Cognitive Therapy for Anxiety

Supplemental Treatment Manual

(To Be Used in Conjunction with The Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth)

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University of Pittsburgh Health Systems

Services for Teens at Risk

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Introduction

Purpose

This section on cognitive therapy of anxiety is designed to serve as a supplement to the CBT manual and assumes the reader has mastered the material therein. In this supplemental section we will cover the discussion of the assessment of anxiety disorders, education about anxiety and, different anxiety disorders and specific treatment interventions to target anxiety disorders.

Assessment of Anxiety

Cognitive assessment with anxious patients can prove challenging because anxious patients are often unable to identify thoughts related to their anxiety and avoidant behaviors. More often patients will describe the "feeling" or physical symptoms vs. thought statements. Asking the patient to "imagine" or "picture" their fear may spontaneously elicit cognitions. Cognitive assessment is particularly important when performing an evaluation for anxiety disorders because often the same anxious or avoidant behaviors demonstrated by the patient may "reflect very different disorders depending on the personal meaning of the situations to the patient" (Freeman, 1990). Thus, any given phobic stimulus and avoidance may be part of a simple phobia, social phobia, and/or panic disorder depending on the cognitions behind the fear. Always clarify what the patient is afraid of happening; this will better indicate the nature of the disorder. For example, if an adolescent is afraid to take an exam in front of other students, it is important to find out if the fear is due to the adolescent's concern about how others will evaluate him (performance anxiety), or whether the adolescent is afraid he or she may have a panic attack and therefore avoids the situation.

As mentioned, the anxious patient may have difficulty identifying his or her anxious thoughts but instead may be able to report various behaviors including nervousness, heart racing, sweaty palms, lightheadedness, butterflies in stomach etc. Asking the patient to complete the

SCARED (Self-Report for Childhood Anxiety Related Disorders, and the BAI (Beck Anxiety Inventory) much like reviewing the BDI for mood symptoms) during the assessment can help the patient pinpoint specific anxiety symptoms as well as to provide the therapist opportunities to educate the patient about the relationship between thoughts, feelings, and physical symptoms. Once in treatment, the patient should complete a BAI weekly at the beginning of each session. Thus, the mood check should be part of the agenda of every session. The mood check consists of objective (e.g. score on a given instrument) and subjective (patient's sense of severity) portions.

Psychoeducation

Approximately 40-70% of patients who present with a depressive disorder have comorbid anxiety disorder. Because depression with comorbid anxiety may be associated with a poorer response to psychotherapy, it is essential to target both anxiety and depression. This is essential for both patients and parents to know due to the prevalence of both anxiety and depression to run in families. For patient's with comorbid anxiety disorders, we have prepared a manual, "Child and Adolescent Anxiety, A Handbook for Families". As noted above, both patient and parents(s) will be given this manual to read (as one of their first tasks), asked to identify sections that seem particularly applicable, and write down any questions that they might have for the therapist at the next session for discussion.

What is Anxiety?

Anxiety is one of the most common emotions, and is a normal reaction to danger or a threat. Anxiety at moderate levels can be positive as it can serve to energize and motivate people to accomplish tasks and goals. However, high levels of anxiety can often debilitate and paralyze individuals and cause "physical and emotional discomfort" (Freeman, 1989). In fact, anxiety

disorders come about in part because people with a predisposition to anxiety respond to non-threatening situations as if they are dangerous.

The Cognitive Model of Anxiety

The cognitive model of anxiety views anxiety as having three components: cognitive, emotional and behavioral. An anxious individual perceives threats in relation to self, the world, or related to the future**.** The perception of a threat elicits a physiologic reaction, known as a "flight or fight" response, associated with increased pulse, blood pressure, sweating, and an overall sense of high vigilance. For example, a person who is walking down a dark street hears footsteps behind them. Their first thought might be, "someone is following me", their cognitive appraisal might be, "they're going to hurt me". The individual begins to experience increased arousal in response to perceived threat including physiological reactions such as an increased heart rate and sweatiness (fight or flight). The individual may then feel scared (emotional response) and begin running or "freeze" (behavioral response).

The cognitive model of anxiety states that an individual's beliefs impact their perceptions in several crucial ways. First an individual may have the belief that they cannot cope or manage stress effectively and thus would perceive situations that elicit stress or uncomfortable feelings as risky. Also, since anxiety elicits physiological symptoms through cognitions or images, these feelings alone may cause the individual to inaccurately assess a situation as threatening. The perception of a situation as threatening coupled with the person's belief that they cannot cope with the situation serves to increase feelings of anxiety, and vigilance to "watch out" for threatening stimuli both internally and in the environment. For instance, as people become more vigilant, they become more "tuned in" to internal signs of anxiety (physical sensations such as heart racing, difficulty breathing, sweating, chest pain, numbness) they may make catastrophic interpretations of physical symptoms

or of the situations itself. This increased vigilance leads to greater cognitive distortions of both internal and environmental stimuli, thereby increasing anxiety. Furthermore, this cognitive appraisal of internal and external experience may decrease the person's sense that they could cope and increase the anxiety.

The patient with intense anxiety tends to be "hypervigilant" for signs of danger or is preoccupied with "perceived" danger or threat. Therefore he is selectively "tuned in" to looking for signs of danger when it is maladaptive (Freeman, 1990). Because of his preoccupation the patient then is often unable to tend to other tasks and may complain of forgetfulness, lack of recall and ability for self-reflection may be restricted (Freeman, 1990). One of the main goals of cognitive therapy is to help the patient "test" whether a situation that has been "labeled dangerous is actually dangerous" (Beck & Emery, 1985). This is accomplished via exploration of cognitive processes, specifically by: 1) identifying automatic thoughts around the anxiety, 2) examining automatic thoughts, 3) challenging cognitions; and through 4) exposure, whereby the patient will be able to "detach and extinguish the fears that have been erroneously attached to a given situation or object" (Beck & Emery,1985). As the patient is able to identify automatic thoughts, they learn that there is a relationship between the occurrence of automatic thoughts relevant to danger and the anxiety experienced (Beck & Emery, 1985). This is extremely important to demonstrate to anxious parents, who tend to attribute their anxiety solely to external causes.

Some of the specific types of cognitive distortions associated with anxiety include: catastrophizing (predicting a disastrous outcome), selective abstraction (focusing on a single negative aspect of an event while excluding evidence that contradicts this information), personalization (viewing external events as relevant to them), overgeneralization (drawing global conclusions from single or small series of events) and dichotomous thinking (looking at things in

"all or nothing terms"). For example, an adolescent with generalized anxiety may have the belief that he is a “failure”. His compensatory strategy then is to do flawless or perfect work. An automatic thought could be, “If I don't get an A on the exam I'm a failure.” Because anxious patients tend to look to external causes for their anxiety, it is often difficult for the anxious patient to identify automatic thoughts. Therefore, socialization to the cognitive model is critical in order for further therapeutic progress to occur.

II. Anxiety Disorders (overview)

First, a brief overview of anxiety disorders including Generalized anxiety disorder (GAD), Panic disorder, Social Phobia and Post-traumatic stress disorder will be provided. Next, common themes among all anxiety disorders will be discussed along with a description of specific interventions and strategies to use when working with anxiety disorders. Due to special problems in the phenomenology and treatment of PTSD, interventions and techniques used in treating this disorder will be presented following “Interventions”.

Generalized Anxiety

A theme common to patients with Generalized Anxiety disorder (GAD) is the fear of failure, and the inability to cope with their own or others’ expectations of them (Beck & Emery, 1985). GAD differs from phobias in that the fears are more “generalized” or are activated across a number of different situations. (Beck & Emery, 1985). Anxiety producing situations for patients with GAD are not easily avoided, which differs from people suffering from phobias. (Beck & Emery, 1985). Thus, a patient’s anxiety may be effectively diminished by increasing their self-competency in social situations. This is an important reason why social skills training is so important in the treatment of GAD.

Social Phobia

Central to social anxiety is the concern about negative evaluation by others. The anticipation of this scrutiny by others often leads to increased feelings of anxiety because the individual may have "extreme" predictions about the outcome of the situation (Beck, 1985). This results in a vicious cycle as the individual increases his/her avoidance behavior in order to reduce these feelings of anxiety. This in turn worsens the situation. The very means he used for protection in turn heightens future anticipatory anxiety. It is essential when working with anxiety disorders to identify that individual's "protective mechanisms". For example, if the patient's tendency is to avoid the perceived threat the patient must approach the feared situation. If the patient attempts to decrease feelings of anxiety by continually seeking reassurance, the therapist would help the patient to refrain from such reassurance. The goal is to help the patient engage in behaviors which make avoidance impossible, and allow learning to cope with anxiety possible. Specific cognitive, behavioral and affective interventions are discussed below.

Often, because anxious patients have engaged in "protective" behaviors for so long (to reduce their anxiety), they have a low sense of self-efficacy (Freeman, 1990). Therefore it will be important early in treatment to begin social skills training to increase competence, and, through behavioral interventions, allow for an increase in the patient's sense of self-efficacy.

Panic Disorder

The main feature of panic disorder is the "presence of recurrent, unexpected panic attacks" (Freeman, 1990). A main fear in panic disorder is the fear of loss of control and its main feature is a sense of helplessness. This feeling of helplessness stems from the sense of being trapped in a dangerous and physically overwhelming situation. (Beck, 1985). The anticipatory fear of his own vulnerability to future panic attacks creates a vicious cycle of fear and avoidance. The most

important and debilitating concern for the patient is the sense of the uncontrollability of their psychological, physical and affective symptoms (Beck, 1985). When the anxiety becomes so intense that it feels intolerable, the patient begins "catastrophizing" e.g. "I'm going to die", I'm having a heart attack" or "I'm going crazy!" For those suffering from phobias, avoidance may forestall this condition. However, if escape or avoidance is not possible, then the individual may have a panic attack.

Post-Traumatic Stress Disorder

According to Pynoos (1987) Post-traumatic stress disorder (PTSD) is recognized as a "response to intense overwhelming physical or psychological trauma". This disorder is characterized by the following criteria: 1) the person has experienced an event outside the rage of normal human experience and which would be distressing to almost anyone; 2) the trauma is persistently reexperienced; 3) the patient persistently avoids stimuli related to the event or there is numbing of general responsiveness, and 4) symptoms of increased arousal persist that were not present before the trauma. PTSD is characterized by intense fear in which the patient is unable to escape because of intrusive thoughts and images of the trauma. The treatment of PTSD is targeted to help the patient to tolerate and assimilate the "traumatic helplessness" that they experienced.

Helplessness is experienced in several ways. First, there is the acute perceptual awareness of the event. Patients can often describe the sights, sounds, and smells of a trauma before, during and after the event. Second, there is an internal processing of the event in which the patient is consciously or unconsciously assigning meaning to the event and experiencing fantasies of

intervention. Finally, there are intense affective experiences that often coincide with increased autonomic arousal.

III. Common Features of all Anxiety Disorders

Vulnerability

Consider the following: A musician preparing to go on-stage for a live performance suddenly begins to question his ability to perform well and ignores the fact (evidence) that he has performed successfully in the past (minimization). He feels vulnerable when he senses that he no longer has control over his situation, and believes that if he makes a mistake everyone will notice and he will never be invited to play concerts again (catastrophization). Throughout the concert he notices those in the audience who seem bored or disinterested (selective abstraction). As he feels more threatened, this individual's vulnerability is heightened by an increased awareness of physiological symptoms such as increased heart rate, rapid breathing, shakiness, and sweatiness. The above noted example illustrates how feelings of vulnerability to a real or perceived threat is at the core of anxiety (Beck & Emery, 1985). Anxiety can actually interfere with performance when a patient believes that he lacks the skills to manage the threatening situation effectively. For example, the musician's automatic thoughts during the performance were: "I don't know this material well enough, I haven't practiced enough". Several of his assumptions were: "If I make a mistake everyone will know I'm incompetent" and then, "If I'm seen as incompetent, noone will accept me" (catastrophic prediction). As he experienced these automatic thoughts the musician felt more exposed to danger and because he felt that he lacked the skills to handle the ultimate threat (rejection by others) he felt increasingly vulnerable. The more vulnerable he felt the more he began to notice internal signs of danger. Cognitively, the musician perceived a threat and emotionally was experiencing intense vulnerability. His body began to react physiologically to the perceived danger

by increased heart rate, increased breathing, and mind going blank. This is an example of how cognitions particularly catastrophic predictions, as well as an individual's real or *perceived* lack of skills combine to escalate the feeling of vulnerability which in turn escalates anxiety.

Assessment of skills is important because the patient may lack the necessary skills to manage a particular situation effectively. For example, a patient who lacks interpersonal skills such as assertiveness may find it difficult to ask someone out. Thus, when faced with a situation such as going to a dance, a lack of interpersonal skills can increase the sense of vulnerability to the "threat" of being rejected or humiliated. Therefore, developing skills is a way to challenge and counter the danger that patients' associate with the situation. When a patient acquires the skills to effectively handle a difficult situation, this adds to confidence and a sense of self-efficacy.

IV. Interventions

A. Behavioral

Behavioral interventions with anxious patients must begin early in treatment. *Exposure* to anxiety producing stimuli is one of the most important elements of treatment with anxiety disorders. Anxious patients have an unrealistic fear that is often fueled by catastrophic predictions. The fear elicits severe physiological responses that make the patient avoid the stimulus. Before exposure however, it is important to prepare the patient by developing improved coping skills such as relaxation skills. After the patient has learned relaxation skills he is in a better position to manage the intense feelings of anxiety experienced during behavioral experiments.

Relaxation

Early in treatment the patient is taught relaxation skills including deep breathing, muscle relaxation, and guided imagery. The patient learns how to use relaxation techniques during session and learns how deep breathing effects heart rate and other common physiological responses that they experience when anxious. It is important that the patient is socialized as to: 1) *why* these techniques are important, 2) *how* to use these techniques and 3) *when* these techniques should be used.

The most important point when introducing relaxation techniques is to offer the patient choices so that he can choose from the technique that feels the most comfortable for him. For example, some anxious patients might be too focused on deep breathing and become focused on whether they are doing it "right". Patients such as this might do better with another method such as muscle relaxation. Relaxation tapes can be made during session and given to the patient to listen to and practice over the week. The patient can also listen to relaxing music at home while practicing techniques such as deep breathing and muscle relaxation. The patient is asked to practice relaxation at home and specifically at times when he is feeling anxious. The patient is then asked to rate anxiety level before and after using relaxation. After the patient feels comfortable with relaxation and begins to feel an increased sense of mastery he can then begin behavior experiments**.**

Exposure

The use of role-plays, "in-vivo" experiments or even discussion of "in-vivo" exposure can often elicit "hot" cognitions that can be identified during the therapy session. For example, a patient who has social phobia might be extremely afraid to ask a girl out on a date. The therapist could role-play this scenario with the patient and throughout the role-play ask the patient to identify automatic thoughts. This also a good tool to use to identify level of social skills. If the patient lacks social skills it is essential to introduce social skills training prior to sending the patient out to do

experiments. Assertiveness training, use of eye contact, tone of voice, making "I" statements are important skills to teach patients who lack social skills.

Developing a hierarchy of fears and graded tasks are effective interventions as they allow the patient to approach his or her fears in a gradual step-by-step process. The therapist and patient decide on the least anxiety-producing situation to the most anxiety-producing situation. The patient is asked to stay in the situation until his anxiety diminishes. If the patient is unable to tolerate these feelings, then the next less anxiety producing situation is chosen. Creating a hierarchy is important because it helps both therapist and patient to move up gradually and build on success. For example, a patient with social phobia who is afraid to talk to their peers could practice initiating a conversation with a non-threatening person such as a family member, call up a store and ask for information, start a conversation with a sales clerk and then gradually build up talking to a peer. The patient would rate how anxiety-producing they think each situation would be and start with the task that would evoke the "least" fear. Since anxious patients talk about feeling "overwhelmed" by their anxiety, this helps the patient to view their response to anxiety-producing situations in concrete and manageable steps and also creates a sense of control.

Developing coping cards in which the patient generates "coping statements" to help him get through a situation helps the patient have a concrete reminder that he can "cope" but also helps the patient begin to learn that <u>how</u> he talks to himself has an important impact on his ability to tolerate anxiety. For example, a patient who feels panicky, might have the thought, "I'm going crazy (after feeling their heart racing, palms becoming sweaty) a self-coping statement might be, "I know I can get through this, no one has ever gone crazy from a panic attack". Positive self-instruction (self-talk or self-coping statements) are useful techniques to help the patient focus on what they can "do", this helps to combat feelings of helplessness. Rehearsing positive self-talk in a non-threatening

environment helps to prepare the patient to confront their fears outside of the session and helps to decrease the level of anxiety so that the patient will feel more comfortable in trying the particular behavioral task. For example, if a patient is afraid to ask a girl out on a date he could practice during the session saying postive self-statements out loud such as "I'm going to ask her out, if she says no I'll be ok". "I'll never know though if I don't try". Practicing like this can help decrease the anxiety assoicated with the situation as the patient states out loud that he can handle the situation. Also, this allows the therapist to provide positive, non-threatening feedback to the patient, helping to increase the patient's sense of competency. As the patient becomes more confident that they can actually tolerate intense anxiety, they start to develop an increased sense of self-mastery which in turn lessens anticipatory anxiety.

Behavioral rehearsal is essential during session to prepare the patient for the out-of-session task, and especially to expose social skills deficits. Having identified a particular fear during the role play (e.g. patient may believe that if they make a mistake while giving a talk in class they'll be ridiculed) the therapist and patient can come up with strategies the patient could use to respond to the "worst" outcome and discuss how "realistic" it is that this would actually happen. For example, practicing <u>how</u> a patient would handle ridicule by others (if this really happened) would be an important skill to practice. Assertiveness strategies are helpful here to prepare patients' for the worst. For example, if a patient imagines being ridiculed by his class he could practice looking people in the eye and saying: "I made a mistake", "I don't deserve to be treated like this". Simply having a "response strategy" can improve sense of confidence and lessen the sense of danger attached to the situation.

The following behavioral experiment is especially useful for patients with social anxiety who fear the negative evaluation by others. If a patient believes they must be competent in all respects,

an experiment could be set up in which they deliberately do a task less than perfectly and observe the consequences. For instance, asking the patient to make a conscious error when doing their homework can be effective in helping the patient to see the "realistic" consequences of making a mistake i.e. if the patient believes (in all or nothing terms) "if I make a mistake I'm a failure", then such an exercise can help the patient to begin to challenge his assumptions and create more realistic parameters for self-evaluation. If the patient believes that total control over emotions is necessary at all times, he could practice being out of control either by having a panic attack (the therapist could induce a panic attack during session) or allowing themselves to experience other strong emotions. The patient who believes that it would be the "end of the world" to be rejected by others and therefore does not ask people out could "collect rejections" as a task. As a related example, one could role play a situation in session in which the patient requests something from the therapist which is refused by the therapist. The emphasis for such a task is to build up the patient's tolerance for "surviving" rejection. The patient is then asked to identify and explore any associated automatic thoughts and to compare the "actual" outcome to the feared one.

B. Cognitive

After a patient learns skills to lower his anxiety even slightly, the therapist and patient can begin work on cognitive restructuring. An important goal to achieve with anxiety disorders in the cognitive model of treatment is the promotion of self-observation and self-awareness. One technique to use to achieve self-awareness is through the elicitation of automatic thoughts. This helps the patient to gain objectivity about the "fear" as the patient can start to "examine" his thinking and identify distortions. Asking the patient to identify as many automatic thoughts as he can by writing them on a board is an effective way of helping the patient gain some distance from their cognitive and affective experience of the situation. This helps the patient to become an observer of

his own thinking. The patient can also increase skills in self-observation by keeping a diary to track the precipitants, intensity, frequency and duration of the anxiety.

Anxiety can be dealt with therapeutically only if it is experienced. Therefore, it is important for the patient to induce anxiety during the session. Anxiety experienced in-vivo can provide important information on anxiety-related cognitions. Teaching the patient to identify and monitor automatic thoughts is often best accomplished by in-session anxiety-provoking tasks such as reading aloud, writing letters, making phone calls etc. and then pinpointing automatic thoughts by asking, "what is going through your head as you pick up the phone?" "What are some of your thoughts as you write this letter?" Thought recordings between sessions is an important strategy to increase self-awareness. A diary of automatic thoughts and feelings related to anxiety can help patients to pinpoint their fears about the situation, by helping patients see the relationship between thought and feelings. Often patients with anxiety disorders attribute their anxiety to external events and become passive recipients of anxious feelings. The patient can be taught how to take an active role in their anxiety by making “I” statements for example, “I’m making myself feel nervous” rather than “he or she or makes me nervous”. Teaching patients to ask “how” questions rather than “why” questions also helps the patient to be an observer of their anxiety and learn “how” thinking contributes to the experience of anxiety.

Often the therapist must create specific situations in which anxiety will be experienced. For example, patients with social phobia can effectively avoid the stimuli that cause anxiety and appear free of anxiety during the session. Asking an anxious patient to make a phone call during the session or read aloud are examples of how to elicit cognitions around their fear. The patient would record their thoughts and feelings during this exercise and review them with the therapist.

Anxious patients often "block out" their uncomfortable feelings. It is necessary for the therapist to teach the patient that by doing this, they are actually creating stronger, more intense feelings of anxiety. Therefore it is important that the patient learn the importance of the uncomfortable feelings. For example, the patient who suffered a panic attack at school might have the thought while at school, "I'm going to go crazy, everyone will think I'm crazy". The patient would be asked to think through the situation and tolerate the feelings generated by the scenario. The object is to help the patient to identify his worst fear. The goal is to help the patient not only tolerate the uncomfortable affect, but to identify the thoughts associated with these feelings.

Automatic Thoughts

When working with any type of anxiety disorder, it is important to elicit cognitions about how the self-evaluation of the patient in relation to performance (social anxiety) and how others might rate him. It is essential when working with patients to restructure their distortions to teach the patient strategies to identify automatic thoughts. A simple method at the beginning of treatment (first 1-2 sessions) is to ask the patient to simply rate their mood over the week on a scale from 1-10 (1=least anxious, 10=most anxious). The patient is asked to bring their mood diary back to the next session. This helps the therapist to pinpoint times when the patient experienced increased anxiety and thus can aid in the questioning. For example, the therapist might ask, "I noticed that on Tuesday your mood was at a 9, can you tell me what was going on that day? When did you notice starting to feel anxious? Was this feeling all day, some of the day? Asking for specific details or by using imagery (e.g. do you remember what you were wearing or where you were when you were feeling like that? Was anyone else around?) helps the patient to pinpoint specific feelings and cognitions related to the situation. For example the patient might respond with, "I don't know I was just nervous all day".

Therapist: Were you feeling like this when you woke up? Before school?

Patient: No, I felt ok until around 5th period.

Therapist: Do you remember how you felt then?

Patient: Yeah, I started to feel worried.

Therapist: Can you think of anything that was going on right before you started to feel worried?

Patient: Umm, The teacher said we had a test next week.

Therapist: What were some of the thoughts that were going through your head then?

This is an example of how to help patients begin identifying their automatic thoughts. Another method is to ask patients to "count" their automatic thoughts. This is especially helpful for patients who report feeling "anxious all the time". Patients can be asked to pick five minutes during the day to stop what they are doing and simply count their thoughts and record them. This helps to socialize the patient to identifying and recording their thinking. It also serves to help the patient gain some distance and promote objectivity from their thinking.

Becoming a Detective

One of the most important strategies in helping patients to restructure their thinking is the use of questioning. Asking questions helps the patient to identify the distortions in their thinking and helps them to challenge and eventually modify their thinking. The three basic questions include: 1) What is the evidence for or against that thought? 2) Is there another way of looking at the situation? 3) If that did happen what would be the worst thing that would happen? One of the main goals in the use of questioning is to help the patient to examine their thinking for accuracy as well as to test out the validity of predictions of fears. Since a common concern for anxious people is the inability to handle a situation effectively, (and often catastrophize about the outcome), it is important for them to identify the errors in their thinking and realize that the outcome they fear (or imagine)

may not be that bad. It is important early in treatment to identify specific distortions that contribute to the anxious state. This way, questions can be targeted specifically to these distortions. A list of common distortions and questions to ask is provided to act as a guide:

1. **All or Nothing Thinking**: Seeing things in extremes. Example the patient who believes that because they did not get an A but a B on the exam means that they are a failure. Question: Is it possible that you're thinking about this in black and white terms? Use of a continuum to help the patient to examine his extreme thinking is an effective tool. Asking the patient to define "failure" and "success" and then asking questions to create a gray area can help the patient to better see the unrealistic aspect of his thinking. Questions such as, "do you know anyone else who didn't get an A? Do you consider that person a failure?" These are examples of how to begin challenging the distorted thinking.

2. **Overgeneralization:** Drawing global conclusions from a single or small series of events. Example: The patient who believes that because a friend did not invite him to his party means that noone likes him. Questions such as "What evidence do you have that "no one" likes you? What else might it mean that you weren't invited? Could there be any other explanations?" are examples of strategies to help the patient take a different perspective on his thinking.

3. **Selective Abstraction:** Focusing on a single negative aspect of an event while excluding evidence that contradicts this information. Example: A senior girl who was nominated for homecoming queen but lost attributes the loss to being unpopular. She is unable to acknowledge that the nomination for this event is an honor. This could be followed up with questions such as, "What did it mean to you that you had been nominated? How many people got that far? Who else didn't win? How do you think they're taking this? Asking patients to take the perspective of another person is a useful tool in helping them to modify their thinking.

4. **Catastrophizing:** Exaggerating the possibility and severity of a negative outcome. Example: A student who is afraid of speaking in public fears that if she makes a mistake she will look stupid, everyone will make fun of her, she won't get a good grade, other teachers will find out and realize she's a poor student, and she won't graduate from high school. Asking questions to help the patient examine her predictions such as, "What is the worst thing that could happen while you are giving your talk?" How bad would that be? What evidence do you have that this will happen? What has happened in the past? How bad was that?

5. **Emotional Reasoning:** Patients conclude that something is a "fact" based on how they "feel". Example: A patient reports that she believes her best friend is mad at her because she (patient) feels worried and nervous after talking to her today. It is important to ask specific, concrete questions to help the patient be more clear in communicating what it is exactly that they fear. If a patient does not understand a question rephrase the question as it is essential that the therapist allow the patient to answer the question so that they can arrive at their own conclusion as well as learn to think through their assumptions. Questions such as, "How do you *know* she is mad at you? Has she ever been mad in the past? If so, what happened? How did you know? How can you find out if she is mad? Questions such as these are used to help the patient to learn to base information on factual evidence vs. "feeling". By asking "how" questions the patient can begin to move into a problem-solving mode of responding rather than increasing their anxiety by waiting for the others' response.

Automatic Thought Sheets

It is important in the beginning of treatment to introduce the patient to the daily thought sheet (1-4 sessions). The patient can begin learning how to complete the thought sheet by starting with the 3-column record. The patient is asked to complete the sheet as soon as possible after becoming anxious. The patient describes the situation, records their automatic thoughts associated with the

event and records their feelings (the patient rates their how intense their feelings are on a scale from 0-100). The objective is for the patient to begin to see a relationship between thoughts and feelings. After the patient has become familiar with using this thought record, they are ready to use the 5-column sheet in which they can generate alternative meanings and responses and re-rate feelings. Thought sheets can also be helpful as therapist and patient can write down questions to remind patient to ask when examining accuracy of automatic thoughts. It is also helpful for the patient to have a list of his common distortions and identify these distortions on the automatic thought sheets.

C. Imagery

Identifying images of what the patient anticipates and fears is as important in identifying automatic thoughts. Often the images an anxious patient experiences will provide important information that can pinpoint more specifically what the patient fears. For example, a boy who had previously had a panic attack at school was afraid to go to school for fear of having another attack. He was asked to picture what it would be like to have an attack at school. He described vivid images of himself losing control, falling on the floor kicking and screaming. He then described losing all of his friends because everyone would think he was crazy. This technique can help to clarify the ultimate fears of the patient and thus can provide opportunity to use questions to reality-check and challenge distortions.

Asking a patient to imagine the fearful situation (so that he can see it through completion) is also a useful way to decrease anxiety. This is an important technique because most anxious patients imagine the worst and stop at that point. For example, a patient described a situation in which a friend told her that she was going to fix her up with a boy that patient had met briefly at a party. The friend told patient that she would call her as soon as she talked with this boy. The patient described intense feelings of anxiety and was extremely fidgety and nervous during the session. When the

patient was asked to imagine what she thought was going to happen the patient stated that she "pictured herself on the phone with her friend and the friend telling her the boy did not want to go out with her. She then described feeling "embarrassed and humiliated" in front of this friend and would be "devastated". When asked to take the image further the patient was able to generate a different picture and begin to restructure her imagery. An example of how patient achieved is demonstrated below:

Therapist: So, your friend calls you and tells you this boy does not want to go out with you and you feel humiliated and embarrassed.

Patient: It would be awful, I hate to think about it.

Therapist: Let's take this a little further. I wonder what might happen next. Is that ok?

Patient: ok

Therapist: Picture yourself on the phone with your friend and she just told you this news. What happens next? Do you hang up?

Patient: Well, I might ask my friend if she knows why he said no.

Therapist: Ok, what do you think she might say?

Patient: She probably wouldn't know, she doesn't know him well.

Therapist: She doesn't know him well, and I guess knows that you don't know him well.

Patient: I hardly know him at all, I just shook hands with him.

Therapist: What do you picture your friend doing after she tells you this?

Patient: I don't know

Therapist: Do you picture her saying something bad about you because of this or thinking differently about you?

Patient: No, I guess not, I don't think it would mean that much to her. She'd probably say something about him-he's missing out.

Goal rehearsal is an important imagery exercise for patients to use specifically because it helps to prepare them to actually perform tasks outside of session. The patient is asked to imagine a frightening situation (during therapy session first) and then try doing this outside of session. The objective is to allow the patient a safe place to imagine what they fear and develop strategies to work through the situation in their mind before trying the actual behavior. Patients can also imagine ways they would cope with possible problems and practice imagining coping strategies prior to actually practicing them.

D. Emotional

Often patients with anxiety feel ashamed of these feelings and the behavior that they engage in when anxious. Patients may think that they look foolish because others can see that they are anxious or believe that others would have a negative opinion of them because they appear anxious. It is important to help the patient explore their feelings of shame and begin doing exercises to help decrease these feelings. Patients are encouraged to "check out" these ideas by asking others how they view anxiety. Most people do not view anxiety as a "sickness' or attribute anxiety to a character flaw. Gathering evidence in this way can help the patient to challenge the idea that others view him as defective or "crazy" (or whatever the meaning the patient attributes to his anxiety). Normalizing anxiety by demystifying it can make the symptoms less frightening for the patient. For example, explaining to the patient that anxiety is actually a biological response to perceived threat and has served throughout evolution to protect us against danger is a way to normalize these feelings.

Strategies to Increase Mastery

Helping the patient to "act normal" even when feeling anxiety is another strategy to help the patient gain a sense of mastery. Asking the patient who is giving a talk, asking a friend to go to the movies to continue talking, finish the sentence even if they think they can not do it. This also reinforces the point that if a patient leaves the situation that is evoking anxiety, they only temporarily find relief. If they can stay and tolerate these feelings, anxiety will often lessen. A patient can increase tolerance for anxiety through the use of positive self-statements such as "I can handle this" rather than "I can't stand this". This also helps the patient to develop increased confidence that they will be able to handle future anxiety.

Concentration exercises are another useful technique that help to instill a sense of mastery. The patient is asked to imagine a situation that makes them feel anxious and rate their anticipated level of anxiety. When the patient begins experiencing high levels of anxiety they are then asked to focus on an object until they feel the anxiety starting to decrease. For example, if the patient is imagining asking a girl out on a date and starts to feel a sense of anxiety increasing, one way to cope might be to focus on an object in the room until experiencing a decrease in anxiety. In the office the patient would be instructed to look at an object in the room, for example the chair or desk and describe that object in detail. The patient then re-rates their anxiety to determine if anxiety has diminished. The patient can then practice concentration exercises during the week and therapist and patient can generate ideas together of different exercises e.g.: brushing hair, washing hands, chewing gum etc.

As mentioned previously, due to specific treatment interventions used when treating Post-traumatic stress disorder this will be discussed in a separate category. The description of this disorder as well as treatment strategies will be discussed below.

V. Post-Traumatic Stress Disorder

A major difference between Post-Traumatic Stress Disorder (PTSD) and other anxiety disorders is that patients with PTSD suffer intrusive images of the event and attempt to avoid certain stimuli associated with the event. In order to understand how the patient is experiencing anxiety, it is important to conduct a cognitive assessment. As with other anxiety disorders, it may be difficult for the PTSD patient to identify automatic thoughts. Therefore, the assessment must include asking the patient to describe mental images, scenes, pictures, etc. that are considered to be intrusive. It is just as important to be able to pinpoint and modify mental imagery as it is to pinpoint and modify verbal automatic thoughts. Following a traumatic event (e.g., witnessing violence; physical or sexual abuse), it is not abnormal for individuals to experience anxiety. One prominent correlate of post-traumatic anxiety is the avoidance of triggers for the painful memories and emotional experience of the traumatic event.

Techniques

Since avoidance is a key component of many anxiety disorders, techniques used to treat other anxiety disorders such as "exposure" are used to help the patient decrease his or her anxiety. Concomitantly, techniques such as deep breathing, muscle relation, assertiveness training, role playing etc. are taught to help the patient learn effective ways to "cope" with anxiety symptoms following a trauma.

Following a traumatic event, patients may describe feelings of shock and numbness. The therapist can frame this experience as the body's way of "shutting down", protecting itself from an overload of stimuli. However, this may result in what (Foa, 1989) describes as an "inadequate emotional processing of the event". This lack of integration may further elicit PTSD symptoms including: intrusive images, nightmares, or inappropriate expression of emotions. The inability to integrate the event into the existing cognitive structure sets PTSD apart from other anxiety disorders

and necessitates a somewhat different approach for treatment. Therapy then, should be aimed at helping the patient reduce PTSD symptoms by restructuring the experience so that the patient can increase functioning and adequately process the event.

Cognitive Restructuring

In order to help the patient restructure their experience and process the event in a different, healthier way, the fearful memory must first be activated. That is, the patient must be asked to recall the event in detail. Secondly, new information that contains "elements incompatible with some of those that exist in the fear structure" must be incorporated into the patient's "old" way of thinking so that a new memory can be formed (Foa, 1986). This new information must then be integrated into "the evoked information structure for an emotional change to occur" (Foa, 1986). For example, a patient who is suffering from intrusive images of being mugged and, therefore, will not go outside would be asked to talk about the actual event and with the help of the therapist critically examine her fear (e.g., how often are people actually mugged, does going outside means you will be mugged? etc.).

Exposure

Exposure-based interventions involve asking the patient to "imagine" the event by recalling the trauma in vivid detail to the therapist. The exposure is paced to allow the patient to build up his or her ability to tolerate the anxiety, so that details that would produce the most anxiety will occur in later sessions. Through systematic desensitization, the patient and therapist develop a hierarchy that contains elements of the trauma (least to most fearful). The patient visualizes the event and engages in progressive relaxation, gradually moving up the hierarchy until the recall of the events does not

elicit anxiety. Homework involves daily "imaginal exposure" (e.g., the patient listening to a tape of him or herself recalling the event and in-vivo exposure e.g., sleeping alone at night) (Foa, 1986).

The integration of anxiety management training and exposure-based interventions is often the most effective treatment of PTSD. Cognitive behavioral techniques include: self-monitoring of activities with mastery and pleasure responses, graded task assignments, and modification of maladaptive cognitions (Foa, 1986). Anxiety management techniques are most effective because these interventions help the patient to develop new coping strategies and create "alternative responses to anxiety" (Foa, 1989). Through cognitive restructuring, arousal symptoms can be reduced as the patient modifies the meaning that she has attached to the event (e.g., a rape victim associates a dark room with danger and therefore does not sleep without a light on can remove the interpretation of danger and distinguish between a realistic "safe" situation vs. an unsafe situation). Often victims of sexual abuse or assault blame themselves for the event. It is important to understand what meaning the patient gives to the event and through cognitive restructuring, help the patient modify her attributions of the event. It is essential when doing work with PTSD victims to explore include appropriate family members and explore the meaning of the trauma for them and the attributions they have made about the victim. Family members need to be educated about the physiological, emotional and behavioral responses to trauma. Often family members may be confused by a patient's behavior and need to understand the behavior in context of the trauma. Depending on the nature of the trauma it may be necessary to have other family members evaluated for post-traumatic stress.

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