Cognitive-Behavioral Therapy Helps Clients Cope with Anxiety Disorders

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Anxiety disorders are the most commonly diagnosed psychiatric disorder in the United States. Approximately 40 million adults suffer from anxiety severe enough to negatively affect their lives. In addition, about 13 percent of American children and adolescents are affected by anxiety disorders each year. The impact can be debilitating, as people who suffer anxiety are often unable to have normal social interactions, leave their homes or go to stores, school or work. According to the Anxiety Disorders Association of America (www.adaa.org), anxiety disorders cost the U.S. more than 42 billion dollars a year, about a third of the country's total mental health bill.

In a 2002 article in the journal "Dialogues in Clinical Neuroscience," Thierry Steimer, Ph.D. explains that anxiety serves the very necessary function of warning us of danger or threat, and spurring us to protect or remove ourselves from that danger. According to Aaron T. Beck, MD and David A. Clark, Ph.D. in their 2010 book "Cognitive Therapy of Anxiety Disorders," though, there is considerable empirical evidence that those with excessive anxiety hold beliefs that lead them to perceive danger when there isn't any and think that they don't have the ability to tolerate anxious feelings. Beck and Clark also report that excessive attempts to stay safe and avoid situations perceived as threatening can get in the way of functioning effectively in the world. While it is natural to avoid what makes us anxious, doing so reinforces our belief that we can't handle what we are avoiding and places significant limits on our social and vocational functioning.

Anxiety takes many forms; people can suffer from separation anxiety, social phobia, obsessive compulsive disorder, generalized anxiety disorder, panic attacks, agoraphobia and post traumatic stress disorder. Along with the worried thinking associated with anxiety disorders, many sufferers also struggle with physical symptoms such as sweaty palms and rapid heartbeat, and behavioral symptoms such as avoiding going to a crowded mall or checking many times to see if the stove is turned off.

The good news is that anxiety disorders are very treatable. Yet only about a third of those who have an anxiety disorder get help. Cognitive behavioral therapy, or CBT, is considered the gold standard for the treatment of anxiety disorders, and is a well-researched, highly effective, and lasting treatment. A large number of peer-reviewed, controlled studies have demonstrated that CBT alone can greatly reduce anxiety symptoms. In some cases, however, CBT with medication produces the best treatment outcomes.

So what is CBT? According to Jesse H. Wright, MD and his co-authors in "Learning Cognitive Therapy," CBT is based on ideas about the role of cognition in controlling human behavior that have been traced to writers from ancient times to the present. CBT emphasizes that thoughts, feelings, and behaviors all influence each other. CBT is a very collaborative approach where the therapist and the client together develop therapy goals that often involve identifying and changing maladaptive thinking patterns and core beliefs, coping with feelings of anxiety more effectively, and facing situations or experiences rather than avoiding them.

In 2008, the Jewish Board of Family and Children's Services (JBFCS) launched a program to train all of its approximately 400 mental health professionals in cognitive-behavioral therapy. So far, many of the psychologists, social workers, art therapists, and case workers from JBFCS's community mental health clinics, adolescent specialty clinics, and programs for the chronically mentally ill have received intensive training in CBT. To ensure that all JBFCS clients have access to a therapist competent in CBT, staff at all levels participate in training. First, directors and supervisors receive training, individual supervision, and group supervision on CBT. Next, their staff members receive training. Learning by doing is encouraged, and all are asked to treat a client with a CBT approach and receive case-based supervision. The results are promising. Many clinicians have found that their clients respond positively and rather quickly to CBT. Below are some case examples. All names have been changed to protect privacy.

Anita

Anita, a married mother in her 40's, was diagnosed with panic attacks after repeated visits to the emergency room for what she believed were symptoms of a dangerous gastrointestinal disease or food allergies. In response to these attacks, she had been limiting herself to a few "safe" foods. Her therapist at one of JBFCS's community counseling centers in Brooklyn educated Anita about the nature of panic attacks, and informed her of research findings about effective interventions. Anita agreed to collaborate on a CBT treatment that would include psychoeducation to help her better understand her condition, relaxation training, gradual exposure to a wider range of foods, and modification of her beliefs about her fears and worries.

Anita worked hard in therapy, following up on "homework" assignments between therapy sessions, and reading David Carbonell's *The Panic Attack Workbook*, which her therapist had recommended. She learned and practiced relaxation techniques such as deep breathing, muscle relaxation, and "safe place" imagery, and discovered that with active use she could calm herself. This provided some quick relief while increasing her confidence that her problem was not medical, and that she could overcome it. In another assignment, she developed a list of foods she was afraid to eat, and rated them from the least to the most anxiety-producing. She introduced the least frightening foods, one at a time. Her instructions were to use relaxation exercises if she felt anxious, and to keep eating the same food until she could eat it without experiencing anxiety. She became more aware of the way she thought about herself and her problems, and how this affected her feelings. Her therapist helped her identify, examine, evaluate, and modify her thoughts when they were unrealistic, and develop more accurate, balanced, and useful alternatives. Anita told her therapist that she no longer fears having panic attacks because she knows how to change her experience by modifying her thinking and using coping skills.

Alicia

When six-year-old Alicia first came to one of JBFCS's community counseling centers in the Bronx, she made no eye contact, constantly clung to her mother and refused to speak. She was terrified of men, had difficulty falling asleep and sleeping alone, and became extremely distressed when her mother dropped her off at school or left her with trusted family members. Though Alicia had signs of other disorders, the main problem appeared to be separation anxiety. Alicia's excessive distress when separated from a major attachment figure, reluctance to go to school because of fear of separation, and reluctance to go to sleep without being near a major attachment figure clearly met the criteria for separation anxiety disorder.

Alicia's therapist worked with both Alicia and her mother. Cognitive-behavioral therapists often use modified play therapy techniques to help children express their thoughts and feelings and learn new behavioral skills. Using play and art work, Alicia's therapist helped Alicia learn to identify and modify her anxious thoughts about being away from her mother. The therapist provided psychoeducation for Alicia's mother about separation anxiety disorder, about how creating structure can reduce anxiety, and about how learning to sleep on her own would reinforce Alicia's self-soothing skills. The therapist also taught Alicia's mother to use behavioral charting as a tool to reward behaviors that moved Alicia toward her goals.

Alicia now looks forward to going to school everyday and no longer cries. She is able to fall asleep at bedtime and sleeps most of the night alone in her bed. When her mother leaves home, Alicia shows minimal distress. She told her therapist that she no longer worries when away from her mother.

Group Treatment

JBFCS's continuing day treatment program in Brooklyn provides day treatment services for clients diagnosed with severe and persistent mental illnesses. Some have co-morbid anxiety disorders, and most struggle with significant symptoms of anxiety that interfere with their mood, relationships, and activities. Staff members find group CBT interventions to be useful for many of their clients.

In group sessions, clients learn to use breathing exercises, progressive muscle relaxation, visualization, and aerobic exercise for reducing their anxiety and coping with stress. As members identify specific stressors, together they practice their problem-solving skills and generate possible responses. Social anxiety and interpersonal problems are targeted by having members identify, discuss, and role play social skills for meeting people, reading social cues, starting conversations, making friends, and coping with conflicts and rejection.

In a number of groups, clients identify individualized coping strategies. In group, members quickly realize how many of their struggles and solutions are shared. They also note their differences, and learn to respect their own individuality in tailoring self-help interventions to their own needs, personalities, cultures, and circumstances.

Groups also become a living social laboratory that allows members to test out some of the thoughts and perceptions connected to their anxiety, and to get feedback. One member often felt overwhelmed and anxious because of his perception that he was alone and disliked. When group members responded by spontaneously sharing how much they like and care for him, he was able to take in their support,

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they should be avoided. Check with your physician or pharmacist before taking any additional medications.

The family is very important in the recovery of a person with an anxiety disorder. Ideally, the family should be supportive but not help perpetuate their loved one's symptoms. Family members should not trivialize the disorder or demand improvement without treatment. If your family is doing either of these things, you may want to show them this booklet so they can become educated allies and help you succeed in therapy.

The Role of Research in Improving the Understanding and Treatment of Anxiety Disorders

NIMH supports research into the causes, diagnosis, prevention, and treatment of anxiety disorders and other mental illnesses. Scientists are looking at what role genes play in the development of these disorders and are also investigating the effects of environmental factors such as pollution, physical and psychological stress, and diet. In addition, studies are being conducted on the "natural history" (what course the illness takes without treatment) of a variety of individual anxiety disorders, combinations of anxiety disorders, and anxiety disorders that are accompanied by other mental illnesses such as depression.

Scientists currently think that, like heart disease and type 1 diabetes, mental illnesses are complex and probably result from a combination of genetic, environmental, psychological, and developmental factors. For instance, although NIMH-sponsored studies of twins and families suggest that genetics play a role in the development of some anxiety disorders, problems such as PTSD are triggered by trauma. Genetic studies may help explain why some people exposed to trauma develop PTSD and others do not.

Several parts of the brain are key actors in the production of fear and anxiety. Using brain imaging technology and neurochemical techniques, scientists have discovered that the amygdala and the hippocampus play significant roles in most anxiety disorders.

The amygdala is an almond-shaped structure deep in the brain that is believed to be a communications hub between the parts of the brain that process incoming sensory signals and the parts that interpret these signals. It can alert the rest of the brain that a threat is present and trigger a fear or anxiety response. It appears that emotional memories are stored in the central part of the amygdala and may play a role in anxiety disorders involving very distinct fears, such as fears of dogs, spiders, or flying.

The hippocampus is the part of the brain that encodes threatening events into memories. Studies have shown that the hippocampus appears to be smaller in some people who were victims of child abuse or who served in military combat. Research will determine what causes this reduction in size and what role it plays in the flashbacks, deficits in explicit memory, and fragmented memories of the traumatic event that are common in PTSD.

By learning more about how the brain creates fear and anxiety, scientists may be able to devise better treatments for anxiety disorders. For example, if specific neurotransmitters are found to play an important role in fear, drugs may be developed that will block them and decrease fear responses; if enough is learned about how the brain generates new cells throughout the lifecycle, it may be possible to stimulate the growth of new neurons in the hippocampus in people with PTSD.

Current research at NIMH on anxiety disorders includes studies that address how well medication and behavioral therapies work in the treatment of OCD, and the safety and effectiveness of medications for children and adolescents who have a combination of anxiety disorders and attention deficit hyperactivity disorder.

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see himself and his relationships more accurately and positively, and notice an improvement in the way he felt.

JBFCS clinicians have found that CBT has been very effective in helping clients of all ages better manage their anxiety and function more effectively. As the case studies indicate, CBT can be used in individual and group therapy and in several different treatment settings. JBFCS plans to continue to build its capacity to provide the most effective evidence-based CBT treatments for anxiety and other disorders.

Thanks to the dedicated therapists and case associates who contributed to this article: Katie McCaskie, LMSW; Tzipporah Wisansky, LCSW; Dana Barth, LMSW; Abigail Bryskin, LCSW; Cristina Caroli, LMSW; Manuel Olavarria, LMSW; Malik Wright, CA; and Natalie Zvyagina, CA.

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have been detected at very low levels or below the threshold for detection when infant blood levels have been measured and in general infants whose mothers have taken SSRIs and other related medications have tolerated it well. Of course any decision regarding taking medication should involve a discussion with the treating clinician to address the specific considerations for that person. For women who have OCD and are planning for a pregnancy or who discover they are pregnant, careful consideration needs to go into the decision whether to continue medication through pregnancy. The data about the specific medication needs to be weighed against their history and severity of illness off medication. Although there is substantial awareness about the potential side effects of medications, there is less appreciation for the impact of maternal stress and anxiety on the developing fetus and on the pregnancy. Untreated OCD during pregnancy is also a risk factor for postpartum depression as well. Some women do well off medication during pregnancy but may experience an exacerbation post partum. Optimally the women with a diagnosis of OCD will take the opportunity to consider her options and preferences in advance of becoming pregnant while medication reduction or changes can be considered and when CBT skills and other therapy can be introduced if this had not been done before.

In Ms. J.'s case she had weaned her baby and wanted to start medication along with therapy. She had a trial of paroxetine that helped reduce her overall anxiety level and made it easier for her to implement ERP to fight back against the OCD symptoms. Even once her symptoms had subsided significantly she felt discouraged and somewhat sad about the experience she had had in the early months of motherhood. Ms. J. was an accomplished person who set high standards for herself and believed that if she worked hard, she would be successful. Prior to becoming a mother she had determined that anything short of perfection was not acceptable. As a new mother, however, she was confronted with the reality that no amount of reading or preparing guaranteed that she would always have the baby satisfied or her home under control. The intrusive thoughts she was having amplified the belief that she was failing as a mother. Addressing these beliefs helped her gain confidence and pleasure in her new role.

In recent years, celebrity memoirs and media attention have focused attention on postpartum depression. Even now, 15 years since I met Ms. J peri-natal anxiety disorders go unrecognized by many individuals. This is unfortunate because of the toll that untreated anxiety disorders takes on the woman as well as on her entire family. Hopefully with increased awareness, more women and their families will realize that there is help for these conditions as well.

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where he did not receive the best of care. However, he was safe. He had a room, meals, and financial help through social security. At the end of ten years he enrolled at The Bridge, a wonderful multi-service program on the Upper West Side of Manhattan. He changed medications and became an active member of the agency's Art Group.

Back again in France, it was impossible to locate Pierre for many years. His mother then learned Pierre had been discharged from a hospital near Paris and was going to the South of France on foot to look for a job when he was hit by a truck and killed in the village of Sens. His mother was surprised and shocked to receive the tragic news about her son's death. He never would have been identified had the receipt for a French National ID Card application not been found in his pocket.

Pierre's mother and I compared laws concerning the treatment and care of the mentally ill here in New York and in France. The differences are significant. In France the rights of the mentally ill are virtually nonexistent. Lack of follow-up after hospitalization and no government support for housing or living expenses make consumers vulnerable to following their "voices". Guy and I planned to move back to France after our retirement, but our son's mental illness made us change our plans. We are happy to live in a country where the mentally ill receive support. Had he lived in New York, Pierre may not have died so tragically.

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occurred within the hospital, significant environmental changes were made and the rates dropped – this was a major achievement. How to systematically lower post-discharge suicide rates is far more difficult to imagine; yet real data on frequency compels us to address this more sizeable challenge. As we attempt to meet this challenge, in an age of limited resources, it will be important to weigh the benefits of purchasing and building increasingly sophisticated environmental safety elements against the costs of enhancing the skills of staff who provide programs and aftercare.

In conclusion, the OMH report makes clear that more than 2 decades of effort have made our inpatient units far safer. These gains are the result of concerted and collaborative efforts among governmental agencies, hospitals, and the professional teams providing direct care to our patients. While no system should "rest on its laurels," the mental health care system in NYS has done a remarkable job of driving down the number and probability of inpatient suicides. Persons admitted to our hospitals have every reason to believe they are in a safe place. All who worked to realize these goals should feel justifiable pride in what has been accomplished.

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