CBT FOR DEPRESSION

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**Introduction to CBT for Depression**

- CBT in a context, growing awareness of Depression and burden of this illness
- Is it only skills and techniques?
- Why CBT?
- Role of cognitions in the vulnerability to Depression
What do we know about Depression?

- Lifetime prevalence of depression: 2.6-12% in men, 7-12% in women.
- For Canada: 5.6% of Canadians over 18 had a depression in the last 12 months.
- Even sub-syndromal symptoms of depression may result in significant impairment and decreased quality of life.
Depression: Core Symptoms

- Sad or low mood for greater than two weeks
  
or
  - Loss of interest or pleasure for greater than 2 weeks

  Plus

- Appetite/weight changes
- Sleep problems
- Agitation
- Fatigue
- Worthlessness/guilt
- Thoughts of dying
- Concentration difficulties
Major Depression

B. The symptoms do not meet criteria for a Mixed Episode

C. The symptoms cause clinically significant distress or impairment in social, occupation, or other important areas of functioning

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
Depression and The Cognitive Model

Cognitively, in depression thoughts center around:

- Loss
- Inadequacy
- Rejection
The Cognitive Triad

- The Cognitive Triad identifies the relationship between the self, the future, and others.
- In depression these variables are viewed quite differently than when not depressed.
Cognitive Triad in Depression

Self
I should be able to cope

others
People will think I am incompetent

future
He will never come back
Beck’s Model of Depression

- “Cognitive structures” or “schemas” develop early in life, or even later from interactions with the environment
- Negative events will shape the development of negative schemas or “core beliefs”
- Information “filtered” through these schemas will focus on negative information and “filter out” more neutral or positive information
- Schemas are dormant and become activated in specific situations
Beck...

(cont)

- In depression prone individuals a specific stressful event will activate a latent schema (contains negative information) which will activate negative cognitions and related patterns of thinking.
Beck...

(cont)

- What is vulnerability to Depression?
- A schema needs to be sufficiently activated
- Stressors will differentially activate schemas with matching contents
Beck...

(cont)

- There are two cognitive vulnerabilities to Depression

  - Interpersonal; Sociotropy/dependency
  - Achievements; Autonomy/self-criticism

- Depression is always about LOSS
  - Anxiety is about threat
The Efficacy of CBT

- CBT is considered to be as efficacious as medications and is often recommended as a first-line treatment.
- Some evidence that CBT results in lower relapse rates.
- Evidence that CBT can help prevent relapse when used as an adjunct to medication discontinuation.
- Recent evidence that even in more severe cases of depression, CBT is as efficacious as anti-depressants.
The Application of CBT

10 principles of CBT

1. CBT is based on a cognitive model of emotional disorders
2. CBT requires a sound therapeutic alliance
3. CBT emphasizes “collaborative empiricism” (see the CTS Cognitive Therapy Scale)
4. CBT is goal oriented and problem focused
5. Theory and techniques rely on the Socratic questioning or “scientific method”
The Application of CBT

6. CBT initially emphasizes the present
7. CBT is educative and didactic
8. CBT aims to be time limited
9. CBT sessions are structured
10. Homework is a central feature
Assumptions of the Cognitive Model of Psychological Problems

- Perception and experiences are active processes
- Thoughts are critical in the regulation of feelings and behaviors
- Changes in the content of thoughts will change emotions
- Patients can become aware of the changes in their thoughts through therapy
A Model of Cognitive Behavior Intervention

Stressors such as life events or highly driven behavior causing poor social routine or sleep deprivation

Biological vulnerability, i.e. circadian rhythm instability

Episode

Stigma, relationship problems

Poor coping strategies

Prodromal stage or early symptoms

2014-04-10
The CBT Model

Trigger/Situation
i.e., interaction, event, physical sensation, object

Cognition
i.e., interpretation, beliefs, information processing, images, evaluation

Behavioral Response or Coping Behaviors
i.e., avoidance, withdrawal, rituals, safety-seeking

Emotional/Physical Sensations
i.e., depression, anxiety, palpitations, dizziness
Characteristics of a CBT Approach

- Consideration of thoughts
- Strong therapeutic alliance is essential
- Goal-oriented, problem-focused therapy
- Present-oriented (at least initially)
- Active & experiential

(J. Beck, A. Beck)
Characteristics of CBT (cont)

- See the Cognitive Therapy Scale (therapist rating scale)
- Educational
- Collaborative & empowering “collaborative empiricism”, inductive reasoning
- Therapist as coach, not expert
- Homework is essential
- Time-limited
- Structured
Session 1

Session I CBT
Session 1  (all this in 50 minutes)

- Complete the BDI (Beck Depression Inventory)
- Psycho education about Depression
- Review the patient’s list of symptoms/write them down
- Develop a problem list
- Introduction to the CBT model of Depression
- Cognitive Triad
- Illustrate the CBT model with a personal (from the patient) example
- Assign homework; WAS, Thought Record
- Summary
- Feedback
Course of Therapy

- Usually 16 to 20 sessions, weekly. Can be done twice weekly for the first 4 weeks
  - Session 1&2, Introduction to CBT
  - Session 2 to 4 or 5 Behavioural Activation
  - Session 6 to 10 Cognitive Interventions
  - Session 11 to 16 Core Beliefs
  - Session 17 to 20 Relapse Prevention and Termination
Structure of Sessions

- Agenda
- Review of week; events and mood check
- Review of homework
- Psycho education and application of cognitive or behavioral strategy
- Deciding on new homework
- Feedback
Why writing information is so important?
Techniques CBT uses for Depression

- Behavioral Activation
- Thought monitoring
- Working through thoughts
- Belief work
Why the Need for Structure in CBT

- Structure matters because CBT is:
  - Educative (learning must occur)
  - Focused (structure is consistent with targeted approach)
  - Collaborative (structure helps ensure collaboration)
  - People with depression are usually having difficulty focusing and organizing their thoughts
  - Research (structure elements of CBT appear to be important for outcome)
Necessary Components in CBT

- Empathy & compassion/therapeutic alliance
- Thorough & ongoing assessment
- Treatment goal consensus
- Good therapeutic treatment rationale
- Flexibility in skills application
Collaborative Case Conceptualization

Christine A. Padesky PhD
Tape
Case Example
Formulation Information

- Typical problematic situations from the assessment
- Triggers for episode and what this means for core beliefs
- Problematic compensatory strategies
- Continue to gather data to refine the formulation
  - Practice the Case Conceptualization Form

Why do a case conceptualization?

Keep the big picture in mind

“Cognitive Map of the patient’s psychopathology”
(J. Beck)
Which experiences contributed to the development and maintenance of the core belief?

Core Belief(s)
What is the most central belief about herself?

Conditional Assumptions/Beliefs/Rules
Which positive assumption helped her cope with the core belief?
What is the negative counterpart to this assumption?

Compensatory Strategy (ies)
Which behaviors help her cope with the belief?

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<th>Situation 2</th>
<th>Situation 3</th>
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Automatic Thought
What went through her mind?

Meaning of the A.T.
What did the automatic thought mean to her?

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Beck, J.S.  Cognitive Therapy: Basics & Beyond

2014-04-10
Behavioral Activation
The B in CBT

- Behavioral Activation is the usual start point in CBT
  - Effective
  - Energy/Motivation
  - Teaches basic homework skills
  - One of the best interventions to improve self-esteem
Examples of Behavioral Activation Techniques

- Introduce the Weekly Activity Schedule (WAS)
- Monitor daily activities
- Assess and track the **Pleasurable** and **Mastery** (Accomplishment) activities
- Graded task assignments
- Cognitive rehearsal and problem solving around tasks
- Social skills (assertion, communication)
Getting Activated

- Provide the rationale behind behavioral activation

- Illustrate the reinforcement cycle in depression and how this is likely to undermine even helpful or pleasant activities

- Illustrate how energy and motivation are decreased in depression and many times it is too difficult to be active, there may be guilt, or fear of failure
Getting Activated – cont’d

- It may be difficult to ‘buy into this’…
- Suggest behavioral activities can be added on an ‘experimental basis’ and ‘see what happens’
- Encourage that you are ‘moving in the right direction’
- Educate and reinforce the relationship between: feelings → behaviors
Getting Activated – Step 1

- Establish a Baseline
  - Have the patient record their activity on a schedule (WAS), calendar, or book
  - Begin to record both the behavior and the mood rating
  - Educate that mood varies and is systematically tied to events and activities
Getting Activated – Step 2

Once the Baseline has been established

- Have the patient rate the activities on the dimensions of Mastery (M) and Pleasure (P)
  - M = a sense of accomplishment
  - P = a sense of enjoyment
    - Examine levels of M and P for balance and quality
Getting Activated – Step 3

- Add M and P activities in a graduated fashion to provide balance

- Draw activities from:
  - The patient’s desires, plans, or hopes
  - The patient’s past
  - The ‘Pleasant Activity List’

- Increase reinforcement of the relationship between what we do and how we feel
  This will increase self-concept
Getting Activated – Step 4

- Make longer term goals for ongoing activity
- Expand frequency, scope of mastery, and pleasant activities
- The patient is able to reflect on a success
- Concrete plans allow for an objective assessment of progress
Other Important Components of Behavioral Activation

- **Cognitive Rehearsal**
  - Have the patient imagine doing an activity
  - Do this in a step-wise fashion, to imagine each of the details
  - Identify the roadblocks, and problem solve around the roadblocks

- The goal is to provide both a plan and the ability to evaluate contingencies
Roadblocks to Activation

- I am too tired
- What is the point I will get no pleasure
- I have already tried that and it will not work
- I can’t afford it
- I don't want anybody to see me the way I am
- It is too overwhelming
- I cannot do it alone
- What is the point? It will never change, I will kill myself anyway
- I will fail anyway
- Nobody appreciates it anyway
- How is that going to help my depression anyway?
Activity Scheduling

Jacqueline B. Person, PhD
Joan Davidson, PhD
Michael A. Tompkins, PhD
Tape
- Feedback
- Homework Review
The C in CBT

- Cognitive techniques are learned progressively for 6 – 8 sessions

- Once basic skills are learned, specific techniques can be implemented or created

- Use a companion manual ("Mind Over Mood")

- Use homework to consolidate and test skills
How do you get people to talk about their thoughts?

- Utilize the ‘mood shift’ moments to identify the thoughts
- Use the Thought Record
- Have the patient write down the thoughts associated with the mood shift and the emotion
Generating thoughts:

- It may be difficult to access thoughts – we are emotional creatures and many times we are not aware of what we are thinking only how we feel.

- Try asking the following to help get at the thoughts:
  - What was going through your mind just then?
  - What were you saying to yourself when that happened?
  - What images did you have?
  - What was going through your mind just before you started to feel this way?
  - What am I afraid would happen in this situation?
  - What does this say about me?
Generating Thoughts – cont’d

- Use imagery of the situation to ‘walk through’ a mood shift situation
- Role play the situation
- As a last option (therapist) suggest plausible thoughts or suggest an opposing thought

Make the Internal Dialogue, External
No **WHY** questions as there is no answer to these questions and it can promote defensiveness

*Turn the question into a statement*
The Automatic Thought

- The goal is the articulation of the Automatic Thought (AT)
- Automatic Thoughts are what carries the negative emotional weight
- They can be words, images, or memories
Automatic Thoughts have the following characteristics:

- They are specific not vague
- They occur in shorthand
- They do not arise from reasoning
- They follow no logic
- They happen ‘by reflex’
- They require no effort
- They are difficult to ‘turn off’
Socratic Questioning

- Socrates’ method of philosophical inquiry involved questioning people on the positions they asserted and working them through questions into a contradiction, thus proving to them that their original assertion was wrong.

- The Socratic dialogue eventually gave rise to **dialectic**, the idea that truth needs to be pursued by modifying one's position through questioning and conflict with opposing ideas.
Socratic Questioning cont’d

- **Socratic Method**
  - Wonder: Pose a question
  - Hypothesis: Suggest a plausible answer from which some conceptually testable hypothetical propositions can be deduced
  - ‘Testing’, ‘refutation’, or ‘cross examining’
  - Accept the hypothesis as provisionally true
  - Act accordingly
What to Ask…

- Ask anything that will help to fill out the full picture
- Be non-judgmental and open about your own conclusions
- Do not cross examine!!

*It doesn’t matter if you get to the answer unless the patient got there with you*
Socratic Questioning; Examples

- Discuss Padesky’s examples (To be read by the therapists)
Types of Cognitive Interventions

- **Awareness of Automatic Thoughts (AT)**
- Questioning the Validity of AT
- Cognitive Distortions
- Evidence Technique
- ReattrIBUTion Technique
- Costs Benefits
Awareness of Automatic Thoughts
Depressive Thoughts and Beliefs

- I’m a loser
- I can’t do anything right
- No one will ever care about me
- I’m useless
- I am a burden to others
- This is hopeless – there is no point in even trying
- Others would be better off without me

*Think of the Cognitive Triad*
Cognitive Triad in Depression

Self
I should be able to cope

Others
People will think I am incompetent

Future
He will never come back
The Mood Shift

➢ The intent here is to sensitize the patient to changes in their emotional state

➢ The emotion of interest should be patient driven

➢ Ratings of a range of emotions are a prerequisite
The Mood Shift – cont’d

- Have the patient use the WAS to rate their moods, and record activities

- Examine content of activities in the mood shifts

These shifts are key in CBT
It’s the Thought That Counts

- When a mood is experienced, a thought is connected to it
- When we choose to engage in a specific behavior, a thought is connected to it
- When we have physical reactions, thoughts are connected to them

*Thoughts connect the system of emotion, behavior, and physical reactions*
The Hot Thought

- The thought that is most related to the emotion or the thought that carries the emotional charge is the ‘hot thought’

- Repeating the automatic thoughts aloud may reveal the emotional charge

- Have patients rate the ‘hotness of thoughts’

*Identify the key cognitive distortion*
Types of Cognitive Interventions

- Awareness of Automatic Thoughts (AT)
- *Questioning the Validity of AT*
- Cognitive Distortions
- Evidence Technique
- Reattribution Technique
Testing Automatic Thoughts with Thought Records

Christine A. Padesky
Tape
Types of Cognitive Interventions

- Awareness of Automatic Thoughts (AT)
- Questioning the Validity of AT
- Cognitive Distortions
- Evidence Technique
- Reattribution Technique
Cognitive Distortions
Thought Distortions

- Record all information on the DRDT

- Thought Distortions:
  - All-or-nothing Thinking: You see things in black and white categories
  - Overgeneralization: You see a single negative event as a never ending pattern
  - Disqualifying the Positive: You reject positive experiences by insisting they ‘don’t count’
  - Mind Reading: You arbitrarily conclude that somebody is reacting negatively to you
Thought Distortions – cont’d

- The Fortune-Teller Error: You anticipate that things will turn out badly, and you feel convinced that your prediction is an already established fact.
- Catastrophizing: You attribute extreme and horrible consequences to the outcomes of events.
- Emotional Reasoning: You assume that your negative emotions necessarily reflect the way things really are.
- “Should” Statements: You try to motivate yourself with “should” and “shouldn't”
- Personalization: You see negative events as indicative of some negative characteristic of yourself or you take responsibility for events that were not your doing.

Troubleshooting

- The rhetorical question (Is it my fault?)
- The core belief ‘revelation’
- Avoidance and fear/embarrassment
Evidence Technique
Vignette

- Practice the evidence technique in the group (therapists to role play)
- Role play in group of three (participants)
Gathering the Evidence

- Test the Hot Thought – use of Socratic questioning
- Gather evidence that supports the negative conclusion (facts, data, experiences that support the conclusion)
- This will be straightforward in most instances
- “Evidence For” will help to make an ‘honest’ thought record
Evidence Against

- Now examine the “Evidence Against” the hot thought

- The best question to elicit ‘evidence against’ tends to stem from the specific situational parameters

- The following is a list of potential questions:
Evidence Against – cont’d

- Have I had any experiences to show that this thought is not completely true all the time?
- If my best friend had this thought, what would I tell him or her?
- If someone who loved me knew I was thinking this thought, what would they say to me?
- When I am not feeling this way, does this sort of situation look different to me?
Evidence Technique – cont’d

- Have I been in this type of situation before? What happened then?
- Are there small things that contradict my thoughts that I might be discounting?
- Five years from now, as I look back on this, will I think about it any differently?
- Am I blaming myself for something over which I have no control?
- What is the worst that could happen here? What is the best thing that could happen? What is the most likely thing that will happen?
The Dispute Handles

- Do I know for certain that (AT) will happen?
- Am I 100% sure of the awful consequences?
- What evidence do I have that supports the (AT)?
- Does the situation equal or lead to the AT?
- Do I have a crystal ball?
- Could there be any other explanation?
- What is the likelihood the AT will occur/is true?
- Is the situation really so important or consequential?
- Does (Person’s) opinion reflect that of everyone else?
- Is (Situation) really so important that my entire future resides with its outcome?
Alternative/Balanced Thoughts

- Synthesize the evidence in both columns (For/Against)
- This typically has one of three results:
  - The evidence doesn’t support the thought therefore the thought is not true
  - The evidence provides a more balanced view than the Automatic Thought suggests
  - The evidence supports the thought therefore the thought is true
Balanced Thought – cont’d

- If the evidence does not support the AT, write an alternative view that does fit

- If the evidence partially supports the AT, write a thought that balances what you have discovered
  - The simplest technique: (1) write a phrase that summarized the evidence “for” then (2) write a phrase that summarized the evidence “against” then (3) join the phrases with an “and” and finish the balanced thought

- If the evidence supports the thought, implement a problem solving intervention (or an experiment)
KEEP IN MIND!

- This is not substituting a positive thought for a negative one

- CBT is not to make the person think more positively rather to challenge distorted thinking and provide a balanced way of thinking

- Once the alternative thought is written, have the person re-rate their mood

**Summarize all of the evidence to create a balanced view**
Experiments

- Apply when evidence is missing or incomplete

- Experiments involve gathering new information. This can be as simple as asking someone a question

- Experiments can also apply to new behavior that will answer a question
Action Plans

- When a thought record identifies a real problem that needs solving...use an action plan

- Helps to clarify problem solving steps

- Anticipates hurdles
Troubleshooting

- If there is no change in emotion, check out the following:
  - Was the AT the one related to that particular mood?
  - Is there an AT that might be more related to that mood?
  - Was there any evidence missing?
  - Did you run into a deeply held belief?
Types of Cognitive Interventions

- Awareness of Automatic Thoughts (AT)
- Questioning the Validity of AT
- Cognitive Distortions
- Evidence Technique
- *Reattribution Technique*
Reattribution or Responsibility Distribution Technique

- Helpful where one blames oneself
- In Depression people tend to incorrectly assign the blame or responsibility for the outcome of adverse events.
- The outcome is due to some internal characteristics or flaw rather than some external characteristics.
Responsibility Distribution Technique

*(cont)*

- Examples of internal flaws (talent, ability, intelligence)
  - Personal deficiency (I’m weak, I’m a loser)
  - Lack of ability (I’m not smart enough)
  - Lack of effort (I’m lazy)
Responsibility Distribution Technique

- Examples of external characteristics
  - The timing may have been bad
  - The amount of effort put into the task
  - The task may have been difficult
Other Responsibility Distribution Techniques

- “The Best Friend technique” or “Double Standard”; How would you assign the responsibility if someone else was in the same situation
- The Responsibility Pie
Responsibility Pie

*Negative Thought or situation; they don’t care if we die*

*Emotion; Guilt, Anger*
Responsibility Pie

- Describe all people or circumstances of the situation that could have contributed to this outcome...
  - Equipment is defective
  - People in charge
  - Early morning, tired
...

Use vignette
- Feedback
- Homework review
Why attend to Anxiety?

- Strong co morbidity between Depression GAD and PTSD
- Co morbidity associated with increased severity of symptoms and functional impairment
- CBT is a phenomenologically based therapy
- It is important to educate patients about symptoms of anxiety (the education component of CBT). Discuss the case conceptualization with the patient
- It is important for patients to discriminate symptoms of anxiety from symptoms of depression
  - Anxiety is about threat and perception of helplessness and uncertainty
  - When co morbidity present (not pure anxiety) the helplessness and uncertainty are prolonged
Approach to the Assessment of the Depression Anxiety Comorbidity

- **Assessment** *(self report measures Anthony et. al., Hand book of Assessment and Treatment Planning for psychological disorders, 2002, Guilford)*
- Temporal relationship
- List of anxiety and depressive symptoms
- Which ones are interfering the most at the time of assessment?
- Ask about substance abuse
- Understand the behaviours associated with each disorder
- Adjust the case conceptualization
Patient’s name: ____________ Date: ____________
Diagnosis: Axis I __________ Axis II ____________

**Situation 1**
- What was the problematic situation?
- Automatic Thought: What went through her mind?
- Meaning of the A.T.: What did the automatic thought mean to her?
- Emotion: What emotion was associated with the automatic thought?
- Behaviour: What did the patient do then?

**Situation 2**
- Automatic Thought: What went through her mind?
- Meaning of the A.T.: What did the automatic thought mean to her?
- Emotion: What emotion was associated with the automatic thought?
- Behaviour: What did the patient do then?

**Situation 3**
- Automatic Thought: What went through her mind?
- Meaning of the A.T.: What did the automatic thought mean to her?
- Emotion: What emotion was associated with the automatic thought?
- Behaviour: What did the patient do then?

**Core Belief(s)**
- What is the most central belief about herself?

**Conditional Assumptions/Beliefs/Rules**
- Which positive assumption helped her cope with the core belief?
- What is the negative counterpart to this assumption?

**Compensatory Strategy (es)**
- Which behaviours help her cope with the belief?

**Relevant Childhood Data**
- Which experiences contributed to the development and maintenance of the core belief?
Treatment Approaches

- Physical sensations
- Cognitive component
- Behavioral component
- Few outcome studies available
  - If OCD present treat the Depression first
  - If the AD is primary treating the AD first improves the Depression
  - Concurrent or sequential treatment should be decided on a case-by-case basis
Depression-GAD

- Watch for the “what if...” that will interfere with the implementation of the Behavioural Activation or other experiment
- Think of coping strategies if negative outcome
- Integrate interventions for GAD
  - “What if I go for therapy and I am discharged from the military”
Depression-PTSD

- Slow the pace of therapy because of possible dissociation
- Challenging thoughts with evidence can be difficult
- Try other interventions such as advantages or disadvantages of holding onto a particular thought
Generalized Anxiety Disorder

Criteria:
1. Excessive worry and anxiety (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)

2. The person finds it difficult to control the worry

3. The anxiety and worry are associated with 3 (or more) of the following (with at least some symptoms present for more days than not for the past 6 months):
   - Restlessness or feeling keyed up or on edge
   - Being easily fatigued
   - Difficulty concentrating or mind going bland
   - Irritability
   - Muscle tension
   - Sleep disturbance (difficulty falling asleep, staying asleep, or restless unsatisfying sleep)
Generalized Anxiety Disorder

4. The focus of the anxiety and worry is not confined to features of an Axis I disorder (i.e., the anxiety associated with Panic Disorder, Social Phobia, OCD, Anorexia Nervosa, Somatization Disorder, Hypochondriasis, or PTSD)

5. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

6. The disturbance is not due to the direct physiological effects of a substance or a general medical condition and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder
Generalized Anxiety Disorder

What is GAD?

- Excessive anxiety & worry about a number of events or activities
- The person finds the worry difficult to control
- The worry is associated with physical symptoms
- Symptoms cause distress and/or impairment in functioning
Generalized Anxiety Disorder

Physical symptoms associated with GAD

- **Restlessness** – feeling keyed up, or on edge
- **Difficulty concentrating** – or mind goes blank
- **Irritability**
- **Muscle Tension**
- **Sleep Disturbance** – difficulty falling or staying asleep
Generalized Anxiety Disorder

Examples of Worry

- Will I get to the appointment on time?
- What if I can’t find a parking spot?
- What if my doctor doesn’t believe me?
- What if my mother gets cancer?
- What if my husband leaves me?
- What if my children die before I do
- What if my children don’t find jobs when they finish university
Generalized Anxiety Disorder

Strategies for GAD

- Intolerance of Uncertainty
- Cost and Benefits of Worry
- Cognitive Exposure
- Problem-Solving
- Progressive Muscle Relaxation
Generalized Anxiety Disorder

Strategy # 1
Intolerance of Uncertainty

- This concept is the crux of GAD
- Research has shown that the way a person deals with uncertainty will predict how much they will worry
- A person with GAD seeks certainty
Generalized Anxiety Disorder

Expressions of Intolerance of Uncertainty

- Avoidance of situations
- Imaginary obstacles
- Procrastination
- Avoidance of delegation
- Partial commitments
- Over researching
- Second guessing
- Reassurance seeking
- Double-checking
- Over-protecting
Generalized Anxiety Disorder

Exposure Hierarchy to Uncertainty
List of situations provoking anxiety
Start with them most anxiety provoking to the least

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<th>Item</th>
<th>Anxiety (%)</th>
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Generalized Anxiety Disorder

Exposure Monitoring Form

- What is the situation to be practiced?
- What is your anxiety rating?
- What is the feared outcome?
- What is your supporting evidence?
- What evidence do you have that it might not be true?
- What was the outcome?
- What did you learn?
Generalized Anxiety Disorder

Strategy # 2

Costs & Benefits of Worry

- People with GAD think that worry is more useful than people without Gad
- Useful to have patient explore costs and benefits of worry
- Opportunity to empathize with patients
Generalized Anxiety Disorder

Five Types of Beliefs about the Usefulness of Worry

1. Worrying helps find solutions
2. Worrying helps motivate
3. Worrying protects from negative emotions
4. Worry can prevent negative outcomes
5. Worrying represents a positive personality trait
Generalized Anxiety Disorder

Strategy # 3
Cognitive Exposure

- Used for potential worries
- These worries often concern major life events that are very threatening
- Two targets of this strategy are cognitive avoidance and neutralization
Generalized Anxiety Disorder

Cognitive Exposure

- **Cognitive Avoidance:** Refers to the ways that we try to avoid thoughts that scare us. We try to not think about thoughts that scare us.

  i.e., White Bear Phenomenon

- **Neutralization:** Effort to decrease anxiety by trying to think about something else
Generalized Anxiety Disorder

Example Exposure Scenario

Guidelines for Exposures:

- Read the text slowly and with expression, then close his/her eyes and keep imagining the scenario
- Should be written in the present tense
- Should be frightening but believable
- Should refer to the five senses
- It should be done repeatedly (i.e., daily for 30 to 60 minutes)
- Stay fixed on the exposure until anxiety decreases
- Avoid neutralization
Generalized Anxiety Disorder

Strategy # 4
Problem-Solving

Strategy for managing current problems

**Five Step Process**
1. problem orientation
2. Problem definition and goal formulation
3. Generation of alternative solutions (brainstorming)
4. Decision making
5. Solution implementation and verification
Generalized Anxiety Disorder

Strategy # 5
Progressive Muscle Relaxation

**Purpose:** To decrease the unpleasant physical symptoms, muscle tension, and anxiety associated with worry

- it is a skill that needs to be practiced regularly
- 16, 8, 4 muscle groups
- Different positions, different rooms
- Low, moderate, and high anxiety situations
  - Jon Kabat Zinn, MBSR; Mindfulness Based Stress Reduction
Generalized Anxiety Disorder

Additional Strategies

- Worry behavior prevention
- Worry delay & scheduled worry time
- Assertiveness
- Adhering to agendas
- List making
Group CBT

1. Suitability and screening for The group
2. Group Rules
3. Group Process
4. Challenges in a Group
Group CBT

• Support & sharing of the experience of the illness. Learning through helping others
• Public commitment
• Peer learning
• Encouragement through others success
• Replication of life situation
• Modelling
• Practice of CBT
  • Need to clarify misconceptions: “Touchy feely myth”, least expensive least effective, fear of being a casualty
Suitability for Group CBT

- Issues
  - Diagnostic Interview; Who should be excluded?
  - Optimal Pharmacological Treatment
Suitability for Group CBT

1. Accessibility of Automatic Thoughts
   - Do you recall what you were thinking in that situation?
   - What was going through your mind when that event happened?
   - Are there any images that came to mind as you recall that event?

2. Awareness of Differentiation of Emotions
   - Do you recall what you were feeling in the situation?
   - Is that different from the way you normally feel?
   - How strong or intense is that feeling?
Suitability for Group CBT

Acceptance of Personal Responsibility for Change and Compatibility with Cognitive Rationale

- What is your understanding of how cognitive therapy works?
- Does what you understand so far make sense to you?
- What role do you see the therapist playing?
- What role do you see yourself playing in therapy?
- What is your understanding of what causes your problems?

4. Alliance Potential

- How are you feeling about the interview today?
- Have you had any close relationships in which you were able to confide?

5. Chronicity versus Acuteness

- Onset of illness?
Suitability for Group CBT


- Attempts to control the interview?
- Tangential or circumlocutory – talking that makes it difficult to deal with the subject in depth
- Changing the topic
- Excessive confusion in the interview
- Preoccupation with topics that distract from themes
- Dealing with issues in an overly rational way
- Blaming others for one’s own weakness or vulnerabilities
Suitability for Group CBT

7. Focality

- Problems oriented focus
- Starting with the situation at hand and not straying to things that might have happened in the past
- Problems are broken into subunits/targets
- Wanting to work on everything at once
- Multiple problems while attempting to work on a single difficulty
- Patient is not able to elaborate without bringing in tangential information
Suitability for Group CBT

8. Patient Optimism/Pessimism about Therapy

- Hopeful or hopeless about therapy leading to possible changes in your life?
- How likely are you to benefit from therapy?
Group Rules

Therapist Responsibilities:

- Confidentiality – as a member of the group you will be assured that the information compiled in the group will remain confidential. At the end of the group a discharge summary/note may be sent back to the referring source. Confidentiality will only be broken if:
  - If a child is at risk of or is being sexually abused, physically abused, or neglected, the obligation is to report any such information to the appropriate authorities
  - If your therapist judges you to be at risk of harming yourself or another person
  - If you learn that another registered healthcare professional has sexually abused a patient or made sexually inappropriate remarks to a patient, the obligation is to report any such information to the appropriate authorities

- Manuals – these will be supplied to the group

- Time Management – the therapists will be responsible for ensuring that the group time is managed efficiently and that all members are given equal time to participate
Group Rules

Patient Responsibilities:

- Homework completion – every session of CBT consists of learning new skills that build on each other each week. These skills need to be used and practiced regularly. The more they are practiced the better the results.

- Attendance and Punctuality – 100% attendance is expected. If you cannot attend or will be late, please contact us. Each CBT session builds on the material learned in the previous session. If you miss a session you may fall behind and not adequately learn the CBT techniques. If you miss two or more sessions, we will need to determine whether you will be able to continue in the group.
Group Rules

- Participation – Group participation is very important. The best way to learn is to ask questions and interact with the other group members. Remember, “No question is a dumb question”.

- Forms – Any forms that you may need to have filled out (CPP, ODSP) while in group must be completed by your referring doctor, as they are more familiar with your history.

- Scales – The Beck Depression Inventory (BDI) will be completed at the beginning of each session and at the beginning and end of the group. The rationale for this is objective assessment and corroboration with clinical progress.
Group CBT

- Tape; Group CBT, Mood Disorder Program
- Feedback
- Homework review
Core Beliefs or Schemas

(schemata's)
Schemas

- **A schema** is a pattern imposed on reality or experience to help individuals explain it, to mediate perception, and to guide responses.

- **A schema** is an abstract representation of the distinctive characteristics of an event...a kind of blueprint of the events most important elements.
Schemas

- Schemas help the individual organize, interpret, and assimilate information.
- This is usually based on life events or experiences.
Schemas

- According to Beck et al. (1979), schemas are ‘relatively stable cognitive patterns that form the basis of the regularity of interpretations of a particular set of situations’.
- Schemas, that are usually formed in early life, continue to be elaborated and then superimposed on later life experiences, even when they are no longer applicable.
- Schemas create ‘cognitive consistency’ to maintain a stable view of oneself and the world, even if it is, in reality, inaccurate or distorted.
- They are fixed and over generalized.
Schemas

- Schemas can be positive or negative, adaptive or maladaptive...schemas can be formed in childhood or later in life.

- J. Young (1990, 1999) suggested that some of the schemas, especially those developed in early life are as a result of toxic childhood experiences and might be at the core of personality disorders, milder characterological problems, and many chronic Axis I disorders.
How do Schemas work?
Schemas

- When Early Maladaptive Schemas are triggered the individual (adult) is flooded with emotions and bodily sensations
- They may or may not be able to consciously connect the present real time experience to the original memory
- The memories are at the heart of the schema that the therapist will help uncover
Schemas

- Early Maladaptive Schemas fight for survival
- The schema is what the individual knows, what is familiar and comfortable
- Although it causes suffering as it is comfortable and familiar....it just ‘feels right’
- Individuals are drawn to events that trigger their schemas
- Individuals regard their schema(s) as the ‘priori truth’ and thus the schema influences the processing of all information and experiences so this is the reason they are so hard to change
- The schema plays a major role in how patients think, feel, act, and relate to others...that paradoxically leads them to inadvertently recreate in their adult lives the conditions in childhood that were most harmful
Schemas & Behavior

- Remember, an individual’s behavior or coping style is not part of the schema itself rather
  - it is a response to the schema
- Behaviors are driven by the schema but are not a part of the schema
Schemas

- The coping styles however only serve to perpetuate the schema and not heal them
- The schema contains the memories, emotions, bodily sensations, and cognitions but not the individual's behavioral responses
- Behavior is not part of the schema...it is part of the coping response so *it can be changed*
- The schema drives the behavior
- Each individual utilizes different coping styles in different situations at different stages in their lives to cope with the same schema
- Therefore the coping styles for a given schemas may not remain the same but the schema does
Two types of core beliefs

- As per A. Beck
  - Two types of Core Beliefs
    - Helplessness
    - Unlovability

- As per J. Beck
  - Three types of Core Beliefs
    - Helplessness
    - Unlovability
    - Worthlessness
Helpless Core Beliefs

- “I am inadequate, ineffective, incompetent; I can’t cope”
- “I am powerless, out of control; I can’t change; I’m stuck, trapped, a victim”
- “I am vulnerable, weak, needy, likely to be hurt.”
- “I am inferior, a failure, a loser, not good enough; I don’t measure up to others.”
Unlovable Core Beliefs

- “I am unlikable, undesirable, ugly, boring; I have nothing to offer.”
- “I am unloved, unwanted, neglected.”
- “I will always be rejected, abandoned; I will always be alone.”
- “I am different, defective, not good enough to be loved.”
Worthless Core Beliefs


- “I am worthless, unacceptable, bad, crazy, broken, nothing, a waste.”
- “I am hurtful, dangerous, toxic, evil.”
- “I don’t deserve to live.”
Downward arrow technique

- Identify a key automatic thought;
- *I should be able to cope*
  - Ask about the meaning of this thought assuming the AT were true
  - What does it mean about you?
Coping Styles or Compensatory Strategies

- Maladaptive coping styles keep the individual prisoner in their schemas
- Remember, the coping style is the behavior and not the schema itself...rather a result of the schema
- The connection between the schema and the coping strategy is best seen in the “If....then” conditional assumption
Compensatory Strategies or Coping Styles (J Beck)

*If … then statements*

- Avoid negative emotion
- Try to be perfect
- Be overly responsible
- Avoid intimacy
- Seek recognition
- Avoid confrontation
- Try to control situations
- Act childlike
- Try to please others

- Display high emotion
- Purposely appear incompetent or helpless
- Avoid responsibility
- Seek inappropriate intimacy
- Avoid attention
- Provoke others
- Abdicate control to others
- Act in an authoritarian manner
- Distance self from others or try to please only oneself
Constructing New Underlying Assumptions & Experiments

Christine A. Padesky

Tape
Schema Based Therapy
Core Beliefs/Schemas; Understanding Their Origin

- It is important to help people understand the origin of their beliefs by gently examining the past.
- It helps individuals make sense of the world and their experiences.
- They are “absolute” as they often develop in childhood.
Schemas

- The goal of schema therapy is psychological awareness.
- The therapist helps the patient identify their schemas and become aware of the childhood memories, emotions, bodily sensations, cognitions, and coping styles associated with them.
- Once patients understand their schemas and coping styles, they can begin to exert control over their maladaptive responses, weaken the memories, emotions, bodily sensations, cognitions, and behaviors associated with them.
Schemas & Intermediate Beliefs

- The connection between the coping strategy and the schema that is driving it can be more easily understood when we join the two by means of an "if...then" statement.

- Intermediate Beliefs are the next layer of thinking, a deeper layer between automatic thoughts and core beliefs that represent the person’s expectations of him or herself and others in a given situation, depending on the schema.
Schemas & Intermediate Beliefs

Intermediate Beliefs are the next layer of thinking between Automatic Thoughts and Core Beliefs that are composed of positive and negative Assumptions, Attitudes, and Rules

**Assumptions**: If I am perfect then I will be worthy
If I fail then I am worthless

**Attitudes**: It is unacceptable to fail

**Rules**: I must always succeed
Finding Intermediate Beliefs and Schemas

- Statements in thought records – look for Rules (I must always be...) or Assumptions (If I were Attractive....then...) or Attitude (only attractive people...)
- Look for patterns of behavior – avoidance (may identify assumption that keeps him or her stuck i.e. “if I [do what I am avoiding] then...) or repetitive or rigid coping behaviors (may be maintained by assumptions (if I am always helpful then...)
- Providing the first part of the assumption: If...then
- Downward arrow technique: of the self, future, and others
- Using available lists of schemas
- Case conceptualization
CBT Treatment for Schemas

- Once identified, the core belief and assumptions and coping strategies used in response to the belief can be challenged to determine if they are helpful, dysfunctional, and unbalanced.
- If determined to be dysfunctional, the behavior can be modified to develop new functional beliefs, assumptions, and strategies.
- Evidence technique and responsibility distribution can work however schemas are more deeply rooted.
- Cost/Benefit analysis helps with core beliefs.
CBT Treatment for Schemas

- Cost Benefit Analysis involves identifying the assumption/coping strategy and identifying all the costs and benefits that go along with them...eventually developing a new assumption and strategy
- Implementing the new strategy and assumption, in real life, is vital
- The model of CBT alone allows for a shift in perspective (decentering)
- Emphasis on the importance of experience rather than rational exercise (evidence) in changing schemas
  - *The best way to change a belief is to behave against it*
Intermediate Beliefs Come From

- Our Families of Origin
- Cultural Values
- Media and more
Intermediate Beliefs

- These are a level of thoughts between automatic thoughts and core beliefs.
- Intermediate beliefs include rules, attitudes and conditional assumptions.
Rules

- Often expressed as should statements on thought records.

Examples:
- You should always do your best.
- Other people should consider our feelings.
- Never tell family problems to outsiders.
- I must keep my house spotless.
Conditional Assumptions

- The level of intermediate beliefs most effective to work on modifying
- Often are presented in If...Then statements
- Connect compensatory strategies to core beliefs
Conditional Beliefs Outline the Conditions Under Which the Core Belief Will Be Activated or Avoided

If I say yes to everybody, then everyone will like me, and I will feel lovable.

If I say no to people and express my own needs, they might reject me and I will feel really unlovable.

- If I work hard to get all my work done every day, others will respect me and I will feel competent.
- If I do not get my work done perfectly, others will think I am incompetent and I will feel like a failure.
Costs and Benefits

- There is always a benefit or perceived benefit to the conditional assumption and behaviors associated to it.
- It is important to elicit the benefits from the patient, as well as the costs of maintaining this belief.
Developing New Conditional Assumptions

- It is helpful in developing new assumptions to try to incorporate some of the benefits of the old belief.

- It is also helpful to have the patient visualize a new core belief they would like to develop.

- This new core belief needs to be realistic and not be part of all or nothing thinking.
If I do everything perfectly, I will be a valuable human being, I will have worth and be good enough

- Benefits of belief - I do things very well, this improves my self-esteem, at times I do feel valuable, others think well of me.

- Costs of belief - I give up a lot of what I want to do, I don’t try new things in case I don’t do them well, I stop doing some things because I can’t do them perfectly, I can never be spontaneous or flexible, a lot of the time I do not feel good enough because I can only do things perfectly some of the time.
Potential New Belief -
I Am Lovable and Worthy Just By Being

- If I do things that I value well, but not perfectly, some of the time, then it encourages my self-esteem, I feel valuable without “crashing” and going to bed when I don’t do things perfectly. I can feel as worthy as the next person and others will still think well of me.
Action Plan

- I have always wanted to take dancing lessons and I am going to join a belly dancing class and just have fun.

- I will try to go to the gym twice a week instead of trying to go every day, then not going at all.

- When my friends invite me to go to the movies I will say yes instead of staying home to clean my house.
CBT Interventions for Changing Schemas/Core Beliefs

- Help the patient to identify a potential new, more functional core belief.
- This could be based on what they used to think about themselves at a time in their lives when things were going well.
- It could also be an image of what they would like to think about themselves.
- Avoid black and white thinking.
Collecting Evidence

- People tend to very easily collect evidence that a negative core belief is true, with selective attention and disqualifying positive data.

- Now you want the patient to collect evidence that a new more functional core belief is true.
Positive Data Log

- Have the patient begin to collect evidence to support new thought, i.e. new core belief.
- Start this work in the session, because the patient may have difficulty with this.
- This self-help activity can replace any “journaling” that your patient may tend to do where they likely focus on negative material.
- Look for evidence from the past as well as current ongoing evidence.
Behavioural Experiments and Action Plans

- If your patient continues with coping behaviours that are not very functional, this can interfere with finding evidence to support a new belief.
- Therefore plans to try out new behaviours are important.
- It is important to problem solve potential negative outcomes.
- New information can be added to positive data log.
- e.g. I was assertive with my husband about cleaning up the kitchen after himself; he still is not doing it all the time, however, I was able to express my feelings about it and I feel I have more respect for myself than when I was ignoring it.
Developing New Conditional Assumptions

- Developing new conditional assumptions are a key to changing negative core beliefs
- Behavioural experiments and action plans can follow from these new beliefs
Cognitive Continuum

- Since core beliefs are part of all or nothing thinking, using a continuum can be helpful to patients

- Have your patient use a metaphor and develop characteristics for each end

<table>
<thead>
<tr>
<th>0</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally incompetent</td>
<td>Totally competent</td>
</tr>
<tr>
<td>Homer Simpson</td>
<td>Oprah</td>
</tr>
<tr>
<td>Almost blows up nuclear plant</td>
<td>Has her own TV show</td>
</tr>
<tr>
<td>Constantly messes up</td>
<td>Always looks great</td>
</tr>
<tr>
<td>Embarrassed his family</td>
<td>People respect her</td>
</tr>
</tbody>
</table>
Next Step

- Where would you rate yourself on this continuum?
- Is it realistic to aim for 100, “Oprah”?
- How much money and how many people does it take to help Oprah maintain that role?
- Do you imagine that Oprah would put herself at 100 on this continuum?
- Are there areas where Oprah is not competent?
Rating Yourself

- Where would you place yourself on this continuum?
- Where would you place some of the people in your life?
- What could you do differently to move yourself up on this continuum?
- This can lead again to an action plan or behavioural experiment.
Flashcards

- Flashcards can be used to capture significant new beliefs

- When old dysfunctional beliefs are triggered, flashcards can be a quick reminder of new belief
Relapse Prevention

- Depression is a recurrent illness
  - Recognize early signs/symptoms or relapse signature
  - Do regular BDI’s
  - Develop an action plan