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Continuing Education Information

Understanding Complex Anxiety Disorder

with C. Alec Pollard, PhD

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CENTER FOR PREVENTION, OUTREACH, AND PROFESSIONAL EDUCATION

Summary

Due to the home and community-based location of their work, community support staff and other in-home care providers have unique challenges in maintaining appropriate clinical boundaries with their clients. In this session participants will explore numerous potential pitfalls that can ensnare well-meaning professionals. The Code of Ethics for Psychiatric Rehabilitation Practitioners will be used to demonstrate how an ethics code can be beneficial in guiding practice.

Transcript

more effectively; reduce their stress, and then maybe, eventually, strategically do some things that would increase the likelihood that the identified patient will go get help.
So we started experimenting with that; we've been doing some research on it; we're getting some results now, and it looks like we can have some effect on it for those families. So that's a very promising intervention, and I would encourage clinicians to keep that in mind—that, both for individuals who are sort of ambivalent enough to come to the clinic but not avoid you all together, and for families who are terribly stressed by a treatment refuser, a treatment avoider, that there may be things that we can do for these people that, in the past we just said, "Go home; we can't do anything." So I'm really encouraging my fellow clinicians to be thinking actively about these people—how can we help them, rather than just tell them to come back when you're ready.

TP: Well, thank you, Dr. Pollard. It's been a wealth of information today. And thank you for taking the time to join us. If you're watching this program online, and you'd like to receive Continuing Education credit for it, click on the post-test button on this page, complete the post-test and the CEU application, and submit those for credit. If you're watching off line, on a DVD, the materials for your post-test and your CEU application should have been included with your DVD. At any time, you may drop us a line at feedback@MIMHTraining.com, if you have suggestions on speakers or topics for this format or any other program formats that we use. We're always looking for your ideas and suggestions. It's feedback@MIMHTraining.com. Thank you for joining us. And thank you, Dr. Pollard.

AP: Thank you.

Transcript

motivational enhancement work with. But now those procedures are being tried with other disorders—Depression, Anxiety Disorders—with some success. At our clinic, we've been working on something called Readiness Therapy, which incorporates Motivational Interviewing, but we add a few other tricks to the bag, because we feel that not all treatment resistance or ambivalence has to do with motivational issues. Much of it does. But sometimes people have skill deficits or misinformation that needs to be addressed in order to really be able to fully participate. So we kinda think of it as sort of an integrative, Cognitive Behavioral approach to helping people prepare for treatment, and we've been studying that as a way to help reduce resistance and help people participate in treatment more effectively.

TP: But we still have the issue of getting people to the clinic; getting people there. I mean, how do you help get people—how do you work with the families—how do you get them into the treatment to begin with?

AP: Well that's an excellent point. Because, I suppose, if you're truly resistant to treatment, you're not gonna be at the clinic. You're gonna be at home, or somewhere else, but you're certainly not gonna be in my office. And, again, a similar story, for years people—I would get a husband or a wife or a father or a mother of a patient who would say, "My brother, John, has this terrible OCD, but he doesn't think it's a problem; he won't get help. He's driving the rest of us nuts. Plus, we're concerned about him. Let me bring him over to you, and could you just talk him into doing treatment?" And there was a time when I was naïve enough to actually do that; I'd try to talk him into it. But, even I'm capable of learning; that doesn't work. So, we just sort of tell them well, kind of what we would tell our non-ready individuals, we'd tell the families, "Well, there's nothing we can do; he doesn't want treatment, so don't come back until he's ready."
Once again, not feeling that was very satisfactory, so we started to think about, maybe we can help the families, because they seem to be motivated. You know, there's this key thing about motivation—you know the old joke about how many psychologists does it take to change a lightbulb? And the answer is "one," but the lightbulb has to want to change. And that is kind of true. But if the family is motivated, we can help them deal with this situation

Presenter

Dr. C. Alec Pollard is the Director of the Anxiety Disorders Center at the St. Louis Behavioral Medicine Institute, and Professor of Community and Family Medicine at Saint Louis University. He is the Chair of the Clinical Advisory Board of the Anxiety Disorders Association of America, a member of the Scientific Advisory Board of the Obsessive-Compulsive Foundation, and a consultant for the National Insitute of Mental Health Anxiety Disorders Education Project. He serves on the editiorial board or as a reviewer for numerous journals, and has organized national training programs for both the ADAA and the OCF. Dr. Pollard has authored at least 85 professional and scientific publications pertaining to Anxiety Disorders and related topics, including two books, Dying of Embarassment: Help for Social Anxiety and Phobia, and The Agoraphobia Workbook. His primary research interest is the nature and treatment of refractory anxiety disorders.

Contact Hour

The University of Missouri– Columbia Missouri Institute of Mental Health (MIMH) will be responsible for this program and maintain a record of your continuing education credits earned. The Missouri Institute of Mental Health will award 1 clock hour or 1.2 contact hour (.1 CEU) for this activity. The MIMH credit will fulfill Clinical Social Work and Psychologist licensure requirements in the State of Missouri. If your profession is not listed or if you are from outside of Missouri, check with your Board prior to completing this program to ensure you are seeking the proper Accreditation.

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Transcript

important area, and, there are advances in that area as well that are happening with the psychosocial area. Today, my emphasis is on psychosocial interventions, but I don't want to imply that interesting things aren't happening in the biological area—people are looking at deep brain stimulation, different types of neurosurgery, and a technique called TMS, or Trans-containial Magnetic Stimulation. These treatments—while we don't have time to go into what they are exactly, they sound so exotic—but they're all ways of trying to get at the brain, and modify the functioning of the brain and the structure of the brain in a way that would support recovery from an Anxiety Disorder. They've also been looked at with Depression as well. I think a sweeping statement would be at this point that these are experimental procedures, as are some of the psychosocial treatments.

But we're not just looking at innovations in biological treatments, we're also looking at psychosocial treatments in our field. We're looking at how can we help more people who do not respond today to treatment. We know that most people will get better if they have and Anxiety Disorder, but many do not. Now some don't get better because they're never given proper treatment or they have no access to it; that's a major—that's more of a societal, healthcare, system issue, which is overwhelming at times to think of how to solve. But there are patients who have access to treatment, and they either refuse it, or they accept it, but they don't participate fully in treatment, because of treatment ambivalence, and/or what's called resistance. Those are people that many new interventions are trying to address—their needs. Because, you know, for years we would just tell people, "Well, if you're not ready for treatment, if you're not ready to go, go home and come back when you are." And that's not really a very satisfactory response. Are there ways that we can help people who have some ambivalence about treatment—help them resolve that and be able to take advantage of the effective treatments that are available to them, so they can participate fully in the treatment?

And so, there are a number of interventions being tried. One very famous one now is Motivational Interviewing, where the focus is really on helping people clarify their motivation for change prior to doing the more active part of the treatment. No shock that these procedures were first tried with substance abuse patients because more than a few of them have at least some ambivalence about recovery and treatment, and so they're a good population

Transcript

learning, and have no direct effect on symptoms, but on the psychological process that is involved in recovery. And, so there's some really interesting, pioneering research—one example is dcycloserine--looking at this, which is actually an immunosuppressant, but turns out that it modulates learning through modulation of NMDA, which is a neurotransmitter, and that seems to be involved in the learning of safety and the un-learning of fear. So, in animal research, you give a rat dcycloserine, and you expose that rat to something that he's afraid of, and he learns safety twice as fast as the rat who is given the placebo. So, could this double the rapidity at which people recover? We don't know yet, but it's a very exciting area of research, and studies are now being done with human beings looking at how this might affect Social Anxiety, how this might affect Panic Disorder and OCD, and fear of heights was the very first study that came out with human beings—and the early research suggests that there may be some promise, at least with some of the phobias. It's a little questionable about OCD at this point.
So that's a very exciting idea; that's a whole new category of medicine—drugs that would facilitate psychotherapy—very new and exciting area.
We'll see what happens; the jury is way out on these, so we have some more research to do.

TP: Sounds interesting, though. One of the other topic areas that's frequently discussed are the treatment-resistant people—

AP: Oh, yes.

TP: --not sure you've had any experience with that in your years on the job, but you've said that other people have had that, so you've heard about it.

AP: That's right. I've heard about treatment resistance, but my—personally have never had a patient who resisted treatment at all. But, because I'm concerned about my colleagues in other places, I certainly want to help them out.
Well, okay, before my nose grows too long, I will admit that, yes, we have dealth with this issue of treatment ambivalence and resistance. It's a really

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Glossary

Acceptance and Commitment Therapy—intervention using acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility

Anxiety Disorders—Group of disorders affecting about 40 million adults per year characterized by excessive, irrational fear and dread.

Body Dysmorphic Disorder—associated with Obsessive-Compulsive Disorder, characterized by a preoccupation with a very slight physical anomaly or imagined defect in appearance

Cognitive Behavioral Therapy—a group of psychotherapies that emphasize the role of thinking in feelings and actions; examples include Dialectic Behavioral Therapy, Rational Emotive Behavior Therapy, Cognitive Therapy and Rational Behavior Therapy

Hypochondriasis—a type of somatoform disorder in which a person has symptoms of a medical illness which cannot be fully explained by an actual physical disorder

Mindfulness Therapy—therapy emphasizing the process of paying attention to thoughts and feelings moment by moment and without judgment, in an effort to change the patient's relationship to the suffering rather than alleviate it

Motivational Interviewing—a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence

Obsessive-Compulsive Disorder—characterized by persistent upsetting thoughts (obsessions) and the use of rituals (compulsions) to control the anxiety produced by the thoughts

Panic Disorder—characterized by sudden attacks of terror, usually accompanied by a pounding heart, sweatiness, weakness, faintness or dizziness; accompanied by a fear of these or other unexplained physical symptoms

Social Phobia—characterized by becoming overwhelmingly anxious and excessively self-conscious in everyday social situations

Transcript

exept Panic Disorder. So, it makes sense, if you look at what people are afraid of with Panic—they're afraid of their own bodies—and they're more likely to see the medicine as affecting their heart rate and all these other things, as opposed to somebody who's afraid of contamination or a bridge, they may or may not see—their fear is outside in the world, and so they don't see the medicine as really controlling their destiny at the heart of where the fear is, as Panic patients do. So, my suspicion is it has to do with the nature of Panic, and it's limited to Panic Disorder.

TP: Take a look into your crystal ball, and look down the field of research and drugs and psychotherapy. Is there anything showing promise in the research now?

AP: There is. There's—first of all, there's a lot of research looking at different types of medication, new medications that will target—at least new in terms of Anxiety—target other neurotransmitters, like glutamate, instead of just always being serotonin or norepanephrin. Then there are new ways of administering medication, you know, will we someday be inhaling our Xanax rather than taking it by a pill? Then there are other fundamentally different medicines that may be looking at either regenerating neruons—these are way off into the future in experiments—or looking at intra-cellular communication—most medicines that are out now for Anxiety Disorders take two—are trying to facilitate communication between two nerve cells—intra-cellular medication would be looking at facilitating the communication within the nerve cell. Maybe those different classes of drugs will give us new treatments, more effective treatments, or ones with less side effects; we don't know.
For me, though, the more exciting research is—there's a few studies coming out now looking at medications that might actually facilitate the process of psychotherapy; that might actually make—we call them "Psychotherapy Boosters"—they would actually facilitate, for example, learning. In this case, we're talking about the un-learning of fear, or the learning of safety. Are there drugs that could actually help our patients—drugs that aren't symptom based—in other words, I take a drug to reduce my symptoms—these are drugs that are specifically aimed at the process

Transcript

because they're severly depressed along with their anxiety, or because they're too anxious to be able to engage in the CBT—without medicine.

TP: Let's turn that around a little bit—excuse me—if we—are there times that you shouldn't add medicine to the CBT?

AP: Well, there's a few clinical situations where, certainly, people are philosophically against medicine—you don't want to get into a power struggle and say, "No, you need to take it." That's probably not gonna be fruitful. You let them come to that themselves over time if they need medicine. But there is one diagnosis, for which the data are a little controversial about that. You know, what I've said is, generally, it doesn't seem to add a whole lot if both—if the person is willing to do both treatments. You might not need the medicine if it's not too severe. Obviously, the more severe the case, the more you're gonna look at adding both treatments together. But Panic Disorder is a unique situation where there actually are some studies that suggest that adding drugs to CBT for Panic Disorder might actually retard the long-term effects of CBT. So, most of the time we're talking about, "Oh, it's not gonna hurt, but maybe it won't help as much." But, in this case, there actually are some data—and that's been replicated with different types of medications, like benzodiazapenes and antidepressants—where, if you compare CBT plus placebo to CBT plus medicine, and you go long term, the CB—when you take the medicine away or the placebo away—those who had medicine do worse than those who had the placebo plus CBT. You have a higher relapse rate. So, it's not just the placebo effect; there's something happening there that is interfering—and there's theories about why that might be—Attribution Theory, maybe patients are making all the attribution to the medicine and not to their own work and what they've accomplished—there's State-Dependent Learning, that suggests that what you learn under one state won't transfer to another state, so, now, "In the state of medicine, what I learned there won't transfer to the—" So, there are these interesting theories. But this phenomenon does not seem to happen in any other Anxiety Disorder

Transcript

Thom Pancella: Hello, and welcome to this MIMHTraining.com presentation on Complex Anxiety Disorders. I'm Thom Pancella, with the Missouri Institute of Mental Health. With me is Dr. Alec Pollard. Dr. Pollard is the Director of the Anxiety Disorders Center at the St. Louis Behavioral Medicine Institute, and Professor of Community and Family Medicine at Saint Louis University. He is the Chair of the Clinical Advisory Board of the Anxiety Disorders Association of America, a member of the Scientific Advisory Board of the Obsessive-Compulsive Foundation, and a consultant for the National Insitute of Mental Health Anxiety Disorders Education Project. He serves on the editiorial board or as a reviewer for numerous journals, and has organized national training programs for both the ADAA and the OCF. Dr. Pollard has authored at least 85 professional and scientific publications pertaining to Anxiety Disorders and related topics, including two books, Dying of Embarassment: Help for Social Anxiety and Phobia, and The Agoraphobia Workbook. His primary research interest is the nature and treatment of refractory anxiety disorders. And, on a personal note, I've had the privilege of escorting Dr. Pollard around Missouri as he educates Missouri's mental health and social service professionals on Anxiety Disorders and Obsessive-Compulsive Disorders. Dr. Pollard, thanks for joining us today.

Alec Pollard: Thank you. It's a pleasure to be here.

TP: Well, let's start with the handbook. We've been working with the DSM-IV-TR for a little while now. I assume there's going to be a DSM-V. How long do you think it's gonna be until that gets published?

AP: Well, there is going to be a DSM-V, but therapists do not have to panic yet. It's not going to be out until 2011 at the earliest; probably later than that.

TP: Can we expect any changes in how Anxiety Disorders will be classified?

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AP: I think that there's a good chance that there'll be quite a few changes. Now, the question is, which ones will end up actually getting into the book? The Anxiety Disorders are actually filled with controversy right now. There's a lot of debates going on about how best to classify the different Anxiety Disorders. But, a few examples of some of the things people are considering or debating right now—one is Generalized Anxiety Disorder. Would that be a better fit in the Mood Disorders, since GAD tends to co-occur with Mood Disorders quite often? There are other reasons why it might be a better fit there, but then there are many people who feel like it's still fundamentally an Anxiety Disorder and should not be removed. So, there's a bit of debate going on there.

The other issue is Obsessive-Compulsive Disorder. Some people would like to take that out of the Anxiety Disorders, because of some differences in OCD between—and other Anxiety Disorders—and one proposal would be to just have a separate section on OCD. Another one would be to expand that section to a more inclusive category called OCD Spectrum Disorders, which would include disorders that are sort of like OCD—certainly Hypochondriasis and Body Dysmorphic Disorder—but, some more expansive proposals would include a whole variety of other disorders that include sort of repetitive behaviors. That's extremely controversial and you have people on all sides of that. So, it's hard to know how that's gonna shake out.

Now, if you take out OCD and GAD, you might say, "Well, what's left in the Anxiety Disorders?" Well, some people have proposed a title for what's left, along the lines of Fear Circuitry Disorders, Fear Circuitry and Stress or Trauma Disorders, and these would include PTSD, Panic Disorder, all the phobias and Social Anxiety, with the idea that a lot of what's happening in the brain with these disorders are in a certain area that they share, and there's a Fear Circuitry that unites them. And, so, that's really the thinking of putting them together.

So those are some of the really significant changes that could occur. There are other smaller things—certain disorders that might be added—Separation Anxiety in Adulthood is one thing that people are looking at

Transcript

treatments. People have lower relapse rates, and they maintain their gains in higher numbers than those with drugs, especially if the drugs are withdrawn. So you always have that issue with medication.

So, if we were to say, CBT versus medication—in the short run, probably equivalent, in the long run, CBT generally is superior.

Now, what if you put them together? And you'd hope that if you take two effective treatments, and one has forty Megawidgets of power, and another one has forty Megawidgets of power, and you put them together then you've got eighty Megawidgets of power—you'd like to think. Well, it doesn't happen—unfortunately. We had hoped that somehow there would be some complementarity of these treatments that would give us this sort of super-treatment. In general, in Anxiety Disorders, that hasn't been the case.

That has been the case in Depression. You actually get, in Depression, more—and even Bipolar Disorder—you get more, when you add, say CBT for example, to Bipolar medication, you get a real additive effect in terms of long-term outcome especially. Those patients do better. Which is sad because you don't—people with Bipolar usually don't get CBT. And that's true to a lesser extent for Depression. But if you take Anxiety Disorders, you generally—the combined group—if they're compared to CBT versus medicine—the way it usually goes is, the group that got both treatments and the group that got CBT are doing the best, medication alone is doing not quite as well, but still better than placebo.

So you could say—if you just look at that naively—you could say, "Well, why even have medicine for Anxeity Disorders, if the CBT-alone group does just as well?" Well, these are in studies where everybody in the study is open to taking either drug and having it randomly assigned; they don't represent the general population of anxious people. So, in fact, if you look at the real world, we know that many patients won't do CBT without medicine—maybe don't even have access to CBT—so that in now way does this imply that there's not an important role for medicine in the treatment of Anxiety Disorders. There is. But, if a person can do CBT without the medicine, they should do reasonably well without the extra complications of medicine. But medicine, for many many patients, serves an important role because many people—either

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completely relaxed—to sort of, okay, anxiety's not bad, but we need to kinda manage it, to not only is anxiety not bad, we need to learn to live with it; it's part of life. So it's a rather dramatic shift over the last forty years.

TP: Sounds like it. All right; well, there's also medications. So, we've been talking about Cognitive Behavioral Therapy, and we know now that certain drugs and psychotherapies are known to be effective treatments. Have we learned enough about the individual and the combined effects of the two treatment types? Do we think that one's better than the other? Or is using two better than one alone? How is that shaking out now?

AP: Well, good question. And, these are questions we don't have all the answers to, but we have more answers than we certainly did ten or fifteen years ago, because there have been quite a few studies, and some consistent trends in some of the findings.
So if we were to—and I will apologize for over-simplifying a complicated field, so I'm gonna give that qualification—but in general I think we can say that after about three or four months of treatment, for the most part if you compare evidence-based drug treatments with evidence-based psychotherapies—for the most part here we're talking about Cognitive Behavioral Therapies—and for the drug treatments, for the most part at this day and age we're talking about SSRI's, although prior to that we were talking about benzodiazipenes and tricyclics, MAO inhibitors—but, in general, when you compare drugs versus CBT, after about three months both groups are about the same, in terms of they both are more improved than placebo, and so they both demonstrated an effect beyond placebo. But if you compare them to each other, in general, they're fairly equivalent after about three months. There's a little difference depending on which disorder we're talking about. But by and large—like OCD for example, probably even after three months CBT is superior to drug treatment alone.
But, not as superior as when we look in the long run. So, if you go a year—six months to a year, two years after initial treatment—there's where you see the differences. CBT is consistently superior to drug

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as a possibility. Behavioral Inhibition Disorder in Childhood would be another. So there are some other new disorders that might get in there. But I think the bigger change are these sort of larger organizational changes of categories of classification—tremendous controversy that, perhaps, will be answered over the next few years. There is a whole series of research projects and research questions that need to be answered. And, the goal is to make this as much empirical as possible in deciding how to categorize mental illness most appropriately and most usefully.
So, we'll see what happens. It's gonna be several years away; we're a lot of research away from getting the answers. But, almost certainly, some changes are in the offing.

TP: Now, in some of your seminars, in some of your presentations, you've said that "we're entering a new age of model-driven interventions" as opposed to the diagnosis-driven interventions. Could you explain what you mean by that?

AP: Yes, and a little historical background might be helpful to understand this. If we go back in time to when DSM-II was around—in the olden days--I didn't know about personally, but my grandfather told me about it—most of the therapies that were done were based on models. They had theoretical models, and from that you developed your interventions. They weren't based on protocols or manuals, because it was in the day when we didn't have clear protocols and manuals that had been tested in controlled outcome studies. Eventually, certain types of treatments were put into a protocol or manual form so that they could be replicated in studies and tested to see if they are effective. And clinicians were then to follow the protocols and the manuals. Even though the manuals and the protocols that were developed were not universally accepted by therapists, they had a great influence on therapists, and some therapists did practice out of these protocols and manuals. And they created evidence-based treatments that allowed psychosocial treatments to get more respect in the healthcare field and from insurance companies, who could not ignore the data. Without those data, we might not have

Transcript

reimbursment for psychosocial treatments for a lot of conditions.
So that was a very important phase, and I refer to that as the "diagnosis-driven" phase, because these protocols were directly related to a particular diagnosis—so, Panic Disorder treatments were made strictly for Panic Disorder, and treatments were made for Social Phobia, and then there was a manual you followed to treat Social Phobia. So all of those were what we would call the sort of "diagnosis-driven" era, and we're sort of still in that. But, we're starting to see a movement towards—back towards "model-driven" interventions. And the reason is that the protocols don't answer all the questions; they don't tell you how to deal with somebody who comes in with Panic Disorder but also has some Impulse Control Disorder that makes them do dangerous things. Or, that they have some other sort of personality issue that you can't manage—the realities of clinical practice don't always get addressed by these protocols and manuals, and clinicians are quick to—rightfully—point out those limitations.
So, people are looking for more. But the other reason is, if you had to memorize or work or become familiar with a protocol for each Anxiety Disorder—if you just take the Big Five, that's five different protocols. And, if you work with kids, now you've got ten different protocols, 'cause the kid protocol's gonna be different than the adults'. So the pragmatics of really having to become familiar with all of these different manuals is not practical. So now we're talking about developing models—actually the models these protocols were originally developed on—but models that will allow clinicians to design interventions for a variety of conditions without having to become familiar with a particular protocol.
So were going, in some ways, backwards, but not really—so some people could say, "Well, we used to do this." But, actually, we're doing it now, but we're doing it based on models that are better substantiated, and are based on evidence-based protocols.
So, hopefully, it's a newer, better version of designing interventions based on a theory and a model. So now, when a patient comes into our clinic, instead of pulling out a manual, we use these models—mostly cognitive behavioral models at this point for Anxiety Disorders—to

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Now we're moving into an age where we're actually seeing that some of these coping strategies that we've been teaching patients may actually do harm in this way: That there are certain anxiety syndromes where you actually need to let the anxiety come out, so you can see what happens. So, for example, panic patients are so afraid of their physiological responses, that they try control it, and the therapy actually encourages them to let themselves feel those feelings, and to not be afraid of it.
There's also new therapies—Mindfulness Therapies—that many people have heard of—and Acceptance and Commitment Therapy—these are therapies that have at the heart of them the acceptance of feelings rather than the control of feelings. And, rather than trying to control things, that you let them happen, and you accept them. So it was antithetical to these new approaches to actually try to teach people how to control anxiety, because they want you just to learn to let it go. And let it come; let it pass. Because some people, paradoxically, the more they try to control it, the more they make it worse.
So there's a lot of—a lot of these ideas make a lot of sense, and ring true with those of us who have been in the field. At the same time, more traditional cognitive behavioral therapists are coming to more of the same conclusions—that some of these things we do, like teach deep breathing for panic disorder, are actually counter to what we are trying to accomplish. We want them to learn that they can have a panic attack and not die, and not go crazy. So if we give them techniques to try and prevent a panic attack, we're giving them the message that, "You need to control it, or you'll die or go crazy." So we're actually being inconsistent in the messages we give our patients.
So now, most of the experts are leaning towards not using a lot of excessive coping strategies, and when people are out exposing themselves to the things they're afraid of, and, when you do, to be very careful and vigilant that you're tracking that, so you're making sure that the patient isn't using it as a way to avoid dealing with what they need to deal with.
So yeah, actually, even though exposure has been the constant over these forty years, you've seen this gradual shift from relaxation—you must be

Transcript

that was incompatible with anxiety—it's called reciprocal inhibition—that you're inhibiting the anxiety response, putting the person in a different state. Most often we're talking about relaxation. But actually there are other states that Wolpe experimented with that were incompatible with anxiety—in animals, eating is incompatible with anxiety; now, it doesn't work as well with humans, so that never took on with human beings. But anger is also incompatible with anxiety. Anger inhibits anxiety, so you can't be angry and anxious at the same time. You can switch back and forth, but anger will predominate. So he experimented with inducing anger in the presence of things you were afraid of as a way to inhibit anxiety and make that connection go away. But most of the time he was talking about relaxation, so he would try to relax people, and then gradually expose them to the things they're afraid of—and try to keep them in a relaxed state. Now you can imagine how that might take a while—as soon as they got anxious, he would stop and slow down and try to get them more relaxed again. It was a very arduous process. It worked; but it took quite a while.

Then the British—largely the British—started doing what's called, just in vivo exposure, where they would just take people and expose them to situations, and they didn't worry about keeping them relaxed. They just exposed them, and if they stayed in front of the thing they're afraid of long enough they eventually started to get better, and there was no relaxation being taught or anything, they just went out and did it. Now it takes a while, because they have to stay around the stimulus long enough to habituate, but eventually the response would extinguish.

Later, they said, "Well, okay, let's—we don't want them to be terribly uncomfortable, so we're gonna teach them coping strategies." So you had this concept of Anxiety Management. So now, "Yes, we're gonna send you out there, but we're gonna give you some skills to try to keep the anxiety down; manage your anxiety; teach you techniques. Maybe you're not gonna be completely relaxed, but we'll give you some deep breathing, some other things you can do out in the real world when you're exposing yourself—and to try to manage the anxiety. So, anxiety—so relaxation is not necessary, but we'd like to take the edge off the anxiety for you."

Transcript

design an individually-tailored treatment plan for that particular person. And, some of the prinicples for treating Panic Disorder versus Social Anxiety versus OCD are actually similar, and the model can incorporate these different disorders and provide a heuristic for our treatment design.

TP: Moving to the category of Fear Extinction, what do you think is the single most important element of fear extinction?

AP: Well, if you look at scads and scads of research, there's one thing that jumps out at you—and probably not going to be a shock to clinicians—is exposure is the single most important element; that it is very difficult to overcome a fear of something that is irrational without involving exposure to that stimulus.

Now, once you get past that, you certainly have many other questions left to answer. But that is a very significant observation--even though it's simple—that exposure to what you are afraid of is significant and essential to recovery. Because, what that means is, any therapies that are being conducted with Anxiety Disorders that do not involve exposure, are unlikely to be effective. And, indeed, the research supports that. And all of the therapies that are effective—even though they are called different things and may look dissimilar are actually inolving exposure. If you take PTSD for example—you have Cognitive Processing Therapy, you have Prolonged Exposure, and you have Eye Movement Desensitization and Reprocessing—these are three evidence-based treatments for PTSD—they've all been found to be superior to placebo. However, there's one element that they all have in common, in that in some way they expose the person to the memories of the trauma. And that's the one essential thing and consistent element that they share. So exposure is absolutely critical, and clinicians need to make sure that they're incorporating exposure into their therapy.

TP: You're implying that a lot of what we know about exposure and about fear extinction comes from basic research. So, if we get back to Anxiety Disorders, are there lessons to be learned from the laboratory that may have direct implications on clinical practice?

Transcript

AP: There are, and I know this is hard for a lot of clinicians to believe, ‘cause most clinicians see basic research as kind of not relevant to their daily practice. But Anxiety Disorders is one area where basic research really does have implications for what we do—it can inform our practice. And it’s hard to keep track of that, so those of us in the field need to translate that to the clinicians and keep them updated on some of the information.

But just a couple of things that we’ve learned that really, at the very least, help us understand what happens with our patients and, perhaps gives us ideas for how best to treat them: In the old days, we used to think that—there I go back to the olden days again; I swore I’d never say that when I was younger—but, sadly, it was the olden days—we used to think that when a person got better from a phobia, that they got better because the association between the thing they were afraid of and the perception of danger, that the danger-stimulus association somehow weakened through repeated exposure. So, if I go over the bridge—and I have a bridge phobia—and I go over that bridge over and over again, eventually my brain will see nothing happens, it’s not dangerous, and I’ll not associate bridge with danger; that will start to weaken. And that’s how we used to think that change ocurred. But basic research, because of the things you can do with animals that you can’t do with humans, has taught us—we can record activity in the areas of the brain that involve fear responding; we can manipulate things easier so we can isolate elements of recovery that we need to be able to study.

So, in this basic research, we’ve learned that what happens in recovery is that the danger association never goes away—or doesn’t go away for a long time—even in people who are getting better. What happens is a new association of safety gets formed in the brain, so that phobia—excuse me, bridge and safety association gets learned, and that competes with the danger-bridge association, and overrides it when it gets strong enough, and suppresses that danger association and allows the person to not be afraid when they go over the bridge.

Now, that learning from the lab also has some implications for understanding relapse, because before we didn’t understand, well, if the

Transcript

danger association was going away, why are they relapsing? Well, now this kinda makes sense, because if you don’t keep that safety association strong—if it starts to weaken—then the danger association which is still there predominates. And so you can imagine that, perhaps under times of stress—which is often when people relapse—or when they have some other learning experience that reignites the fear, that maybe that safety association is being weakened, and then the danger association—which has been there all the time—predominates and now they have relapse.

So those are important things from the lab that we’ve learned, and have direct implications for how we think about our patients, and perhaps how we even help them.

TP: Of course, now you throw back to the “olden days,” and desensitization, exposures, those have been around for forty years—is there something different about therapy for Anxiety Disorders now—I mean, has it changed much from its original form?

AP: It actually has. Although, the one thing that is constant is the thing we were talking about earlier, that exposure still remains the most essential element. But, once you get past that understanding, it begs the question, “Okay, how do we maximize the effects of exposure? How do we facilitate it? What conditions best facilitate recovery, maybe make the exposure go quicker, or with less complications or with less distress? What’s the best way to implement exposure?” Those are legitimate questions open, still, for discussion. Although, even there, we’re starting to have some lessons learned—some from basic research, but also from clinical research—at looking at what’s the best way to expose people to the things they’re afraid of. And that is reflected in the shift over the years in some of the basic features of the therapy.

Back to those olden days—in the ‘60’s, for example, there were behavior therapists running around exposing people to things they’re afraid of, but the predominant model was Systematic Desensitization—Joe Wolpe’s design—and in those days, the goal was to keep the person as non-anxious as possible, no matter how slow you had to go. Anxiety was bad. Because you wanted to pair whatever the stimulus was with a state