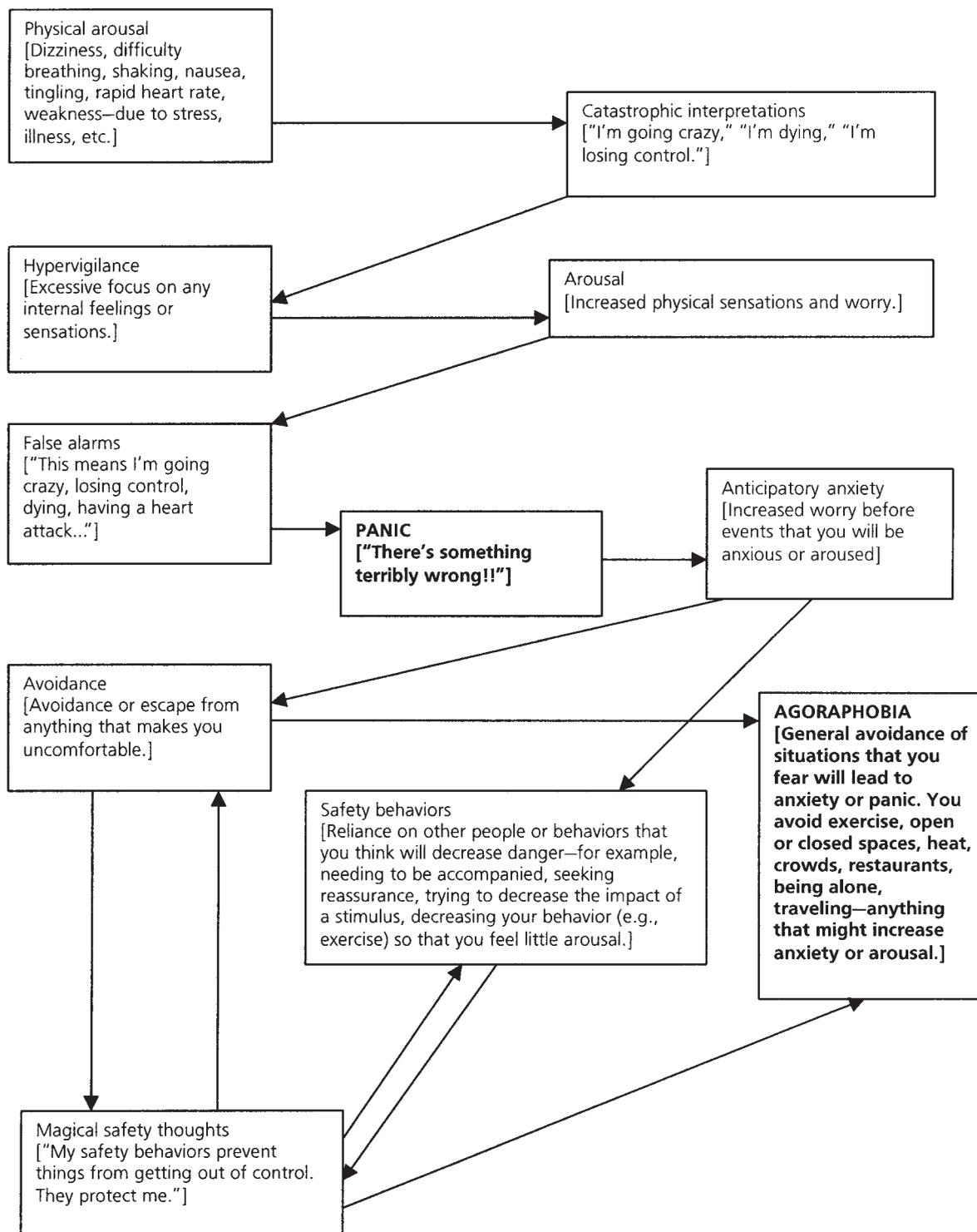
TABLE 3.5 (*cont.*)

Have patient write down predictions before exposure, identify cognitive challenges, and record outcome
Have patient monitor and challenge all types of cognitive distortions related to current everyday
conflicts

Have patient anticipate anxiety-provoking situations that might arise and list possible coping strategies
(behavioral, interpersonal, and cognitive)

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FORM 3.1. Cognitive–Behavioral Model of Panic Disorder and Agoraphobia for Patients



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FORM 3.2. Evaluation of Panic Disorder and Agoraphobia: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Structured Clinical Interview for DSM-IV-TR Axis I (SCID) _____

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) _____

Beck Depression Inventory-II (BDI-II) _____

Beck Anxiety Inventory (BAI) _____

Panic Disorder Severity Scale (PDSS) _____

Mobility Inventory _____

Fear Questionnaire (Agoraphobia subscale) _____

Global Assessment of Functioning (GAF) _____

Other questionnaires (specify): _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of panic/agoraphobia:

Onset	Duration	Precipitating events	Treatment
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(cont.)

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Key symptoms

Panic attacks (indicate average frequency, duration, intensity, whether limited or full-blown symptoms, and physical and cognitive symptoms): _____

Avoidance/escape and safety behaviors: _____

External triggers of anxiety (list places, situations, activities avoided or feared): _____

Internal triggers of anxiety (list panic symptoms avoided or feared): _____

Feared consequences (if none reported, reevaluate after implementing cognitive strategies): _____

Treatment progress (later evaluations only)

Situations still avoided: _____

Situations approached that were previously avoided: _____

Recommendations

Medication evaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 3.3. Evaluation of Anxiety and Avoidance for Patients

Patient's name: _____ Today's date: _____

Which of the following situations do you avoid? (Circle each one.)

- | | | |
|-----------------|-----------------|------------------|
| Restaurants | Stores | Malls |
| Subways | Buses | Airplanes |
| Elevators | Stairwells | Trains |
| Walking outside | Exercise | Bridges |
| Driving | Riding in a car | Viewing horizons |
| Being out alone | Tunnels | Open fields |
| Sunlight | Heights | Being home alone |

Other situations avoided: _____

The three situations that I fear the most are:

1. _____
2. _____
3. _____

Do you avoid any of the following public situations because you might appear anxious? (Circle.)

- | | |
|--------------------------------------|--|
| Public speaking, eating, or drinking | Using a toilet or urinal not in your house |
| Undressing in a locker room | Parties |
| Family gatherings | Classrooms |
| Eye contact | Standing close to someone |

Other situations: _____

I fear that in the situations circled in the lists above, I will become anxious and (check as many of the following that apply):

- ___ I will have a heart attack or become physically ill.
- ___ I will lose control and go insane.
- ___ I will lose control and embarrass myself.
- ___ I will not be able to get to a toilet in time.

(cont.)

FORM 3.3. Evaluation of Anxiety and Avoidance for Patients (p. 2 of 3)

___ I will be harmed by someone.

___ I am not afraid of my anxiety; I am afraid of the situation (for example, I am afraid the plane I am riding on will crash).

___ I will collapse.

___ People will see that I am anxious.

___ Other: _____

___ None of the above apply to me.

When did you start avoiding each of these situations?

Which of the following have you experienced in the situations you try to avoid? (Circle.)

Palpitations Heart pounding Chest pain or discomfort

Sweating Trembling Shaking

Shortness of breath Smothering Choking

Nausea Dizziness Light-headedness

Numbness Tingling Chills or hot flashes

Feeling that I myself am not real

Feeling that the situation is not real

Other: _____

During the past week, has there been any time when you experienced four of the symptoms listed above? (Circle.)

No Yes Which symptoms? _____

What would you say your average level of anxiety is during the last week? (Circle.)

None (0) Slight (2.5) Somewhat (5) Very (7.5) Extreme (10)

Do you ever wake up in a panic? (Circle.) Yes No

Do you worry about having anxiety or panic attacks? (Circle.) Yes No

What are some current stressors in your life?

(cont.)

FORM 3.3. Evaluation of Anxiety and Avoidance for Patients (p. 3 of 3)

How many coffees or caffeinated drinks do you have per day? _____

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

Have you ever been diagnosed as having hyperthyroidism, Cushing's syndrome, hyperventilation, mitral valve prolapse? (Circle.)

What medical conditions do you have now?

Who treats each of these?

Which of the following do you do to make yourself feel safe when you are afraid of having a panic or anxiety attack? (Circle any that apply.)

Ask for reassurance

Take someone along when you go out

Repeat thoughts or words to yourself

Look around for signs of danger

Focus on physical sensations to see if you are OK

Clutch things for support

Sit down

Pace

Tense my body or hands

Take deep breaths (try to calm myself)

Other behaviors: _____

FORM 3.4. Patient's Panic Record

Patient's name: _____

Date/time/ situation	Anxiety before entering situation (0–100%)	Predictions/ thoughts and confidence in accuracy of them (0–100%)	Physical sensations while in situations	Rating of actual anxiety in situation (0–100%)	Outcome (what happened)

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FORM 3.5. Information for Patients about Panic Disorder and Agoraphobia

WHAT ARE PANIC DISORDER AND AGORAPHOBIA?

Almost everyone feels anxious at times. But panic attacks are characterized by severe levels of anxiety, which you may misinterpret as an indication that you are having a heart attack or another medical problem, going insane, or completely losing control. During a panic attack, you may feel shortness of breath, tingling sensations, stomach distress, ringing in your ears, a sense of impending doom, trembling, light-headedness, sensations of choking, chest pain, sweating, and heart pounding. You should first see your physician in order to rule out medical causes for these symptoms, such as hyperthyroidism, caffeine addiction, mitral valve prolapse, or other causes. Once medical causes are ruled out, it is important that a qualified mental health professional evaluate you to determine whether you suffer from “panic disorder.”

Panic disorder is often called the “fear of fear,” because people who suffer from this disorder become afraid of the symptoms of fear (or a “panic attack”) and interpret these symptoms to mean that something is imminently wrong with them. Fear normally occurs when we are in true danger, and it serves as an alarm or a signal to our brains that we are in danger, so that we can protect ourselves against it. The symptoms of fear (heart pounding, overbreathing, etc.) are designed to energize us for either running or fighting danger (this is called the “fight-or-flight response”). For example, our hearts pound fast when we are in danger in order to pump more blood, which carries oxygen. Oxygen gives us more energy to run or fight when we are faced with danger. This is a natural response to actual danger, or what we call a “true alarm,” and we have had this system built in for millions of years.

In panic disorder, your body thinks you are in danger, even though no danger is actually present. When fear comes in the absence of danger, we call it a “false alarm.” It is like a fire alarm going off even though there is no fire. Over time, this false alarm becomes a “learned alarm,” meaning that you begin to fear the very symptoms of fear that are designed to protect you from true danger, because you don’t understand why you are experiencing these symptoms. You begin to assume that having a panic attack is dangerous—that it means there is something wrong with you. But as you begin to perceive panic attacks as dangerous, you keep triggering more fear or more panic attacks in the future, as a way of coping with what you believe is dangerous. The irony of panic disorder is that you begin to fear the very symptoms that are designed to protect you from danger. “Believing” that you are in danger, your brain keeps producing more and more fear (or more and more panic attacks), because in a sense it “does not realize” that what you are afraid of are the very symptoms of fear itself and that there is no true danger present.

Given that they believe that panic attacks are dangerous, individuals with panic disorder begin to worry about having future attacks. They also begin to fear and avoid anything that mimics symptoms of panic and brings on similar sensations (heat, exercise, sunlight, pleasure or excitement, sexual arousal, anger, etc.). Individuals with panic disorder begin to focus on these internal sensations: “My heart is pounding—I’m going to have a heart attack,” or “I’m feeling weak and dizzy—I’m going to collapse.” Many individuals with panic disorder also experience panic when they are asleep.

Many patients who have panic disorder also experience “agoraphobia.” Individuals with agoraphobia fear places or situations from which escape might be difficult if they have a panic attack (e.g., “I may have an anxiety attack on the subway and faint in front of everyone”). They may avoid being out alone, being home alone, supermarkets, trains, airplanes, bridges, heights, tunnels, open fields, driving, elevators, and the like. These individuals fear that they will have a panic attack in these situations and, as a result, exert great efforts either to avoid or to escape the situations (e.g., “I need to get out of here”). In fact, avoidance and escape become

(cont.)

the major coping mechanisms for handling anxiety. When these situations cannot be avoided, the individuals typically come up with various ways to make themselves feel “safe” (e.g., carrying around a bottle of water). Many people with panic disorder and agoraphobia enlist a “safe person”—someone who accompanies them in case they become anxious and need to escape.

Even though their avoidance/escape may have led to few or no anxiety attacks in months, individuals with panic disorder and agoraphobia continue to worry about the next attack. The world becomes smaller and smaller as a result of their avoidance. Because of this constriction in their lives, many individuals with panic disorder and agoraphobia become depressed and chronically anxious, and they begin to medicate themselves with alcohol, Valium, or Xanax.

Furthermore, although these efforts are successful in the short term, in the long run they actually strengthen these individuals’ beliefs that they are in danger and in need of protection. Therapy is designed to help “retrain” the brain that the feared situations are not dangerous, that panic attacks are harmless symptoms of fear, and that no safety behaviors are needed.

WHAT ARE THE CAUSES OF PANIC DISORDER AND AGORAPHOBIA?

Although in any given year 30–40% of the general population will have a panic attack, most of these people will not have a catastrophic interpretation of their panic attack and develop panic disorder. Panic disorder and agoraphobia occur in individuals who appear to be vulnerable to them. Research suggests that they run in families and appear to result from a combination of genetics, temperament, biological factors, and psychological vulnerabilities. People with anxiety may have a temperament that makes them more vulnerable to developing panic disorder. Research also shows that anxiety can be inherited, may be the result of biological factors, and/or may be learned through early experiences. Early experiences linked to the development of panic disorder include those that teach individuals to perceive the world as a dangerous place, and specifically to perceive internal bodily sensations as harmful. Individuals with panic disorder tend to focus excessively on their physical sensations and to develop catastrophic interpretations of sensations. For example, they may focus on their heart rate and jump to conclusions about having heart attacks.

Many situations that activate panic and agoraphobia are also situations that earlier in our evolutionary history were truly dangerous to our ancestors. For example, being trapped in a tunnel could lead to suffocation or collapse; heights might be dangerous; in open fields, individuals were more susceptible to predators (like lions or wolves); public places might have brought our ancestors into contact with hostile strangers. Thus we now view many of the fears of agoraphobia as reminiscent of these earlier instinctive and adaptive fears. However, these situations are not dangerous today.

Initial panic attacks may also be activated in vulnerable individuals by stressful situations—for example, leaving home, relationship conflict, surgery, new responsibilities, or physical illness. Many people who have panic disorder and agoraphobia also experience depression, partly as a consequence of their feeling out of control and feeling unsure about how to handle their problem.

WHAT ARE SOME COMMON MISCONCEPTIONS ABOUT PANIC DISORDER AND AGORAPHOBIA?

Most individuals misinterpret their panic symptoms as a sign of a dangerous medical condition, serious mental illness, or loss of control. They may believe that they actually have heart disease or schizophrenia; that they may lose touch with reality, faint, or have a stroke; or that other frightening things may or will happen. Individuals with panic disorder and agoraphobia may also fear that having panic attacks is a sign of a flaw or weakness, and may become depressed, dependent, and self-critical as a result.

(cont.)

Some people may also incorrectly believe that panic attacks are just a symptom of deeper-seated problems. Individuals with panic disorder and agoraphobia often have unrealistic beliefs about anxiety, such as “All anxiety is bad” and “I have to get rid of my anxiety immediately.” Others believe that because they have had panic attacks and agoraphobia for many years—and because traditional therapy has not been helpful for these problems—they can never improve.

Educating patients that panic disorder and agoraphobia are extremely responsive to treatment is critical for treatment to succeed. Cognitive-behavioral therapy, with or without medication, is extremely effective in the treatment of panic disorder and agoraphobia. This type of therapy helps people correct their myths, misconceptions, and judgments about these disorders. Patients are helped to accept that they have an illness that can be treated by using psychotherapeutic strategies, and are helped to understand that it can be treated effectively without long-term therapy exploring childhood experiences.

HOW EFFECTIVE IS COGNITIVE-BEHAVIORAL THERAPY FOR PANIC DISORDER AND AGORAPHOBIA?

Fortunately, there have been a number of studies examining the effects of cognitive-behavioral therapy for panic disorder and agoraphobia. These studies have been done at Oxford University in England, the University of Pennsylvania, the State University of New York at Albany and at other universities, medical schools, and clinics. Over a course of 12–15 sessions, the efficacy ranges from 85% to 90%. Furthermore, once treatment is terminated, most patients who are tested 1 year later have maintained their improvement.

MEDICATIONS FOR PANIC DISORDER AND AGORAPHOBIA

Many medications that are useful in the treatment of panic disorder and agoraphobia. These include a wide range of antidepressants (such as Prozac, Zoloft, and, Tofranil), as well as Xanax and other medications for anxiety. These medications help reduce symptoms of panic disorder and agoraphobia, but once you terminate the medication, your panic symptoms may return. Consequently, we recommend that even if you use medication, you should also include cognitive-behavioral therapy.

WHAT ARE SOME OF THE STEPS IN COGNITIVE-BEHAVIORAL TREATMENT?

The cognitive-behavioral treatment of panic disorder and agoraphobia is organized around several goals: first, helping you to understand the nature of anxiety, panic, and agoraphobia; second, determining the range of situations that you avoid or fear; third, evaluating the nature of your symptoms, their severity and frequency, and the situations that elicit your panic; and, fourth, determining whether any other problems coexist with panic—for example, depression, other anxieties, substance abuse, overeating, loneliness, or relationship problems.

Your therapy may include some or all of the following treatments: educating you about panic so that you learn not to fear it; breathing retraining; relaxation training; inducing panic (to show your brain that panic attacks are harmless and that you are not in danger); gradual exposure to situations that elicit panic; identification and modification of your misinterpretations of your panic or arousal (e.g., “My heart is pounding, so I must be having a heart attack”), as well as the assumptions (e.g., “Physical sensations are dangerous”) and beliefs (e.g., “I am fragile and weak”) on which the misinterpretations may be based; coping with life stresses; assertion training (when needed); and training in the ability to recognize and reduce your panic symptoms when they occur. Any other problems that you may have (such as depression) may also be addressed in the therapy.

(cont.)

WHAT IS EXPECTED OF YOU AS A PATIENT

Cognitive-behavioral therapy is not a passive experience for patients. You are expected to come to sessions weekly (sometimes more than once per week), fill out forms that evaluate your problems, and do therapy assignments between sessions that you and your therapist plan and assign. As indicated, most patients who participate in this treatment experience improvement—and some experience rapid improvement. *Even if you experience rapid improvement, however, you should complete the full treatment package.* Premature dropout from treatment increases the likelihood that you will have relapses.

The course of treatment is planned for 12 sessions. The first few sessions are used for evaluation and explanation of the treatment with the remaining sessions used to implement strategies. After acute treatment is over, follow-up sessions may be scheduled biweekly, monthly, and so on to maintain gains and prevent relapse.

The treatment package that we use combines the treatment techniques developed at Oxford University, the University of Pennsylvania, and the State University of New York at Albany. We view the treatment as a way in which you can learn how to help yourself. That is why doing homework in therapy is so important.

FORM 3.6. Patient's Most Common Automatic Thoughts When Anxious/Panicking

Patient's name: _____ Today's date: _____

Check every automatic thought that you have when you start getting anxious or panicking. Then rank your top three automatic thoughts, using 1 for the thought you have most often, and 2 and 3 for the next most frequent thoughts.

____ I'll go insane.

____ I'll embarrass myself.

____ I'll lose control.

____ I'll start yelling.

____ I'll have a panic attack.

____ I'll become violent.

____ I'll have a heart attack.

____ I'll start crying.

____ I'll faint.

____ I'll start shaking.

____ I'll go into a coma.

____ I'll kill or harm myself.

____ I'll be unable to escape.

____ I'll never stop feeling this way.

____ I'll be unable to get home.

____ I'll vomit.

____ I'll be unable to get to the bathroom.

____ I won't be able to breathe.

____ I'll choke/suffocate.

____ I will die.

____ I'll be unable to handle it.

____ I'll have a nervous breakdown.

Other thoughts: _____

FORM 3.7. Coping Statements for Patients

Normalize your anxiety:

Anxiety is normal.

Everyone has anxiety.

Anxiety shows that I am alert.

Anxiety may be biologically programmed (this may be the “right response at the wrong time”—there is no danger that I have to escape from).

Take the danger away:

Anxiety is arousal; it is not dangerous.

I’ve been through this before, and nothing bad has happened.

Anxiety passes and goes away.

Challenge your negative thoughts:

I’m having false alarms.

I’m not going crazy or losing control.

These sensations are not dangerous.

People can’t see my feelings.

I don’t need to have 100% control.

Learn from the past:

I’ve made many negative predictions before that haven’t come true.

I have never gone crazy, had a heart attack, or died from my anxiety.

Remember that panic is overbreathing not underbreathing—I will not die from it.

Plan acceptance:

I can sit back and watch my arousal.

I can accept that my arousal goes up and down.

I can observe my sensations increasing and decreasing.

I can accept my arousal and examine my negative thoughts.

FORM 3.9. Your New Rule Book for Your Panic and Agoraphobia

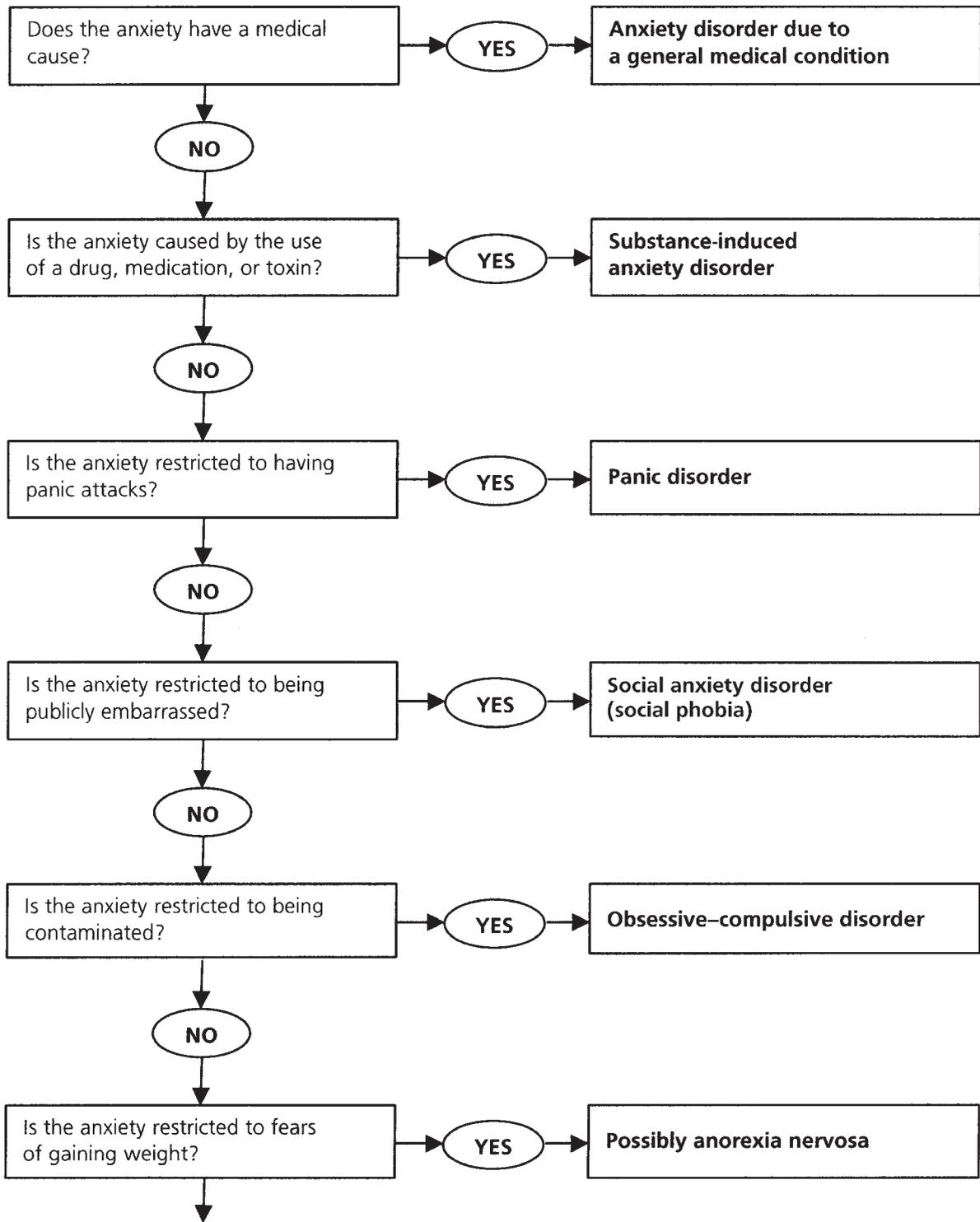
Steps in developing panic and agoraphobia	Rational way of looking at the situation
<p>Initial physiological arousal [Dizzy, difficulty breathing, shaking, nausea, tingling, rapid heart rate, weakness due to stress/illness, etc.]</p>	<p>Arousal is not dangerous. It's perfectly reasonable for anyone to have some unpleasant or unexpected experiences of feeling dizzy, short of breath, or rapid heartbeat. If you know that almost everyone has these experiences at times, then maybe this is normal.</p>
<p>Catastrophic interpretation ["I'm going crazy," "I'm dying," "I'm losing control."]</p>	<p>Nothing terrible is really happening. People don't go crazy because they feel dizzy or because their hearts are beating rapidly. Insanity is defined by hearing voices, seeing apparitions, or having delusions that the world is plotting against you. Heart attacks are not the same thing as your heart beating rapidly. Your heart beats rapidly when you are excited, exercising, or having sex. Arousal is not the same thing as losing control.</p>
<p>Hypervigilance [You are overly focused on any internal feelings or sensations.]</p>	<p>You don't need to detect danger—because there is no danger. You may think that focusing on your heartbeat, breathing, and dizziness will help you catch things before they get out of hand. But it is really this overfocus on your internal sensations that makes you more anxious. You can direct your attention to things outside of you. For example, when you find yourself focusing on your heartbeat, redirect your attention back to the situation you are in.</p>
<p>False alarms ["This means I'm going crazy, losing control, dying, having a heart attack ... "]</p>	<p>Nothing terrible is happening—once again! Increased heart rate and rapid breathing may simply be signs of feeling anxious. How many times before have you misinterpreted these sensations? Why should they be dangerous now? Hasn't your doctor told you that you are OK? People don't go insane because they are anxious. Have you really lost control because you were breathing rapidly or because you were dizzy?</p>
<p>Anticipatory anxiety [Increased worry before events that you will be anxious/aroused.]</p>	<p>You don't need to worry, since there is nothing dangerous about anxiety or arousal. What if you are anxious in the future—so what? Anxiety is normal; everyone feels anxious some of the time. Haven't you done a lot of things even when you were anxious? Do you think that worrying about it will keep you from being anxious? You should plan on tolerating anxiety, so that you can learn that there is nothing to be afraid of. Think of anxiety as increased arousal—very much like the arousal (such as increased heart rate and breathing) that you feel when you are exercising.</p>

(cont.)

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Steps in developing panic and agoraphobia	Rational way of looking at the situation
<p>Avoidance [Avoiding or escaping from anything that makes you uncomfortable.]</p>	<p><i>You need to do the things that make you anxious.</i> Avoiding situations that make you anxious only adds to your future anxiety. Exactly what do you predict will happen if you confront these situations? Have these terrible things really happened? Have you really gone insane, had a heart attack, or lost complete control? Or did you simply feel anxious and afraid? As unpleasant as anxiety may be, it is temporary, normal, and nonlethal. It may feel momentarily more comfortable to avoid these situations, but you are teaching yourself that the world is a dangerous place. You should make a list of places and experiences that you are avoiding and list them in your hierarchy of feared situations. Then you can practice imaginal and direct exposure as described by your therapist. You will find that facing your fears—and conquering them—will make you feel less anxious in the future.</p>
<p>Safety behaviors [Reliance on other people or behaviors that you think will decrease danger—for example, needing to be accompanied; seeking reassurance; trying to decrease the impact of a stimulus; decreasing your behavior (e.g., exercise) so that you feel little arousal.]</p>	<p><i>You don't need safety behaviors to control anything, since there is nothing dangerous happening.</i> These safety behaviors maintain your belief that the situation is really dangerous. You think, "The only way I got through this is because I relied on my safety behaviors." You should make a list of every behavior that you engage in that makes you feel safer, and then practice giving it up. What do you predict will happen? Do you think that you will not be able to survive the situation without the safety behavior? What will it mean if you actually get through the situation without any safety behaviors? Does this mean that the situation is actually safe? Giving up safety behaviors will help you get the most out of practicing your exposure to your fears.</p>

Generalized Anxiety Disorder



(cont.)

FIGURE 4.1. Diagnostic Flow Chart for Generalized Anxiety Disorder

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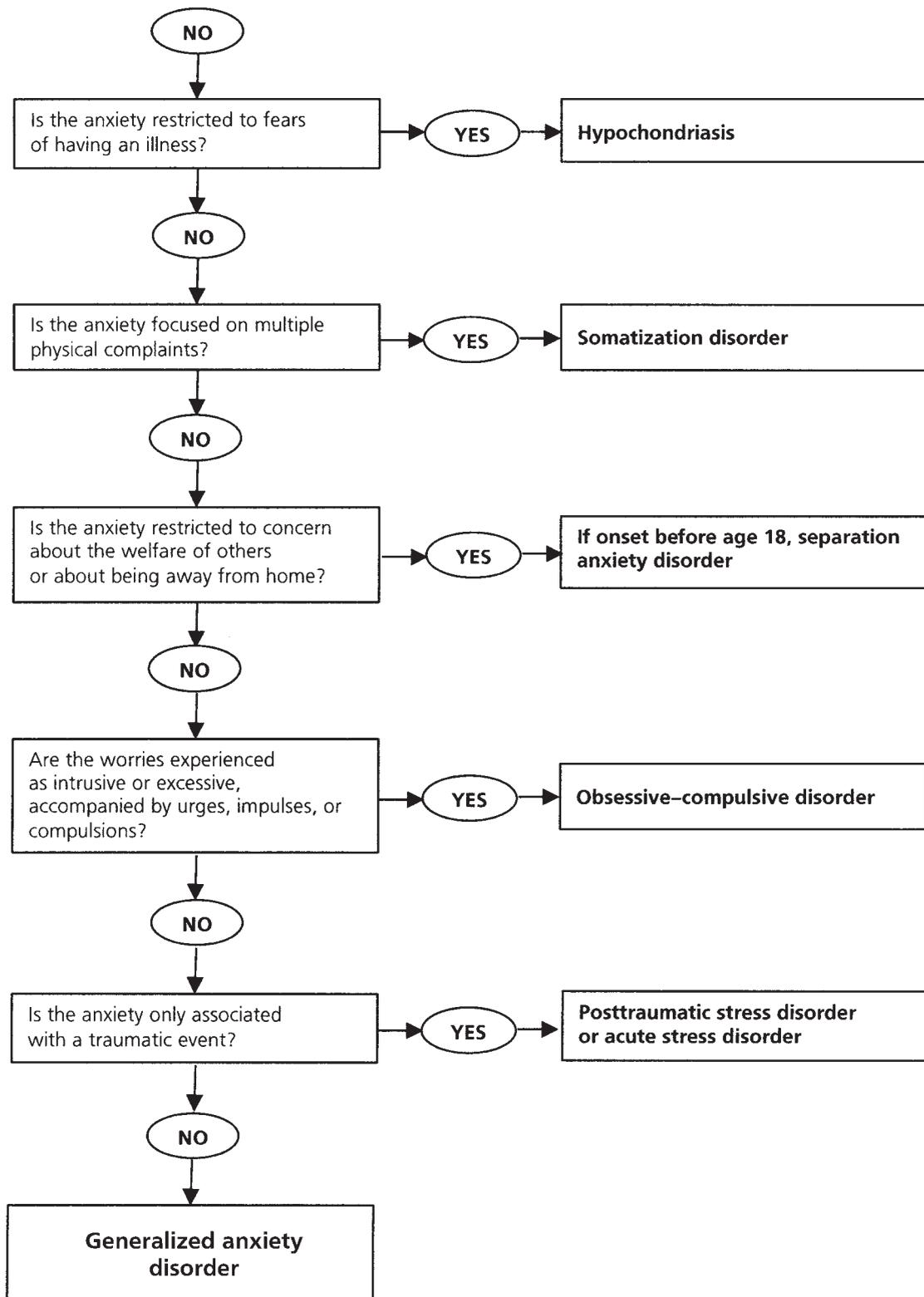


FIGURE 4.1 (cont.)

TABLE 4.2. General Plan of Treatment for Generalized Anxiety Disorder

- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
- Socialization to treatment
- Relaxation training
- Mindfulness training
- Assessing and confronting avoidance: Exposure and other techniques
- Monitoring worries and assigning “worry time”
- Cognitive evaluation and treatment of worrying
 - Step 1: Distinguishing between productive and unproductive worry
 - Step 2: Acceptance and commitment
 - Step 3: Challenging worried automatic thoughts and maladaptive assumptions
 - Step 4: Examining core beliefs about self and others
 - Step 5: Examining fear of failure
 - Step 6: Using emotions rather than worrying about them
 - Step 7: Putting time on the patient’s side
- Interpersonal interventions
- Problem-solving training
- Phasing out treatment

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TABLE 4.5. Sample Symptoms for Generalized Anxiety Disorder

Anxious mood

Excessive worry

Irritable mood

Restlessness

Feeling on edge

Fatigue

Impaired concentration

Digestive problems

Muscle tension

Insomnia

Specify length of time symptoms have been present

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TABLE 4.6. Sample Treatment Goals and Interventions for Generalized Anxiety Disorder

Treatment goals	Interventions
Reducing physical symptoms of anxiety	Relaxation or breathing exercises
Reducing agitation about thinking and feeling	Mindfulness training, meditation
Reducing time spent worrying (to under 30 minutes/day)	Distraction, worry time, activity scheduling
Reducing negative automatic thoughts	Cognitive restructuring
Enhancing acceptance	Cognitive restructuring, mindfulness training, metacognitive techniques
Eliminating avoidance (specify)	Exposure, behavioral activation
Eliminating assumptions about danger of anxiety	Cognitive restructuring, behavioral experiments
Eliminating assumptions about positive value of worry (or other assumptions—specify)	Cognitive restructuring, metacognitive techniques
Modifying need for certainty	Uncertainty training (costs–benefits of tolerating uncertainty, flooding oneself with uncertainty, practicing the negative emotional image, problem-solving training)
Modifying schemas of threat/vulnerability/need for control (or other schemas—specify)	Cognitive restructuring, developmental analysis, other schema work
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

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TABLE 4.7. Detailed Treatment Plan for Generalized Anxiety Disorder

Sessions 1–2

Assessment

- Evaluate presenting problems
- Evaluate specific anxiety problems with the Leahy Anxiety Checklist for Patients (Form 4.2), plus other anxiety instruments as appropriate
- Administer worry evaluations (PSWQ, MCQ-30, IUS; see Forms 4.3–4.5)
- Administer standard intake battery (see Form 4.6)
- Identify specific content of worries, as well as metacognitive factors
- Determine differential diagnosis and evaluate for any comorbid diagnoses
- Evaluate for substance abuse, use of caffeine or tobacco, sleep disorders

Socialization to Treatment

- Provide patient with information handouts on GAD (Form 4.7) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
- Bibliotherapy: Assign *The Worry Cure: Seven Steps to Stop Worry from Stopping You* (Leahy, 2005) or *Anxiety Free: Unravel Your Fears before They Unravel You* (Leahy, 2009)
- Indicate how GAD involves motor tension and arousal
- Indicate that worries are a central part of GAD, and that worries are reinforced by their nonoccurrence
- Develop short-term and long-term goals

Behavioral Interventions

- Identify triggers for anxiety and avoidance
- Evaluate and decrease use of anxiety-producing substances (e.g., caffeine, amphetamine) and abuse of self-medicating substances (e.g., alcohol, benzodiazepines)

Cognitive Interventions

- Normalize worrying—review productive versus nonproductive worrying
- Determine whether patient “worries about worrying” (e.g., “Worrying means I’m going crazy or I have no control over my thoughts and feelings”)
- Introduce Patient’s Worry Log (Form 4.8)

Medications

- Consider use of SSRIs or benzodiazepines

Homework

- Have patient begin reading Leahy (2005) or Leahy (2009)
- Assign use of Patient’s Worry Log to monitor worries

Sessions 3–5

Assessment

- Evaluate anxiety (BIA) and depression (BDI-II)
- Continue to identify themes of patient’s worries
- Review Patient’s Worry Log—frequency, duration, situations (triggers), precursors, and consequences of worries

Behavioral Interventions

- Train patient in progressive muscle relaxation and/or relaxing breathing, and/or use mindfulness exercises
 - Use reward planning/activity scheduling to monitor pleasure, mastery, and anxiety
 - Describe and encourage “worry time”
 - Evaluate need for exposure to avoided situations; discuss exposure with patient
-

TABLE 4.7 (*cont.*)

Evaluate need for assertion training, communication training, conflict resolution, couple therapy
Encourage exercise
Treat insomnia, if necessary

Cognitive Interventions

Introduce Questions to Ask Yourself If You Are Worrying (Form 4.9)
Begin to identify and categorize automatic thoughts (with specific emphasis on fortunetelling, catastrophizing, discounting positives, personalizing, etc.)
Begin challenging thoughts by evaluating costs and benefits of worrying, using other cognitive techniques (see Chapter 10 and Appendix B)
Utilize acceptance strategies (advantages and disadvantages of accepting limitations and uncertainty, current examples of acceptance, etc.)
Utilize metacognitive strategies (identify patient's theories about worry, increase recognition that worry is a mental event, modify beliefs that worry needs to be controlled)

Medication

Evaluate side effects of medication
Evaluate need to increase dosage
If no improvement, either increase dosage, add another medication, or change class of medication (consider need to taper or discontinue one class when adding another class)

Homework

Assign breathing relaxation, progressive muscle relaxation, mindfulness exercises
Have patient follow self-help tips for insomnia (Form 2.11 in Chapter 2)
Assign worry time
Have patient increase exercise
Have patient engage in reward planning/activity scheduling
Have patient continue to monitor worries, test predictions, track negative thoughts, and categorize those thoughts
Assign continued reading

Sessions 6–8

Assessment

As in Sessions 3–5
Review homework

Behavioral Interventions

Train patient in generalizing relaxation and/or mindfulness to new situations
Encourage patient to decrease rumination time—develop an antirumination script
Examine situational/life sources of stress (e.g., financial, interpersonal, work, family, etc.)
Introduce problem-solving skills and apply to situational sources of stress
Guide patient in confronting avoided situations

Cognitive Interventions

Identify patient's underlying maladaptive assumptions
Challenge assumptions via cost–benefit analysis, other cognitive techniques (see Chapter 10 and Appendix B)
Continue challenging automatic thoughts
Introduce Patient's Daily Record of Dysfunctional Automatic Thoughts (Form 2.10 in Chapter 2)

(*cont.*)

TABLE 4.7 (*cont.*)

Use vertical descent on worries

What is the ultimate outcome or fear that the patient anticipates?

Distinguish between possible and probable outcomes

Examine worries for probability, plausibility

Medication

As in Sessions 3–5

Homework

As in Sessions 3–5

Have patient begin use of Form 2.10

Encourage patient to schedule stress breaks, self-reward for behavior

Assign use of problem solving

Encourage patient to decrease rumination through distraction, activity scheduling, rational responding

Sessions 9–15

Assessment

As in Sessions 6–8

Behavioral Interventions

Continue with assertion training and introduce anger control training (if needed)

Continue with problem-solving training

Begin self-efficacy training: Have patient list personal positives, take credit for positives, continue with self-reward

Cognitive Interventions

Continue evaluating and challenging automatic thoughts

Identify, evaluate, and modify dysfunctional personal schemas (see Chapter 10 and Appendix B)

Examine how worries are related to schemas (about defectiveness, failure, biological vulnerability, abandonment, responsibility, etc.)

Continue to evaluate and modify maladaptive assumptions (about control, excessive responsibility, time pressure, what is “essential,” and imminence of “disasters”)

Identify beliefs about failure, and introduce rational responding to fear of failure

Identify and modify emotional schemas (beliefs about emotions as dangerous, out of control, incomprehensible, shameful, etc.)

Encourage patient to practice self-validation for emotional distress

Focus on putting time in perspective—living in the moment, mindfulness, stretching time, looming-vulnerability interventions (slowing down image of impending threat and identifying intervening or contingent events)

Medication

As in Sessions 3–5

Homework

As in Sessions 3–5 and 6–8

Have patient increase exposure to feared situations as appropriate

Assign assertion and anger control practice

Have patient increase self-reward

Have patient identify and challenge maladaptive assumptions and dysfunctional schemas (including beliefs about control, responsibility, and imminence)

TABLE 4.7 (cont.)

Sessions 16–20

Assessment

As in Sessions 6–8

Behavioral Interventions

Plan phase-out of treatment

Have patient identify short-term and long-term goals for self-help

Identify how behavioral techniques can be used in future

Cognitive Interventions

Review what has been learned about automatic thoughts, assumptions, and schemas

Use rational responding to play “devil’s advocate” for patient

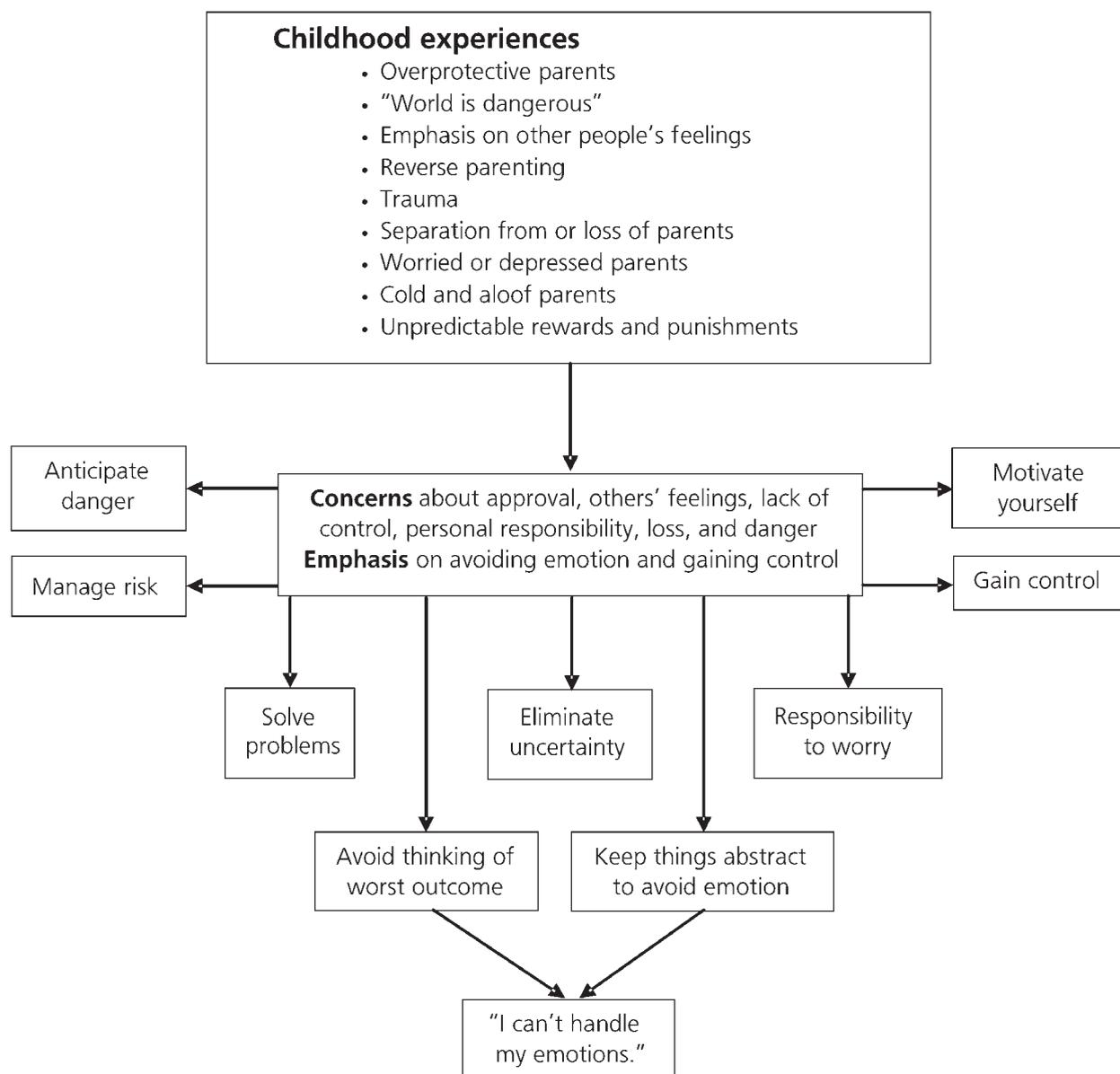
Help patient develop new, more pragmatic assumptions and schemas

Homework

Have patient self-assign homework focused on troubleshooting future problems

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FORM 4.1. Generalized Anxiety Disorder: Antecedents and Underlying Processes



FORM 4.2. Leahy Anxiety Checklist for Patients

Patient's name: _____ Today's date: _____

Place a number next to the answer that best describes how you have been feeling generally during the past month. Use the scale below:

1 = Not at all 2 = Slightly true 3 = Somewhat true 4 = Very true

1. Feeling shaky _____
2. Unable to relax _____
3. Feeling restless _____
4. Get tired easily _____
5. Headaches _____
6. Shortness of breath _____
7. Dizzy or light-headed _____
8. Need to urinate frequently _____
9. Sweating (unrelated to heat) _____
10. Heart pounding _____
11. Heartburn or upset stomach _____
12. Easily irritated _____
13. Startled easily _____
14. Difficulty sleeping _____
15. Worried a lot _____
16. Hard to control worries _____
17. Difficulty concentrating _____

FORM 4.3. Penn State Worry Questionnaire (PSWQ)

Patient's name: _____ Today's date: _____

Enter the number that best describes how typical or characteristic each item is of you, putting the number next to the item.

- | | 1 | 2 | 3 | 4 | 5 |
|-------|--------------------|---|------------------|---|--------------|
| | Not at all typical | | Somewhat typical | | Very typical |
| _____ | 1. | | | | |
| _____ | 2. | | | | |
| _____ | 3. | | | | |
| _____ | 4. | | | | |
| _____ | 5. | | | | |
| _____ | 6. | | | | |
| _____ | 7. | | | | |
| _____ | 8. | | | | |
| _____ | 9. | | | | |
| _____ | 10. | | | | |
| _____ | 11. | | | | |
| _____ | 12. | | | | |
| _____ | 13. | | | | |
| _____ | 14. | | | | |
| _____ | 15. | | | | |
| _____ | 16. | | | | |

Your total score: _____

Note that (R) after a question indicates a reverse score. Thus, to reverse-score your question, if you give an answer of 1 (Not at all typical), score it as a 5.

Add up your scores on the test—and be sure to note which items are reversed-scored (see above for how to reverse score your responses). On the average, people with some problems with worry score above 52, and really chronic worriers score above 65. “Nonanxious” people have average scores around 30. It is also quite possible to score below the clinical range (somewhere between 30 and 52) but still feel that your worries are bothering you.

The PSWQ itself (not the scoring instructions) is from Meyer, Miller, Metzger, and Borkovec (1990). Copyright 1990 by Pergamon Press. Reprinted by permission of Elsevier B. V.

Score ranges are based on Table 11-2 from Molina and Borkovec (1994).

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FORM 4.4. Metacognitions Questionnaire 30 (MCQ-30)

Patient's name: _____ Today's date: _____

This questionnaire is concerned with beliefs people have about their thinking. Listed below are a number of beliefs that people have expressed. Please read each item and say how much you *generally* agree with it by *circling* the appropriate number. Please respond to all the items; there are no right or wrong answers.

Metacognitions	Do not agree	Agree slightly	Agree moderately	Agree very much
1. Worrying helps me to avoid problems in the future	1	2	3	4
2. My worrying is dangerous for me	1	2	3	4
3. I think a lot about my thoughts	1	2	3	4
4. I could make myself sick with worrying	1	2	3	4
5. I am aware of the way my mind works when I am thinking through a problem	1	2	3	4
6. If I did not control a worrying thought, and then it happened, it would be my fault	1	2	3	4
7. I need to worry in order to remain organized	1	2	3	4
8. I have little confidence in my memory for words and names	1	2	3	4
9. My worrying thoughts persist, no matter how I try to stop them	1	2	3	4
10. Worrying helps me to get things sorted out in my mind	1	2	3	4
11. I cannot ignore my worrying thoughts	1	2	3	4
12. I monitor my thoughts	1	2	3	4
13. I should be in control of my thoughts all of the time	1	2	3	4
14. My memory can mislead me at times	1	2	3	4
15. My worrying could make me go mad	1	2	3	4
16. I am constantly aware of my thinking	1	2	3	4
17. I have a poor memory	1	2	3	4
18. I pay close attention to the way my mind works	1	2	3	4
19. Worrying helps me cope	1	2	3	4

(cont.)

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FORM 4.4. Metacognitions Questionnaire 30 (p. 2 of 2)

20. Not being able to control my thoughts is a sign of weakness	1	2	3	4
21. When I start worrying, I cannot stop	1	2	3	4
22. I will be punished for not controlling certain thoughts	1	2	3	4
23. Worrying helps me to solve problems	1	2	3	4
24. I have little confidence in my memory for places	1	2	3	4
25. It is bad to think certain thoughts	1	2	3	4
26. I do not trust my memory	1	2	3	4
27. If I could not control my thoughts, I would not be able to function	1	2	3	4
28. I need to worry, in order to work well	1	2	3	4
29. I have little confidence in my memory for actions	1	2	3	4
30. I constantly examine my thoughts	1	2	3	4

This questionnaire pinpoints the five most common types of beliefs about worry. These include Positive Worry Beliefs (e.g., “Worrying helps me to avoid problems in the future”); Uncontrollability and Danger: Negative Beliefs (e.g., “My worrying is dangerous for me”); Cognitive Confidence (or lack of it—e.g., “I have little confidence in my memory for words and names”); Need for Control (e.g., “If I did not control a worrying thought, and then it happened, it would be my fault”); and Cognitive Self-Consciousness (e.g., “I think a lot about my thoughts”).

These factors reflect conflicting functions that you believe worry serves. For example, you may feel conflicted between having positive views of worry and, at the same time, believing that worry is uncontrollable and dangerous. You may also distrust your own memory, believing that there is something that you may overlook. This distrust in your memory may make you worry that you will neglect something. You may be scanning your mind to monitor your own thoughts, continually focusing on what you are thinking, perhaps because you believe your worry thoughts may signal impending danger.

In order to determine your score for each of these five factors on the MCQ-30, use the table below. For example, to find your score for Positive Worry Beliefs, add up your scores for each of this factor’s six questions (1, 7, 10, 19, 23, 28) to get your score. Go through each of the factors this way. Then, at the end, add up your scores for each of the factors. Although there are no established norms yet for this scale, you will be able to see whether you have relatively more elevated scores on certain factors than on others.

Factor—“Your theory about your worry”	Your total score on each factor
Positive Worry Beliefs —questions 1, 7, 10, 19, 23, 28	_____
Uncontrollability and Danger: Negative Beliefs —questions 2, 4, 9, 11, 15, 21	_____
Cognitive Confidence —questions 8, 14, 17, 24, 26, 29	_____
Need for Control —questions 6, 13, 20, 22, 25, 27	_____
Cognitive Self-Consciousness —questions 3, 5, 12, 16, 18, 30	_____

FORM 4.5. Intolerance of Uncertainty Scale (IUS)

Patient's name: _____ Today's date: _____

You will find below a series of statements that describe how people may react to the uncertainties of life. Please use the scale below to describe to what extent each item is characteristic of you (please write the number that describes you best in the space before each item).

1	2	3	4	5
Not at all characteristic of me	A little characteristic of me	Somewhat characteristic of me	Very characteristic of me	Entirely characteristic of me

- _____ 1. Uncertainty stops me from having a firm opinion.
- _____ 2. Being uncertain means that a person is disorganized.
- _____ 3. Uncertainty makes life intolerable.
- _____ 4. It's not fair that there are no guarantees in life.
- _____ 5. My mind can't be relaxed if I don't know what will happen tomorrow.
- _____ 6. Uncertainty makes me uneasy, anxious, or stressed.
- _____ 7. Unforeseen events upset me greatly.
- _____ 8. It frustrates me not having all the information I need.
- _____ 9. Being uncertain allows me to foresee the consequences beforehand and to prepare for them.
- _____ 10. One should always look ahead so as to avoid surprises.
- _____ 11. A small unforeseen event can spoil everything, even with the best of planning.
- _____ 12. When it's time to act uncertainty paralyzes me.
- _____ 13. Being uncertain means that I am not first-rate.
- _____ 14. When I am uncertain I can't go forward.
- _____ 15. When I am uncertain I can't function very well.

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Scores ranges are based on Dugas et al. (2004) and Ladouceur et al. (2000).

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FORM 4.5. Intolerance of Uncertainty Scale (p. 2 of 2)

- _____ 16. Unlike me, others always seem to know where they are going with their lives.
- _____ 17. Uncertainty makes me vulnerable, unhappy, or sad.
- _____ 18. I always want to know what the future has in store for me.
- _____ 19. I hate being taken by surprise.
- _____ 20. The smallest doubt stops me from acting.
- _____ 21. I should be able to organize everything in advance.
- _____ 22. Being uncertain means that I lack confidence.
- _____ 23. I think it's unfair that other people seem sure about their future.
- _____ 24. Uncertainty stops me from sleeping well.
- _____ 25. I must get away from uncertain situations.
- _____ 26. The ambiguities in life stress me.
- _____ 27. I can't stand being undecided about my future.

Total score (Sum your scores above) _____

There are five different factors on the IUS. These reflect the following beliefs:

1. Uncertainty Is Unacceptable and Should Be Avoided
2. Uncertainty Reflects Badly on a Person
3. Frustration with Uncertainty
4. Uncertainty Causes Stress
5. Uncertainty Prevents Action

In order to obtain your total score, simply add up your responses for each question. Overall, scores below 40 reflect tolerance of some uncertainty; scores above 50 reflect problems with uncertainty; and scores above 70 suggest real problems in handling uncertainty. People with GAD have an average score of 87 on the IUS. However, even if your score is below 87, your intolerance of uncertainty can be a vulnerability factor for your worry and anxiety.

FORM 4.6. Evaluation of Generalized Anxiety Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Beck Depression Inventory-II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Global Assessment of Functioning (GAF) _____ Leahy Anxiety Checklist _____

Penn State Worry Questionnaire (PSWQ) _____ Metacognitions Questionnaire 30 (MCQ-30) _____

Intolerance of Uncertainty Scale (IUS) _____

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) _____

Other questionnaires (specify) _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Treatment
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Treatment progress (later evaluations only)

Situations still avoided: _____

Situations approached that were previously avoided: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 4.7. Information for Patients about Generalized Anxiety Disorder

WHAT IS GENERALIZED ANXIETY DISORDER?

People with generalized anxiety disorder (GAD) have persistent and disturbing worries on a daily basis. They also experience physical symptoms, such as restlessness, shortness of breath, palpitations, muscle aches, sweating, and insomnia. Often people with GAD will have another anxiety disorder; for example, many people with GAD also have social anxiety and worry about other people seeing them as anxious. If untreated, GAD often leads to depression.

WHAT CAUSES GENERALIZED ANXIETY DISORDERS?

There are many factors that may account for GAD. Between 30% and 50% of the cause may be genetic, but early childhood experiences (such as loss of a parent, feeling the need to comfort and protect a parent, parental separation/divorce of parents, parental overprotection, or parental statements that the world is a dangerous place), recent stresses in life, unrealistic expectations about yourself and others, relationship conflicts, alcohol or caffeine use, poor coping skills, and other factors all contribute to the experience of anxiety. Studies indicate that the level of anxiety in the general population has been increasing over the last 50 years—perhaps due to a decrease in social connectedness and community, unrealistic expectations about what life should be, an overfocus on bad news in the media, and other social and cultural factors.

HOW DOES THINKING AFFECT GENERALIZED ANXIETY DISORDER?

Anxious persons are plagued with a stream of irrational thoughts that further increase their anxiety: “People can see I’m anxious. They think less of me. I’m the only one with this problem. I can’t stand to be disapproved of. It’s awful that this could happen.” Many people with GAD have an endless stream of worries that begin with “What if?” Typical thoughts of this type are “What if I’m losing control/going crazy/making a fool out of myself?” They may also worry about their worrying—for example, “I need to get rid of this anxiety [obsession, behavior, etc.] immediately. I am going to fail. My worrying is out of control and I’ll go crazy. I should never worry.” Chronic worriers often have mixed feelings and beliefs about their worry. On the one hand, they believe that their worry prepares and protects them. But, on the other hand, they believe that their worry will make them sick and that they need to stop worrying completely. Worriers are also often highly intolerant of uncertainty, often believing that if they don’t know something for sure, then it will turn out badly. People who are anxious tend to predict the worst, expect that they will not be able to handle stress, and demand certainty in an uncertain world. If you are a worrier, you may have difficulty living in the present moment and enjoying your life. You are constantly seeking answers that you may never get.

HOW DOES PERSONALITY AFFECT GENERALIZED ANXIETY DISORDER?

People with GAD are anxious about things that are personally relevant to their concerns. Depending on your personality, you may worry about being rejected, making mistakes, not achieving success, getting sick, or being abandoned. Furthermore, you may avoid or leave situations that make you anxious, or you may try to compensate for your anxiety by trying to be overly controlling, by being overly concerned about approval, or by

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trying to be perfect. Your individual concerns and your style of coping with anxiety may thus actually make you more vulnerable to anxiety.

HOW CAN TREATMENT BE HELPFUL?

Cognitive-behavioral therapy and/or medication are especially useful in treating GAD. Both during therapy sessions and as part of the your self-help homework, you may be instructed in a number of techniques to decrease anxiety. Let's take a look at some of these techniques.

- **Decrease your arousal.** You are more likely to feel anxious when you are physically aroused. You should examine how much caffeine (coffee, teas, sodas) and alcohol you use. Your therapist may teach you breathing and relaxation exercises that can help you moderate your general arousal. Meditation and yoga are often very helpful to calm your body and mind. In addition, regular exercise may be helpful. Medications can also help reduce your arousal.
- **Identify and confront your fears.** Your therapist will assist you in recognizing the specific situations, sensations, or thoughts that are disturbing to you. You may be asked to rank these fears from least to most feared and to identify exactly what you are afraid will happen. Through gradual and guided exposure to these fears, with the help of your therapist, you may begin to modify the way you experience these situations.
- **Modify your thinking.** Your therapist may help you to identify and modify your negative thinking. You may be taking things too personally, engaging in fortunetelling about events that never happen, or predicting catastrophes that turn out to be mere inconveniences. Many worriers have a set of rules about life, such as "If I'm not perfect, I'm a failure" or "If someone doesn't like me, it's a disaster." Other rules might be "I need to know for sure" or "I should never feel anxious." You can learn to use cognitive therapy techniques to identify and modify your thinking in ways that are more realistic and fairer to yourself.
- **Learn how to deal with worry.** Like many worriers, you may believe that your worry prepares and protects you. You can learn how to distinguish between productive and unproductive worry, how to accept limitations and live with reasonable uncertainty, how to enjoy the present moment in a nonjudgmental way, and how to view your worries as "background noise" that does not need to control you. You can learn how to turn off the sense of urgency that makes you feel constantly under pressure.
- **Develop "emotional intelligence."** Many worriers have a hard time coping with their emotions. They often believe that their emotions will overwhelm them, will last indefinitely, or don't make sense. Life is not about eliminating emotions; it entails learning to live meaningfully with your emotions. Cognitive-behavioral therapy can help you come to terms with the emotions that give richness and meaning to your life.
- **Improve your relationships.** Your anxiety may often be related to conflicts and misunderstandings in your relationships. Therapy can assist you in identifying these problematic issues, developing more effective ways of thinking about your relationships, and actively coping to make things better. Communication, listening, assertion, mutual problem solving, and increasing positive experiences can be important parts of your therapy.
- **Become a problem solver.** Worriers often generate a lot of problems that don't exist, but often avoid solving problems that they can address. This is because a lot of their anxiety is based on avoiding

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experiences that make them anxious. Your therapist can help you become a practical and productive problem solver, which will make you more confident about "potential" problems.

MEDICATION

Depending on how severe your GAD is, and on whether depression is also part of the problem, your doctor may prescribe any number of medications that have proven effective for these disorders. Cognitive-behavioral therapy may be augmented with medication for anxiety disorders. Benzodiazepines and some antidepressants have been found useful for GAD. Your doctor can assist you with medication. You should never self-medicate.

HOW EFFECTIVE IS TREATMENT?

Until about 10 years ago, treatments for GAD had limited success. However, today the outcome is very promising for GAD and most other anxiety disorders. The newer forms of cognitive-behavioral therapy have proven quite effective for chronic worriers.

WHAT IS EXPECTED OF YOU AS A PATIENT?

The treatment of GAD requires your regular attendance in therapy and your willingness to carry out self-help homework assignments that can be very effective in helping you cope with your anxiety. Many patients also benefit from medication, which should only be taken as prescribed by your doctor.

FORM 4.8. Patient's Worry Log

Patient's name: _____

Content area for each worry	Factors in situation that bring out the worry	Prediction (Specify exactly what you think will happen and when it will happen)	Anxiety rating for each prediction (0-10)	Rating of confidence in accuracy of prediction (0-10)	Actual outcome (Exactly what happened?)	Anxiety rating at outcome (0-10)

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FORM 4.9. Questions to Ask Yourself If You Are Worrying: A Self-Help Form for Patients

Specific worry:

Questions to ask yourself:	Your response:
Specifically, what are you predicting will happen?	
How likely (0–100%) is it that this will actually happen? How negative an outcome are you predicting (from 0% to 100%)?	Likelihood: How negative:
What is the worst outcome? The most likely outcome? The best outcome?	Worst: Most likely: Best:
Are you predicting catastrophes (awful things) that don't come true? What are some examples of the catastrophes that you are anticipating?	
What is the evidence (for and against) your worry that something really bad is going to happen? If you had to divide 100 points between the evidence for and against, how would you divide these points? (For example, would it be 50–50? 60–40?)	Evidence for: Evidence against: Points: Evidence for = _____ Evidence against = _____
Are you using your emotions (your anxiety) to guide you? Are you saying to yourself, "I feel anxious, so something really bad is going to happen"?	
Is this a reasonable or logical way to make predictions? Why/why not?	
How many times have you been wrong in the past about your worries? What actually happened?	

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FORM 4.9. Questions to Ask Yourself If You Are Worrying (p. 2 of 2)

Questions to ask yourself:	Your response:
<p>What are the costs and benefits to you of worrying about this? If you had to divide 100 points between the costs and benefits, how would you divide these points? For example, would it be 50–50? 60–40?)</p>	<p>Costs:</p> <p>Benefits:</p> <p>Points: – _____ (costs) _____ (benefits)</p> <p>Subtract costs from benefits: _____ – _____ = _____</p>
<p>What evidence do you have from the past that worrying has been helpful to you and hurtful to you?</p>	
<p>Are you able to give up any control in order to be worried less?</p>	
<p>Is there any way that worrying really gives you any control, or do you feel more out of control because you are worrying so much?</p>	
<p>If what you predict happens, what would that mean to you? What would happen next?</p>	
<p>How could you handle the kinds of problems that you are worrying about? What could you do?</p>	
<p>Has anything bad happened to you that you were not worried about? How were you able to handle that?</p>	
<p>Are you usually underestimating your ability to handle problems?</p>	
<p>Consider the thing you are worried about. How do you think you'll feel about this 2 days, 2 weeks, 2 months, and 2 years from now? Why would you feel differently?</p>	
<p>If someone else were facing the events that you are facing, would you encourage that person to worry as much as you? What advice would you give him or her?</p>	

FORM 4.10. Challenging Your Core Beliefs

1. Identify your core beliefs about yourself and other people.
2. Examine the costs and benefits of these beliefs.
3. How has this belief affected you in the past?
4. Are you viewing yourself in all-or-nothing terms?
5. What is the evidence for and against your belief?
6. Would you be as critical of other people?
7. Is there some truth in your belief?
8. Can you act against your belief?
9. Can you develop a more positive belief?

Conclusions:

FORM 4.11. Possible Interventions for Worrying: A Self-Help Guide for Patients

1. **Relax your mind and relax your body.** Practice muscle relaxation and mindful breathing. Learn how to stay in the moment and let go of your thoughts and tension.
2. **Examine the advantages of letting go of worry.** Be honest with yourself about your mixed motives about worrying. Part of you wants to decrease worry; the other part feels a need to worry to be prepared. The key here is knowing whether your worry will lead to productive action. If not, then it's useless mental energy.
3. **Keep in mind that a thought is a thought—it's not reality.** Keep your thoughts *in mind*, and recognize that reality is not the same thing as your thoughts. As you become a mindful observer of your breathing, you can practice simply *observing* your thoughts. You can stand back and say, "That's just another thought." And then you can practice saying, "Let it go."
4. **Ask yourself whether your worries are really rational.** Practice the cognitive therapy techniques you have learned. Examine the evidence for and against it; ask yourself what advice you would give a friend; review how many times you have been wrong in the past; and so on.
5. **Set aside "worry time," write out your predictions, and keep a worry log to test out what actually happened.** You will find that your worries are almost always false predictions, and you can set them aside for your worry time—which, let's hope, will eventually bore you!
6. **Validate your emotions.** Keep a daily journal of your emotions, both positive and negative. Identify why your emotions make sense, why they are not dangerous, and why other people would have many of the same feelings. Validate yourself.
7. **Accept uncertainty, and accept your limitations.** You can't control or know everything. It's not all up to you. The more you accept what you cannot do, the greater your sense of being empowered in the real world will become.
8. **Realize that it's not urgent.** You don't need to know right now. Nothing will happen if you don't know. But you can focus on enjoying the present moment—and making the best of the moment in front of you.
9. **Practice losing control.** Rather than trying to stop or control your worry, flood yourself with it. Surrender to the worry, repeat the worry, and bore yourself with constant repetitions of exactly the same worried thought. You will get bored and less worried.
10. **Similarly, try to go crazy.** You can't go crazy from your worry. But you can learn that letting go of control allows you to overcome your fear of losing control.
11. **Practice your worst fears.** Imagine the worst outcome, and repeat imagining it. You will find that with time, your images and thoughts will become boring. Think about it: The "cure" is boredom?

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Social Anxiety Disorder (Social Phobia)

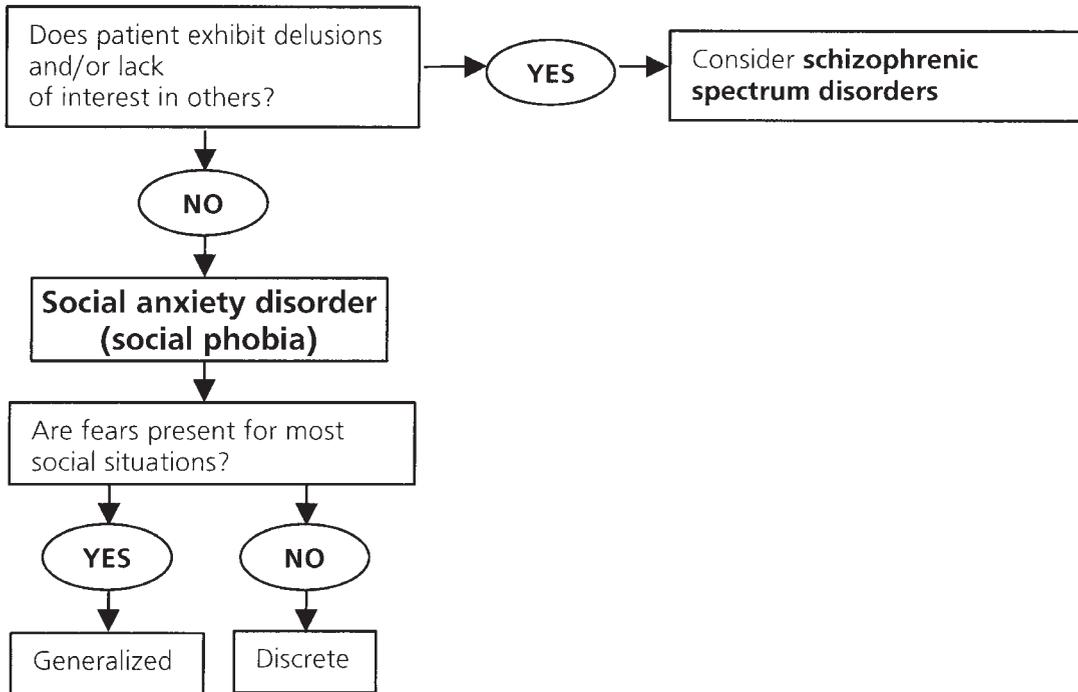


FIGURE 5.1 (cont.)

TABLE 5.3. General Plan of Treatment for Social Anxiety Disorder

- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
 - Socialization to treatment
 - Cognitive restructuring
 - Examining content
 - Examining information processing
 - Exposure
 - Imaginal
 - Role-play
 - *In vivo*
 - Social skills training (as needed)
 - Applied relaxation (as needed)
 - Phasing out treatment
-

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TABLE 5.4. Maladaptive "Rules" in Social Anxiety Disorder

Before you interact with people:

1. Think about all the ways you can look foolish and anxious.
2. Rehearse in your mind how anxious you will feel.
3. Try to prepare all kinds of safety behaviors to hide your anxiety.
4. If possible, come up with an excuse to avoid people.

When you are around other people:

1. Assume that people can see every anxious feeling and thought that you have.
2. Focus your attention on how anxious you feel.
3. Try to hide your anxious feelings.

After you interact with people:

1. Review how awful it felt.
 2. Assume that people are now talking about how awkward you looked.
 3. Focus on any signs of imperfection in how you appeared.
 4. Criticize yourself for being less than perfect.
-

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TABLE 5.5. Sample Symptoms for Social Anxiety Disorder

Fear of social situations (specify)	Feeling faint
Fear of negative judgment by others	Numbness
Feelings of embarrassment or humiliation	Tingling
Anxious mood	Chills
	Hot flashes
Specify physical symptoms of anxiety:	Specify cognitive symptoms:
Blushing	Mind going blank
Sweating	Difficulty speaking
Shaking	Loss of concentration
Palpitations	Derealization
Difficulty breathing	Depersonalization
Chest pain	Specify behavioral symptoms:
Nausea	Panic attacks
Dizziness	Avoidance (specify)

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TABLE 5.6. Sample Treatment Goals and Interventions for Social Anxiety Disorder

Treatment goals	Interventions
Reduce physical anxiety symptoms	Relaxation training, exposure
Reduce fear of scrutiny/evaluation	Cognitive restructuring, exposure
Eliminate safety behaviors	Self-monitoring, exposure
Acquire social skills	Social skills training (modeling, role play, <i>in vivo</i> practice)
Reduce anxiety in specific social situations to 2 or less on a scale of 0–10	Cognitive restructuring, exposure
Eliminate avoidance of social situations (specify)	Exposure
Modify assumption of need for approval (or other assumptions—specify)	Cognitive restructuring
Modify schema of inadequacy (or other schemas—specify)	Cognitive restructuring, developmental analysis
Eliminate impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Eliminate all anxiety symptoms (BAI and/or SAQ in normal range)	All of the above
Acquire relapse prevention skills	Reviewing and practicing techniques as necessary

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TABLE 5.7. Detailed Treatment Plan for Social Anxiety Disorder

Sessions 1–2

Assessment

Ascertain presenting problems
Inquire regarding all symptoms
Administer SAQ (Form 5.2)
Administer standard battery of intake measures (see Form 5.3), plus additional anxiety questionnaires as appropriate
Assess avoidance and safety behaviors (have patient fill out Forms 5.4 and 5.5)
Assess impairment in social, educational, and occupational functioning
Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
Evaluate substance use; evaluate need for counseling or detoxification if patient has substance abuse or dependence
Assess need for medication

Socialization to Treatment

Inform patient of diagnosis
Indicate that disorder is common and brief treatment is available
Educate patient regarding option of medication
Discuss any fears/reservations patient has regarding treatment
Provide patient with information handouts on SAD (Forms 5.1 and 5.6) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
Begin developing short-term and long-term goals for therapy

Homework

Have patient use Forms 5.4 and 5.5 to self-monitor avoided situations and safety behaviors
Have patient write out goals for therapy

Sessions 3–4

Assessment

Evaluate homework
Evaluate anxiety (SAQ) and depression (BDI-II)

Cognitive Interventions

Teach identification of automatic thoughts, using recent social situation

Behavioral Interventions

Assess need for relaxation training
If indicated, begin teaching progressive muscle relaxation and breathing relaxation

Homework

Have patient continue to self-monitor avoided situations, safety behaviors
Have patient begin recording automatic thoughts (on Form 2.10 in Chapter 2 or on Form 10.4 in Chapter 10)
Have patient begin practicing relaxation (if applicable)

Sessions 5–6

Assessment

As in Sessions 3–4

TABLE 5.7 (cont.)

Cognitive Interventions

Teach categorization of automatic thoughts, examination of evidence, and rational responding
Identify patterns of pre- and postevent processing
Introduce behavioral experiments

Behavioral Interventions

Help patient create hierarchy for exposure; plan first exposures
Assess social skills deficits and discuss rationale for training (if indicated)
Provide feedback about patient's actual performance (video, audio, therapist, and/or group)
Help patient practice shifting attention from internal to external cues
Continue teaching relaxation techniques (if indicated)

Homework

Have patient continue using thought records to record/challenge negative thoughts
Have patient practice external focus of attention in social situations
Have patient practice modifying pre- and postevent processing
Have patient continue practicing relaxation (if applicable)

Sessions 7–13

Note: The first session involving exposure may be 90 minutes; subsequent sessions may be 45 minutes, if patient is able to habituate in that time

Assessment

As in Sessions 3–4

Cognitive Interventions

Obtain automatic thoughts before, during, and after exposure, and have patient practice rational responding
Note changes in patient's mood during sessions, obtain automatic thoughts, and dispute
Continue behavioral experiments
Introduce concepts of maladaptive assumptions, dysfunctional schemas

Behavioral Interventions

Begin exposure (imaginal, role-play, and/or therapist-guided *in vivo* exposure)
As each item is mastered, have patient move up exposure hierarchy
Plan and discuss self-directed *in vivo* exposures
Identify safety behaviors
Continue with social skills training (if indicated) via modeling, role play

Homework

Have patient listen to tapes of imaginal exposure
Have patient engage in self-directed *in vivo* exposure, dropping safety behaviors
Have patient practice self-directed application of cognitive skills before and after exposure
Have patient practice external focus of attention
Have patient continue practicing social skills (if indicated)

Sessions 14–16

Assessment

As in Sessions 3–4

(cont.)

TABLE 5.7 (*cont.*)

Cognitive Interventions

Continue identifying and challenging automatic thoughts

Continue behavioral experiments

Identify and challenge core assumptions and schemas (developmental analysis, imagery rescripting, etc.)

Behavioral Interventions

Continue with exposures, moving up hierarchy

Homework

As in Sessions 7–13

Sessions 17–20 (biweekly or monthly)

Assessment

As in Sessions 3–4

Cognitive Interventions

Continue to focus on assumptions and schemas

Review techniques patient has found useful

Discuss possible future problems and ways of coping with them

Behavioral Interventions

Complete exposure hierarchy

Have patient design own exposures

Review techniques patient has found useful

Discuss possible future problems and ways of coping with them

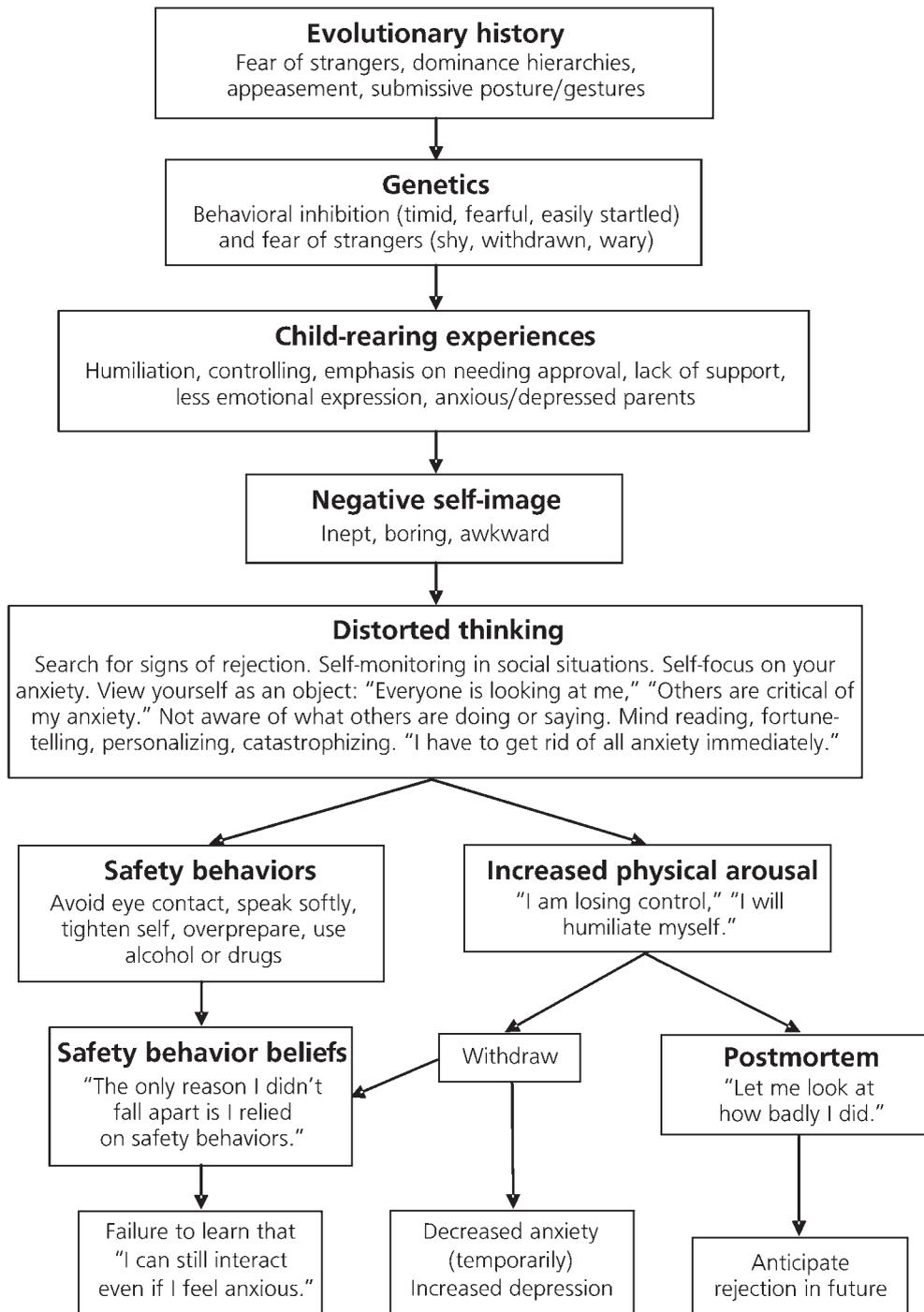
Homework

Have patient seek opportunities to be anxious and use these for further exposure

Encourage continued practice of all skills

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FORM 5.1. The Causes of Social Anxiety



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FORM 5.2. Social Anxiety Questionnaire (SAQ) for Patients

Patient's name: _____ Today's date: _____

Listed below are social situations that commonly make people anxious. Please rate how anxious you usually feel in each situation. If the situation is one you avoid, rate how anxious you think you would feel if you were in the situation. Please add any additional social situations that cause you anxiety.

Situation	None (0)	A little (1)	Moderately (2)	A lot (3)
Speaking in front of other people	_____	_____	_____	_____
Going to parties	_____	_____	_____	_____
Meeting new people	_____	_____	_____	_____
Starting a conversation	_____	_____	_____	_____
Disagreeing with someone	_____	_____	_____	_____
Talking to a superior at work	_____	_____	_____	_____
Asking someone for a date	_____	_____	_____	_____
Going to business meetings	_____	_____	_____	_____
Looking someone in the eye	_____	_____	_____	_____
Eating or drinking in front of other people	_____	_____	_____	_____
Writing in front of other people	_____	_____	_____	_____
Asking for help or directions	_____	_____	_____	_____
Using public bathrooms when others are present	_____	_____	_____	_____
Other:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FORM 5.3. Evaluation of Social Anxiety Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Social Anxiety Questionnaire (SSQ) _____ Beck Depression Inventory (BDI-II (BDI-II)) _____

Beck Anxiety Inventory (BAI) _____ Dyadic Adjustment Scale (DAS) _____

Global Assessment of Functioning (GAF) _____

Other questionnaires (specify): _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Treatment
-------	----------	----------------------	-----------

(cont.)

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FORM 5.3. Evaluation of Social Anxiety Disorder (p. 2 of 2)

Previous episodes of depression or other psychiatric disorder (specify nature):

Onset	Duration	Precipitating events	Treatment
-------	----------	----------------------	-----------

Treatment progress (later evaluations only)

Completed exposures: _____

Situations still avoided _____

Remaining safety behaviors: _____

Cognitive distortions to be addressed: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 5.5. Safety Behaviors Inventory for Patients with Social Anxiety

Patient's name: _____ Week: _____

Please list any behaviors that you do or avoid doing in social situations in order to feel less anxious. Examples of behaviors you might do to feel less anxious are holding a glass tightly so no one sees your hand shaking or sitting in the back of a class so no one looks at you. Examples of behaviors you might avoid are introducing yourself to a stranger or disagreeing with someone. In the second column, please note how anxious you would feel if you changed the behavior, from 0 (no anxiety) to 10 (maximum anxiety).

Safety behaviors	Distress (0–10)
Behaviors done: _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____
Behaviors avoided: _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____

FORM 5.6. Information for Patients about Social Anxiety Disorder

WHAT IS SOCIAL ANXIETY DISORDER?

Social anxiety disorder is the fear of one or more social situations. Commonly feared situations include public speaking, meeting new people, being at parties, asking for dates, eating in public, using public restrooms, speaking to people in authority, and disagreeing with others.

People with social anxiety disorder are afraid they will act in ways that will make other people think badly of them. They often fear that others will see some sign of anxiety, such as blushing, trembling, or sweating. People with social anxiety disorder usually try to stay away from the situations that make them anxious. When they cannot avoid a situation, they tend to feel very anxious or embarrassed. Sometimes they may have panic attacks. Social anxiety disorder is a severe form of shyness that can cause problems in people's lives. Sometimes these problems are minor, such as not being able to speak up in class. Sometimes, however, the problems can be very serious. People with severe social anxiety disorder often have few friends, feel chronically lonely, and have trouble reaching their goals in school or at work.

WHO GETS SOCIAL ANXIETY DISORDER?

Social anxiety disorder is very common. More than one out of eight people will suffer from social anxiety disorder at some point in their lives. Many more people have symptoms of shyness that are not severe enough to be called social anxiety disorder. Social anxiety disorder usually starts when people are in their early teens, but it can begin much earlier. If people do not get help, the problem can last for years.

WHAT CAUSES SOCIAL ANXIETY DISORDER?

A number of factors can contribute to the development and maintenance of social anxiety disorder:

- **Genetics.** People with social anxiety disorder often have relatives who are anxious or shy.
- **Prior experiences.** Many people with social anxiety disorder remember having been embarrassed or humiliated in the past. This leads them to be afraid that the same thing will happen again. Negative experiences with parents, other family members, and/or peers may all contribute to social anxiety.
- **Negative thinking.** People with social anxiety disorder often have negative expectations about what will happen in social situations. Common thoughts are "I won't be able to think of anything to say," "I'll make a fool of myself," and "People will see I'm anxious." They also tend to have standards that are hard to meet, such as "I should never be anxious," "You have to be beautiful and smart to be liked," or "I have to get everyone's approval." Typically they have negative beliefs about themselves, such as "I'm boring," "I'm weird," or "I'm different from other people."
- **Avoidance:** People with social anxiety disorder often avoid situations that make them afraid. This helps them feel less anxious in the short run. In the long run, avoidance prevents them from learning that their social fears are exaggerated, which keeps them feeling anxious.
- **Safety behaviors:** Sometimes people participate in social situations, but do certain things to try to avoid possible embarrassment, such as not asking questions or holding a glass tightly so no one will see their

(cont.)

hand shake. These “safety behaviors,” like avoidance, prevent people from learning that they can do well in social situations without extra effort.

- **Lack of social skills.** Some people with social anxiety disorder never had the chance to learn social skills. This can cause them to have problems in social situations. Other people with this disorder have good social skills, but get so anxious that they have a hard time using them.

HOW DOES COGNITIVE-BEHAVIORAL THERAPY FOR SOCIAL ANXIETY DISORDER WORK?

Cognitive-behavioral therapy helps you change the beliefs that cause your fear. Your therapist will teach you how to recognize your negative thoughts and to think more realistically about social situations and about yourself. He or she will also help you gradually face the situations you have been afraid of in the past. This allows you to discover that your fears usually do not come true, and that the consequences of any negative things that might happen are not so bad. Over time, you are likely to feel less anxious and more confident. In addition, your therapist can teach you social skills and ways to relax if necessary.

A number of studies have shown that most people who get cognitive-behavioral therapy for social anxiety disorder feel less anxious. People usually continue to feel better even after therapy has stopped.

HOW LONG DOES THERAPY LAST?

For people with mild to moderate social anxiety disorder, 16–20 sessions is usually enough. People with fear of just one social situation, such as public speaking, may need fewer sessions. People with more serious symptoms may need more.

CAN MEDICATION HELP?

Several different types of medication have been found to be helpful for social anxiety disorder. Your physician or a psychiatrist can recommend whether medication might be a good option for you. Medication may provide more rapid initial relief. However, cognitive-behavioral therapy has been found to be at least as effective as medication and may provide better long-term outcome.

WHAT IS EXPECTED OF YOU AS A PATIENT?

Many people feel anxious at the beginning of therapy. It is common to worry about being embarrassed or judged in therapy, and to wonder whether you can be helped. All you have to do is be willing to give therapy a try. Your therapist will teach you things you can do to help yourself and ask you to practice them between sessions. Early exercises will be quite easy, but they will become more challenging as you feel more comfortable. The more you work on these exercises, the more likely it is that your social anxiety disorder will get better.

Posttraumatic Stress Disorder

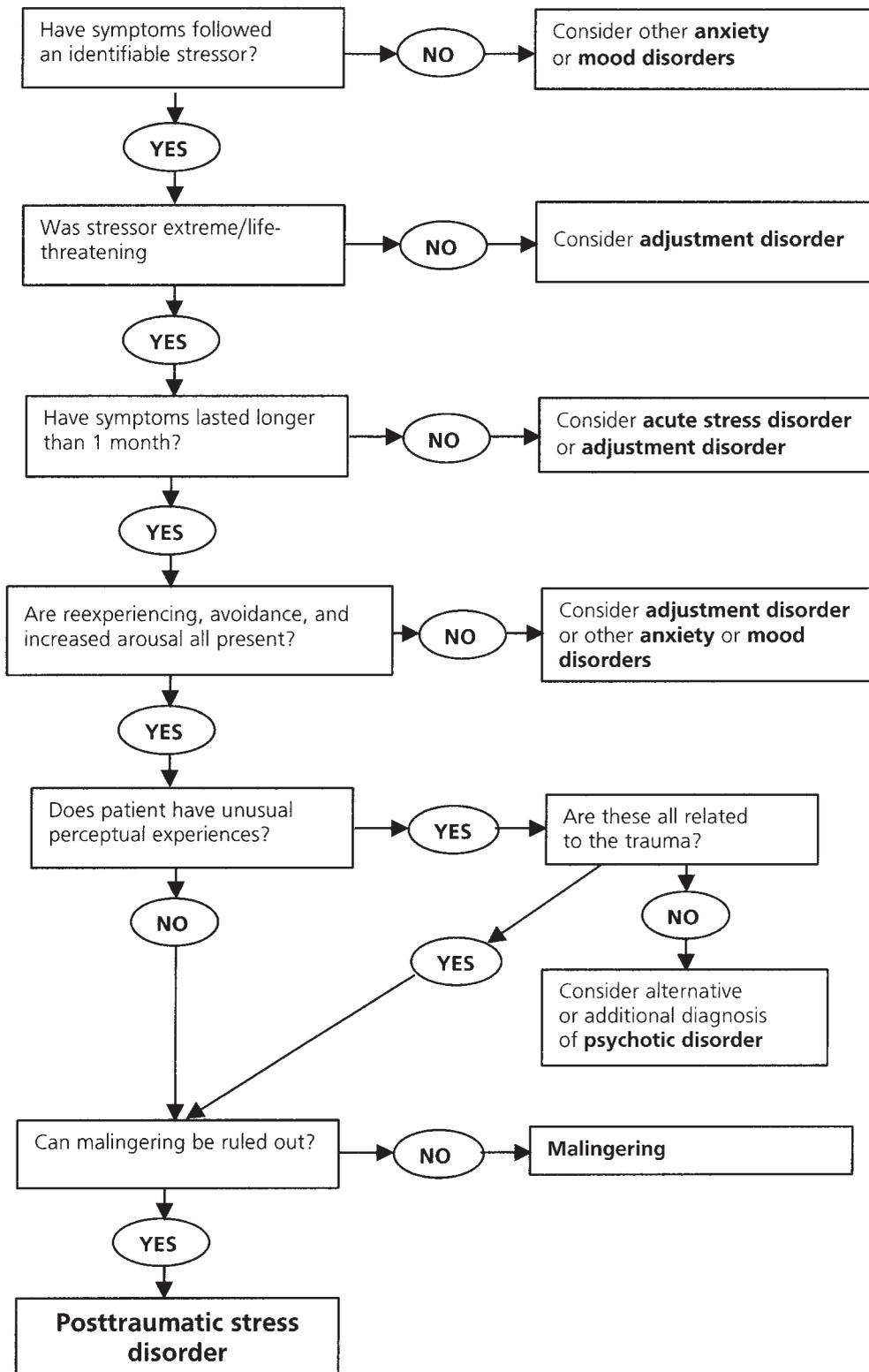


FIGURE 6.1. Diagnostic Flow Chart for Posttraumatic Stress Disorder

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TABLE 6.1. Maladaptive "Rules" in Posttraumatic Stress Disorder

1. Since something terrible happened, then terrible things will happen again.
 2. Images and sensations are a sign of danger.
 3. You have to stop having any memories of what happened.
 4. If you feel afraid, then it's happening again.
 5. Avoid anything that reminds you of the trauma.
 6. Try to numb yourself so you don't feel anything.
 7. Your life is changed forever.
-

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TABLE 6.3. General Plan of Treatment for Posttraumatic Stress Disorder

- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
 - Socialization to treatment
 - Skills training (optional)
 - Emotional regulation
 - Interpersonal skills
 - Exposure
 - Imaginal exposure to trauma memory
 - Exposure to internal and external cues
 - *In vivo* exposure to avoided situations
 - Cognitive restructuring
 - Coping with life problems
 - Phasing out treatment
-

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TABLE 6.4. Examples of Techniques for Addressing Trauma-Related Cognitive Distortions

Target belief	Techniques
“The world is dangerous.”	<ol style="list-style-type: none">1. Calculating probabilities of specific events.2. Listing advantages/disadvantages of world view.3. Doing a cost–benefit analysis of specific vigilance and avoidance behaviors.4. Identifying reasonable precautions.
“Events are unpredictable and uncontrollable.”	<ol style="list-style-type: none">1. Listing advantages/disadvantages of belief.2. Listing all areas of life in which patient has some control, and rating degree of control for each.3. Doing a cost–benefit analysis of specific efforts at prediction/control.4. Keeping a daily log of behaviors that produce predicted outcomes.5. Engaging in behaviors with high probability of predictable outcome.6. Accepting that some events are unpredictable.
“What happened was my fault.”	<ol style="list-style-type: none">1. Examining knowledge and choices available to patient at the time. Were any better choices actually available? Could patient reasonably have predicted outcomes?2. Using double-standard technique: “Would you blame a friend in a similar situation?”3. Constructing a “pie chart” assigning responsibility for event to all relevant parties.4. Examining societal biases (e.g., men are sent to war, then blamed for killing; women are urged to look “sexy,” then blamed for being raped).5. Practicing self-forgiveness—all humans make mistakes.
“I am incompetent.”	<ol style="list-style-type: none">1. Examining evidence for competence in daily life.2. Examining unreasonable expectation of competence in extreme and unusual circumstances.3. Keeping a daily log of competent coping.4. Using graded task assignment (see Chapter 9).
“Other people cannot be trusted.”	<ol style="list-style-type: none">1. Listing known persons who are trustworthy, and listing specific ways in which each can be trusted.2. Rating people on a continuum of trustworthiness.3. Examining patient’s history of relationship choices. Are better alternatives available?4. Carrying out behavioral experiments that involve trusting others in small ways.5. Keeping a daily log of people who honor commitments.
“Life is meaningless.”	<ol style="list-style-type: none">1. Listing activities that formerly were rewarding (see Chapter 9).2. Scheduling pleasurable/rewarding activities (see Chapter 9).3. Recognizing feelings of loss as a way of confirming meaning.4. Examining which goals and activities no longer seem meaningful and which now appear more important.5. Working toward an acceptance of death.6. Finding meaning in each day.

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TABLE 6.5. Sample Symptoms for Posttraumatic Stress Disorder

Specify traumatic event(s)	Derealization
Intrusive memories	Emotional numbness
Nightmares	Restricted affect
Flashbacks	Inability to imagine the future
Intense distress when exposed to memories or cues	Insomnia
Avoidance (specify what is avoided)	Irritability
Inability to recall parts of the trauma	Anger outbursts
Withdrawal from usual activities (specify)	Impaired concentration
Detachment	Hypervigilance
Dissociation	Exaggerated startle response
Depersonalization	

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TABLE 6.6. Sample Treatment Goals and Interventions for Posttraumatic Stress Disorder

Treatment goals	Interventions
Reducing symptoms of hyperarousal	Relaxation training
Reducing distress associated with memories to 2 or less on a scale of 0–10	Imaginal exposure
Eliminating avoidance of memories	<i>In vivo</i> exposure
Engaging in previously avoided activities (specify)	<i>In vivo</i> exposure
Eliminating anger outbursts	Anger management training
Increasing range of affect	Exposure to emotional cues
Increasing social contacts to three times a week	Activity scheduling, support groups
Eliminating feelings of guilt	Cognitive restructuring
Stating reduced belief (10%) in schemas of danger, lack of predictability/control (or other schemas—specify)	Cognitive restructuring, developmental analysis
Eliminating intrusive memories (and/or flashbacks/nightmares)	Imaginal exposure
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Finding sources of meaning in life	Life review, activity scheduling/reward planning
Eliminating all anxiety symptoms (PCL-C scores in normal range)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

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TABLE 6.7. Detailed Treatment Plan for Posttraumatic Stress Disorder

Sessions 1–2

Assessment

- Ascertain presenting problems
- Administer standard battery of intake measures (see Form 6.3)
- Inquire about history of trauma, including possible multiple traumas
- Inquire about reexperiencing, avoidance, and hyperarousal symptoms (Form 6.2), as well as triggers (Form 6.4)
- Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
- Assess need for medication
- Rule out contraindications for PTSD treatment (e.g., current substance abuse/dependence, current suicidal threat, unstable life circumstances)
- Rule out malingering
- Assess premorbid functioning (including strengths, weaknesses, prior treatment, etc.)
- Obtain developmental history
- Assess social supports

Socialization to Treatment

- Inform patient of diagnosis
- Indicate that the symptoms are a common and understandable response to a traumatic event
- Inform patient that short-term treatment is available, with high probability of a significant reduction in distress
- Provide patient with information handouts on PTSD (Forms 6.1 and 6.5) and cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
- Discuss option of medication
- Explore and discuss any fears/reservations patient has regarding treatment

Homework

- Have patient write out goals for therapy
- Have patient begin monitoring trauma related triggers during the week (using Form 6.4)

Session 3

Assessment

- Review homework
- Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)
- Assess automatic thoughts, assumptions, and schemas related to the trauma
- Assess patient's coping skills and need for possible skills training

Socialization to Treatment

- Review cognitive-behavioral conceptualization of PTSD, treatment, and rationale
- Link treatment plan to patient goals
- Discuss advantages/disadvantages of proceeding with treatment

Coping with Life Problems

- Discuss any current life problems that might interfere with treatment
- Teach patient to utilize cognitive-behavioral skills as needed

Homework

- Have patient continue monitoring triggers
- Ask patient to list avoided situations

(cont.)

TABLE 6.7 (*cont.*)

Sessions 4–5

Assessment

Review homework

Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Evaluate patient's readiness to proceed with exposure

Skills Training

Teach breathing relaxation

Teach additional affect regulation and interpersonal skills as necessary

Exposure

Explain rationale and procedures for imaginal exposure

Plan first exposure session

Cognitive Restructuring

Teach patient to identify automatic thoughts

Teach patient rational responding

Homework

Have patient continue monitoring triggers, avoided situations

Ask patient to write automatic thoughts and rational responses (using Form 6.8, or form 2.10 in Chapter 2)

Have patient practice breathing relaxation (and any other skills taught)

Session 6

Note: The first exposure session may be done earlier or later than Session 6, depending on the patient's readiness; allow 90 minutes for this session

Assessment

Review homework

Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Exposure

Create first imaginal exposure recording of trauma memory

Have patient listen to recording repeatedly in session

Homework

Have patient continue to practice relaxation and other coping skills (not during exposure)

Have patient listen to exposure recording repeatedly each day until SUDs level decreases by half

Sessions 7–8

Note: These sessions may be 45 or 90 minutes, depending on patient's needs

Assessment

Review homework and any problems completing exposure assignment

Assess patient's current SUDs level in response to trauma memory

Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Exposure

Have patient retell and re-record trauma story

Have patient continue imaginal exposure to trauma memory

Expose patient in session to other trauma-related cues

TABLE 6.7 (cont.)

Cognitive Restructuring

Note cognitive distortions during discussions of patient's reaction to exposure
If cognitive distortions do not spontaneously change with continued exposure, use cognitive techniques to challenge them (see Chapter 10 and Appendix B)

Homework

Have patient continue listening to exposure tape
Have patient continue writing automatic thoughts and rational responses (see Form 6.8 or 2.10)
Ask patient to construct hierarchy of avoided situations, safety behaviors

Sessions 9–13

Assessment

Review homework and any problems
Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Exposure

Continue imaginal exposure to remaining “hot spots” in trauma memory (see Form 6.6)
Continue exposure to trauma cues
Plan and review *in vivo* exposures

Cognitive Restructuring

Identify any problematic cognitions remaining and challenge these

Homework

Have patient continue imaginal exposure to “hot spots”
Assign self-directed *in vivo* exposure, forgoing safety behaviors
Have patient continue to identify and challenge cognitive distortions as they occur

Sessions 14–16 (Scheduled Biweekly or Monthly)

Assessment

Review homework
Note any trauma-related memories, cues, or situations that continue to be avoided or evoke anxiety
Note any remaining maladaptive thoughts, assumptions, and/or schemas
Evaluate anxiety and depression (use PCL-C, BAI, and/or BDI-II, as appropriate)

Exposure

Continue exposure to any cues that remain problematic

Cognitive Restructuring

Address any remaining problematic beliefs
Modify maladaptive schemas

Coping with Life Problems

Discuss ways of coping with any remaining life problems

Phasing Out Treatment

Review techniques patient has found useful
Discuss possible sources of stress in future, predict possibility of temporary renewal of symptoms, and discuss ways of coping with them

(cont.)

TABLE 6.7 (*cont.*)

Homework

Have patient self-assign homework

Encourage continued practice of affect and interpersonal regulation skills

Encourage self-directed exposure to avoided situations

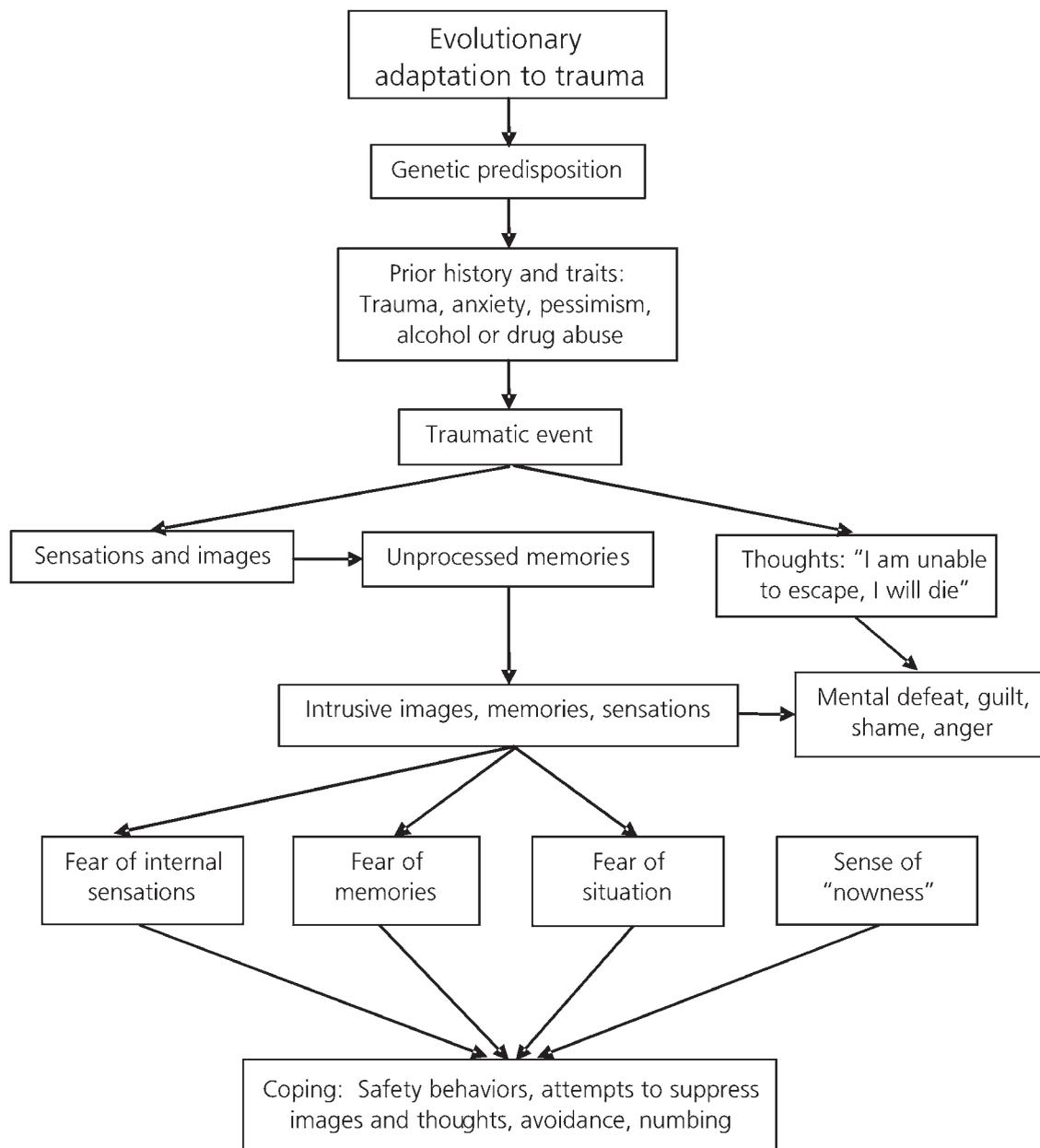
Encourage continued practice of cognitive techniques

Encourage continued practice of life-problem-related skills

Write list of favorite techniques to be used after termination

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FORM 6.1. The Causes of Posttraumatic Stress Disorder



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FORM 6.2. PTSD Checklist—Civilian Version (PCL-C)

Patient's name: _____ Today's date: _____

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. In the column at the right, enter the number that best indicates how much you have been bothered by that problem *in the last month*.

1 = Not at all	2 = A little bit	3 = Moderately	4 = Quite a bit	5 = Extremely
Response				Rating
1. Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?				
2. Repeated, disturbing <i>dreams</i> of a stressful experience from the past?				
3. Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?				
4. Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?				
5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?				
6. Avoid <i>thinking about or talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?				
7. Avoid <i>activities or situations</i> because <i>they remind you</i> of a stressful experience from the past?				
8. Trouble <i>remembering important parts</i> of a stressful experience from the past?				
9. Loss of <i>interest in things that you used to enjoy</i> ?				
10. Feeling <i>distant or cut off</i> from other people?				
11. Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?				
12. Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?				
13. Trouble <i>falling or staying asleep</i> ?				
14. Feeling <i>irritable</i> or having <i>angry outbursts</i> ?				
15. Having <i>difficulty concentrating</i> ?				
16. Being " <i>super alert</i> " or watchful on guard?				
17. Feeling <i>jumpy</i> or easily startled?				

The PCL-C is a U.S. government document in the public domain.

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FORM 6.3. Evaluation of Posttraumatic Stress Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

PTSD Checklist for Civilians (PCL-C) _____ Beck Depression Inventory-II (BDI-II) _____

Beck Anxiety Inventory (BAI) _____ Dyadic Adjustment Scale (DAS) _____

Global Assessment of Functioning (GAF) _____

Other questionnaires (specify): _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous traumatic episodes (specify nature):

Onset	Duration	Precipitating events	Treatment
-------	----------	----------------------	-----------

(cont.)

FORM 6.3. Evaluation of Posttraumatic Stress Disorder (p. 2 of 2)

Previous episodes of anxiety, depression, or other psychiatric disorder (specify nature):

Onset

Duration

Precipitating events

Treatment

Treatment progress (later evaluations only)

Completed exposures: _____

Situations still avoided: _____

Remaining safety behaviors: _____

Cognitive distortions to be addressed: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 6.5. Information for Patients about Posttraumatic Stress Disorder

WHAT IS POSTTRAUMATIC STRESS DISORDER

Posttraumatic stress disorder (or PTSD) is a common reaction to very stressful or traumatic events. Many different kinds of events can lead to PTSD, including being in a car accident; being raped or being the victim of another crime; being physically or sexually abused; living through a disaster such as a flood or a bombing; or seeing someone else die.

People with PTSD have three main types of problems or symptoms

1. **Reliving the trauma.** This can include frequent memories, nightmares, and flashbacks that make people feel as if they are living the event all over again. Memories often come back when something people see or hear reminds them of the event.
2. **Avoiding.** Because it is upsetting to remember what happened, people with PTSD try not to think about it. They also stay away from people, places, or things that bring back memories. Often they feel numb or detached from other people. Some turn to alcohol or drugs to dull the pain.
3. **Signs of physical stress.** These can include trouble sleeping, feeling irritable or angry all the time, trouble concentrating, and feeling tense or on guard.

WHAT CAUSES POSTTRAUMATIC STRESS DISORDER?

When people live through a trauma, the memories of what happened get connected in their minds with what they saw, heard, smelled, or felt at the time. Later a similar sight, sound, smell, or other feeling can bring the memories and emotions flooding back.

A second reason memories come back is that people have a need to make sense of what happened to them. Traumatic events often make people question things they once believed—for example, that the world is basically safe or that bad things won't happen to them. To understand the trauma, they have to think about it. But thinking about it brings the memories and feelings back, so they try not to think about it. Instead of finding understanding and peace, people often end up going back and forth between remembering and trying to forget.

HOW DOES POSTTRAUMATIC STRESS DISORDER DEVELOP?

Most people begin to have symptoms of PTSD shortly after the trauma. For about half of these people, the symptoms get better on their own within 3 months. For others, the symptoms can last for years. Some people don't start to have symptoms until many years after the event.

HOW DOES COGNITIVE-BEHAVIORAL THERAPY FOR POSTTRAUMATIC STRESS DISORDER HELP?

Cognitive-behavioral therapy is designed to help reduce the upsetting memories and emotions from the trauma, and to help you make sense of what happened in a way that allows you to move on with your life. First, your

(cont.)

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therapist will give you some simple exercises to help reduce your anxiety. Then he or she will help you face the upsetting memories by retelling the story of what happened in a safe way. At first, you may find that some of the old feelings return. However, the more you do this, the more the emotions will begin to fade, allowing you to achieve a sense of peace. Your therapist will also help you think more realistically about what happened to you and what its implications are the future.

A number of studies have found that cognitive-behavioral therapy helps people with PTSD feel significantly better, and that about two-thirds of patients no longer have PTSD by the end of treatment. These studies have included combat veterans as well as victims of rape, assault, childhood abuse, political violence, and automobile accidents.

HOW LONG DOES THERAPY LAST?

How long treatment for PTSD lasts depends on how many traumas you suffered and how severe they were, how bad your symptoms are now, and how many other problems you are having in your life. For people who have been through a single traumatic event, 12–20 sessions are usually enough. Most of these sessions will be 45–50 minutes long, but a few may be as long as 90 minutes.

CAN MEDICATIONS HELP?

Medications by themselves are usually not enough for treating PTSD. However, they can be helpful for some people when combined with therapy. Your physician or a psychiatrist can suggest which medication might be best for you.

WHAT IS EXPECTED OF YOU AS A PATIENT?

It is best not to start treatment for PTSD if you are currently abusing drugs or alcohol, or if you have a major current crisis in your life. Your therapist can help you deal with these problems first, and then can help you begin working on your PTSD symptoms. Other than that, all you need to do is to be willing to try therapy and to spend some time each week practicing the things you learn.

FORM 6.6. "Hot Spots" in My Story

Image of the "hot spot"	What it makes me think and feel

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FORM 6.7. Safety Behaviors in Posttraumatic Stress Disorder

Typical safety behaviors	Examples of my safety behaviors	How I think these safety behaviors protect me
Continually looking for signs of danger		
Avoiding people, places, and things		
Looking away from sounds, images, or experiences that remind me of the trauma		
Seeking reassurance		
Repeating prayers or using superstitious behaviors		
Physical tensing (holding my body, holding my breath, walking a certain way, etc.)		
Using alcohol or drugs to make myself feel more calm		
Bingeing on food to take my mind off memories		
Other behaviors		

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FORM 6.8. Negative Thoughts and Realistic Responses in Posttraumatic Stress Disorder

Triggers: Sensations and images		
Triggers	Negative thoughts	Realistic thoughts

Why I am safe now	
Beliefs about danger	Why I am safe

Self, others, and the world	
Negative thoughts	Realistic thoughts
Self	
Others	
World	

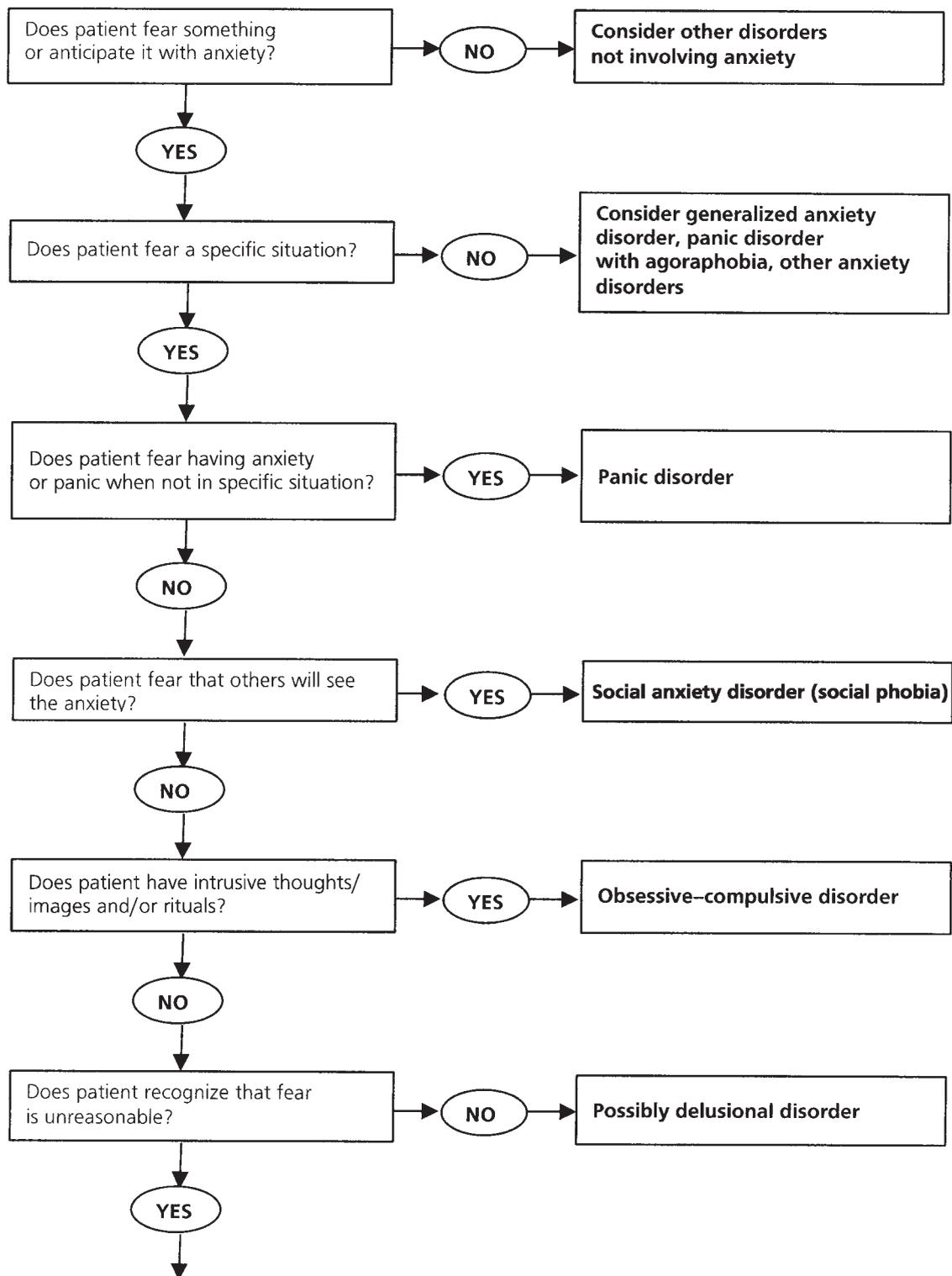
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FORM 6.9. Possible Interventions for Posttraumatic Stress Disorder: A Self-Help Guide

1. **Practice relaxation.** Set aside time every day for deep muscle relaxation, mindful breathing, or a body scan.
2. **Examine the costs and benefits of changing.** Getting better will require doing some things that are uncomfortable. How will your life be better if you no longer have PTSD?
3. **Be an observer.** Rather than struggle against sensations, images, and thoughts, just stand back and watch them. Observe that they are temporary. They are mental events, not reality.
4. **Don't struggle; let it be.** Allow thoughts, sensations, and images to come and go like water flowing along a stream. Surrender to the moment.
5. **Evaluate your negative beliefs.** Challenge the negative thoughts that you have about helplessness, guilt, and the lack of meaning in life. What advice would you give a friend?
6. **Challenge your belief that you are still in danger.** It happened in the past, but it sometimes feels as if it is happening now. Remind yourself of how safe you really are.
7. **Retell the story in more detail.** Write out and tape-record your retelling of the story of your trauma. Pay attention to the details of sounds, sights, and smells. Try to recall the sequence of how things actually happened.
8. **Focus on the "hot spots" in your story.** Certain images and thoughts make you feel more anxious. Try to notice what they are and what they mean to you. Slow yourself down and examine the negative thoughts that are associated with these images.
9. **Restructure the image.** Create a new image in which you are triumphant, dominant, and strong. Imagine yourself as the victor and as more powerful than anything and anyone that has traumatized you.
10. **Eliminate safety behaviors.** Notice any superstitious things that you do to make yourself feel safer—like repeating reassurance to yourself, avoiding doing certain things at certain times or places, tensing your body, scanning for danger. Eliminate these behaviors.
11. **Be realistic about anxiety.** Realize that life includes anxiety, because anxiety is necessary for living. Don't think of your anxiety as awful or as a sign of weakness. Everyone has anxiety. It is temporary; it passes; it is part of getting better. You will do things that make you anxious to overcome your anxiety. Go through it to get past it.
12. **Expose yourself to your feared sensations.** You have been afraid of your internal sensations—dizziness, breathlessness, feeling spaced out. Practice the exercises to make yourself intentionally feel these sensations, to learn that they are temporary and not dangerous.
13. **Practice your fears.** The best way to overcome your PTSD is to practice the things that make you afraid:
 - Set up a hierarchy.
 - Imagine yourself in the situation.
 - Look at pictures that remind you of the trauma.
 - Answer your negative thoughts in the situation.
 - If possible, revisit the scene.
14. **Reward yourself.** Remind yourself that you are the one who is doing all this hard work. Give yourself credit. Praise yourself, cheer yourself on, and treat yourself to something special.

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Specific Phobia



(cont.)

FIGURE 7.1. Diagnostic Flow Chart for Specific Phobia

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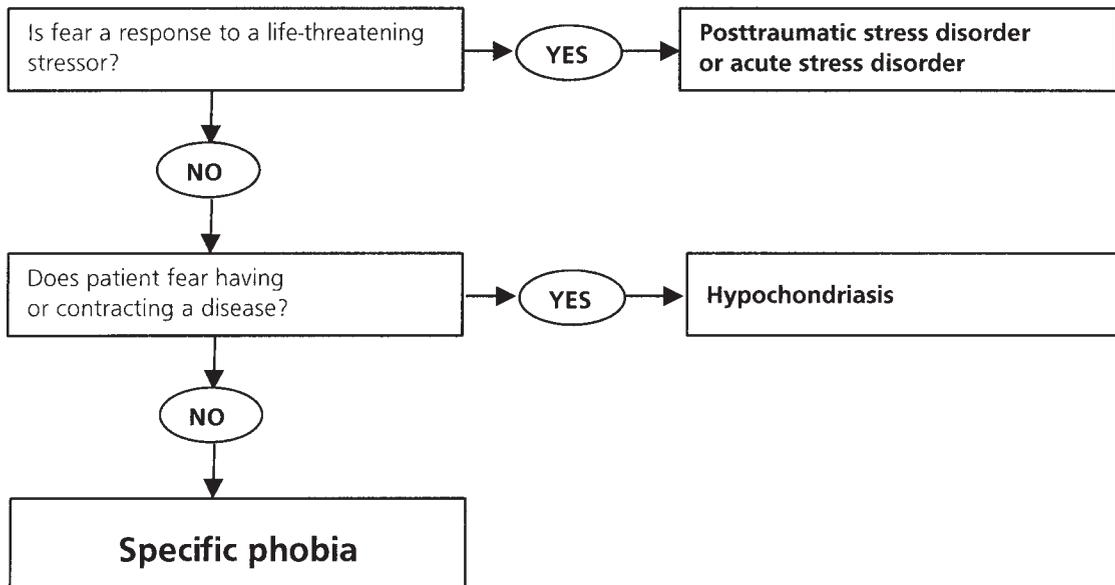


FIGURE 7.1 (cont.)

TABLE 7.1. General Plan of Treatment for Specific Phobia

- Assessment
 - Tests and clinical interviewing
 - Consideration of medication
 - Socialization to treatment
 - Behavioral interventions
 - Fear hierarchies and planned exposure
 - Adapting behavioral treatment for different types of phobias/fears
 - Eliminating avoidance, escape, and safety behaviors
 - Cognitive interventions
 - Phasing out therapy
-

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TABLE 7.3. Sample Symptoms for Specific Phobia

Specify feared object or situation

Anxiety

Specify physical/cognitive symptoms of anxiety:

- Panic attacks
- Palpitations
- Difficulty breathing
- Chest pain
- Nausea
- Dizziness
- Feeling faint
- Sweating
- Shaking
- Mind going blank
- Derealization
- Depersonalization
- Numbness
- Tingling
- Chills
- Hot flashes

Avoidance, escape, and other safety behaviors (specify)

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TABLE 7.4. Sample Treatment Goals and Interventions for Specific Phobia

Treatment goals	Interventions
Reducing physical symptoms of anxiety	Exposure
Stating reduced fear of phobic object/situation phobic object	Cognitive restructuring
Reporting anxiety <1/10 when encountering phobic object/situation	Exposure
Modifying schemas of danger and vulnerability (or other schemas—specify)	Cognitive restructuring, cost–benefit analysis
Eliminating all avoidance, escape, and safety behaviors	Exposure
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Eliminating all anxiety symptoms (test scores in normal range)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

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TABLE 7.5. Detailed Treatment Plan for Specific Phobia

Session 1

Assessment

Elicit objects or situations feared, as well as degree of avoidance and escape
Note onset of fear, level of fear, duration, episodic nature
Elicit beliefs about feared stimulus/response
Identify safety behaviors
Assess impairment in social, occupational, and educational functioning
Administer standard battery of intake measures (see Form 7.3), plus additional questionnaires as appropriate
Have patient complete Fear Evaluation for Patients (Form 7.4)
Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
Evaluate substance use; evaluate need for counseling or detoxification if patient has substance abuse or dependence
Assess need for medication

Socialization to Treatment

Indicate that fears and phobias are common and that brief treatment is available
Provide patient with information handouts on specific phobia (Forms 7.1, 7.2, 7.5) and on Cognitive/behavioral therapy in general (Form 10. 1 in Chapter 10)

Session 2

Assessment

Provide feedback on evaluation
Explain costs-benefits of eliminating fears

Socialization to Treatment

Explain to patient the evolutionary, behavioral, and cognitive models of fear acquisition and of fear maintenance through avoidance
Explain need for exposure treatment

Behavioral Interventions

Construct fear hierarchy (see Form 7.8) and train patient in use of SUDs

Cognitive Interventions

Begin identifying patient's distorted automatic thoughts

Homework

Have patient begin self-monitoring fears (see Form 7.7)

Sessions 3–4

Note: All sessions involving exposure may be double-length.

Assessment

Review homework

Behavioral Interventions

Elicit imagery of feared stimuli
Review fear hierarchy
Begin imaginal exposure in session
Begin *in vivo* exposure in session, if possible (or therapist may model exposure)

(cont.)

TABLE 7.5 (*cont.*)

Identify safety behaviors during exposure
Encourage patient to eliminate safety behaviors
[Exposure may be concentrated in one session (massed exposure) or spaced over several sessions, with homework exposure in between sessions.]

Cognitive Interventions

Elicit patient's negative automatic thoughts during exposure
Begin to challenge patient's automatic thoughts

Homework

Have patient engage in and self-monitor *in vivo* exposure experiences (using Form 7.7)
Have patient identify and challenge automatic thoughts

Sessions 5–6

Assessment

Review homework

Behavioral Interventions

Continue exposure (imaginal or *in vivo*) during session
Encourage “overpractice” of exposure
Encourage decreased reliance on companions
Begin to phase out treatment; discuss possible future problems and ways of coping with them

Cognitive Interventions

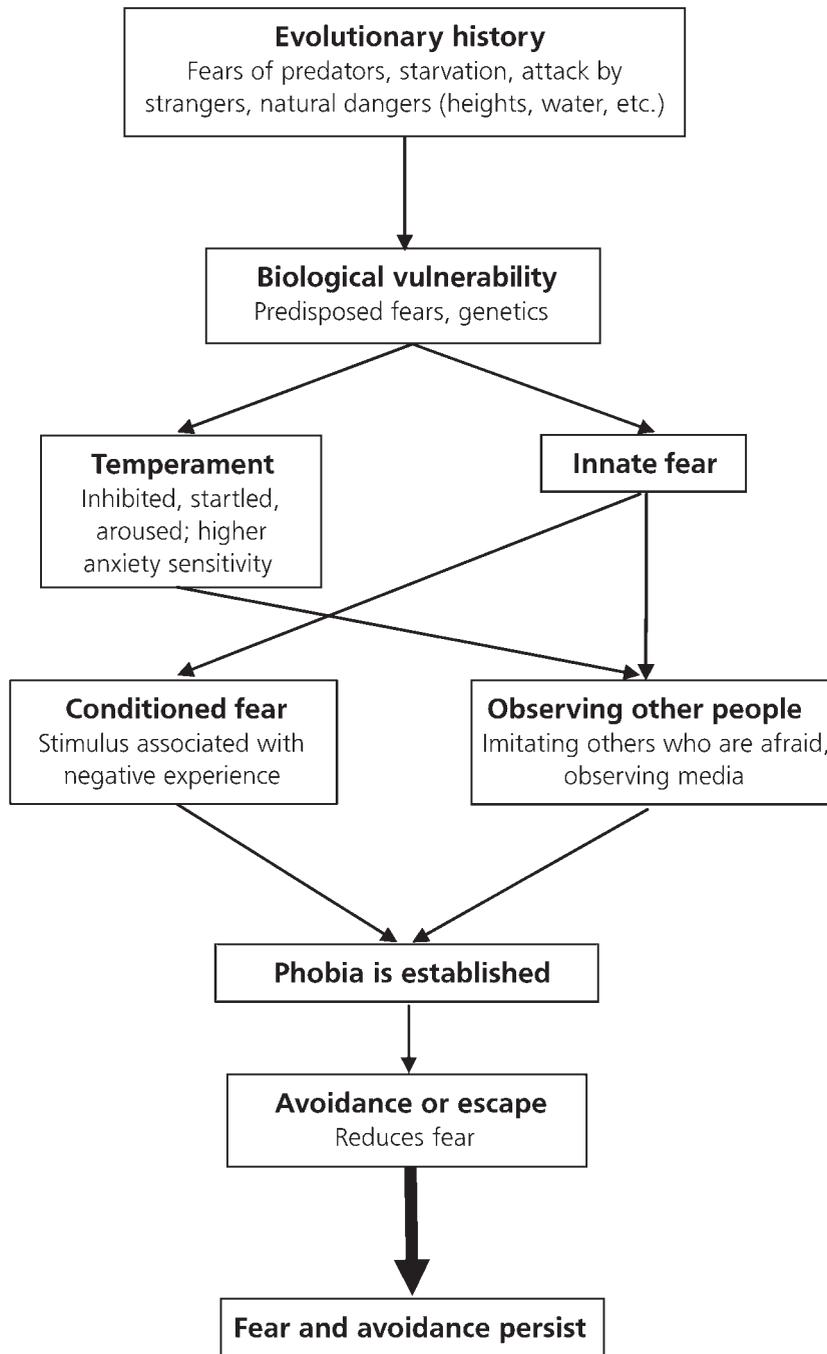
Practice stress inoculation during session (develop coping cards, model arguing against negative thoughts, model making coping/self-reinforcing statements, have patient imitate therapist's coping statements, plan stress inoculation as homework)
Examine patient's explanations for improvement (e.g., presence of therapist, exposure, disconfirmation of negative beliefs, safety behaviors, luck)
Encourage self-efficacy statements
Begin to phase out treatment; discuss possible future problems and ways of coping with them

Homework

Encourage patient to continue eliminating safety behaviors
Have patient plan further *in vivo* exposure experiences, and encourage self-monitoring of these
Encourage continuing work on automatic thoughts

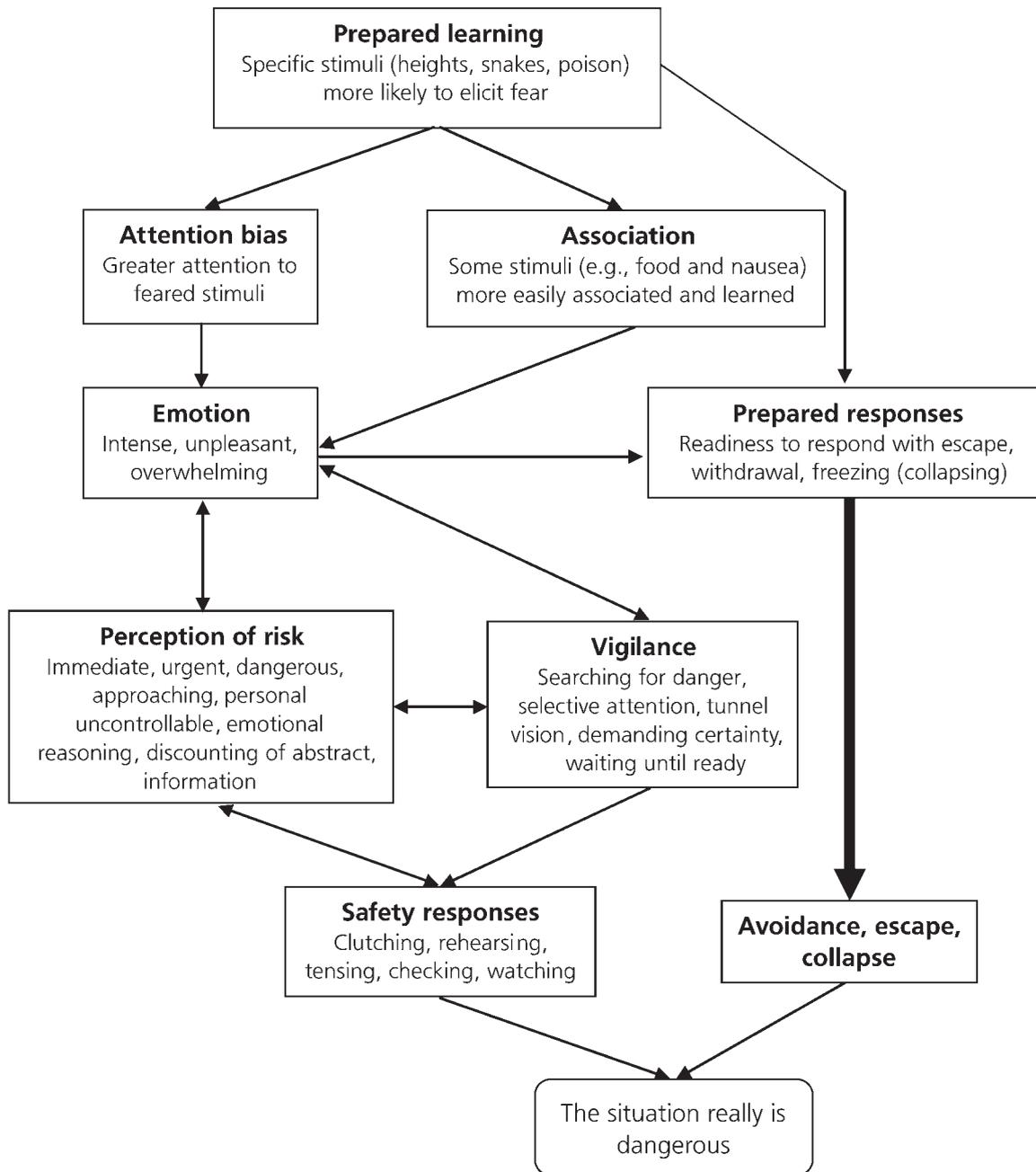
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FORM 7.1. Where Your Fear Comes From and Why It Persists



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FORM 7.2. Fearful Thinking



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FORM 7.3. Evaluation of Specific Phobia: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Beck Depression Inventory-II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Global Assessment of Functioning (GAF) _____ Dyadic Adjustment Scale (DAS) _____

Structured Clinical Interview for DSM-IV-TR, Axis I (SCID) _____

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) _____

Other questionnaires (specify) _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Treatment
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(cont.)

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Treatment progress (later evaluations only)

Situations in which stimulus is still avoided: _____

Situations in which stimulus is approached but was previously avoided: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 7.4. Fear Evaluation for Patients

Patient's name: _____ Today's date: _____

Therapist's name: _____

Choose a number from the scale below to show how much you fear each of the situations listed below, and write that number next to each fear.

0 25 50 75 100
None Somewhat Moderate Very Extreme

1. Flying	11. Meeting strangers	21. Traveling in a bus, train, or subway
2. Elevators	12. Speaking in public	22. Walking alone
3. Heights	13. Using a public bathroom	23. Being alone at home
4. Insects	14. Eating in public	24. Dirt or soiled things
5. Snakes	15. People seeing I'm nervous	25. Lightning or thunder
6. Animals	16. Crowded stores	26. Darkness or night
7. Blood or injections	17. Malls	27. Standing in line waiting
8. Rats and mice	18. Restaurants, churches, movies	28. Exercise
9. Water	19. Closed spaces	29. Increasing my heart rate
10. Hospitals	20. Open spaces	30. People criticizing me

FORM 7.5. Information for Patients about Specific Phobia

WHAT IS SPECIFIC PHOBIA?

Specific phobia is a fear of a particular object, animal, or situation. The fear is great enough that you wish to avoid the situation or experience it only with considerable anxiety. Fears and phobias are very common. In a recent national survey, 60% of the people interviewed reported that they feared some situation or thing. The most common fears were fears of bugs, mice, snakes, bats, heights, water, public transportation, storms, closed spaces, tunnels, and bridges. Many people reported that they feared several things and that they consciously avoided them. In fact, over 12% of the people indicated that their fears qualified as specific phobias. That is, their fears were persistent and associated with intense anxiety; they avoided or wanted to avoid certain situations; they realized that their fears were excessive and unreasonable; and that their fears resulted in distress and difficulty in their normal lives.

WHAT ARE THE CAUSES OF SPECIFIC PHOBIA?

There are several causes of specific phobia. Cognitive-behavioral theorists make a distinction between how you learned to fear something and why you still fear that thing even years later.

Some theories suggest that people tend to develop phobias about objects, animals, or situations that were dangerous in prehistoric times. For example, bugs, mice, snakes, many other animals, heights, strangers, bridges, and water were all potentially dangerous for early humans. In a wild environment, these fears were very adaptive and useful. People with these fears were better prepared to avoid contamination, poisonous bites, falling off cliffs or bridges, being murdered by strangers, or drowning. But in today's technological world, these fears are no longer as accurate as they once were.

A second origin of phobias is through learning—either connecting a bad experience with the thing you are afraid of (for example, perhaps you were bitten by a dog and developed a fear of dogs) or observing someone who is afraid and learning from their fear (for example, perhaps other family members had a fear of flying and you learned that fear from them). A third reason for phobias may be distortions in thinking. For example, a phobia may be based on incorrect information, on a tendency to predict the worst, on a tendency not to use evidence that challenges the phobia, or on a belief that you cannot tolerate anxiety.

Once you learn a fear or phobia, it is maintained in a number of ways. The most important reason is that you avoid the situation you fear. If you fear flying, you feel less anxious every time you decide to avoid getting onto a plane. Each time you avoid flying, you teach yourself that “the way to reduce my fear is to avoid”—that is, you learn to avoid. This is like taking a drink every time that you are anxious—you learn to drink more because it temporarily reduces your anxiety. But by avoiding the thing you fear, you never learn that you can overcome your fear. Another way you may maintain your fear is by engaging in “safety behaviors.” These are things you do or say that you think will protect you. For example, in an elevator you may hold onto its side, or in an airplane you may hold onto your seat. Or you may repeat prayers or otherwise seek reassurance when you are in a feared situation. You can come to believe that these safety behaviors are necessary for you to overcome your fear.

HOW CAN COGNITIVE-BEHAVIORAL THERAPY HELP?

Your fear and anxiety will begin to fade when you learn, from experience, that your phobia is unfounded. Cognitive-behavioral therapy for specific phobia is about helping you face what you fear rather than avoiding it.

(cont.)

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In order to overcome your fear, your therapist will have you make a list of the objects or situations that you fear, describe how intense your fear is, and indicate what your beliefs are about each object or situation (for example, do you think that you will be contaminated, die, be attacked, or go insane?). Your therapist may ask you to form images in your mind about a feared situation and hold these images in mind until you feel less anxious. You may observe your therapist doing the things you fear, and later you may imitate him or her. Your exposure to the things that you fear will be gradual: Your therapist will explain everything before you do it; you are free to refuse to do anything; there will be no surprises sprung on you; and you will determine the pace at which you make progress. Most patients using these techniques find that they feel much less tense, become able to do things that they feared, and feel more effective in their lives. Many patients are able to improve rapidly with a few sessions. Depending on the fear, between 80% and 90% of patients improve when they use these techniques. Although some patients may use antidepressants or anti-anxiety medications for these fears, the treatments that we have described do not require these medications.

WHAT IS EXPECTED OF YOU AS A PATIENT?

Overcoming fears may require you to put yourself gradually into situations that make you anxious. You should let your therapist know which situations or things make you most anxious, what kinds of thoughts you have about those things, and whether you are willing to experience some anxiety in order to overcome your fears. Your therapist will help guide you through gradual exposure to these situations. You will have to carry out some self-help homework between therapy sessions, with which you will practice many of the same things that you are learning in the sessions with your therapist.

FORM 7.6. Costs and Benefits of Overcoming Your Fear

My specific fear is:		
Costs	Benefits	What I will be able to do if I overcome this fear

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FORM 7.7. Patient's Self-Monitoring of Fears

Patient's name: _____ Today's date: _____

To collect information about your fears for treatment, please record the information below for times when you were in a feared situation. In the first column, write the date and time. In the next, describe the feared situation. Use a scale of 1-10, where 10 represents the greatest fear you can imagine. In the fourth column, describe the actual outcome: Did you avoid the situation, engage in the behavior, seek safety, etc.? What sensations and thoughts did you have? What happened? For example: "I was able to take the elevator. I thought I was going to panic, but I got up and down safely." In the last column, indicate the actual level of fear you felt in the situation, again using a scale of 0–10 where 10 represents the greatest fear you can imagine.

Date/time	Situation feared and my prediction	Expected fear level (0–10)	Actual outcome	Actual fear level (0–10)

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FORM 7.8. Patient's Fear Hierarchy for Specific Phobia

Patient's name: _____ Today's date: _____

We are interested in the degree to which you fear a specific thing. For example, if you had a fear of flying, you might have a greater degree of fear if you were in an airplane during a storm, and a lot less fear if you were just sitting in your house and thinking about an airplane. We want you to decide what fear you want treatment for (for example, a fear of flying, elevators, heights, water, animals, blood, injection, snakes, etc.). Now we want you to imagine a number of different ways that you could come into contact with that feared situation or thing. Rank these in order from least to most frightening, and then write these in the boxes under "Situation." For example, if you had a fear of flying, rank how frightening you would find these different situations: driving to the airport, getting onto the plane, engines starting up, planes taking off, flying, and landing. In the last column, note how afraid each situation would make you, from 0 (no fear) to 10 (maximum fear). Also, sometimes people feel more or less anxious if someone is accompanying them. You may also note this in constructing your list or "hierarchy" of feared situations—for example, are you more or less anxious if someone is with you on the plane?

Rank	Situation	Avoided? (Yes/No)	Fear level (0–10)

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FORM 7.9. Costs and Benefits of Avoidance Behaviors in Specific Phobia

Examples of avoidance behaviors	Costs to me of avoiding	Benefits to me of avoiding

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FORM 7.10. Safety Behaviors in Specific Phobia

Categories of safety behaviors	My specific behavior	Yes/No
Tensing, clutching		
Scanning the environment		
Asking for reassurance		
Praying, repeating phrases		
Rehearsing distracting images or sounds (e.g., singing to myself)		
Breathing differently		
Moving in a different manner (slowly, quickly, rigidly, etc.)		
Other		

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FORM 7.12. Rational and Irrational Thoughts in Specific Phobia

Irrational automatic thought	What distorted thought category is this?	Rational response
The elevator will crash.	Fortunetelling Catastrophic thinking	The chances of the elevator falling and killing me are 398 million to 1. I have made these predictions before, and they have never come true.
Yeah—but this time it could happen. There is no guarantee.	Discounting the positive Perfectionism Demand for certainty	Of course, anything could happen—but life has to be lived with what is probable, not with what is possible.
I shouldn't get on the elevator until I feel comfortable.	Demand for certainty and the need to be ready	The only way to make progress is to do things when I am not ready—like exercise and facing my fears. In fact, I will need to feel the fear to get over it.

Note: List any irrational negative thoughts that you have, and identify the categories of distorted thoughts that these fall into. Then give the most useful rational responses that you can give. You can go back over this form at later times and add to your rational responses.

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FORM 7.13. Your Phobia-Free Rule Book

Rules that make you afraid	Rules that overcome your fears
If you are afraid, then it must be dangerous.	Your fear does not mean the danger is real—emotions are not reality.
The danger is approaching rapidly.	The danger may be only in your head (it may not be approaching at all), or it may be slowly approaching.
Don't rely on probabilities. You could be "the one" who gets hurt.	Probabilities are reality—you "could" always be "the one"—but that's no way to live. There is no certainty in an uncertain world.
You must have absolute certainty, or it is dangerous.	There is no certainty. Uncertainty is neutral, not dangerous.
It will be catastrophic—it could kill you.	You probably have no evidence it is going to be catastrophic. You've had these beliefs before, and you are still alive.
Focus on the threat—this will save you.	You should recognize that there is always some evidence of a "threat"—but there is also evidence of safety.
Look for "clues" that it is dangerous.	Use all the information—not just the "signs" of threat.
You will not be able to cope—you are potentially helpless.	You may be stronger than you think.
Ignore anyone who tells you it's safe—you could get overconfident.	Use the information other people have. After all, phobia is not evidence of danger—it's evidence of your emotion.
You must get out of or avoid the situation immediately.	You might be better off staying as long as possible to find out that it is really safe.
Use safety behaviors to tolerate the discomfort.	Safety behaviors maintain your fears. Eliminate them as soon as possible.
If you survive, it's because your safety behaviors helped you.	If you survive, it has nothing to do with safety behaviors—it has more to do with the fact that the situation is safe.
Always avoid the things you fear.	Try to do the things that you fear doing.

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Obsessive–Compulsive Disorder

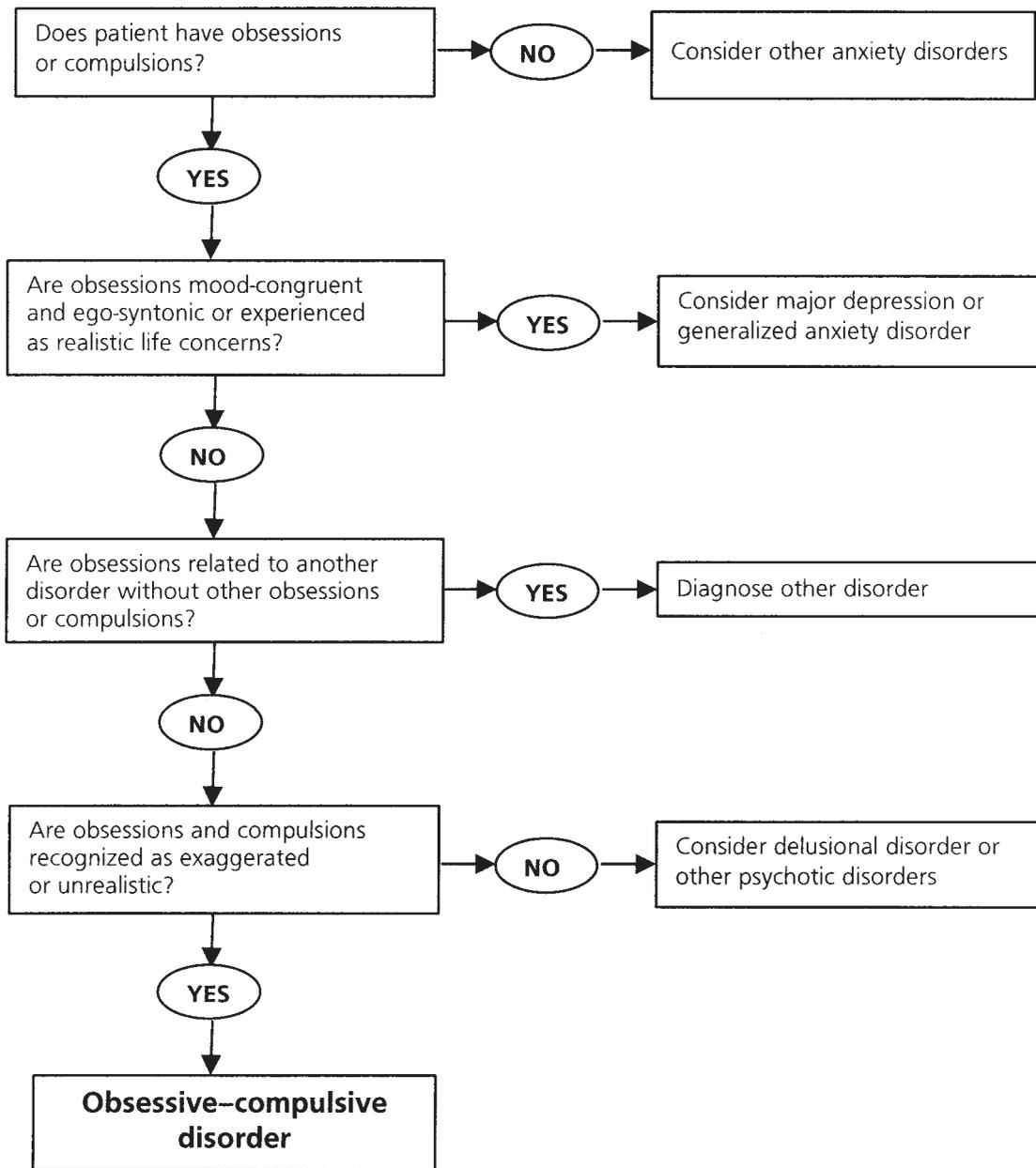


FIGURE 8.1. Diagnostic Flow Chart for Obsessive-Compulsive Disorder

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TABLE 8.2. General Plan of Treatment for Obsessive–Compulsive Disorder

- Assessment
 - Tests and clinical interviewing
 - Considerations of medication
 - Socialization to treatment
 - Building motivation
 - Cognitive interventions
 - Behavioral interventions
 - Exposure
 - Response prevention
 - Phasing out therapy and preventing relapse
-

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TABLE 8.3. Sample Symptoms for Obsessive–Compulsive Disorder

Obsessions (specify)—for example:	Nausea
Fear of contracting disease (specify)	Dizziness
Fear of contamination (specify)	Feeling faint
Fear of hurting someone (specify)	Sweating
Fear of failure to do something (specify)	Shaking
Fear of losing control (specify)	Numbness
Compulsions (specify)—for example:	Tingling
Excessive washing or cleaning (specify)	Chills
Checking (specify)	Hot flashes
Repeating (specify)	Specify cognitive symptoms:
Hoarding (specify)	Mind going blank
Ordering (specify)	Difficulty speaking
Anxious mood	Loss of concentration
Specify physical symptoms of anxiety:	Derealization
Palpitations	Depersonalization
Difficulty breathing	Avoidance (specify)
Chest pain	

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TABLE 8.4. Sample Treatment Goals and Interventions for Obsessive–Compulsive Disorder

Treatment goals	Interventions
Reducing physical anxiety symptoms	Imaginal exposure
Reporting obsession-related distress less than 2 on a scale of 0–10	Exposure
Eliminating compulsions (specify)	Response prevention
Stating belief that anxiety is not dangerous and can be tolerated	Cognitive restructuring, exposure
Stating understanding that seeking perfect certainty exacerbates symptoms	Cognitive restructuring
Modifying schemas of danger and responsibility (or other schemas—specify)	Cognitiving restructuring, developmental analysis
Engaging in previously avoided behaviors (specify)	<i>In vivo</i> exposure
Reducing functional impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Reducing anxiety symptoms (MOCI and/or OCQ scores in normal range)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

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TABLE 8.5. Detailed Treatment Plan for Obsessive–Compulsive Disorder

Sessions 1–2

Assessment

- Assess presenting problem
- Inquire regarding all symptoms
- Assess presence of obsessions and compulsions
- Assess avoidance behaviors
- Assess feared consequences
- Assess internal and external triggers of obsessional anxiety
- Assess impairment in social, educational, and occupational functioning
- Assess social supports and involvement of family members in rituals
- Have patient complete OCQ (Form 8.2)
- Administer standard battery of intake measures (see Form 8.3), plus other anxiety questionnaires as appropriate
- Evaluate for comorbid conditions
- Evaluate substance use; evaluate need for counseling or detoxification if patient has substance abuse or dependence

Socialization to Treatment

- Inform patient of diagnosis and provide education on OCD
- Educate patient regarding treatment options, including medication
- Provide patient with handouts on OCD (Form 8.5) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)

Homework

- Have patient write out goals for therapy
- Assign self-help reading material (*Anxiety Free, Stop Obsessing!, When Once Is Not Enough*)

Sessions 3–4

Assessment

- Evaluate homework
- Readminister self-report questionnaires to assess mood and track progress
- Review all obsessions, compulsions, and avoided situations
- Assess motivation for treatment

Socialization to Treatment

- Build motivation
- Describe cognitive-behavioral conceptualization of OCD and describe cognitive-behavioral treatment
- Educate patient regarding outcome research
- Obtain patient's commitment to proceed with treatment
- Educate family members regarding diagnosis and their role in treatment, if appropriate

Cognitive Interventions

- Introduce cognitive model
- Identify automatic thoughts, obsessional anxiety, compulsions or urge to ritualize, and triggering situations
- Evaluate automatic thoughts

Homework

- Have patient list advantages and disadvantages of proceeding with treatment
 - Have patient begin to log all obsessions and rituals (Form 8.4)
-

TABLE 8.5 (*cont.*)

Assign further chapters from selected self-help book(s)
Have patient begin recording automatic thoughts, feelings, emotions, behaviors

Sessions 5–6

Assessment

Evaluate homework
Readminister self-report questionnaires to assess mood and track progress

Cognitive Interventions

Educate patient regarding intrusive thoughts as normal phenomena
Evaluate validity of automatic thoughts
Modify automatic thoughts, dysfunctional assumptions about danger; challenge magical thinking
Identify and modify overresponsibility
Help patient devise behavioral experiments (e.g., avoiding or not avoiding thoughts and tracking results; attempting to influence events by thoughts)

Behavioral Interventions

Help patient begin constructing hierarchies of obsessions and avoided situations/other stimuli

Homework

Have patient continue modifying automatic thoughts and assumptions
Have patient continue to log obsessions/rituals
Have patient conduct behavioral experiments
Assign practice in disrupting rituals

Sessions 7–10

Assessment

As in Sessions 5–6

Cognitive Interventions

Continue modifying automatic thoughts, dysfunctional assumptions, and personal schemas of responsibility, self-blame, and vulnerability to harm
Continue helping patient devise behavioral experiments

Behavioral Interventions

Help patient complete exposure hierarchies
Plan initial exposure sessions
Conduct exposure to initial items on hierarchies of obsessions and avoided situations/other stimuli (imaginal and *in vivo*)

Note: Initial exposure sessions, particularly imaginal exposure, should be 90 minutes to allow for habituation; it may be advisable, after the first exposure session, to schedule a 45-minute session later in the week to monitor any problems with exposure homework

Teach postponing, slowing, and changing repetitions
Help patient block all rituals (abstinence or near-abstinence), or block rituals associated with current exposure items (or use other ways to grade response prevention)

Homework

Have patient continue modifying automatic thoughts (not during exposure)

(*cont.*)

TABLE 8.5 (*cont.*)

Assign daily repetition of exposure
Have patient log and block rituals based on response prevention plan

Sessions 11–16

Assessment

As in Sessions 5–6

Cognitive Interventions

Examine and challenge any thoughts related to avoidance of exposure
Examine and challenge any thoughts related to lapses in rituals
Help patient evaluate advantages/disadvantages of rituals
Continue modifying assumptions and schemas of danger, responsibility, and the like.

Behavioral Interventions

Complete exposure to items higher up hierarchies of obsessions and avoided situations/other stimuli
Monitor continuation of safety behaviors or any avoidance of exposure homework
Be sure to include both *in vivo* and imaginal exposure unless contraindicated
Continue to help patient block rituals
Examine any lapses in response prevention
Use behavior modification strategies to increase compliance with response prevention

Homework

Have patient continue logging obsessions/rituals
Have patient record automatic thoughts related to any lapses
Assign continued daily repetition of exposures
Have patient continue modifying dysfunctional thoughts, assumptions, and schemas

Sessions 17–20 (Schedule Biweekly or Monthly)

Assessment

As in Sessions 5–6
Assess attainment of goals to determine whether treatment may be tapered
Track progress in identifying and modifying thoughts
Assess and address any residual symptoms
Assess any life problems related to OCD or patient improvement

Cognitive Interventions

Continue with cognitive challenges to schemas of danger, responsibility, and the like
Have patient apply cognitive skills to life stressors

Behavioral Interventions

Ensure that exposure is being performed to items highest on the hierarchy
Ensure that obsessional fear is decreasing
Continue helping patient block all rituals
Monitor any lapses

Relapse prevention

Educate patient regarding likelihood of residual symptoms and use of lapses as opportunity to practice skills
Evaluate possible future stressors
Review coping skills and develop strategies for future stressors

TABLE 8.5 (*cont.*)

Address current life problems

Have patient prepare list of skills learned in therapy

Encourage patient to call if booster sessions are needed

Homework

Have patient self-assign exposure homework

Encourage patient to continue practicing all skills learned

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FORM 8.1. Maudsley Obsessional–Compulsive Inventory (MOCI)

Patient's name: _____ Today's date: _____

Please answer each question by putting a circle around the "True" or the "False" following the question. There are no right or wrong answers, and no trick questions. Work quickly and do not think too long about the exact meaning of the question.

- | | | |
|---|------|-------|
| 1. I avoid using public telephones because of possible contamination. | True | False |
| 2. I frequently get nasty thoughts and have difficulty in getting rid of them. | True | False |
| 3. I am more concerned than most people about honesty. | True | False |
| 4. I am often late because I can't seem to get through everything on time. | True | False |
| 5. I don't worry unduly about contamination if I touch an animal. | True | False |
| 6. I frequently have to check things (e.g., gas or water taps, doors, etc.) several times. | True | False |
| 7. I have a very strict conscience. | True | False |
| 8. I find that almost every day I am upset by unpleasant thoughts that come into my mind against my will. | True | False |
| 9. I do not worry unduly if I accidentally bump into somebody. | True | False |
| 10. I usually have serious doubts about the simple everyday things I do. | True | False |
| 11. Neither of my parents was very strict during my childhood. | True | False |
| 12. I tend to get behind in my work because I repeat things over and over again. | True | False |
| 13. I use only an average amount of soap. | True | False |
| 14. Some numbers are extremely unlucky. | True | False |
| 15. I do not check letters over and over again before posting them. | True | False |
| 16. I do not take a long time to dress in a morning. | True | False |
| 17. I am not excessively concerned about cleanliness. | True | False |
| 18. One of my major problems is that I pay too much attention to detail. | True | False |
| 19. I can use well-kept toilets without any hesitation. | True | False |

(cont.)

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FORM 8.1. Maudsley Obsessional–Compulsive Inventory (p. 2 of 2)

20. My major problem is repeated checking.	True	False
21. I am not unduly concerned about germs and diseases.	True	False
22. I do not tend to check things more than once.	True	False
23. I do not stick to a very strict routine when doing ordinary things.	True	False
24. My hands do not feel dirty after touching money.	True	False
25. I do not usually count when doing a task.	True	False
26. I take rather a long time to complete my washing in the morning.	True	False
27. I do not use a great deal of antiseptics.	True	False
28. I spend a lot of time every day checking things over and over again.	True	False
29. Hanging and folding my clothes at night does not take up a lot of time.	True	False
30. Even when I do something very carefully I often feel that it is not quite right.	True	False

For each subscale, count the total number of answers that match those listed below.

Checking

6-T 22-F 15-F 28-T 20-T 26-T 14-T 8-T 2-T

Cleaning

17-F 21-F 24-F 1-T 19-F 9-F 5-F 13-F 27-F 4-T 26-T

Slowness

2*-F 16-F 8*-F 23-F 29-F 4-T 25-F

*Note: These two items load on this factor in the opposite direction from what would be expected.

Doubting

7-T 3-T 30-T 12-T 11-F 10-T 18-T

TOTAL

1-T 2-T 3-T 4-T 5-F 6-T 7-T 8-T 9-F 10-T 11-F 12-T 13-F 14-T 15-F 16-F 17-F 18-T 19-F 20-T 21-F 22-F 23-F
24-F 25-F 26-T 27-F 28-T 29-F 30-T

FORM 8.2. Obsessive–Compulsive Questionnaire (OCQ) for Patients

Patient's name: _____ Today's date: _____

Obsessions

Listed below are some common fears people have. Please check how much you have been bothered by each one in the past week. If you have additional fears that are not listed, please write them in and rate how much they bother you.

Fear	None (0)	A little (1)	Moder- ately (2)	A lot (3)
Fear of germs				
Fear of getting or having a disease				
Fear of contact with poisonous or dangerous substances				
Fear of dirt				
Fear of making a mistake or doing something wrong				
Fear of forgetting to do something (e.g., lock a door, turn off a stove)				
Fear of hurting or killing someone (in the past or future)				
Fear of someone being injured or dying				
Fear of being killed or injured				
Fear of doing or saying something bad, immoral, or embarrassing				
Fear of not having something available or on hand when you need it				
Fear of having things out of order				
Fear of things not being perfect				
Other obsessions:				

(cont.)

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Compulsions

Listed below are typical compulsions or rituals. An action is considered a compulsion if you do it more often than it is commonly done by others or if it is done to make you feel less anxious. Please check how much time or effort you have spent on each compulsion in the past week. If you have additional compulsions, please add them.

Compulsions	None (0)	A little (1)	Moderately (2)	A lot (3)
Washing hands, showering, or other personal cleansing				
Cleaning (objects, surfaces, rooms, etc.)				
Checking to make sure you did (or didn't do) something				
Checking to make sure things are right or perfect				
Repeating actions				
Hoarding or collecting things				
Putting or keeping things in a certain order				
Saying things to yourself repeatedly (such as prayers, lists, or other phrases)				
Asking for reassurance from others				
Other compulsions:				

FORM 8.3. Evaluation of Obsessive–Compulsive Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test/data scores

Structured Clinical Interview for DSM-IV-TR Axis I (SCID) _____

Anxiety Disorder Interview Schedule for DSM-IV (ADIS-IV) _____

Beck Depression Inventory–II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Yale–Brown Obsessive Compulsive Scale (Y-BOCS) _____

Maudsley Obsessional–Compulsive Inventory (MOCI) _____

Obsessive–Compulsive Questionnaire (OCQ) _____ Global Assessment of Functioning (GAF) _____

Other questionnaires (specify) _____

Use of pharmacological agents

Current medications (include dosage): _____

Past medications (include dosage): _____

Current use of alcohol or other substances (note kind and amount): _____

Past use of alcohol or other substances (note kind and amount): _____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Prior Treatments
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(cont.)

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Key symptoms

Obsessions: _____

Compulsions: _____

Other avoidance/escape and safety behaviors: _____

External triggers of anxiety: _____

Internal triggers of anxiety: _____

Feared consequences (if none reported, reevaluate after implementing cognitive strategies): _____

Treatment progress (later evaluations only)

Obsessions and compulsions still engaged in: _____

Obsessions and compulsions no longer engaged in: _____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 8.5. Information for Patients about Obsessive–Compulsive Disorder

WHAT IS OBSESSIVE–COMPULSIVE DISORDER?

People with obsessive–compulsive disorder (OCD) have obsessions, compulsions, or both. “Obsessions” are thoughts, mental pictures, or impulses that are upsetting but that keep coming back. “Compulsions” are actions that people feel they have to perform to keep from feeling anxious or to prevent something bad from happening. Most people with OCD suffer from both obsessions and compulsions.

Common obsessions include:

- **Fears of getting a disease**, such as AIDS or cancer.
- **Fears of touching poisons**, such as chemicals.
- **Fears of hurting or killing someone**, often a loved one.
- **Fears of forgetting to do something**, such as turn off a stove or lock a door.
- **Fears of doing something embarrassing or immoral**, such as shouting obscenities.

Compulsions are also called “rituals.” Common compulsions include the following:

- **Excessive washing or cleaning**, such as washing one’s hands many times a day.
- **Checking**, such as looking at a stove repeatedly to make sure it is off.
- **Repeating actions**, such as always turning a light switch on and off 16 times.
- **Hoarding or saving things**, such as keeping old newspapers or scraps of paper.
- **Putting objects in a set pattern**, such as making sure everything in a room is symmetrical.

Most people with OCD know that their fears are not completely realistic at least some of the time. They also feel that their compulsions do not make sense. However, they find themselves unable to stop.

OCD is a common problem. During any 6-month period, over 4 million people in the United States suffer from OCD. One person in every 40 will have OCD at some point during his or her life.

OCD can cause serious problems. People with OCD often spend hours a day doing rituals. This makes it hard to work or take care of a family. Many people with OCD also avoid places or situations that make them anxious. Some become homebound. Often they have family members help them perform their rituals.

WHAT ARE THE CAUSES OF OBSESSIVE–COMPULSIVE DISORDER?

The exact causes of OCD are not known. Genes play a role. Family members of people with OCD often have OCD and other anxiety problems. However, genes alone do not explain OCD; learning and life stress also appear to contribute to the disorder.

HOW DOES OBSESSIVE–COMPULSIVE DISORDER DEVELOP?

Studies show that 90% of people have thoughts similar to those that trouble people with OCD. However, people with OCD appear to be more upset by these thoughts than other people are. Often the thoughts that worry people with OCD go against their beliefs and values—for example, a very religious man fears that he will commit blasphemy, or a loving mother fears harming her child.

(cont.)

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Because people who develop OCD are upset by these thoughts, they try to avoid them. Often they try to force themselves to stop thinking the thoughts. The problem is that the more you try not to think about something, the more you end up thinking about it. You can try this yourself: Try *not* thinking about a pink elephant for the next 60 seconds. The chances are good that the first thing that comes to your mind will be just what you are trying to avoid thinking about—a pink elephant.

When people find that they cannot avoid upsetting thoughts, they often turn to other ways to feel less anxious. They may begin to perform some action, such as washing a lot or saying a silent prayer. This usually relieves their anxiety. The problem is that the relief is only *temporary*. Soon they must perform the action more often in order to feel better. Before long, the action has become a compulsion.

HOW DOES COGNITIVE-BEHAVIORAL TREATMENT FOR OBSESSIVE–COMPULSIVE DISORDER WORK?

People with OCD are afraid that if they let themselves think their feared thoughts without doing any compulsions, they will get more and more anxious, and they won't be able to stand it. They often worry that they might go crazy.

Cognitive-behavioral treatment is aimed at helping you learn that you can control your anxiety without compulsions. You will learn coping strategies such as ways of thinking that can help you feel less anxious. You will also learn that if you face your fears rather than avoid them, they will go away. This may be hard to believe, but it's true. Your therapist will help you gradually face the things that you fear most, until you are confident that you can handle your fears without compulsions.

Cognitive-behavioral treatment for OCD usually takes about 20 sessions. Treatment may take longer for people with severe symptoms.

HOW EFFECTIVE IS COGNITIVE-BEHAVIORAL TREATMENT FOR OBSESSIVE–COMPULSIVE DISORDER?

Studies show that over 80% of people who complete cognitive-behavioral treatment for OCD are moderately to greatly improved. It is common to have occasional obsessions and urges to ritualize, even after treatment. However, patients usually feel much more in control and able to enjoy their lives. The studies also show that most people continue to feel better after therapy has stopped.

CAN MEDICATIONS HELP?

The medications that work best for OCD increase the level of the chemical serotonin in the brain. Your physician or a psychiatrist can suggest the medication that would be best for you. Studies show that 50–60% of patients improve with these medications. However, most patients find that their symptoms return if the medication is stopped. For this reason, cognitive-behavioral therapy should always be used in addition to medication. For some patients, the combination of medication and therapy will give the best results.

WHAT IS EXPECTED OF YOU AS A PATIENT?

It is common to feel anxious at the beginning of therapy and to have doubts about whether you can be helped. All that is required is that you be willing to give therapy a try. Your therapist will teach you new ways of dealing with your anxiety and will help you begin to face the things you fear. You will be asked to practice these new skills between sessions. If you work on the exercises your therapist gives you and complete the treatment, your chances for feeling better are excellent.

Behavioral Techniques

APPENDIX A

Summary of Behavioral Techniques

Technique	Description
Assertiveness training	Training patients to use behaviors that protect their rights while respecting the rights of others.
Behavioral activation (reward planning and activity scheduling)	Helping patients to increase activities that are likely to bring feelings of pleasure and/or mastery.
Communication skills training	Training patients in skills that will make them more effective as both speakers and listeners.
Distraction	Teaching patients to use mentally absorbing activities to prevent themselves from dwelling on negative thoughts.
Exposure—Imaginal	Using guided imagery to expose patients to feared cues in their imaginations.
Exposure— <i>In vivo</i>	Exposing patients to actual anxiety-provoking cues in real-life situations.
Graded task assignment	Helping patients to break tasks they find overwhelming into small steps, and to start with the easiest step; as they gain confidence, patients are encouraged to try more difficult steps.
Mindfulness	Teaching patients to focus attention on immediate experience in order to break patterns of negative thinking, increase tolerance for avoided experience, and promote a sense of calmness.
Modeling	Demonstrating adaptive behavior so that patients may imitate it. Used in skills training and exposure, for example.
Problem solving	Training patients to generate, evaluate, and implement possible solutions to problems they face.

(cont.)

Technique	Description
Rebreathing	A technique for patients with panic disorder who hyperventilate; involves teaching patients to breathe in air they have already exhaled, in order to restore proper oxygen balance.
Relaxation	Training patients in various techniques to induce physical relaxation as a means of coping with anxiety.
Breathing relaxation	Teaching patients breathing exercises to induce a relaxation response.
Progressive muscle relaxation	Teaching patients a set of techniques in which different muscle groups are first tensed and then relaxed, in order to induce a relaxation response.
Self-reward	Teaching patients to reward themselves for positive behaviors.
Social skills training	Training patients in skills necessary for common social activities, such as meeting new people, initiating conversations, going on job interviews, and dating.
Visualization	Teaching patients to use pleasant imagery in order to distract themselves from negative thinking and to induce relaxation.

FORM 9.1. Patient's Imaginal Exposure Practice Record

Patient's name: _____ Week: _____

Each day that you do exposure, please note the imagined situation practiced. Then note the highest level of distress you feel for each trial (repetition) of the exposure. Repeat the exposure until the highest distress on the last trial is less than half the highest distress on the first trial for that day.

Date: _____ Exposure: _____		Date: _____ Exposure: _____		Date: _____ Exposure: _____	
<u>Trial</u>	<u>Maximum distress (0-10)</u>	<u>Trial</u>	<u>Maximum distress (0-10)</u>	<u>Trial</u>	<u>Maximum distress (0-10)</u>
1		1		1	
2		2		2	
3		3		3	
4		4		4	
5		5		5	
6		6		6	
7		7		7	
8		8		8	
9		9		9	
10		10		10	
Date: _____ Exposure: _____		Date: _____ Exposure: _____		Date: _____ Exposure: _____	
<u>Trial</u>	<u>Maximum distress (0-10)</u>	<u>Trial</u>	<u>Maximum distress (0-10)</u>	<u>Trial</u>	<u>Maximum distress (0-10)</u>
1		1		1	
2		2		2	
3		3		3	
4		4		4	
5		5		5	
6		6		6	
7		7		7	
8		8		8	
9		9		9	
10		10		10	

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FORM 9.2. Patient's *In Vivo* Exposure Practice Record

Patient's name: _____ Week: _____

Each day that you practice exposure, please note the trigger or situation you are working on. Then note the level of distress when you feel when you first begin the exposure and every 5 minutes after that. Continue the exposure until the distress level has dropped by at least half.

Date: _____ Exposure: _____		Date: _____ Exposure: _____		Date: _____ Exposure: _____	
<u>Trial</u>	<u>Distress (0–10)</u>	<u>Trial</u>	<u>Distress (0–10)</u>	<u>Trial</u>	<u>Distress (0–10)</u>
Initial		Initial		Initial	
:05		:05		:05	
:10		:10		:10	
:15		:15		:15	
:20		:20		:20	
:25		:25		:25	
:30		:30		:30	
:35		:35		:35	
:40		:40		:40	
:45		:45		:45	
:50		:50		:50	
:55		:55		:55	
:60		:60		:60	
Date: _____ Exposure: _____		Date: _____ Exposure: _____		Date: _____ Exposure: _____	
<u>Trial</u>	<u>Distress (0–10)</u>	<u>Trial</u>	<u>Distress (0–10)</u>	<u>Trial</u>	<u>Distress (0–10)</u>
Initial		Initial		Initial	
:05		:05		:05	
:10		:10		:10	
:15		:15		:15	
:20		:20		:20	
:25		:25		:25	
:30		:30		:30	
:35		:35		:35	
:40		:40		:40	
:45		:45		:45	
:50		:50		:50	
:55		:55		:55	
:60		:60		:60	

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Cognitive Concepts and Techniques

APPENDIX B

Summary of Cognitive Techniques

Technique	Description or example
	<u>Socializing patient</u>
Establishing therapeutic contract	Directly ask the patient about commitment to therapy, such as willingness to come regularly and do homework.
Bibliotherapy	Assign readings, such as patient information handouts or books (e.g., Leahy's <i>Anxiety Free</i> or <i>Beat the Blues Before They Beat You</i>).
Indicating how thoughts create feelings	Example: "I feel anxious [mood] because I think I'll fail [thought]."
Distinguishing thoughts from facts	Example: "I can believe that it is raining outside, but that doesn't mean it's a fact. I need to collect evidence—go outside—to see whether it's raining."
	<u>Identifying and categorizing distorted automatic thoughts</u>
Identifying negative thoughts that come spontaneously and seem plausible	Examples: "I think I'll fail," "I always fail," "It's awful to fail."
Identifying the emotions these thoughts create	Examples: Sadness, anxiety.
Rating confidence in accuracy of thoughts, as well as intensity of feelings	Example: "I feel anxious [80%] because I think I'll fail [95%]."
Categorizing thoughts (see Form 10.2 for complete list of categories)	Examples: "I think I'll fail" (fortunetelling), "I always fail" (dichotomous/all-or-nothing thinking), "It's awful to fail" (catastrophizing).

(cont.)

Technique	Description or example
<u>Challenging distorted automatic thoughts</u>	
Providing direct psychoeducation	Example: Give information about elevator safety to a patient with a specific phobia of elevators.
Defining the terms (semantic analysis)	Example: Ask patient, "How would you define 'failure' and 'success'?"
Examining testability of thoughts	Can patient make any real-world observations that will confirm or refute thoughts?
Examining logic of thoughts	Is patient jumping to conclusions that don't follow logically from premises (e.g., "I'm a failure because I did poorly on that test")?
Examining limits on patient's information	Is patient jumping to conclusions without sufficient information? Is patient only looking for evidence that supports his or her thoughts, not evidence that might refute them?
Vertical descent	Ask, "What would it mean [what would happen, why would it be a problem] if X occurred? What would happen next? And what would that mean [what would happen, why would it be a problem]?"
Double standard	Ask, "Would you apply the same thought [interpretation, standard] to others as you do to yourself? Why/why not?"
Challenging recursive self-criticism	Is patient locked in a loop of self-criticism for being self-critical (e.g., "I think I'm a loser because I'm depressed, and I'm depressed because I think I'm a loser")?
Examining internal contradictions	Does patient have contradictory thoughts (e.g., "I'd like to meet as many people as possible, but I never want to be rejected")?
Reductio ad absurdum	Are implications of patient's thought absurd (e.g., "If I'm single, I'm unlovable; all people who are married were once single; therefore, all married people are unlovable")?
Distinguishing behaviors from persons	Example: Indicate how failing on an exam is different from being a failure as a person.
Challenging reification	In self-criticisms, is patient making "real" something that is abstract/unobservable (e.g., worthlessness)? Can patient change reifications into "preferences" (e.g., "I prefer doing better at exams")?
Examining variability/degrees of behavior	Help patient examine evidence that his or her behavior varies across time, situations, and persons, and that it occurs to varying degrees (not in all-or-nothing ways).
Weighing the evidence for and against a thought	Example of thought: "I'll get rejected."

Technique	Description or example
	<p>Evidence in favor: "I'm anxious [emotional reasoning]," "Sometimes people don't like me."</p> <p>Evidence against: "I'm a decent person," "Some people like me," "There's nothing rude or awful about saying hello to someone," "People are here at the party to meet other people."</p> <p>For: 25%. Against: 75%.</p> <p>Conclusion: "I don't have much convincing evidence that I'll get rejected. Nothing ventured, nothing gained."</p>
Examining quality of evidence	Would patient's evidence stand up to scrutiny by others? Is patient using emotional reasoning and selective information to support arguments?
Keeping a daily log	Have patient keep a daily log of behaviors/events that confirm or disprove a thought.
Surveying others' opinions	Have patient survey others for their opinions and see whether these confirm or disprove a thought.
Cost–benefit analysis	<p>Example of thought: "I need people's approval."</p> <p>Costs: "This thought makes me shy and anxious around people, and lowers my self-esteem."</p> <p>Benefits: "Maybe I'll try hard to get people's approval."</p> <p>Costs: 85%. Benefits: 15%.</p>
Alternative interpretations	Example: Ask patient, "If someone doesn't like you, might it simply be that the two of you are different? Or perhaps the other person is in a bad mood, or shy, or involved with someone else? Or perhaps there are many other people who can and do like you?"
Negation of problems	Have patient list all the reasons why the current situation is not a problem, rather than all the reasons why it is a problem.
Defense attorney	Tell patient, "Imagine that you have hired yourself as an attorney to defend yourself. Write out the strongest case you can in favor of yourself, even if you don't believe it."
Carrying out an experiment	Have patient test a thought by engaging in behavior that challenges the thought (e.g., for the thought "I'll be rejected," approaching 10 people at a party).
Continuum technique	Have patient place current situation or event on a 0–100 continuum of negative outcomes and examine what would be better and worse than this situation/event.

(cont.)

Technique	Description or example
Putting situation/event into perspective	What would patient still be able to do even if a negative thought were true? Or how does patient's situation compare to that of someone with, say, a life-threatening illness?
"Pie" technique	Have patient draw a "pie chart" and divide up responsibility for situation/event.
Examining mitigating factors; reattribution	Are there other causes for a situation/event that should be considered (e.g., provocation, duress, lack of knowledge or preparation, lack of intention, failure on others' part, task difficulty, lack of clear guidelines)? If so, can patient reattribute some of the responsibility for the situation/event to these causes?
Externalizing both sides of a thought through role play	Take the "con" aspects of a thought while patient takes the "pro" aspects, and engage in a role-play argument (e.g., say, "You'll fail the exam"; patient replies, "There's no evidence that I'll fail"; and continue in this manner).
Using role play to apply a negative thought to a friend	Take the role of a friend to whom patient applies a negative thought. How does it sound?
Acting "as if"	First in role play and then in actual situations, have patient act as if he or she does not believe negative thoughts.
Challenging absolutistic thinking	Example: Ask patient, "If you believe that no one will like you, is it plausible that no one in the whole world will?"
Setting a zero point for comparisons; depolarizing comparisons	If patient always compares him- or herself to the best, how does he or she compare to the worst? And how does patient compare to people in the middle of the distribution?
Positive reframing (finding positives in negatives)	Is there a more positive way of interpreting patient's behavior or situation (e.g., instead of saying, "I really bombed on the exam," can patient say, "I learned I can't procrastinate," or "Thank God that course is over")?
Decatastrophizing	Ask patient, "Why would X not be so awful after all?"
Examining the "feared fantasy"	Ask patient, "Imagine the worst possible outcome of X. How would you handle it? What behaviors could you control even if it happened?"
Anticipating future reactions	Ask patient, "How will you [or others] feel about X 2 days, a week, a month, and a year from now?"
Examining past predictions, failure to learn from false predictions, and self-fulfilling prophecies	Has patient generally made negative predictions in the past that have not come true? If so, has patient failed to learn that these predictions have been distorted and biased? Have these predictions turned into self-fulfilling prophecies (i.e., has patient behaved as if they will come true and thus ensured that they will come true)?

Technique	Description or example
Testing predictions	Have patient make a list of specific predictions for the next week and keep track of the outcomes.
Examining past worries	Has patient worried about things in the past that he or she no longer thinks about? If so, have him or her list as many of these as possible and ask, "Why are these no longer important to me?"
Examining future distractions	What are all the other events (unrelated to current event) that will transpire over the next day, week, month, and year and that will cause patient not to care as much about the current event?
Distinguishing possibility from probability	Example: Ask patient, "It may be possible that you will have a heart attack if you are anxious, but what is the probability?"
Calculating sequential probabilities	Have patient multiply the probabilities of a predicted sequence of negative events.
Fighting overgeneralization	Ask patient, "Just because X happened once, does that mean it will inevitably happen?"
Challenging the need for certainty	Tell patient, "You can't have certainty in an uncertain world. If you are trying to rule out absolutely all possibility of negative outcomes, you will be unable to act."
Advocating acceptance	Suggest to patient, "Rather than trying to control and change everything, perhaps there are some things you can learn to accept and make the best of. For example, perhaps you won't be perfect in your job, but perhaps you can learn to appreciate what you can do."
Using "point-counterpoint" with difficult thoughts	For difficult thoughts that are resistant to other techniques, engage in "point-counterpoint" role play with patient.
Reexamining original negative thought and emotion, confidence in accuracy of thought, and intensity of emotion	Example: "I feel anxious [15%] because I think I'll fail [20%]."
Developing rational response to thought (new, more realistic, more adaptive thought)	Example: "There isn't much actual evidence that I'll fail; therefore, there's no real reason for me to think I'll fail, and no real reason for me to be anxious."
<u>Identifying maladaptive assumptions</u>	
Determining contents of patient's "rule book" ("shoulds," "musts," "if-then" statements underlying distorted automatic thoughts)	Examples: "I should succeed at everything I do," "If people don't like me, it means there's something wrong with me," "I must be approved by everyone."

(cont.)

Technique	Description or example
	<u>Challenging maladaptive assumptions</u>
Using techniques for challenging distorted automatic thoughts	See above.
Evaluating patient's standards	Ask patient, "Are you setting unrealistic expectations for yourself? Are your standards too high? Too low? Too vague? Do your standards give you room for a learning curve?"
Examining patient's value system	Ask patient, "What is your hierarchy of values? For example, do you place success above everything else? Are you trying to accomplish everything simultaneously?"
Examining social standards	Ask patient, "Are you trying too hard to measure up to society's standards—for example, beauty and thinness for women, or power and status for men? If you don't exactly meet these standards, do you think this makes you a bad or worthless person?"
Distinguishing progress from perfection	Help patient examine the advantages of trying to improve, rather than trying to be perfect.
Challenging idealization of others	Have patient try to list all the people he or she knows who are completely perfect. Since it's unlikely that there will be any, what does this mean about patient's achieving perfection? Or have patient ask an admired person whether he or she has ever made any mistakes or had any problems, and consider what this person's response implies about patient's idealization of others and devaluation of self.
Advocating adaptive flexibility	Help patient examine the benefits of being more flexible in standards and behaviors.
Borrowing someone else's perspective	Ask patient, "Instead of getting trapped by your way of reacting, try to think of someone you know who you think is highly adaptive. How would this person think and act under these circumstances?"
Emphasizing curiosity, challenge, and growth rather than perfection	Example: Suggest to patient, "If you do poorly on an exam, work on how you can develop curiosity about the subject matter or feel challenged to do better in the future, rather than focusing on your grade as a final measure of your worth."
Reexamining maladaptive assumptions and substituting new, more adaptive assumptions	Example: "I'm worthwhile regardless of what others think of me," instead of "If people don't like me, it means there's something wrong with me."
Examining costs and benefits of more adaptive assumptions	Example of more adaptive assumption: "I'm worthwhile regardless of what others think of me." Costs: "Maybe I'll get conceited and alienate people."

Technique	Description or example
	<p>Benefits: "Increased self-confidence, less shyness, less dependence on others, more assertiveness."</p> <p>Costs: 5%. Benefits: 95%.</p> <p>Conclusion: "This new assumption is better than the one that I have to get other people to like me in order to like myself."</p>
	<p><u>Identifying dysfunctional schemas</u></p>
Identifying negative or otherwise dysfunctional views of self and others underlying distorted automatic thoughts and maladaptive assumptions	Examples: "I'm incompetent," "I'm no good," "I must be admired," "Others are rejecting," "Others are all-powerful," "Others must pay tribute to me."
Explaining schematic processing	Indicate how dysfunctional schemas are formed and how they systematically bias the ways events are attended and responded to.
Identifying strategies of avoiding/compensating for schemas	Help patient determine how he or she avoids challenging a schema (e.g., "If you think that you are unlovable, do you avoid getting involved with people?") or compensates for a schema (e.g., "If you believe you are inferior to others, do you attempt to become perfect in order to overcome your 'inferiority'?").
	<p><u>Challenging dysfunctional schemas</u></p>
Using techniques for challenging distorted automatic thoughts and maladaptive assumptions	See above.
Activating early memories to identify sources of schemas	Ask patient, "Who taught you to think in this dysfunctional way? Was it your parents? Teachers? Friends? Do you think that their teaching was valid? Were they poor role models?"
Challenging the sources of schemas through role play	Have patient role-play him- or herself challenging the source of a schema and arguing vigorously against this person.
Imagery restructuring; rewriting life scripts	Have patient imagine going back in time and confronting a schema's source. Or have patient revise his or her negative life script so that it has a positive outcome (e.g. for a negative early image of humiliation, have patient write a script in which he or she rejects or criticizes the person responsible for the humiliation).
Writing letters to the source	Have patient write letters to a schema's source (which need not be sent) expressing his or her anger and frustration.

(cont.)

Technique	Description or example
Imagery and emotion	Have patient close eyes, evoke a negative feeling (e.g., loneliness), and then associate a visual image with this feeling. Ask patient to complete this sentence: "This image bothers me because it makes me think . . ."
Coping imagery	Help patient to develop an image of him- or herself coping competently with a feared person or situation.
Miniaturizing the frightening image	Help patient to develop an image of a feared person or thing as much smaller and weaker, instead of bigger and more powerful than the patient.
Desensitizing images	Have patient engage in repeated exposure to a feared image or situation, in order to diminish its capacity to elicit fear.
Nurturant self-statements	Have patient imagine him- or herself as a child and make nurturing statements to the child of the kind he or she wishes had actually been made.
"Bill of rights"	Help patient compose a personal "bill of rights" (e.g., the right to make mistakes, to be human, etc.).
Reexamining original schemas and developing new, more adaptive schemas	Examples: "I am competent" and "Others are only human," instead of "I am incompetent" and "Others are all-powerful."
<u>Problem solving and self-control</u>	
Identifying a problem	Is there a problem that needs to be solved? For example, if patient does poorly on an exam, perhaps he or she needs to study more.
Accepting the problem	Help patient to accept the existence of the problem and begin working toward its solution, instead of being self-critical or catastrophizing.
Examining the goal; generating alternative goals	What is patient's goal in the situation? If one goal has not worked, can patient modify the goal or generate alternative goals (e.g., replace "to be liked by everyone" with "to meet some new people" or "to learn how well I can do")?
Anti-procrastination steps	Guide patient through a series of steps to minimize procrastination (specifying a goal; breaking it down into smaller steps; examining costs and benefits of first step vs. an alternative; scheduling a specific time, place, and duration for the activity; role-playing resistance to engaging in the activity; carrying out the activity).
Self-correction	Encourage patient to learn from any mistakes instead of engaging in self-criticism.

Technique	Description or example
Developing self-instructional statements; creating a “coping card”	Have patient develop self-instructions for use in times of difficulty (e.g., “Don’t worry about my anxious arousal. It’s arousal. It’s not dangerous. Anxiety doesn’t mean I’m going crazy. I can tolerate it”). Put these statements, along with reminders and so on, on a “coping card” that patient can refer to easily.
Delaying a decision	For an impulsive patient, it may be useful to delay making a decision on a thought until a certain amount of time has passed or until the patient has had two good nights’ sleep.
Canvassing friends	To reduce compulsiveness, a patient can be asked to survey five friends for their advice on the intended thought or action.
Anticipating problems	Have patient list the kinds of problems that might come up and develop rational responses to these.
Inoculation	With the patient, role-play the worst negative thoughts and problems that might come up, and have patient indicate how he or she would challenge them.
Self-reward statements	Encourage patient to list positive thoughts about him- or herself after doing something positive.
Problem solution review	Have patient review past problems and the solutions he or she has used.

TABLE 10.1. Dysfunctional Schemas in Personality Disorders

Personality disorder	View of self	View of others	Main beliefs	Main compensatory/avoidant strategies
Avoidant	Vulnerable to depreciation, rejection Socially inept Incompetent	Critical Demeaning Superior	“It’s terrible to be rejected [put down].” “If people know the real me, they will reject me.” “I can’t tolerate unpleasant feelings.”	Avoid evaluative situations Avoid unpleasant feelings or thoughts
Dependent	Needy Weak Helpless Incompetent	Idealized Nurturant Supportive Competent	“I need people to survive [be happy].” “I need a steady flow of support and encouragement.”	Cultivate dependent relationships
Passive–aggressive	Self-sufficient Vulnerable to control, interference	Intrusive Demanding Interfering Controlling Dominating	“Others interfere with my freedom of action.” “Control by others is intolerable.” “I have to do things my own way.”	Passive resistance Surface submissiveness Evade, circumvent rules
Obsessive–compulsive	Responsible Accountable Fastidious Competent	Irresponsible Casual Incompetent Self-indulgent	“I know what’s best.” “Details are crucial.” “People should be better [try harder].”	Apply rules Perfectionism Evaluate, control Use “shoulds,” criticize, punish
Paranoid	Righteous Innocent, noble Vulnerable	Interfering Malicious Discriminatory Abusive motives	“Motives are suspect.” “Be on guard.” “Don’t trust.”	Be wary Look for hidden motives Accuse Counterattack

(cont.)

TABLE 10.1 (cont.)

Personality disorder	View of self	View of others	Main beliefs	Main compensatory/avoidant strategies
Antisocial	Loner Autonomous Strong	Vulnerable Exploitative	"I'm entitled to break rules." "Others are patsies [wimps]." "Others are exploitative."	Attack, rob Deceive Manipulate
Narcissistic	Special, unique Deserving special rules, superior Above the rules	Inferior Admirers	"Since I'm special, I deserve special rules." "I'm above the rules." "I'm better than others."	Use others Transcend rules Be manipulative Be competitive
Histrionic	Glamorous Impressive	Seducible Receptive Admirers	"People are there to serve or admire me." "They have no right to deny me my just deserts."	Use dramatics, charm Throw temper tantrums, cry Make suicide gestures
Schizoid	Self-sufficient Loner	Intrusive	"Others are unrewarding." "Relationships are messy [undesirable]."	Stay away

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FORM 10.1. General Information for Patients about Cognitive–Behavioral Therapy

Issues	Answers
General description	Cognitive-behavioral therapy is a relatively short-term, focused psychotherapy for a wide range of psychological problems, including depression, anxiety, anger, marital conflict, fears, and substance abuse/dependence. The focus of therapy is on how you are thinking (your “cognitions”), behaving, and communicating <i>today</i> , rather than on your early childhood experiences. Numerous studies have demonstrated that cognitive-behavioral therapy is as effective as medication for depression, anxiety, obsessions, and other fears. Furthermore, because patients learn self-help in therapy, they are often able to maintain their improvement after therapy has been completed.
Evaluation of patients	When you begin cognitive-behavioral therapy, your therapist will ask you to fill out several self-report forms that assess a range of symptoms and problems. These forms evaluate depression, anxiety, anger, fears, physical complaints, personality, and relationships. The purpose of this evaluation is to gather as much information on you as possible, so that you and your therapist can learn quickly what kinds of problems you do (or do not) have and the extent of your problems.
Treatment plans	You and your therapist will work together to develop a plan of therapy. This might include how often you need to come; the relevance of medication; your diagnosis; your goals; skill acquisition; needed changes in the way you think, behave, and communicate; and other factors.
What are therapy sessions like?	Some other forms of therapy are unstructured, but in cognitive-behavioral therapy you and your therapist will set an agenda for each meeting. The agenda might include a review of your experience in the previous session, your homework, one or two current problems, a review of what you’ve accomplished in this session, and homework for the next week. The goal is to solve problems, not just complain about them.
Self-help homework	If you went to a personal trainer at a health club, you would expect to get guidance on how to exercise when the trainer is not there. The same thing is true in cognitive-behavioral therapy. What you learn in therapy is what you practice <i>outside</i> of therapy on your own. Research demonstrates that patients who carry out homework assignments get better faster and stay better longer. Your self-help homework might include keeping track of your moods, thoughts, and behaviors; scheduling activities; developing goals; challenging your negative thoughts; collecting information; changing the way you communicate with others; and other assignments.
Aren’t my problems due to my childhood experiences?	<i>Part</i> of your problems may be due to how your parents, siblings, and peers treated you, but your solutions to your problems lie in what you are thinking and doing <i>today</i> . However, with many people we do find it useful at times to review the sources of your problems and help you learn how to change the way you think about them now.

(cont.)

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FORM 10.1. General Information for Patients about Cognitive-Behavioral Therapy (p. 2 of 2)

Issues	Answers
Aren't my problems due to biochemistry?	<i>Part</i> of your problems may be due to biochemistry, but many other factors—such as the way you think, behave, and relate, as well as current and past life events—are important. Using cognitive-behavioral therapy does not rule out the use of medication. For most psychiatric disorders, there is considerable evidence that cognitive-behavioral therapy is as effective as medication. For very serious levels of depression and anxiety, we believe that it may be best to combine medication with therapy. An advantage of cognitive-behavioral therapy is that you also learn ways to solve your problems on your own.
How will I know if I'm getting better?	You and your therapist can identify specific goals at the beginning of therapy—and you can modify these goals as you continue. Then you can evaluate whether you are becoming less depressed, anxious, angry, or the like. You should feel free to give your therapist feedback on your progress. This feedback from you is useful in order to figure out what works and what doesn't work.
How can I learn more about cognitive-behavioral therapy?	Depending on the problems that you want to solve, your therapist can recommend a number of books or other readings for you. We believe that the more you know about yourself, the better off you will be. We hope that you can learn to become your own therapist.

FORM 10.2. Categories of Distorted Automatic Thoughts: A Guide for Patients

1. **Mind reading:** You assume that you know what people think without having sufficient evidence of their thoughts. "He thinks I'm a loser."
2. **Fortunetelling:** You predict the future negatively: Things will get worse, or there is danger ahead. "I'll fail that exam," or "I won't get the job."
3. **Catastrophizing:** You believe that what has happened or will happen will be so awful and unbearable that you won't be able to stand it. "It would be terrible if I failed."
4. **Labeling:** You assign global negative traits to yourself and others. "I'm undesirable," or "He's a rotten person."
5. **Discounting positives:** You claim that the positive things you or others do are trivial. "That's what wives are supposed to do—so it doesn't count when she's nice to me," or "Those successes were easy, so they don't matter."
6. **Negative filtering:** You focus almost exclusively on the negatives and seldom notice the positives. "Look at all of the people who don't like me."
7. **Overyeneralizing:** You perceive a global pattern of negatives on the basis of a single incident. "This generally happens to me. I seem to fail at a lot of things."
8. **Dichotomous thinking:** You view events or people in all-or-nothing terms. "I get rejected by everyone," or "It was a complete waste of time."
9. **Shoulds:** You interpret events in terms of how things should be, rather than simply focusing on what is. "I should do well. If I don't, then I'm a failure."
10. **Personalizing:** You attribute a disproportionate amount of the blame to yourself for negative events, and you fail to see that certain events are also caused by others. "The marriage ended because I failed."
11. **Blaming:** You focus on the other person as the *source* of your negative feelings, and you refuse to take responsibility for changing yourself. "She's to blame for the way I feel now," or "My parents caused all my problems."
12. **Unfair comparisons:** You interpret events in terms of standards that are unrealistic—for example, you focus primarily on others who do better than you and find yourself inferior in the comparison. "She's more successful than I am," or "Others did better than I did on the test."
13. **Regret orientation:** You focus on the idea that you could have done better in the past, rather on what you can do better now. "I could have had a better job if I had tried," or "I shouldn't have said that."
14. **What if?:** You keep asking a series of questions about "what if" something happens, and you fail to be satisfied with any of the answers. "Yeah, but what if I get anxious?" or "What if I can't catch my breath?"
15. **Emotional reasoning:** You let your feelings guide your interpretation of reality. "I feel depressed; therefore, my marriage is not working out."
16. **Inability to disconfirm:** You reject any evidence or arguments that might contradict your negative thoughts. For example, when you have the thought "I'm unlovable," you reject as *irrelevant* any evidence that people like you. Consequently, your thought cannot be refuted. "That's not the real issue. There are deeper problems. There are other factors."
17. **Judgment focus:** You view yourself, others, and events in terms of evaluations as good–bad or superior–inferior, rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards, and finding that you and others fall short. You are focused on the judgments of others as well as your own judgments of yourself. "I didn't perform well in college," or "If I take up tennis, I won't do well," or "Look how successful she is. I'm not successful."

FORM 10.3. Examples of Maladaptive Assumptions: A Guide for Patients

"I should be successful at everything I try."

"If I am not successful, then I am a failure."

"If I fail, then I'm worthless [I'm unlovable, life is not worth living, etc]."

"Failure is intolerable and unacceptable."

"I should get the approval of everyone."

"If I am not approved of, then I am unlovable [ugly, worthless, hopeless, alone, etc]."

"I should be certain before I try something."

"If I am not certain, then the outcome will be negative."

"I should never be anxious [depressed, selfish, confused, uncertain, unhappy with my partner, etc]."

"I should always keep my eye out for any anxiety."

"If I let my guard down, something bad will happen."

"If people see that I am anxious, they will think less of me [reject me, humiliate me, etc]."

"My sex life [feelings, behaviors, relationships, etc.] should be wonderful and easy at all times."

FORM 10.4. Patient's Event–Mood–Thought Record

Patient's name: _____

Date/time	Event: Describe what happened. What were you doing at the time?	Mood: Describe your feelings (sad, anxious, angry, hopeless, etc.), and rate their intensity on a 0–100% scale.	Thought: Write down your automatic thoughts at the time.

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FORM 10.5. Patient's Form for Categorizing and Responding to Automatic Thoughts

Automatic thoughts: Write your negative thoughts and estimate your confidence in the accuracy of each one (0–100%).	Distortions: Identify the category into which each automatic thought falls (see “Categories of Distorted Automatic Thoughts: A Guide for Patients”).	Rational responses: Substitute more realistic thoughts and estimate your confidence in the accuracy of each one (0–100%).

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FORM 10.6. Patient's Self-Instruction Script

Questions to ask myself	Answers and solutions
What is the behavior I am trying to change?	
In what situations am I most likely to have this problem?	
What sensations and emotions are signs of this behavior?	
What are the costs and benefits to me of this behavior?	
What are some better alternatives?	
What are the costs and benefits of these alternatives?	
What are some more reasonable things I can say to myself to make me less upset?	
What plans can I make to carry out this new behavior?	
What are some rewarding things I can do for myself when I carry out my new behavior?	

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Medications for Depressive and Anxiety Disorders

This chart provides information about different classes of medications that are commonly used in the treatment of depression and anxiety. Many patients will benefit from a combination of medications; the effects of one class of medications can often be enhanced by adding medications from another class. Other patients may benefit from switching from one medication class to another class. The prescribing physician should consult the latest information about initial dosage, increases in dosage, contraindications, dietary restrictions, side effects, and overdose. Patients should never self-prescribe, and nonphysicians should defer to appropriate medical personnel.

Since medications are continually being developed and evaluated, and since some medication classes may eventually be approved for treatment for other disorders, these tables are preliminary and are not intended to replace the most recent information available from the manufacturers of the medications.

Information in these charts is derived from a number of sources, listed below. The following websites can assist the reader in learning more about psychotropic medications:

www.ncbi.nlm.nih.gov/pubmedhealth/s/drugs_and_supplements/a

www.drugs.com

www.pdr.net

www.epocrates.com

www.webmd.com/drugs

(cont.)

MEDICATION CHART

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Antidepressants—monoamine oxidase (MAO) inhibitors</u>			
Marplan	Isocarboxazid	Depression	Orthostatic hypotension, dizziness, constipation, headache, tremors, body weight changes, dry mouth, weakness, fatigue
Nardil	Phenelzine	Depression; mixed anxiety and depression; phobic or hypochondriacal features	Dizziness, headaches, drowsiness, sleep disturbances, tremors, constipation, dry mouth, weight gain, sexual disturbances, sweating, skin rash, blurred vision, manic reaction, acute anxiety reaction
Niamid	Nialamide	Depression, social phobia, GAD	Psychomotor agitation, insomnia, headache, dry mouth, nausea, vomiting, constipation, vision problems, weight gain, impotence
Parnate	Tranylcypromine	Major depressive episode without melancholia	Restlessness or insomnia, weakness, drowsiness, dizziness, dry mouth, nausea, diarrhea, abdominal pain, constipation, chills
<u>Antidepressants—tricyclics</u>			
Adapin, Sinequan	Doxepin	Psychoneurosis with depression and/or anxiety; depression and/or anxiety associated with alcoholism; depression and/or anxiety associated with organic disease; somatic symptoms and concerns; symptoms such as sleep disturbances, guilt, lack of energy, fear, apprehension, and worry	Dry mouth, blurred vision, constipation, drowsiness, hypotension, skin rash, nausea, vomiting, raised or lowered libido, testicular swelling, breast enlargement, weight gain, sweating, chills, hallucinations
Anafranil	Clomipramine	Obsessive–compulsive disorder	Dry mouth, constipation, nausea, anorexia, tremors, dizziness, nervousness, changed libido, ejaculatory failure, fatigue, sweating, increased appetite, weight gain, abnormal thinking
Aventyl, Pamelor	Nortriptyline	Endogenous depression	Hypo-/hypertension, restlessness, insomnia, numbness, tingling, dry mouth, skin rash, nausea, vomiting, weight gain/loss, perspiration, disorientation, anxiety, panic, insomnia, restlessness, hypomania
Elavil, Endep, Laroxyl	Amitriptyline	Endogenous depression	Myocardial infarction, stroke, arrhythmias, coma, seizures, hallucinations, delusions, confusional states, skin rash, nausea, testicular swelling, breast enlargement, dream and sleep disturbances, mania or hypomania

(cont.)

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Antidepressants—tricyclics (cont.)</u>			
Etrafon	Perphenazine and amitriptyline hydrochloride	Moderate to severe anxiety and/or agitation and depressed mood; anxiety and/or depression associated with chronic physical disease; schizophrenia with symptoms of depression	Aching, numbness of limbs, tardive dyskinesia, restlessness, catatonia, eczema, lactation, menstrual disturbances, faintness, cardiac arrest, rash, dry mouth, blurred vision, hypotension, disorientation, confusional states, weight gain/loss
Limbitrol	Chlordiazepoxide and amitriptyline hydrochloride	Moderate to severe depression associated with moderate to severe anxiety	Drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating, vivid dreams, impotence, fatigue, lethargy, hypotension, poor concentration, skin rash, weight gain/loss
Norpramin	Desipramine	Depression	Hypotension, hypertension, palpitations, confusional states, anxiety, numbness, tingling, dry mouth, skin rash, bone marrow depressions, anorexia, nausea, vomiting, weight gain/loss, perspiration, disorientation, anxiety, restlessness, insomnia, nightmares
Surmontil	Trimipramine	Endogenous depression	Hypotension, hypertension, confusional states, numbness, tingling, dry mouth, skin rash, nausea, vomiting, increased or decreased libido, testicular swelling, breast enlargement, delusions, anxiety, restlessness, insomnia, nightmares, exacerbation of psychosis
Tofranil, Presamine	Imipramine	Endogenous depression in adults; childhood enuresis	Hypertension, palpitation, confusional states with hallucinations, disorientation, delusions, anxiety, insomnia, nightmares, numbness, tingling, dry mouth, blurred vision, skin rash, bone marrow depression, nausea, vomiting, weight gain/loss, perspiration
Triavil	Perphenazine and amitriptyline hydrochloride	Moderate to severe anxiety and/or agitation and depressed mood; depression and anxiety associated with chronic physical disease; schizophrenia with depressed mood; symptoms such as psychomotor retardation and anorexia	Sedation, hypotension, neurological impairments, dry mouth, tardive dyskinesia, eczema, nausea, weight gain/loss
Vivactyl	Protriptyline	Depression, particularly for withdrawn and anergic patients	Myocardial infarction, confusional state, seizures, incoordination, constipation, impotence, increased/decreased libido, nausea, vomiting, hypomania, restlessness, disorientation, delusions

(cont.)

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Antidepressants—selective serotonin reuptake inhibitors (SSRIs)</u>			
Celexa	Citalopram	Depression	Abdominal pain, insomnia, agitation, anxiety, drowsiness, dry mouth, impotence, nausea, sweating, weight gain, loss of libido
Lexapro	Escitalopram	Major depression, GAD	Constipation, diarrhea, increased or decreased libido, dizziness, drowsiness, dry mouth, headache, loss of appetite, nausea, insomnia
Luvox	Fluvoxamine	Obsessions and compulsions associated with obsessive–compulsive disorder	Somnolence, insomnia, nervousness, nausea, asthenia, diarrhea, constipation, loss of libido
Prozac	Fluoxetine	Depression; obsessive–compulsive disorder	Anxiety, nervousness, insomnia, drowsiness, fatigue, asthenia, tremors, sweating, loss of libido, gastrointestinal complaints, dizziness
Paxil	Paroxetine	Depression; obsessive–compulsive disorder; panic disorder	Asthenia, sweating, nausea, decreased appetite, insomnia, dizziness, dry mouth, loss of libido, abnormal ejaculation, constipation
Zoloft	Sertraline	Major depression	Gastrointestinal complaints, tremors, dizziness, insomnia, sweating, dry mouth, male sexual dysfunction, loss of libido
<u>Antidepressants—miscellaneous</u>			
Asendin	Amoxapine	Depression in patients with neurotic or reactive depressive disorders, as well as endogenous and psychotic depressions; depression accompanied by anxiety or agitation	Drowsiness, dry mouth, constipation, blurred vision, anxiety, insomnia, skin rash, nausea, dizziness, headaches, excessive appetite, restlessness, nervousness
Desyrel	Trazodone	Major depression, with or without anxiety	Skin condition, blurred vision, constipation, dry mouth, shortness of breath, anger, decreased concentration, drowsiness, dizziness, fatigue, nervousness, nausea, decreased appetite
Effexor	Venlafaxine	Depression; generalized anxiety disorder	Asthenia, sweating, gastrointestinal problems, insomnia, dizziness, nervousness, dry mouth, sexual dysfunction
Ludiomil	Maprotiline	Dysthymic disorder; bipolar I disorder; major depressive disorder; anxiety associated with depression	Nervousness, anxiety, insomnia, drowsiness, dizziness, tremors, dry mouth, constipation, nausea, weight loss/gain, hypomania, mania

(cont.)

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Antidepressants—miscellaneous (cont.)</u>			
Remeron	Mirtazapine	Depression	Asthenia, flu syndrome, back pain, dry mouth, increased appetite, constipation, weight gain, somnolence, dizziness, abnormal dreams, tremor, urinary frequency
Serzone	Nefazodone	Depression	Headache, asthenia, infection, flu syndrome, hypotension, dry mouth, nausea, constipation, somnolence, dizziness, insomnia, light-headedness, confusion, blurred vision
Wellbutrin	Bupropion	Major depression	Seizures, agitation, dry mouth, insomnia, headaches, migraines, nausea, vomiting, constipation, tremors
<u>Anxiolytics—benzodiazepines</u>			
Ativan	Lorazepam	Anxiety, especially before surgery	Sedation, dizziness, unsteadiness, weakness, disorientation, nausea, change in appetite, sleep disturbance
Klonopin	Clonazepam	Seizures	Abnormal eye movements, confusion, depression, chest congestion, hair loss, constipation, dry mouth, muscle weakness, dehydration
Librium	Chlordiazepoxide	Anxiety disorders; withdrawal symptoms from alcoholism	Drowsiness, ataxia, confusion, minor menstrual irregularities, nausea, constipation, increased/decreased libido
Serax	Oxazepam	Anxiety; anxiety associated with depression; especially useful in older patients; acute tremulousness or anxiety associated with alcohol withdrawal	Excitement, dizziness, transient drowsiness, stimulation of affect, nausea, lethargy
Tranxene	Clorazepate	Anxiety disorders; symptoms from acute alcohol withdrawal (short-term relief)	Drowsiness, dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, mental confusion
Valium	Diazepam	Anxiety disorders; symptoms from acute alcohol withdrawal (short-term relief); skeletal muscle spasm	Drowsiness, fatigue, ataxia, confusion, constipation, headache, depression
Xanax	Alprazolam	Anxiety; generalized anxiety disorder	Drowsiness, light-headedness, constipation, increased or decreased appetite, weight gain/loss, sexual dysfunction

(cont.)

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Anxiolytics—miscellaneous</u>			
BuSpar	Buspirone	Generalized anxiety disorder (short-term treatment when symptoms are mild to moderate in severity); possibly social anxiety disorder (social phobia) and posttraumatic stress disorder	Dizziness, drowsiness, headache, dysphoria
Mebaral	Mephobarbital	Anxiety, tension, and apprehension; epilepsy	Somnolence, agitation, confusion, nightmares, nervousness, hypoventilation, nausea, vomiting, headache
Vistaril	Hydroxyzine	Anxiety and tension associated with psychoneurosis and organic disease	Dry mouth, drowsiness
<u>Stimulants</u>			
Adderall	Dextroamphetamine	Attention-deficit/hyperactivity disorder; narcolepsy; treatment-resistant depression; exogenous obesity	Nervousness, headache, insomnia, nausea, loss of appetite, weight loss, dry mouth, diarrhea, constipation, vomiting, stomach pain, increased or decreased libido
Concerta	Methylphenidate	Attention-deficit/hyperactivity disorder; narcolepsy	Nervousness, insomnia, loss of appetite, addiction, rapid pulse rate, tolerance, feelings of paranoia
Desoxyn	Methamphetamine	Attention-deficit/hyperactivity disorder; exogenous obesity	High abuse potential, nervousness, insomnia, loss of appetite, addiction, rapid pulse rate, tolerance, feelings of paranoia
Dexedrine	Dextroamphetamine	Narcolepsy; attention-deficit/hyperactivity disorder	High abuse potential, nervousness, insomnia, loss of appetite, addiction, rapid pulse rate, tolerance, feelings of paranoia
Dexedrine spansules	Dextroamphetamine (slow-release form)	Narcolepsy; attention-deficit/hyperactivity disorder	High abuse potential, nervousness, insomnia, loss of appetite, addiction, rapid pulse rate, tolerance, feelings of paranoia
Focalin	Dexmethylphenidate	Attention-deficit/hyperactivity disorder; narcolepsy; tic disorders	Insomnia, nausea, stomach pain, headache, dizziness, anxiety, weight loss

(cont.)

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Stimulants (cont.)</u>			
Provigil	Modafinil	Narcolepsy	Headache, dizziness, drowsiness; nausea, diarrhea, constipation, loss of appetite; dry mouth, nosebleed, sweating; tight muscles or difficulty moving; burning, tingling, or numbness of the skin; difficulty seeing or eye pain
Ritalin	Methylphenidate	Attention-deficit/hyperactivity disorder; narcolepsy	Nervousness, insomnia, loss of appetite, addiction, rapid pulse rate, tolerance, feelings of paranoia
<u>Antipsychotics—phenothiazines</u>			
Compazine	Prochlorperazine	Psychotic disorders; generalized nonpsychotic anxiety	High sedative effects, drowsiness, dizziness, amenorrhea, blurred vision, skin reactions, hypotension
Mellaril	Thioridazine	Psychotic disorders; depression with anxiety; severe behavioral problems in children	Sedation, low blood pressure and dizziness, dry mouth, constipation, difficulty urinating, blurry vision, jumpiness, parkinsonian syndrome (tremors and muscle stiffness), loss of motivation and decreased movement, weight gain, increased sensitivity to the sun
Prolixin	Fluphenazine	Psychotic disorders; behavioral complications in patients with mental retardation	Sudden muscle stiffness, parkinsonian syndrome, jumpiness, weight gain, neuroleptic malignant syndrome (NMS—i.e., symptoms such as muscle rigidity, altered mental status, irregular pulse, or blood pressure)
Stelazine	Trifluoperazine	Psychotic disorders; nonpsychotic anxiety	Drowsiness, dizziness, skin reactions, rash, dry mouth, insomnia, amenorrhea, fatigue, muscular weakness, anorexia, lactation, blurred vision, neuromuscular reactions
Thorazine	Chlorpromazine	Psychotic disorders; nausea and vomiting; restlessness before surgery; mania; severe behavioral problems in children	Sedation, low blood pressure and dizziness, dry mouth, constipation, difficulty urinating, blurry vision, jumpiness, parkinsonian syndrome, weight gain, increased sensitivity to the sun
Trilafon	Perphenazine	Psychotic disorders; severe nausea and vomiting; behavioral complications in patients with mental retardation	Mild sedation, mild dizziness from lowered blood pressure, dry mouth, constipation, difficulty urinating, blurry vision, jumpiness, parkinsonian syndrome, weight gain, sensitivity to the sun

(cont.)

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Antipsychotics—miscellaneous</u>			
Clozaril	Clozapine	Schizophrenia	Sedation, increased salivation/drooling, rapid heart rate, dizziness caused by lowered blood pressure, fever, nausea/vomiting, constipation, dry mouth
Haldol	Haloperidol	Psychotic disorder (for patients requiring long-term parenteral antipsychotic therapy)	Muscle stiffness, jumpiness, dry mouth, restlessness, movement disorders, low blood pressure, constipation, tardive dyskinesia (involuntary movement after prolonged use)
Loxitane	Loxapine	Psychotic disorders	Mild sedation, mild dizziness from lowered blood pressure, dry mouth, constipation, difficulty urinating, blurry vision, jumpiness, parkinsonian syndrome, akinesia, weight gain, increased sensitivity to the sun
Moban	Molindone	Psychotic disorders	Mild sedation, mild dizziness from lowered blood pressure, dry mouth, constipation, difficulty urinating, blurry vision, jumpiness, parkinsonian syndrome, akinesia, increased sensitivity to the sun (only antipsychotic that doesn't cause weight gain)
Navane	Thiothixene	Psychotic disorders	Sudden muscle stiffness (acute dystonia), parkinsonian syndrome, jumpiness, akinesia, drowsiness, nausea, increase in appetite
Orap	Pimozide	Motor and phonic tics associated with Tourette's disorder	Acute dystonia (sudden muscle stiffness), parkinsonian syndrome, jumpiness, akinesia, weight gain
Risperdal	Risperidone	Psychotic disorders	Anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, nausea, rash, weight gain, increased duration of sleep
Serentil	Mesoridazine	Behavioral problems in mental deficiency and chronic brain syndrome; anxiety, tension, depression, nausea, and vomiting in both acute and chronic alcoholism; borderline personality disorder	Drowsiness, hypotension, dry mouth, dizziness, nausea, impotence

(cont.)

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Antipsychotics—miscellaneous (cont.)</u>			
Seroquel	Quetiapine	Psychotic disorders	Dizziness, postural hypotension, dry mouth, headache, back pain, constipation, weight gain/loss
Zyprexa	Olanzapine	Schizophrenia and other psychotic disorders	Constipation, dry mouth, orthostatic hypotension, increased prolactin levels, weight gain, NMS, somnolence, personality disorders
<u>Antimanics/mood stabilizers</u>			
Cytomel	Liothyronine	Hypothyroidism; augmentation of antidepressants	Headache, sweating, nervousness, arrhythmias
Depakene	Valproic acid	Acute mania; aggression	Nausea, vomiting, indigestion, drowsiness, sedation
Depakote	Divalproex sodium	Mania; epilepsy; migraine headaches	Nausea, somnolence, dizziness, vomiting, asthenia, weight gain
Isoptin	Verapamil	Acute mania	Hypotension, constipation, fatigue, headache, dizziness
Lamictal	Lamotrigine	Seizures; mood stabilization	Skin rash, hives, fever, sores in mouth, dizziness, headache, sleepiness, nausea, vomiting
Lithotabs	Lithium	Acute mania and depression; recurrent bipolar or unipolar affective illness; aggression; anorexia nervosa; phobias; anxiety	Upset stomach and diarrhea, metallic taste in mouth, increased frequency of urination, weight gain, acne, decrease in thyroid gland functioning, tiredness and difficulty concentrating, fine hand tremors
Neurontin	Gabapentin	Seizures; mood stabilization	Dizziness, somnolence, central nervous system depression
Synthroid	Levothyroxine	Hypothyroidism; mood stabilization	Temporary hair loss, rash, cramps, anxiety, weight loss
Tegretol	Carbamazepine	Pain syndromes; aggression; mood disorders	Dizziness, drowsiness, unsteadiness, nausea, vomiting, diplopia, ataxia, clumsiness, slurred speech, irritability

(cont.)

Medication Chart (p. 10 of 10)

Trade name	Generic name	Disorders/symptoms that drug treats	Common side effects
<u>Hypnotics (can be from other drug class, such as benzodiazepines)</u>			
Ambien	Zolpidem	Insomnia; other sleep disturbances	Drowsiness, dizziness, headache, nausea, vomiting, abdominal pain, back pain, anxiety, constipation, lethargy, acne, coughing, increased sweating
Dalmane	Flurazepam	Insomnia	Hangover, confusion, weakness, dizziness, drowsiness, staggering, ataxia
Doral	Quazepam	Insomnia	Headache, fatigue, dizziness, dry mouth, dyspepsia
Halcion	Triazolam	Insomnia	Hangover, headache, dizziness, nervousness, dry mouth
Nembutal	Pentobarbital	Insomnia	Somnolence, agitation, confusion, hypoventilation, nausea, vomiting, headache
Placidyl	Ethchlorvynol	Insomnia	Rash, thrombocytopenia, vomiting, dizziness, facial numbness, blurred vision, hypotension, hangover
ProSom	Estazolam	Insomnia	Hangover, somnolence, hypokinesia, dizziness, abnormal coordination
Restoril	Temazepam	Insomnia	Drowsiness, dizziness, confusion, gastrointestinal complaints, sleep disturbances, headache
Sonata	Zaleplon	Insomnia	Asthenia, headache, nausea, dizziness, somnolence