Experts in the assessment and treatment of complex mental health disorders

Workshop

Transdiagnostic approaches in the treatment in anxiety and emotional disorders

Peter Norton

Friday 30 June 2017
11am - 6.30pm
Transdiagnostic CBT for Emotional Disorders

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MONASH University
Disclosures

Funded by grants and awards from:

- University of Houston
- National Institute of Mental Health (MH064227; MH073920)
- University of Nebraska–Lincoln
- American Psychological Association

Acknowledgements

University of Nebraska-Lincoln
Prof. Debra A. Hope
Cynthia Kraus-Schuman, Ph.D.
Prof. Sarah Hayes-Skelton, Ph.D.
Elizabeth Moore, Ph.D.

University of Houston
Prof. Terri Barrera (Asst. Dir.)
Shannon Bruno, Ph.D.
Jessica Calleo, Ph.D.
Lance Chamberlain, Ph.D.
Ashley Christiansen, Ph.D.
Sarah Garnaat, Ph.D.
Chelsea Gilts, Ph.D.
Jaclyn Grad, Ph.D.
Kelly Green, Ph.D.
Jessica Grogan, Ph.D.
Kelly Grover, Ph.D.
Suzanne Klenck, Ph.D. (Asst. Dir.)
Tannah E. Little, M.A.
Amanda Mathew, Ph.D.
Alicia Pardee, M.A.
Charlotte Parrott, Ph.D.
Daniel Paulus, M.A. (Asst. Dir.)
Laura Philipp, Ph.D.
Prof. Esther Price, Ph.D.
Radhika Reddy, Ph.D.
Christina Robinson, Ph.D.
Stacey Rosenkranz, Ph.D.
Leslie Schart, Ph.D.
Katie Sears, Ph.D.
Justin Springer, Ph.D.
Mona Raouf, M.A.

Monash University
Kelly Harris, B.A.
Isabella Marker, B.A.
Amanda Nagulendran, B.A.
Shaun Pearl, B.A. (Asst. Dir.)

Elizabeth Ross, Ph.D.
Ivy Ikpeme Ruths, Ph.D.
Elaine Savoy, B.A.
Angela Smith, Ph.D. (Asst. Dir.)
Derek Szafranski, Ph.D. (Asst. Dir.)
Alexander Talkovsky, M.A. (Asst. Dir.)
Christi Washington, Ph.D. (Asst. Dir.)
What is *Transdiagnostic CBT*?

- Similar to CBT for DSM-5 Anxiety, Depressive, and related disorders
  - Panic Disorder
  - Agoraphobia
  - Social Phobia
  - Generalized Anxiety Disorder
  - Specific Phobias
  - Major Depressive Disorder
  - Persistent Depressive Disorder
  - Obsessive-Compulsive Disorder
  - Posttraumatic Stress Disorder

- With one key exception:
  - Transdiagnostic CBT deemphasizes DSM disorder diagnoses
  - Focus on all clients having an *excessive or irrational emotional response to* __________
Why Classify?

- Largely because that is how our brains operate
  - Male / Female
  - Yes / No
  - Smaller / Bigger
  - Red / Green

- We make sense of the variability in the world by categorizing it
  - But every classification scheme introduces error
    - Decreases the validity of the classification
Linnaean System

Mammalia

Primates

Anthropoidea

Prosimii

Platyrrhini

Catarrhini

Hominidae

Pongidae

Hylobatidae

Homo

Pongo

Gorilla

Pan

Homo habilis

Homo erectus

Homo sapiens
All Classification Systems are Wrong

- But for many systems, the utility in the classification outweighs the error.

- When the error overwhelms the data, the system is revamped.
Diagnostic and Statistical Manual
Evolution of Emotional Diagnoses

- **DSM-I and DSM-II**
  - 4 related “Reactions” or “Neuroses”

- **DSM-III/DSM-III-R**
  - 9 Anxiety Disorders, Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS

- **DSM-IV**
  - 12 Anxiety Disorders
  - 5 Depressive Diagnoses

- **DSM-5**
  - 18 Anxiety Diagnoses, including subtypes/specifiers
  - 6 OC-Related, and 4 PTSD-related diagnoses
  - 8 Depressive Diagnoses
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<tbody>
<tr>
<td>Anxiety Neurosis</td>
<td>Anxiety Neurosis</td>
<td>Panic Disorder</td>
<td>Panic Disorder without Agoraphobia</td>
<td>Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood)</td>
<td>Panic Disorder without Agoraphobia</td>
<td>Generalized Anxiety Disorder</td>
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<td>Generalized Anxiety Disorder</td>
<td>Generalized Anxiety Disorder</td>
<td>Overanxious Disorder</td>
<td>Overanxious Disorder</td>
<td>Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood)</td>
<td>Generalized Anxiety Disorder</td>
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<td>Phobic Neurosis</td>
<td>Phobic Neurosis</td>
<td>Agoraphobia with Panic Attacks</td>
<td>Panic Disorder with Agoraphobia</td>
<td>Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood)</td>
<td>Panic Disorder with Agoraphobia</td>
<td>Agoraphobia</td>
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<td>Agoraphobia without Panic Attacks</td>
<td>Agoraphobia without History of Panic</td>
<td>Social Phobia</td>
<td>Social Phobia (Social Anxiety Disorder)</td>
<td>Social Phobia (Social Anxiety Disorder)</td>
<td>Social Anxiety Disorder (Social Phobia)</td>
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<td>Social Phobia</td>
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<td>Simple Phobia</td>
<td>Specific Phobia</td>
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<td>Obsessive-Compulsive Neurosis</td>
<td>Obsessive-Compulsive Neurosis</td>
<td>Obsessive Compulsive Disorder</td>
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<tr>
<td>Simple Phobia</td>
<td>Specific Phobia</td>
<td>Hassle Disorder</td>
<td>Substance/Medication-Induced OC and Related Disorder</td>
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<td>Gross Stress Reaction</td>
<td>Adjustment Reaction of Adult Life</td>
<td>Post-Traumatic Stress Disorder</td>
<td>Post-traumatic Stress Disorder</td>
<td>Posttraumatic Stress Disorder</td>
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<td>Acute Stress Disorder</td>
<td>Acute Stress Disorder</td>
<td>Atypical Anxiety Disorder</td>
<td>Anxiety Disorder Not Otherwise Specified</td>
<td>Anxiety Disorder Not Otherwise Specified</td>
<td>Anxiety Disorder not Otherwise Specified</td>
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<tr>
<td>Atypical Anxiety Disorder</td>
<td>Anxiety Disorder Not Otherwise Specified</td>
<td>Anxiety Disorder due to a General Medical Condition</td>
<td>Anxiety Disorder due to a General Medical Condition</td>
<td>Anxiety Disorder due to another Medical Condition</td>
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<td>Separation Anxiety Disorder</td>
<td>Separation Anxiety Disorder</td>
<td>Substance-Induced Anxiety Disorder</td>
<td>Substance-Induced Anxiety Disorder</td>
<td>Substance/Medication-Induced Anxiety Disorder</td>
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<td>Separation Anxiety Disorder</td>
<td>Separation Anxiety Disorder</td>
<td>Substance-Induced Anxiety Disorder</td>
<td>Substance-Induced Anxiety Disorder</td>
<td>Substance/Medication-Induced Anxiety Disorder</td>
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<td>Selective Mutism</td>
<td>Selective Mutism</td>
<td>Selective Mutism</td>
<td>Selective Mutism</td>
<td>Other Specified Anxiety Disorder</td>
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<td>Avoidant Disorder of Childhood/Adolescence</td>
<td>Avoidant Disorder of Childhood/Adolescence</td>
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Evolution of Emotional Disorder Diagnoses

- PD/A
- SOC
- GAD
- OCD
- Depr
- PTSD
Reconceptualization of Emotional Disorders

Emerging reconceptualization of Emotional Disorders as a single common core pathology

- Tendency to interpret neutral or ambiguous stimuli as negative, threatening, and personally relevant


Evolution of Emotional Diagnoses

NA

Emotional D/O

PD/A  SOC  GAD  Depr  PTSD

PTSD

Depr

GAD

SOC

PD/A
Reconceptualization of Emotional Disorders

- This core pathology may be manifested in different ways and elicited by different stimuli

- Becomes tied to various themes/stimuli
  - E.g., loss/hopelessness, negative evaluation, somatic symptoms, contamination, heights, etc.
Purpose of Negative Emotions

- Detect “aversive state of affairs” (e.g., loss, threat)
  - Up or down modulate arousal
  - Alter motivations to cope with aversive state

- Negative Emotional Disorders:
  - Recurrent engagement of negative emotions in absence of “aversive state of affairs”
Evidence Supporting a Transdiagnostic Conceptualization

- Treatment Outcome Evidence
  - CBT
  - SSRI

- Genetic Evidence

- Comorbidity Evidence
Treatment Equivalence Evidence

- Similar treatments are similarly effective across the emotional disorders

  - E.g., CBT using Exposure and Cognitive Therapy effective for all anxiety disorders

- Meta-Analyses

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<tr>
<td>PTSD 1.86(^a)</td>
<td>OCD 1.37(^a)</td>
</tr>
<tr>
<td>GAD 1.80(^a)</td>
<td>Social Phobia 0.62(^{ab})</td>
</tr>
<tr>
<td>Panic/Agoraphobia 1.53(^{a,b})</td>
<td>PTSD 0.62(^{ab})</td>
</tr>
<tr>
<td>OCD 1.50(^{a,b})</td>
<td>GAD 0.51(^{ab})</td>
</tr>
<tr>
<td>Social Phobia 1.27(^b)</td>
<td>Panic/Agoraphobia 0.35(^b)</td>
</tr>
</tbody>
</table>

* Acute Stress Disorder omitted for sake of comparison
SSRI’s (e.g. paroxetine and sertraline) have FDA approval for most emotional disorders [except specific phobia]

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Paroxetine Dose Range</th>
<th>Sertraline Dose Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder</td>
<td>20-60 mg</td>
<td>50-200 mg</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>10-60 mg</td>
<td>50-200 mg</td>
</tr>
<tr>
<td>GAD</td>
<td>20-50 mg</td>
<td>50-200 mg *</td>
</tr>
<tr>
<td>OCD</td>
<td>40-60 mg</td>
<td>200 mg</td>
</tr>
<tr>
<td>PTSD</td>
<td>20-50 mg</td>
<td>50-200 mg</td>
</tr>
<tr>
<td>Depression</td>
<td>20-50 mg</td>
<td>50-200 mg</td>
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</tbody>
</table>

Data accessed from:
Genetic Evidence

- Early familial transmission research suggested heritability of specific disorders
  (E.g., Panic Disorder breeds Panic Disorder, Depression breeds Depression)

- Subsequent Multivariate Genetic Analyses show heritability of any emotional disorder
  (E.g., Panic Disorder breeds OCD, Panic, Phobias, Depression, etc.)
Comorbidity Evidence

- 60%-90% comorbidity within Anxiety and Mood disorders
- Average of 2.1 Anxiety or Depressive diagnoses per client
Evidence Supporting a Transdiagnostic Conceptualization

- **Treatment Outcome Evidence**
  - CBT – Similar Treatments = Similar Outcomes
  - SSRI – Similar Treatments = Similar Outcomes

- **Genetic Evidence** – Only emotional disorder risk

- **Comorbidity Evidence** – >1 Dx more common
Case Example of DSM-IV vs. Transdiagnostic Conceptualization
Case Example

Marie (*pseudonym)

- 27-year old single Caucasian woman
- Student at a large state university in the Midwest US.
- Relocated to the Midwest one year ago after living in a large metropolitan city on the West Coast
- Moved to “get away from some bad history,” but declined to elaborate
- Recently become engaged to be married
- Presented complaining that she was anxious “all the time” and that she “couldn’t even get out of the house any more”
Case Example

- Diagnostic assessment using the Anxiety Disorders Interview Schedule for DSM-IV (Brown, DiNardo, & Barlow, 1994)

- Met diagnostic criteria for:
  - Panic Disorder with Agoraphobia
  - Generalized Anxiety Disorder
  - Obsessive-Compulsive Disorder
  - Specific Phobia
  - Major Depressive Disorder
  - Possible Anorexia Nervosa

- Self-report assessments also indicated significant elevations on each of these constructs
Panic Disorder with Agoraphobia
- Sensitive to internal sensations (nausea, feeling “ill”) leading to symptom escalation and a panic attack
- Avoidance of places because of panic and fear others may have the flu

Generalized Anxiety Disorder
- Frequent worry about a range of topics (usually tied to vomiting)

Obsessive-Compulsive Disorder
- Washing/cleaning due to germ or contamination fears

Specific Phobia
- Vomiting

Major Depressive Disorder
- Depressed mood, Loss of interest in usual activities, isolated

Possible Anorexia Nervosa
- Restricted food intake because of vomit fears

Central theme was a fear of vomiting (emetophobia)
Parsimonious Conceptualization

Psychoeducation
Cognitive Restructuring
In vivo exposure
- Interoceptive exposure?

Behavioral Activation
Response Prevention
Feared Foods
Worry Exposure
Comprehensive Conceptualization

PD/A  Anorexia  GAD  OCD  SpPh  PTSD

Panic CBT  FB/T for AN  E/R for OCD  BT for SpPh  Beh. Act for Dep

Mastery of Your Anxiety and Worry
Mastery of Your Specific Phobia
Mastery of Your Anxiety and Pnak
Behavioral Activation for Depression
Treatment Manual for Anorexia Nervosa
Focus on evidence-based treatment elements, rather than full treatment protocols

- Interoceptive Exposure
- Imaginal Exposure
- In vivo Exposure
- Behavioral Activation
- Cognitive Restructuring
- E/RP for rituals
- Feared Foods
- Marie’s Emotional D/O

Transdiagnostic Conceptualization
Case Conceptualization

1. Education
2. Cognitive Restructuring Skills
3. Emotional Engagement/Response Prevention
   - Interoceptive – internal bodily sensations
   - In vivo – situational and behav. activation
   - In vivo – touching “contaminated” items
   - Imaginal – internal worry cognitions
   - Introducing feared foods
What is Transdiagnostic CBT?

- Similar to CBT for DSM-5 Anxiety, Depressive, and related disorders
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  - Posttraumatic Stress Disorder

- With one key exception:
  - Transdiagnostic CBT deemphasizes DSM disorder diagnoses
  - Focus on all clients having an excessive or irrational emotional response to ______________
Other Practical Advantages of a Transdiagnostic Approach
Balancing Demand and Resources

- **Busy in Graduate School**
  - Difficulty balancing patient needs with staff resources
    - Specialty anxiety disorder clinic with limited (4 - 6) staff
  - Example: 8 new intakes per week
    - 2 Panic Disorder
    - 2 Social Phobia
    - 2 GAD
    - 1 OCD
    - 1 PTSD
  - Individual tx: Overwhelm staff schedules
  - Group tx: Require long delays
Treatment Components

1. 12-week group-based (6-8 clients/group) CBT program
   - Weekly 2-hour group sessions

2. Psychoeducation (1.5 Sessions)
   - Components of emotions; Treatment rationale; Causes of emotional disorders; Daily self-monitoring

3. Cognitive Restructuring (1.5 Sessions)
   - Identify automatic thoughts; Identify misinterpretations and misappraisals; Challenge and develop balanced interpretation or appraisal

4. Emotional Engagement (6 Sessions)
   - Develop Emotional Hierarchy; Conduct in-session and homework EE while engaging in response prevention
4. **Schema-Based Cognitive Restructuring** *(2 Sessions)*
   - Identical to previous CR, but emphasis on general neurotic style; The “tendency to interpret neutral or ambiguous stimuli as negative, threatening, and personally relevant”

5. **Termination/Relapse Prevention** *(1 Session)*
   - Continued self-exposure and CR; Lapses vs. relapses; Emergency Action Plans
Key Research Questions to date

- Does it work?
- Does it work equally for different diagnoses?
- Does it work as well as other treatments?
- What are the consequences of mixed-diagnosis groups?
- What effect does it have on comorbid dx?
Summary of Efficacy Evidence

- It works

- It works equally across diagnoses

- It works as well as other treatments

—Supported by meta-analyses
What are the Consequences of Mixed-Diagnosis Groups?
Group Heterogeneity on Outcomes

- Question if groups with different diagnostic make-ups have different outcomes for different clients

- Examined to see if degree of similarity impacts outcomes

84 initially enrolled in Transdiagnostic Treatment

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Primary</th>
<th>Comorbid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder</td>
<td>26 (31%)</td>
<td>34 (20.2%)</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>35 (41.6%)</td>
<td>47 (28%)</td>
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<tr>
<td>GAD</td>
<td>16 (19.0%)</td>
<td>32 (19%)</td>
</tr>
<tr>
<td>OCD</td>
<td>2 (2.4%)</td>
<td>10 (6%)</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>1 (1.2%)</td>
<td>10 (6%)</td>
</tr>
<tr>
<td>AD NOS</td>
<td>4 (4.8%)</td>
<td>4 (2.4%)</td>
</tr>
<tr>
<td>PTSD</td>
<td>0 (0.0%)</td>
<td>1 (0.6%)</td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td>0 (0.0%)</td>
<td>26 (15.4%)</td>
</tr>
<tr>
<td>EtOH/Substance Use</td>
<td>0 (0.0%)</td>
<td>4 (2.4%)</td>
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</table>
Group Heterogeneity and Outcomes

- **Group Makeup at Session 1**
  - Similarity on primary Dx predicting outcome
    - $R^2$ change = 0.014, $F(1, 49) = 0.932, p = 0.339$
  - Similarity on any Dx predicting outcome
    - $R^2$ change = 0.005, $F(1, 49) = 3.50, p = 0.557$

- Identical results when examining group composition at end-of-treatment (i.e., dropouts removed)
Transdiagnostic Assessment


- Transdiagnostic Emotional D/O assessment
- Diagnosis-Specific Assessment
- Trigger/Response Hierarchy
- Other Assessments?
Transdiagnostic Assessment

- Structured Diagnostic Assessment

  - Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV)
  - Structured Clinical Interview for DSM-IV (SCID-IV)
  - Mini International Neuropsychiatric Interview? (MINI 6.0)
Transdiagnostic Assessment

Quantifying Diagnostic Severity

- Clinical Global Impressions (CGI-S and CGI-I)

<table>
<thead>
<tr>
<th>1. SEVERITY OF ILLNESS</th>
<th>2. GLOBAL IMPROVEMENT</th>
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<tbody>
<tr>
<td>Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?</td>
<td>Rate total improvement whether or not, in your judgment, it is entirely due to treatment</td>
</tr>
<tr>
<td>0 = Not assessed</td>
<td>0 = Not assessed</td>
</tr>
<tr>
<td>1 = Normal, not at all ill</td>
<td>1 = Very much improved</td>
</tr>
<tr>
<td>2 = Borderline mentally ill</td>
<td>2 = Much improved</td>
</tr>
<tr>
<td>3 = Mildly ill</td>
<td>3 = Minimally improved</td>
</tr>
</tbody>
</table>

- Clinician Severity Ratings [for Each Diagnosis (CSR; from ADIS-IV)]

<table>
<thead>
<tr>
<th>Absent</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
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<tbody>
<tr>
<td>0------</td>
<td>1----</td>
<td>2--------</td>
<td>3------</td>
<td>4-----------</td>
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- Transdiagnostic Anxiety Severity Ratings [Overall]

<table>
<thead>
<tr>
<th>Absent</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
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<tr>
<td>0------</td>
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Emotional Disorder Self-Report

- Self-Report Assessments
  - Mood and Anxiety Symptom Questionnaire
    - MASQ
  - Depression, Anxiety, and Stress Scales
    - DASS-21 / DASS-42
  - Beck Anxiety Inventory/Depression Inventory
    - BAI / BDI
  - Overall Anxiety Severity Impairment Scale / Overall Depression Severity Impairment Scale
    - OASIS/ ODSIS
# Diagnosis-Specific Assessment

- **Panic:** PDSS  MI
- **Social:** SPDQ  LSAS
- **GAD:** GADQ-IV  PSWQ
- **OCD:** Y-BOCS  DOCS
- **Depr:** CES-D  PHQ-9
Other Assessments

- Substance Use/Abuse: AUDIT, DAST
- Suicidality: MSSI, BSS
Developing a Trigger/Response Hierarchy

- Need to know the trigger(s) of the emotional response

- Need to know variations that make it more or less distressing

- Need to know what responses are used to make it easier (for response prevention)
Developing a Trigger/Response Hierarchy

- Subjective Units of Distress (SUDS)
  - A handy tool for:
    - Estimating how much distress an Emotional Engagement will cause
    - Reporting how distressed the client is during Emotional Engagement

Rated on a 0 to 100 (or 0 to 10, or 0 to 8) scale

- Zero is absolutely no distress whatsoever
- 100 is the absolute worst distress you have experienced or can imagine experiencing
### Trigger → Response Hierarchy

<table>
<thead>
<tr>
<th>Trigger</th>
<th>SUDS</th>
<th>Odds</th>
<th>Response</th>
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<tbody>
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<td>1</td>
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<tr>
<td>Trigger</td>
<td>SUDS</td>
<td>Odds</td>
<td>Response</td>
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<td>---------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>1 Vomiting</td>
<td>100</td>
<td>100</td>
<td>Curl up, cry. Deep breathing</td>
</tr>
<tr>
<td>2 Eating Indian food</td>
<td>95</td>
<td>100</td>
<td>Never!</td>
</tr>
<tr>
<td>3 Eating greasy food</td>
<td>90</td>
<td>100</td>
<td>Never!</td>
</tr>
<tr>
<td>4 Touching door knob/handle</td>
<td>85</td>
<td>90</td>
<td>Use elbow, or disinfect if can’t use elbow</td>
</tr>
<tr>
<td>5 Feeling bloated</td>
<td>80</td>
<td>60</td>
<td>Sit on toilet, breathe</td>
</tr>
<tr>
<td>6 Leaving the house to go out with fiancée</td>
<td>70</td>
<td>50</td>
<td>Don’t unless he really wants to go out</td>
</tr>
<tr>
<td>7 Queasy feeling in stomach</td>
<td>65</td>
<td>80</td>
<td>Sit on toilet, breathe</td>
</tr>
<tr>
<td>8 Touching elevator buttons</td>
<td>60</td>
<td>100</td>
<td>Take stairs, or use elbow to push button if too high to use stairs</td>
</tr>
<tr>
<td>9 Leaving the house when nothing going on</td>
<td>60</td>
<td>50</td>
<td>Avoid</td>
</tr>
<tr>
<td>10 Having friends over</td>
<td>50</td>
<td>50</td>
<td>Generally don’t</td>
</tr>
</tbody>
</table>
Implementing the Treatment

- Session 1 - Introduction and Education
- Session 2 - More on Emotions & Importance of Thoughts
- Session 3 - Challenging Emotional Thoughts
- Session 4 - Emotional Engagement
- Session 5 - Emotional Engagement
- Session 6 - Emotional Engagement
- Session 7 - Emotional Engagement
- Session 8 - Emotional Engagement
- Session 9 - Emotional Engagement
- Session 10 - Getting Back to Thoughts
- Session 11 - Adjusting Negative Affective Styles
- Session 12 - Relapse Prevention and Moving Forward
Note re: Examples / Vignettes

- The manual contains many suggestions for narratives
  - Sample scripts
  - Examples
  - Vignettes

- These *do not* need to be read verbatim
  - Just examples that my team and I have found instructive/useful/understandable
Session 1: Intro and Education

Session Outline

- Introductions/Socialization
- Review of Group Rules
- Discussion of the Nature of Emotions
  - Why Do Some Experience Emotional Problems?
  - The Three Components of Emotions
  - Downward Spiral of the Three Components
- Treatment Components
- Homework and Preview of Next Session
Introduction and Group Cohesion

Two primary goals:
- Develop group dynamic
- Psychoeducation

Best opportunity to establish cohesiveness
- Ease clients into group interactions
- Identify barriers to engagement
- Develop “buy-in” to treatment model
Education

“You can’t fix what you don’t understand”

Not the most potent component itself, but helps all other techniques

All evidence-based treatments for emotional disorders have some education
Education serves several purposes:

1. Reduces stigma
2. Lets clients know they are not alone
3. Provides hope
4. Provides corrective information about symptoms/reactions
5. Socializes clients to treatment model
6. Other?
Education

- Discuss 3 Components of Emotions
  - Cognitive, Physiological, Behavioral

- Interaction of 3 components

- Treatment elements and rationale
Education

- Other popular points
  - Caffeine, alcohol, and drug use
  - Where emotional disorder come from
    - Genetic, Early Life, Social Learning, Direct Experience
Treatment Components/Rationale

- Education
- Cognitive Restructuring
- Emotional Engagement/Response Prevention
- Advance Cognitive Therapy
- Relapse Prevention and Termination
Self-Monitoring

- Provides relatively unbiased information
- Useful for monitoring progress and placing lapses in context
- Identify relationships
- Shift client from a passive recipient to an analyzing observer
| None | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
|------|----|----|----|----|----|----|----|----|----|     |

<table>
<thead>
<tr>
<th>Date</th>
<th>Average Anxiety (0 to 100)</th>
<th>Average Depression (0 to 100)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

DAILY SELF MONITORING FORM
<table>
<thead>
<tr>
<th>Date</th>
<th>Average Anxiety (0 to 100)</th>
<th>Average Depression (0 to 100)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/6</td>
<td>30</td>
<td>50</td>
<td>Just feelingblah</td>
</tr>
<tr>
<td>20/6</td>
<td>60</td>
<td>50</td>
<td>Funny stomach</td>
</tr>
<tr>
<td>21/6</td>
<td>30</td>
<td>80</td>
<td>Just feeling blah, stayed in bed all day</td>
</tr>
<tr>
<td>22/6</td>
<td>30</td>
<td>20</td>
<td>Nothing exciting</td>
</tr>
<tr>
<td>23/6</td>
<td>75</td>
<td>50</td>
<td>Mike made dinner, felt queasy after</td>
</tr>
<tr>
<td>24/6</td>
<td>30</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>25/6</td>
<td>100</td>
<td>20</td>
<td>Delivery man looked ill</td>
</tr>
<tr>
<td>26/6</td>
<td>40</td>
<td>75</td>
<td>Still worried about delivery guy</td>
</tr>
</tbody>
</table>
Self-Monitoring

What to monitor?

- Average daily anxiety/depression?
- Peak anxiety/depression?
- Symptoms/Thoughts/Behaviors?
- Stress?
- Number of episodes/attacks?
- Duration of episodes/attacks?
Self-Monitoring

- Self-Monitoring – Be careful
  - Self-monitoring compliance is often poor
    - Keep the amount of monitoring low enough so that clients don’t get sick of it
    - But, monitor enough to get useful information
  - If compliance is poor, don’t force it -- but also don’t imply that homework is optional
FORM 1.3: MONITORING THE THREE COMPONENTS OF DISTRESS

Date: ___________________________

Briefly describe the distress-provoking situation

<table>
<thead>
<tr>
<th>Physiological Component</th>
<th>Cognitive Component</th>
<th>Behavioural Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>What I felt was…</td>
<td>What I thought was…</td>
<td>What I did was…</td>
</tr>
</tbody>
</table>
Problems and Troubleshooting

- One or a few clients dominating discussions
- Clients approach the therapy as a process group rather than active skill-based therapy
- Therapists “lecture” rather than “facilitate group”
Session 2: More on Emotions and the Importance of Thoughts

Session Outline

- Review of Self-Monitoring Homework
- Adaptive Basis of the Components of Emotions
- Importance of Thoughts
  - Intro to Cognitive Restructuring
  - Automatic Thoughts
  - In-Session Exercise: Identifying ATs
- Homework
- End of Session 2 and Preview of Next Session
Review of Homework

- Self-monitoring
- Monitoring three components
Self-Monitoring Graph

- = Average Anxiety
\( \Delta \) = Average Depression
Completed example of a Self-Monitoring Graph through six sessions

- = Average Anxiety
\(\Delta\) = Average Depression
Common educational points

1. Emotional disorders are the most common $\Psi$ disorder
2. Emotions are normal responses
3. Emotional symptoms serve a purpose
4. You cannot die from emotions
Adaptive Basis of Emotions

- Primary goal of Session 2:
  - Help clients shift from “emotions are bad” to “emotions are a response”

- Used later in session to highlight that emotions are a response to *perceptions of danger or loss* rather than *actual danger or loss*
<table>
<thead>
<tr>
<th>Physiological Component</th>
<th>Cognitive Component</th>
<th>Behavioral Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racing heart</td>
<td>Anticipatory thoughts of potential danger</td>
<td>Avoidance motivation</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Increasing thoughts of imminent threat</td>
<td>Escape motivation</td>
</tr>
<tr>
<td>Muscle tension/shaking</td>
<td>Thoughts of bad outcomes</td>
<td>Protective motivation</td>
</tr>
<tr>
<td>Numb/tingling sensations</td>
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<tr>
<td>Nausea/Stomach distress</td>
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<tr>
<td>Lightheadedness</td>
<td></td>
<td></td>
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<tr>
<td>Sweating</td>
<td></td>
<td></td>
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<tr>
<td>Hot/cold sensations</td>
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</tr>
</tbody>
</table>
Importance of Thoughts

- Draw on example from homework thoughts

- Emotions not as a result of danger/loss, but PERCEPTIONS of danger/loss
In Session Example - Jacob
Beliefs & Appraisals

- Seem to occur automatically

  “Automatic Thoughts/Beliefs”

- Sometimes so automatic that people have trouble identifying them

- First step is to train clients to become astute observers of their own thoughts
Identifying Thoughts

- Practice is key
- Write down those thoughts that you are having whenever your emotions rise
- Train yourself to immediately ask “what was I thinking” during emotional blips
# Identifying Thoughts/Beliefs

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Situation</th>
<th>Thoughts</th>
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<tr>
<td>Date/Time</td>
<td>Situation</td>
<td>Thoughts</td>
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<td>------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Tues. 1:30pm</td>
<td>Presenting sales data at company meeting</td>
<td>They think I don’t know what I’m talking about … stupid</td>
</tr>
<tr>
<td>Fri. 8:30pm</td>
<td>SMS from Mike about going out to pub</td>
<td>Why bother? I wouldn’t have any fun anyway. Probably drag everyone else down with me.</td>
</tr>
</tbody>
</table>
Describe the trigger that made you distressed.

<table>
<thead>
<tr>
<th>List the Automatic Thoughts you recall having</th>
</tr>
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<tbody>
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</tbody>
</table>
Problems and Troubleshooting

- Difficulties in identifying automatic thoughts
  - Downward Arrow

- Difficulty in articulating Automatic Thoughts because they perceive the thought will cause intolerable emotional distress
Session 3: Challenging Anxious Thoughts

Session Outline

- Review Homework
- Cognitive Restructuring
  - Thinking Errors
  - Challenging Automatic Thoughts
  - In-Session Exercise: Asking/Answering DQs
  - Rational Responses
  - Full Cognitive Restructuring Practice
- Homework
- End of Session 3 and Preview of Next Session
Cognitive Challenging
Review

- Panic Disorder w/ w/o Agoraphobia – fear is tied to beliefs/appraisals about the meaning of the symptoms

- Social Anxiety Disorder – fear is tied to beliefs/appraisals about oneself and others’ negative evaluations

- Obsessive-Compulsive Disorder – fear is tied to beliefs/ appraisals about the meaning of the intrusions
Review

- Generalized Anxiety Disorder — beliefs/appraisals about responsibility, competence, power of worry, appropriateness of worry

- Posttraumatic Stress Disorder — beliefs/appraisals about the dangerousness of the world or certain things

- Depression — negative beliefs/appraisals about the self, world, and future
Transdiagnostic Conceptualization

- Emotional Disorder as a result of biased or exaggerated beliefs of the:
  - … likelihood of threat or loss
  - Or
  - … consequences of threat or loss
Cognitive Challenging

- Three step process

1. Focus on identifying specific beliefs and appraisals (Session 2 & homework)

2. Teach client to challenge the logic of that beliefs or appraisal

3. Replace with more accurate thought/belief
Types of Automatic Thoughts

- Several experts have generated lists of different types of automatic thoughts.

- All-or-nothing thinking
- Overgeneralization
- Disqualify the positive
- Mind Reading
- Emotional Reasoning
- Fortune Telling
- Mental Filter
- Catastrophizing
- Should Statements
- Labeling
- Magnify/Minimize
- Personalization
Types of Automatic Thoughts

- Most can be boiled down into:
  - Catastrophizing (Worst possible outcome)
  - Overestimation (Assume unlikely events are likely)
  - *** Maladaptive Thinking (objectively true, but not helpful) ***
Thoughts and Beliefs

- Many clients find it useful and interesting to classify thoughts/beliefs

  - But, “correct” classification is not required

- What is very important is the realization that thoughts/beliefs aren’t always true or accurate

- Once realized, clients are ready to challenge their thoughts/beliefs
Cognitive Challenging

Primary questions to clients should *ASK and ANSWER* to themselves

How likely is it that ____ will *really* happen?
- Re-evaluate probabilities

How bad would it *really* be if ____ happened?
- Re-evaluate consequences
1. Do I know for certain that ____________________________?
For example: Do I know for certain that I am having a heart attack?

2. Am I 100% sure that ____________________________________________?
For example: Am I 100% sure that the elevator will run out of air?

3. Does _________ really mean ____________?
For example: Does feeling depressed really mean I’m worthless?

4. What evidence do I have that ____________________________________?
For example: What evidence do I have that the future is hopeless?

5. Is there another explanation for ______________ besides ________________?
For example: Is there another explanation for the bumpiness besides “the plane is crashing”?

6. What are the chances that ____________ will actually happen/actually happened?
For example: What are the chances that someone will slip and hurt themselves on that water I spilled?

7. If I did __________, what is the worst that would really happen?
For example: If I did start shaking, what is the worst that would really happen?

8. If ____________ did happen, how bad would it be?
For example: If people did disagree with me, how bad would it be?
Cognitive Challenging

- This *never* is a one-shot deal
- The answer is often still negative
- Often “yes but” or “but what if” or “it still could”
- Continue challenging the beliefs as they come
Developing a Rational Thought

- Once the automatic thought/belief is reasonably challenged
- Develop a more rational response
  - Realistic – not excessively positive
  - In one’s own words
  - Short and easy to remember
  - A reminder of the irrational-ness of your automatic thoughts/beliefs
Developing Rational Response

- This will seem awkward to people at first
- It won’t get rid of their distress at first
- Combating thoughts/beliefs is a skill
- All skills require practice to get good at them
Describe the trigger that made you distressed: ________________________________

__________________________________________________________

_____________________________________________________

List the major Automatic Thoughts you experienced:

1. _______________________________________________________

2. _______________________________________________________

3. _______________________________________________________

4. _______________________________________________________

5. _______________________________________________________

Pick one of these Automatic Thoughts, probably the strongest one, and identify the Thinking Errors in that thought:

<table>
<thead>
<tr>
<th>Thinking Error</th>
<th>Explain</th>
</tr>
</thead>
</table>

[Next Page]
Use Disputing Questions to challenge the Automatic Thought:

Disputing Question: ____________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
Answer: _____________________________
________________________________________________________________
________________________________________________________________

Q: ________________________________
________________________________________________________________
________________________________________________________________
A: ________________________________
________________________________________________________________
________________________________________________________________

Q: ________________________________
________________________________________________________________
________________________________________________________________
A: ________________________________
________________________________________________________________
________________________________________________________________

Q: ________________________________
________________________________________________________________
________________________________________________________________
A: ________________________________
________________________________________________________________
________________________________________________________________

Develop a Rational Response: Remember, the Rational Response should be brief and positive, and it should remind you of the major points from the answers to the Disputing Questions.
Problems and Troubleshooting

- Trying to convince the client of a “rational thought”
  - Aka, arguing

- Difficulty understanding the rationale of the exercise (firmly held beliefs)

- Client “going through the motions”

- Other clients being counter-productive
Sessions 4-9: Emotional Engagements

Session Outline

- Review Homework
- Emotional Engagements
  - Planning the Emotional Engagements
  - Pre-Exposure Cognitive Restructuring
  - Behavioral Goals and SUDS Ratings
  - Conducting the Emotional Engagements
  - Debriefing the Emotional Engagements
- Homework
- End of Session and Preview of Next
Emotional Engagements
Exposure

“A critical element of therapy [for anxiety] is to increase exposure to the stimuli or situations that provoke anxiety”  (Surgeon General of the United States, 1999)

Gradually confront anxiety-provoking stimuli:

◆ Extinction/counter-conditioning
◆ Habituation
◆ Corrective information
Behavioral Activation

Gradually increasing engagement in activities, particularly pleasurable ones:

- Reduce behavioral and social isolation
- Increase exposure to positive reinforcement
- Corrective information
Response Prevention

- Term used in OCD treatment

- For emotional engagements to work, client must also not engage in compulsions that decrease distress

- But compulsions are just one form of negative coping response
Response Prevention

- Almost always, emotional disorders have some form of negative coping response
  - May be subtle

- Need to identify it/them
  - Often obvious – Escape/Avoid/Withdraw

- Must be prevented/inhibited in emotional engagements
Emotional Engagements

- How long should the EE be?

- How often should the EE be done?
EE over Time
Emotional Engagements

“A critical element of therapy is to increase exposure to the stimuli or situations that provoke [distress]...”

How do we do that?
Prior to Session Four: Planning the Emotional Engagement

- Use Trigger/Response Hierarchy as model
- Prepare 1st EE in advance
- Develop preliminary plan for moving through hierarchy
- Plan which EEs each session, and in which order
<table>
<thead>
<tr>
<th>Trigger</th>
<th>SUDS</th>
<th>Odds</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vomiting</td>
<td>100</td>
<td>100</td>
<td>Curl up, cry. Deep breathing</td>
</tr>
<tr>
<td>Eating Indian food</td>
<td>95</td>
<td>100</td>
<td>Never!</td>
</tr>
<tr>
<td>Eating greasy food</td>
<td>90</td>
<td>100</td>
<td>Never!</td>
</tr>
<tr>
<td>Touching door knob/handle</td>
<td>85</td>
<td>90</td>
<td>Use elbow, or disinfect if can’t use elbow</td>
</tr>
<tr>
<td>Feeling bloated</td>
<td>80</td>
<td>60</td>
<td>Sit on toilet, breathe</td>
</tr>
<tr>
<td>Leaving the house to go out with fiancée</td>
<td>70</td>
<td>50</td>
<td>Don’t unless he really wants to go out</td>
</tr>
<tr>
<td>Queasy feeling in stomach</td>
<td>65</td>
<td>80</td>
<td>Sit on toilet, breathe</td>
</tr>
<tr>
<td>Touching elevator buttons</td>
<td>60</td>
<td>100</td>
<td>Take stairs, or use elbow to push button if too high to use stairs</td>
</tr>
<tr>
<td>Leaving the house when nothing going on</td>
<td>60</td>
<td>50</td>
<td>Avoid</td>
</tr>
<tr>
<td>Having friends over</td>
<td>50</td>
<td>50</td>
<td>Generally don’t</td>
</tr>
</tbody>
</table>
Creating an EE Plan

- Some are easier
  - E.g., heights, socializing, shopping centers, driving

- Some are more logistically difficult
  - E.g., flying

- Some may require simulation
  - E.g., simulating asking someone out on a date

- Some require creativity…
Emotional Engagements

- Fear of spiders 🕸️ (Specific Phobia – Animal Type)
  - EE plan?

- Getting up and dressed ⚠️ (Depression)
  - EE plan?

- Fear of public speaking 🔊 (Social Phobia)
  - EE plan?
Emotional Engagements

Now for some tough ones
Emotional Engagements

- Fear of racing heart/body sensations

- EE plan?
Interoceptive Exposure

**Interoception** (*n*)
Sensation of stimuli originating inside of the body

Interoceptive stimuli can often be misinterpreted and create fear/anxiety/distress
Interoceptive Engagements

- Racing heart
- Shortness of breath
- Difficulty concentrating
- Trembling/shaking
- Butterflies in the stomach
- Heart attack
- Suffocation
- Going “crazy”
- Multiple Sclerosis
- Public vomiting or diarrhea
Interoceptive Engagements

- Fear is of bodily sensations
  - How do we expose clients to the sensations?

- Barlow introduced a package of techniques to safely create bodily sensations

[handout]
Interoceptive Engagements

- straw breathing
- chair spinning
- hyperventilation
- head-rolling
- running on the spot/stair running
- head between legs
- holding breath
- tensing body
Interoceptive Engagements

- Get into groups of 3 or 4 -- your group will be assigned an interoceptive engagement to try

- One or more of your group does the exercise
  - And does it aggressively, to really get the experience

- Get SUDS ratings before, immediately after, and every 15 seconds thereafter

- Record symptoms and thoughts experienced
Imaginal Engagements

- For many people, their trigger is their own thoughts
  - Worries/What If Thoughts
  - Intrusive Thoughts, Images, or Impulses
  - Memories of Traumatic Events
Imaginal Engagements

Memories of a terrible event

“What if” thoughts

Engagement plan?
Imaginal Engagements

Need to create the thoughts/memories

Create an imaginal engagement script

But if the thoughts/memories are so terrible, why think about them?
For the next minute, think of anything you want, but DON’T think about the **PINK BEAR**
Imaginal Engagements

- Rules for making a good engagement script

1. Write in the present tense and first person
2. Write graphically and with vivid images
3. Include all senses
4. Take out any safety or softening words

- May require multiple drafts to get through tough parts
Conducting In-Session Engagements

- Decide/negotiate the engagement
- Set Behavioral Goals for the engagement
- Pre-exposure cognitive restructuring
- SUDS reminder
- Do the emotional engagement
- Debrief
  - Goals met?
  - Pattern of SUDS?
  - Expected vs. CR outcomes?
IN-SESSION EXPOSURE FORM

Describe the Exposure: (please be brief but provide the important details)

______________________________________________________________________________

List the major Automatic Thoughts you will probably have in this exposure:
1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________

Pick one Automatic Thought and identify evidence of overestimation or catastrophizing:

Use Disputing Questions to challenge the Automatic Thought:
Q: ____________________________________________________________
A: ____________________________________________________________
Q: ____________________________________________________________
A: ____________________________________________________________
Q: ____________________________________________________________
A: ____________________________________________________________
Q: ____________________________________________________________
A: ____________________________________________________________

Develop a Rational Response: (brief, positive, and summarizes Disputing Question answers)

______________________________________________________________________________

Behavioral Goal(s): ______________________________________________________________________

_______________________________________________________________________________________

SUDS 0-----------50-------------100

Time

None

Moderate

Extreme

------

Time 0 _________
Time 1 _________
Time 2 _________
Time 3 _________
Time 4 _________
Time 5 _________
Time 6 _________
Time 7 _________
Time 8 _________
Time 9 _________
End _________

Notes:
Continuing up the Hierarchy

- As exposure sessions progress:
  1. Increase difficulty based on hierarchy
  2. Decrease/eliminate rituals/protective behaviors
  3. Increase self-directedness
  4. Increase “real-world”
  5. Combine client engagements?
Homework Engagements

- Develop and assign (negotiate) self-directed homework engagements between sessions
  - Preferably extensions of engagements conducted in session
  - Frequency?
    - Usually based on the specific engagement
    - At least 2-3 times during week
HOMEWORK EXPOSURE FORM

Describe the Exposure: (please be brief but provide the important details)

______________________________________________________________________________
______________________________________________________________________________

List the major Automatic Thoughts you will probably have in this exposure:
1.____________________________________________________________________________
2. ____________________________________________________________________________
3. ____________________________________________________________________________

Pick one Automatic Thought and identify evidence of overestimation or catastrophizing:

Use Disputing Questions to challenge the Automatic Thought:
Q: ______________________________________
A: ______________________________________
Q: ______________________________________
A: ______________________________________
Q: ______________________________________
A: ______________________________________
Q: ______________________________________
A: ______________________________________

Develop a Rational Response: (brief, positive, and summarizes Disputing Question answers)

______________________________________________________________________________
Problems and Troubleshooting

- Clients modifying, disengaging, or withdrawing from engagements
- Therapists own fears/beliefs about engagements
Session 10: Getting Back to Thoughts

Session Outline

- Review Homework
- Cognitive Restructuring in Everyday Life
  - Neurotic Style and Automatic Thoughts
  - General Thinking Errors
  - Disputing the Neurotic Style
- In-Session Exercise
- Homework
- End of Session 10 and Preview of Next Session
Schema-Based Cog. Restructuring

- Many (most?) individuals with an Emotional Disorder show broader tendency toward
  - Negative Affectivity
  - Neuroticism/Neurotic Style
  - Anxious/Depressive personality

- Goal of Sessions 10/11 is to broaden CR skills to general neurotic style
  - Buffer against relapse?
The goal of this phase of treatment is to begin to raise awareness in the clients of the general tendencies toward negative emotional states, and to develop skills to try and reduce their tendency to react more negatively to general stressors.

Goal is not to alter established personality characteristics, but to help clients develop skills to soften their emotional experiences in an effort to reduce future lapses.
1. Identify when you are reacting more negatively to a situation or event than is warranted

2. Identify the Automatic Thoughts you were thinking

3. Challenging the thoughts using Disputing Questions

4. Developing a new rational interpretation of the situation or even that is more grounded
**FORM 10.1. DAILY SELF MONITORING FORM (WITH TRIGGER IDENTIFICATION)**

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Strong</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Avg. Anxiety (0 to 100)</th>
<th>Avg. Depression (0 to 100)</th>
<th>Distress Triggers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Describe the trigger that lowered your mood</td>
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</tbody>
</table>
## FORM 11.1: NICHOLAS’ DAILY SELF MONITORING FORM (WITH TRIGGER IDENTIFICATION)

<table>
<thead>
<tr>
<th>None</th>
<th>0</th>
<th>Mild</th>
<th>10</th>
<th>Moderate</th>
<th>20</th>
<th>Strong</th>
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</thead>
<tbody>
<tr>
<td>9/23</td>
<td></td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>9/24</td>
<td></td>
<td>70</td>
<td>Dr. Jones returned my project. ATs: I’m useless. I’ll never amount to anything</td>
</tr>
<tr>
<td>9/25</td>
<td></td>
<td>70</td>
<td>Still upset about project. ATs: I’ll never become a doctor. My life is ruined.</td>
</tr>
<tr>
<td>9/26</td>
<td></td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>9/27</td>
<td></td>
<td>40</td>
<td>Mary (my girlfriend)</td>
</tr>
<tr>
<td>9/28</td>
<td></td>
<td>60</td>
<td>Mary (still). ATs:</td>
</tr>
<tr>
<td>9/29</td>
<td></td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Problems and Troubleshooting

- Difficulty differentiating Automatic Thoughts of fears from Automatic Thoughts based on their general neurotic style

- Rigidly held beliefs
Session 11: Softening Neurotic Style

Session Outline
- Review Homework
- Observation and Self-Reflection
- Anticipation and Preparation Homework
- End of Session 11 and Preview of Next Session
The goal of the advanced cognitive restructuring in the Session 11 is to help the clients generalize the advanced cognitive restructuring from the specific situation to the more broadly underlying beliefs that are driving the specific Automatic Thoughts.
Identifying Core themes

- Based on Homework, identify common general themes to the Negative Affect states

- Usually will tie into beliefs underlying specific automatic thoughts
# FORM 11.1: NICHOLAS’ DAILY SELF MONITORING FORM (WITH TRIGGER IDENTIFICATION)

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</tr>
</tbody>
</table>
Schema-Based Cog. Restructuring

- Similar to previous Cognitive Restructuring, but focus on broader beliefs, e.g.:

  - “I must be perfect or else I’m a failure”
  - “I am a bad person”
  - “I have bad luck/bad things always happen to me”
  - “The world is a dangerous place”
Schema-Based Cog. Restructuring

- Use Disputing Questions to begin challenging Core Themes
  - Develop preparatory “Rational Response” for use in similar Core Theme situations

- Use as tool to help soften schemas
  - Unlikely to immediately alter personality
Problems and Troubleshooting

- Resistance to softening beliefs that the client values
- External attributional style
Session 12: Relapse Prevention and Moving Forward

Session Outline

- Preparation for the Final Session
- Review of Homework
- Maintaining Gains and Continuing Progress
- Dealing with Stressors, Lapses, and Bad Experiences
- Concluding the Treatment
- Scheduling Post-Treatment Assessments (Optional)
Termination/Relapse Prevention

- Recognition of gains made
- Post-treatment self-care plans
- Differentiating *Lapses* versus *Relapses*
- Emergency plans for lapses and relapses
Recognition of gains made

- Review Self-Monitoring Graphs
- Review Trigger/Response Hierarchies
- Review behaviors or situations that each client is now capable of doing
- Other changes since beginning treatment?
1) Approach Emotions

Treat every episode as an opportunity to gain more control by doing your own Engagement exercise. Your goal should be zero avoidance behaviours.

I will not _____________________________ anymore.

2) Practice

Regularly practice and use your Cognitive Restructuring skills with your negative emotions and distress, your negative reactions to daily events and situations, and the core themes you identify.

Practice not only make perfect, but practice makes habit.

3) Reward Yourself

You have worked very hard and made some difficult changes in your lives. You deserve a reward or celebration. Find an enjoyable and memorable way to give yourself the pat on the back you deserve.
I have control over my emotions

If I feel myself having a lapse, I will do the following:

1: Practice Cognitive Restructuring
   - Identify the Automatic Thoughts involved in the lapse
   - Identify Thinking Errors in the Automatic Thoughts
   - Ask and answer Disputing Questions to challenge the thought
   - Develop a Rational Response

2: Begin doing my own Emotional Engagements to intentionally confront the lapse
   - Identify the trigger that started the lapse
   - Develop a hierarchy of how to gradually confront the trigger
   - Identify any coping behaviors you are using, and stop
   - Practice exposures until your distress no longer goes over 40
SIGNS I SHOULD CONSIDER CALLING THE CLINIC FOR A BOOSTER SESSION

Every once in a while, something may happen where you might want or need some help to overcome a lapse and get back on track. We want to be there to help. If you experience any of the warning signs below and cannot regain control yourself using the Cognitive Restructuring and Emotional Engagement, call ____________ or ____________ at _____________.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Problems and Troubleshooting

- apprehension about the conclusion of the therapy group
  - maintain their treatment gains
  - loss of the group as a support system
Where do we need to go from here?

- Replicate equivalent outcomes in comparison to diagnosis-specific CBT (with larger samples)
- Further evaluation of efficacy among OCD, PTSD, and phobias
- Effectiveness trials (ongoing in Quebec)
- Integrating Motivational Interviewing (Monash)
- Telehealth delivery (Meidlinger)
Transdiagnostic CBT for Emotional Disorders

Peter J. Norton, Ph.D.

MONASH University