

Overview - Introduction to Cognitive Therapy  
and Anxiety - P.D.+/-A., G.A.D. - Frank McDonald TGH  
Part of a co-presentation with James Bennett-Levy JCU,  
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1. Why the focus on P.D. +/- A. and G.A.D.?  
- both common and disabling disorders
2. General comments on diagnosis and management of anxiety
3. Prevalence of mental disorders - anxiety conditions the most common of all
4. The two disorders in context:
  - Panic Disorder +/- Agoraphobia and its mimics (differential diagnosis)
  - Generalised Anxiety Disorder
  - Obsessive-Compulsive Disorder
  - Social Phobia
  - Post-traumatic Stress Disorder
  - Specific Phobia
5. P.D. +/- A. and G.A.D.
  - case examples
  - assessment
  - psychological management including cognitive therapy strategies

# Diagnosis and management

The presentation of most anxiety disorders is stereotyped.

Anxiety outside the stereotypes -- particularly in patients over 40 with no previous history of anxiety -- is likely to have other causes that must be recognised and treated:

- Depressive disorder (requiring antidepressant therapy).
- Life crisis (requiring supportive care -- help the patient evaluate the situation, decide what to do, and carry out what has to be done).
- Other physical disorders (e.g. hyperthyroidism) or mental disorders (e.g. schizophrenia).

A central feature of all anxiety disorders is that patients complain of the physical symptoms of the "flight or fight" response -- rapid heart rate, need to overbreathe, tremor and shaking, nausea, sweating and focusing of attention.

Education about the meaning of these symptoms is a key part of treatment (i.e. that they do not indicate physical illness, that they can be understood and controlled).

## Prevalence\* of mental disorders in Australia, 1997

<b>Any anxiety disorder</b>	<b>9.7%</b>
Panic disorder	1.3%
Agoraphobia	1.1%
Social phobia	2.7%
Generalised anxiety disorder	3.1%
Obsessive-compulsive disorder	0.4%
Post-traumatic stress disorder	3.3%
Any affective disorder	5.8%
Any substance-use disorder	7.7%
<b>Any mental disorder</b>	<b>17.7%</b>

\* Over the last 12 months before the survey. Distinguish from other prevalence figures in literature e.g. "lifetime" prevalence and "point" prevalence (at the point in time the survey was done.) Rankings above vary with reference point. Source: Australian Bureau of Statistics. *Mental Health and Wellbeing: profile of adults, Australia, 1997*. [Cat. no. 4326.0]

# Panic Disorder and Agoraphobia

## **Features**

- Sudden attacks of fear or anxiety in situations of little danger
- Symptoms of the "flight or fight" response, complicated by hyperventilation and worsened by the fear of collapse or death
- Avoidance, for fear of panic, of situations from which escape is not possible or help is not available, typically public transport, travelling alone, crowded or lonely places

## **Psychological management**

- Education about nature of disorder
- Hyperventilation control
- Graded exposure to feared situations

More detail on P.D.+/-A. below + case example

## Organic differential diagnoses for Panic Disorder

### *Cardiovascular diseases*

- anaemia
- angina
- congestive heart failure
- hyperactive-adrenergic state
- hypertension
- myocardial infarction
- paroxysmal atrial tachycardia

### *Pulmonary diseases*

- asthma
- hyperventilation
- pulmonary embolus

### *Neurological diseases*

- cerebrovascular disease
- epilepsy
- Huntington's chorea
- infection
- Meniere's disease
- migraine
- multiple sclerosis
- transient ischaemic attacks
- tumours
- Wilson's disease

### *Endocrine disorders*

- Addison's disease
- carcinoid syndrome
- Cushing's syndrome
- diabetes

### *Endocrinal disorders (cont'd)*

- hyperthyroidism
- hypoglycaemia
- hypoparathyroidism
- menopausal disorders
- pheochromocytoma

### *Drug intoxications*

- amphetamine
- amyl nitrite
- anticholinergics
- caffeine
- cocaine
- hallucinogens
- marijuana
- nicotine
- theophylline

### *Drug withdrawal*

- alcohol
- caffeine
- antihypertensives
- opiates and opioids
- sedative-hypnotics

### *Other conditions*

- anaphylaxis
- B<sub>12</sub> deficiency
- electrolyte disturbances
- heavy metal poisoning
- organic solvents/  
hydrocarbons

# Generalised Anxiety Disorder

## Features

- . Excessive anxiety or worry, occurring on most days for more than 6 months
- . The worry is out of proportion to the event, pervasive and excessive, **difficult to control\*** (\*DSM-IV addition)
- . Accompanied by muscle tension, hyperarousal and symptoms of the "flight or fight" response

## Psychological management

- . Education about nature of disorder
- . Somatic relaxation strategies
- . Structured problem solving
- . Graded exposure to difficult situations
- . Cognitive therapy
- . Support
- . Counselling
- . Stress management

More detail on G.A.D. below + case example

# Obsessive-Compulsive Disorder

## **Features**

- Obsessions are thoughts, images or impulses that occur repeatedly, are intrusive and distressing and can't be suppressed or neutralised
- Compulsions are repetitive behaviours used to control or neutralise the obsessions and prevent the harm and reduce the anxiety, but which are excessive and disabling

## **Psychological management**

- Education about the nature of the disorder
- Cognitive-behavioural strategies e.g. response prevention / help to resist carrying out compulsions.

## Case example O.C.D.

A 40-year-old man presented with a long history of checking behaviour that was significantly interfering with his life. He checked on "dangerous" items repeatedly before being able to leave his home because of recurring thoughts that something terrible -- like an appliance starting a fire -- might happen and that he may inadvertently be responsible for harm befalling others. He performed his checking in a ritualised manner, ensuring that all electrical items were switched off and unplugged, at times having to count to four as he stared at each item. If interrupted during these behaviours or if feeling under pressure, he had to restart his checking rituals. Similarly, if the thought that some appliance might have been left on occurred during his checking behaviour, the time spent checking each item was lengthened considerably. He reported that he was consistently late in getting out of the house because of his checking, and frequently had to leave work during the day to go home and check items again. He had been asked to resign from two previous jobs because of his constant lateness and absences from work.

# Social Phobia

## **Features**

- Excessive and unreasonable fears of being the centre of attention in case of negative evaluation because of looking anxious or doing something embarrassing
- Situations that could lead to scrutiny or evaluation (social functions, being in a crowd, speaking to others) are avoided or endured with intense anxiety

## **Psychological management**

- Education about nature of disorder
- Cognitive-behavioural strategies e.g. graded exposure therapy

## Case example Social Phobia

A 35-year-old man presented with anxiety at his workplace. Since a recent promotion, he had been having difficulty attending meetings where he might have to present information to his peers. He found the symptoms of pounding heart, trembling, sweating, and blushing so unpleasant that he had excused himself from many meetings and begun avoiding as many as possible. He was seeking help because his avoidance was beginning to be noticed by his superiors at work. When asked about other situations that caused anxiety, he said he had avoided many social activities since his adolescence, particularly if there was a chance that he might be the centre of attention. He did not get anxious when at home with his wife or with close friends. He was particularly worried about the possibility that he might do or say something foolish or embarrassing at work or at social gatherings, and worried that others would notice him sweating or blushing and know that he was anxious. He believed that they would evaluate him negatively because of this.

# Post-Traumatic Stress Disorder

## **Features**

- Exposure to extreme trauma e.g. that threatens life
- Recurring images of the trauma
- Distress triggered by similar events; persistent hyperarousal
- Avoidance of cues/reminders of trauma

## **Psychological management**

- Education about the nature of the disorder
- Hyperventilation control
- Graded exposure to cues
- Treatment of comorbid disorders, especially depression
- Cognitive-behavioural strategies
- Adjunctive hypnotherapy (PTSD sufferers usually highly hypnotisable because PTSD and hypnosis share two phenomena: absorption and dissociation)

## Case example P.T.S.D.

A 27-year-old man presented six months after having lost his house in a bushfire. He, his wife and children had managed to escape unharmed, but one of his neighbours had died. He stated that he couldn't get the fire out of his mind, was unable to sleep properly and that, when he did sleep, he dreamed about nearly getting caught in the fire. When asked about what happened in the dreams, he stated "We're back in the fire. I can hear the kids screaming, crying, and then I see Joan running towards us, from her house, burning . . . I'm certain we're going to be next, and I wake in a pool of sweat." He also related several instances when similar memories had been triggered, such as hearing fire engine sirens, seeing fires on the news, and when attending a local bonfire. When he experienced these memories, he felt and acted as if the trauma was happening all over again. Since the fire he had felt helpless, hopeless, and was unable to concentrate on much at all. His wife complained that he was not the same person she married, having become withdrawn and emotionally detached.

# Specific Phobia

- Excessive fear of a specific object or situation e.g. flying, heights, animals, sight of blood, medical procedures such as injections.
- Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response e.g. Panic Attack
- The person realises the fear is excessive or unreasonable.

## **Psychological management**

- Education about nature of disorder
- Graded exposure to difficult situations
- Progressive muscle relaxation

No case example of Specific Phobia because clinical presentation rate is low (avoidances are usually not impairing). But in our part of the world toad and frog phobias can be sufficiently debilitating for people to seek help.

**More on P.D.+/- A. and G.A.D. follows**

## Case Example of P.D. + A.

A 30-year-old woman asked her general practitioner to investigate her heart. She reported that several months ago, while attending a postnatal exercise class following the birth of her first child, she noticed a dramatic increase in her heart rate. She also noticed that her breathing became difficult, there was tingling in her fingers and around her mouth, her muscles became stiff, and she felt pains in her chest. Fearing she was having a heart attack, she fled the class and sought help at the local emergency department, where an ECG showed no abnormality. Since then, she had experienced similar symptoms on numerous occasions, always seeking medical advice for reassurance. She could travel alone, provided she carried her mobile phone in case she needed to call for emergency medical help. Even so, she avoided crowded banks, shopping centres, and movies in case medical help would not be able to help her in time should she experience another "heart attack". She was referred to a psychologist for opinion and management.

## **Assessment of P.D.+/- A.**

- Medical evaluation generally recommended first
- Panic Attack Record
  - duration, frequency, context and symptoms
- + behavioural tests of how far/ how long can manage phobic avoidances
  - = more reliable data
- DASS, STAI, BAI
- Structured interview

## **Psychological management**

- Education about nature of disorder - cognitive reattribution of threatening bodily sensations via Socratic dialogue and/or didactic corrective information approaches
- Reduction of any somatic tension component using isometric or progressive muscle relaxation strategies
- Interoceptive exposure (i.e. repeated forced hyperventilation) extinction of bodily cues to panic
- Teaching hyperventilation control (breathing retraining) and self-monitoring. See 'Panic Attacks!' handout
- Graded exposure to feared situations. See example hierarchy below

## Case example G.A.D.

A 25-year-old woman presented with worries about her health, her career and her relationships. She said that she had always worried easily, but over the past several months she had felt more tense and agitated. The current increase in anxiety began following a dispute at work with a colleague who she believed had taken advantage of her, but since then she had been unable to assert herself with this colleague. She frequently worried about the quality of her work and worried that making a mistake would ultimately cause her to lose her job. Over this time she had developed a pattern of waking frequently during the night and being unable to get back to sleep for two to three hours while thinking about all her worries. She had also gone to see her general practitioner for various somatic complaints over the years, which she worried were signs of a serious physical illness.

## **Assessment of G.A.D.**

- DASS and DASS 21 (download via Clinical Links [www.users.bigpond.com/fmcdonald](http://www.users.bigpond.com/fmcdonald) Manual in JCU test library) - Barlow (1993) recommends examination of Stress dimension which correlates with ...
- Penn State Worry Questionnaire (see handout)
- Structured interview based on nosologies like DSM-IV

## **Psychological management of G.A.D.**

- Education about nature of disorder
- Cognitive therapy - one of the core features of G.A.D. is cognitive - a pervasive, difficult to control pre-occupation with threat i.e. worry. So cognitive approaches seem pre-eminently suited
- Relevant strategies: Socratic dialogue, stimulus control techniques, written self-challenges to irrational beliefs, identification of real problems that require structured problem solving, thought-stopping and attention shifting from thoughts that have been given appropriate attention - see relevant handouts
- Progressive and isometric muscle relaxation
- Graded exposure to difficult, avoided situations
- Counselling and support (be aware of reassurance-seeking - reflect back and encourage use of learned strategies)
- Stress management (relaxation, meditation, diet and exercise regimens that improve stress recovery)

# Slow breathing technique

Encourage practice in calmer moments, diary of efforts and application at the earliest symptom of panic in a sustained fashion until calmer.

## **Using the second hand on a watch or clock:**

- Hold your breath for six seconds.
- Breathe in and out on a six-second cycle, saying the word "relax" as you breathe out.
- After one minute, hold your breath again, then continue to breathe on a six-second cycle.
- Repeat the sequence until anxiety has diminished.

**Slow, steady breathing (not deep breathing) is central to controlling panic.**

# Graded exposure

- Identify specific goals and break them into smaller, manageable steps
- Learn to master situations that cause mild anxiety
- Progressively master situations that are associated with greater anxiety
- Confront fears regularly and frequently
- Emphasise habituation to anxiety in each exposure session

## **Example of a graded exposure hierarchy**

**Goal:** To travel alone by bus to the city and back

1. Travelling one stop, quiet time of day  
(anxiety level 4/10)
2. Travelling two stops, quiet time of day
3. Travelling two stops, rush hour  
(anxiety level 6/10)
4. Travelling five stops, quiet time of day
5. Travelling five stops, rush hour  
(anxiety level 8/10)
6. Travelling all the way, quiet time of day
7. Travelling all the way, rush hour  
(anxiety level 10/10)

# Structured problem solving

## **Step 1: What is the problem/goal?**

Think about the problem/goal carefully, ask yourself questions. Then write down exactly what the problem/goal is.

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## **Step 2: List all possible solutions**

Put down all ideas, even bad ones. List the solutions *without evaluation* at this stage.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

## **Step 3: Assess each possible solution**

Quickly go down the list of possible solutions and assess the *main* advantages and disadvantages of each one.

## **Step 4: Choose the "best" or most practical solution**

Choose the solution that can be carried out most easily to solve (or to begin to solve) the problem.

**Step 5: Plan how to carry out the best solution**

List the resources needed and the major pitfalls to overcome. Practise difficult steps, make notes of information needed.

- Step 1. \_\_\_\_\_
- Step 2. \_\_\_\_\_
- Step 3. \_\_\_\_\_
- Step 4. \_\_\_\_\_

**Step 6: Review progress and be pleased with any progress**

*Focus on achievement first.* Identify what has been achieved, then what still needs to be achieved. Go through steps 1 to 6 again in the light of what has been achieved or learned.

What has been achieved?

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What still needs to be done?

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## **Worksheet for Padesky 'Cognitive Therapy for Panic' Video.**

1. Panic can occur in any anxiety disorder. Padesky was aware of the need to assess for the presence of alternative or additional anxiety disorders before beginning cognitive therapy for P.D.+/- A. What are some of these disorders?

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2. When Padesky inquired about the peak of Mary's panics, what two broad classes of the client's experience did she use to structure her inquiry?

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3. Cognitive therapy always includes a psycho-educational component. What were some of the elements of the model that Padesky used to educate Mary? What teaching strategies characterised Padesky's approach and which do you think stood the best chance of raising the credibility of the model?

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4. What are the three stages advanced by Padesky for doing cognitive therapy for panic?

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## **Worksheet for Padesky 'Guided Discovery Using Socratic Dialog' Video.**

Central to the use of cognitive therapy techniques like automatic thought records, core belief records and behavioural experiments is Socratic dialogue. This is a form of teaching using questioning that aids discovery learning. A key is that the person has enough knowledge to answer questions that develop a new awareness. A client's perspective may be narrowed by high affect. This strategy allows the person to re-evaluate beliefs and thoughts that may maintain their strong affective states.

Padesky lists the four stages of Socratic dialogue. In the spaces below list some examples of dialogue from the video that relate to each of the stages.

1. Asking a series of informational questions to find out more about their beliefs and the kind of information they use to support their beliefs.

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2. Empathic listening for what is said and not said and to use this to ask further informational questioning on material that may have a bearing on the negative thought being tested.

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3. Frequent summaries to help organise information and to aid client memory.

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4. Synthesising and analytic questioning e.g. "What do you make of this?" and "How do you put this together with the original idea that you had?"

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Your other observations about the question structure. Contrast what she was doing with what she was not doing e.g. did she use any closed questions, did she give advice, offer her own interpretations, were there too many questions, how was her timing and her sensitivity to the client's feeling versus content?

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