

Low Intensity Cognitive Behaviour Therapy

A Practitioner's Guide

Edited by
Mark Papworth and Theresa Marrinan

2nd Edition



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Contents

List of figures, tables and exercises	vii
About the editors and contributors	xiv
Acknowledgements	xvi
1 Introduction	1
<i>Mark Papworth</i>	
2 The role of the LICBT practitioner	19
<i>Mark Papworth</i>	
3 Understanding the problem	49
<i>Mark Papworth</i>	
4 The therapeutic relationship	67
<i>Anna Chaddock</i>	
5 Interview structure	85
<i>Mark Papworth</i>	
6 Assessment and management of risk	118
<i>Mark Papworth</i>	
7 Behaviour change and client engagement	151
<i>Mark Papworth</i>	
8 Understanding depression	177
<i>Theresa Marrinan</i>	

vi Low Intensity Cognitive Behaviour Therapy

9	Understanding anxiety	197
	<i>Theresa Marrinan</i>	
10	Treatment strategies	221
	<i>Theresa Marrinan</i>	
11	Inclusive values and perspectives	280
	<i>Mark Papworth and Bobbie Petford</i>	
12	Inclusive practice	304
	<i>Mark Papworth and Bobbie Petford</i>	
13	Working with older people	319
	<i>Claire Martin and Daniel Collerton</i>	
14	Working with long-term conditions	350
	<i>Chris Penlington</i>	
15	Adapting LICBT for people with learning disabilities	386
	<i>Dave Dagnan</i>	
16	Work and wellbeing	404
	<i>Theresa Marrinan</i>	
17	Supervision	428
	<i>Mark Papworth and Dominique Keegan</i>	
	Appendix: The use of case studies	462
	<i>Mark Papworth</i>	
	References	485
	Index	522

9

Understanding anxiety

Theresa Marrinan

Learning objectives

- To distinguish between normal and clinical anxiety.
- To describe the key factors which lead to the maintenance of clinical anxiety.
- To identify the main anxiety disorders that can be treated using the LICBT approach.

Introduction

In this chapter, we will be exploring what is meant by the term anxiety, and looking at the differences between the normal anxiety response and clinical presentations of anxiety. We will particularly focus on the way in which anxiety symptoms in clinical disorders are maintained by cognitive processes and behaviours, as explained by the CBT model of anxiety. Whilst many anxiety disorders can be treated successfully using standard CBT, we will focus on those that have an evidence base for treatment using a low intensity CBT approach. This will be followed up in Chapter 10 with a detailed description of the methods for treating anxiety disorders using LICBT.

What is anxiety?

Human beings have evolved in environments that are dangerous and unpredictable. The ability to recognise and deal effectively with threat has been crucial to our survival as a species and thus the associated fear response is thought to be built into our biological makeup (Öhman & Mineka, 2001). In other words, we are hardwired to experience fear in reaction to situations involving danger. When we experience a sense of threat, changes occur in the brain and body that enable us to deal effectively with the situation. This involves the autonomic nervous system, that part of the nervous system that acts without our conscious control and helps to regulate our bodily functions. Adrenaline is released into the bloodstream, resulting in changes such as: increased blood flow to the muscles and diversion of blood flow from other parts of the body in order to provide the body with extra speed and strength, increased heart rate and breathing allowing more oxygen into the body which enables the muscles to produce more energy, closing down of the digestive system so the body can concentrate on the most immediate threat and increased sweating to cool down the body.

When we sense threat, there are also changes to our state of mind: our attention is both heightened as we focus on the threat and its possible consequences and narrows as we selectively attend to cues associated with the danger. This enables us to respond in the most efficient manner as our attention is drawn away from extraneous factors and we focus on the danger at hand. Imagine, for example, you are crossing the road and a speeding car comes towards you. Before responding, would you take the time to note the colour or make of the car, who was driving or the direction the car had come from? Or would you simply jump out of the way? Usually the latter! You might then take the time to consider the contextual information as you contemplate the potential danger you were in, but your immediate instinct would be to get out of the way as quickly as possible without considering less important factors, thereby increasing your chances of survival.

We can break down the anxiety response into five areas: the situation or trigger that set off the response, our emotions, physiological responses, thoughts and behaviours. These will be described in more detail below, however first it may be useful to consider your own experience of anxiety (see Exercise 9.1).

Exercise 9.1 Your experience of anxiety

Think back to the last time you felt anxiety, for example prior to attending a job interview, a dental appointment or doing a presentation. Describe the situation. What kinds of thoughts went through your mind? What did you fear might happen? What emotions did you experience in response? What changes did you notice in your bodily state? What did you do to try to cope with, or reduce your anxiety?

Situation

The anxiety response is usually triggered by a sense that there is some danger or threat present. This may be very obvious, for example a fire alarm going off, or more subtle, such as perceiving a level of criticism in a comment made by another. A variety of situations can elicit anxiety, including those that pose a risk of actual physical danger or an interpersonal one where, for instance, an individual fears being rejected. Sometimes we can explain the fear quite easily, at other times our fears may seem irrational, as with many phobias where the object that produces a fear response may present no obvious danger.

Emotions

The emotion most commonly associated with threat is fear. We may describe this in various ways depending upon the level of perceived threat and the distress caused. This may range from mild discomfort, nervousness and unease to fear, dread or even terror. In addition, there may be associated secondary emotions (Hackmann et al., 2009) such as embarrassment, shame or anger.

Physiological response

When we are in a state of heightened anxiety we may feel this most acutely in our bodies as we experience physical changes such as fast heart beat, quick or shallow breathing, dizziness, shaking, dry mouth, tight chest or sweating excessively. In addition, there can be a sense of unreality, where the person feels as though they are outside their own body observing themselves (*depersonalisation*) or feels dissociated from their environment, almost as though in a fog (*derealisation*). These symptoms are often very distressing for the individual. See Box 9.1 for a list of common physical signs of anxiety.

Thoughts

In situations perceived to be threatening, our thoughts tend to narrow as we consider the potential consequences if we can't escape or at least minimise the danger. Whether we experience anxiety in any given situation may depend on both the objective circumstances as well as our own perceptions of the threat. So, for example, we might expect most people to experience anxiety in the context of a threatened terrorist attack, whereas a social gathering may cause different reactions depending on one's expectations about the event.

Box 9.1 Common physical signs of anxiety

- Muscle tension, aches or pains
- Racing heart
- Sweating
- Trembling/shaking
- Butterflies in stomach
- 'Rubbery' or heavy legs
- Dry mouth
- Blushing or going pale
- Numbness or tingling in fingers, toes or lips
- Blurred vision
- Shortness of breath
- Dizziness or feeling faint
- Tightness in throat or difficulty swallowing
- Indigestion/stomach cramps
- Diarrhoea, nausea
- Urge to urinate
- Depersonalisation
- Derealisation

Behaviours

Our reactions to threat typically involve one of the following responses: to try to get away from the danger, to fight it or to stay very still. These reactions are collectively known as the *fight, flight or freeze* response and can be very adaptive ways to manage danger (see Table 9.1).

The symptoms of anxiety are generally unpleasant and the drive to reduce them means we may go to great lengths to escape or avoid those situations that cause fear. Avoidance may be very overt such as running away from the perceived danger, or quite subtle such as trying not to think about the thing that scares us. We may even restrict our activities in order to avoid placing ourselves in situations that have the potential to raise our anxiety.

In conclusion, the anxiety response to threat can be seen as adaptive in that it provides the drive to avoid or manage threatening situations. However, for some people,

Table 9.1 Protective advantages of the anxiety response

Response	Potential benefits
Fight	An effective way to keep safe is to eliminate the threat at source. By fighting, we can remove the threat or reduce our chances of being harmed, for example by killing or trapping dangerous predatory animals
Flight	Escaping from dangerous situations as quickly as possible is an effective means of removing ourselves from the source of threat
Freeze	By staying very still in the presence of danger we may avoid being noticed. Consider how animals are able to use camouflage (e.g. mountain hares with white fur who can blend into the snowy background, green lizards which appear invisible amongst plants) or the design of soldiers' uniforms which enables them to appear inconspicuous in dangerous environments. Alternatively, by remaining still and unresponsive in the presence of a dangerous predator we may reduce the likelihood of being viewed as a threat

the anxiety response may be exaggerated or beyond what would be considered adaptive for the level of threat posed and may impact on their capacity to carry out the normal activities of everyday life. This is explored further below.

Clinical anxiety

Clinical anxiety has been described as: 'an unpleasant emotional state ... unconnected with or disproportionate to environmental threats' (Roth & Argyle, 1988: 33). When the response to threat is proportionate it can be seen as adaptive in that it helps to keep us safe. Problems arise when the level of threat is persistently overestimated. This can result in excessive or chronic anxiety, high levels of avoidance and disruption to normal functioning.

The way in which clinical anxiety manifests will depend upon the specific anxiety disorder with which the person presents. For example, some people are frightened of particular objects such as spiders, others experience anxiety in social situations, whilst others may worry about the possibility of developing a serious illness. Thus, each anxiety disorder has its own particular features depending upon the situations or objects that trigger the anxiety response. These features are outlined in Table 9.2.

The LICBT practitioner needs to be able to clearly distinguish between the various anxiety disorders in order to both decide whether the LICBT approach might be appropriate and where to target the intervention. LICBT is recommended for a number of anxiety disorders as a first line treatment, namely panic disorder, generalised anxiety

Table 9.2 Key features of anxiety disorders

Anxiety disorder	Key features
Specific phobia	Persistent fear about an object or situation (often recognised as exaggerated), leading to high levels of avoidance of the feared object
Panic disorder	Recurrent, unexpected panic attacks (an abrupt surge of intense fear which reaches a peak within minutes and results in symptoms such as palpitations, breathlessness, dizziness). The person has persistent fear of having further panic attacks. Physical and mental symptoms are misinterpreted as dangerous, leading to behaviours designed to prevent panic attacks, such as avoidance
Agoraphobia	Fear of being in open/closed spaces, crowds, outside of home alone or far from a place of safety, going on public transport. Often comorbid with panic disorder
Social anxiety disorder	Fear of being negatively evaluated in social or performance situations. Such situations are avoided or endured with intense fear or anxiety
Generalised anxiety disorder	Persistent and excessive worries pervading many aspects of the person's life, and difficulties coping with uncertainty. Associated with restlessness, fatigue, problems with concentration, muscle tension, irritability and sleep disturbance
Obsessive compulsive disorder	Recurrent obsessions (unwanted intrusive thoughts, urges, images, doubts) or compulsions (behaviours the person feels driven to perform in response to intrusive thoughts or rules, or as a way to prevent a feared outcome). Compulsions are usually recognised as excessive or unhelpful but the person still feels compelled to perform them
Illness anxiety disorder (previously known as health anxiety or hypochondriasis)	Fears of having or acquiring a serious illness, in the absence of somatic symptoms (or, if present, are very mild), accompanied by excessive health-related behaviours such as repeatedly checking body for signs of illness

disorder (GAD) and obsessive compulsive disorder or OCD (Clark, 2011). In this chapter, we will also present a formulation of specific phobia, as this is a condition that often presents in primary care services, for which CBT has been shown to be effective (Choy et al., 2007) and which can be relatively straightforward to treat. LICBT treatment should be targeted at mild to moderate levels of severity. For more severe presentations of anxiety disorders or where the LICBT approach proves to be ineffective, the person should be stepped up to high intensity CBT which involves longer sessions and lengthier treatment. Often clients present with overlapping disorders. In such instances, it is also important to consider the nature of their comorbidity. Practitioners should refer to established diagnostic manuals such as the DSM-5 (APA, 2013) when making decisions about diagnosis (see Chapter 3 for further detail).

As we have established, it is normal to experience anxiety in particular situations or at different times. Key factors that distinguish clinical presentations from normal anxiety are the level of distress caused, whether the symptoms cause significant impairment to normal functioning (social, family, occupational, etc.) and the length of time the person has been experiencing the symptoms (typically symptoms need to have been present for at least six months, but this may vary according to the disorder). These areas should be assessed by the use of thorough questioning and psychometric measures (see Chapter 3 for a list of disorder specific measures).

Anxiety disorders are common in the general population, with 14–29 per cent of people reporting some form of clinical anxiety during their lives (Michael et al., 2007). Indeed, GAD has been found to be the single most common cause of workplace disability (Ballenger et al., 2001). In any given year the number of adults suffering with an anxiety disorder is highest for phobias (8.7 per cent), followed by social anxiety disorder (6.8 per cent), GAD (3.1 per cent), panic disorder (2.7 per cent), post-traumatic stress disorder (1.3–3.6 per cent) and OCD (1 per cent; NICE, 2011a). There is some evidence that prevalence declines with age (Byers et al., 2010). Rates are generally higher amongst women, with anxiety disorders occurring approximately twice as often than for men, and comorbidity between anxiety disorders is common (APA, 2013). Practitioners should also be alert to symptoms of depression, which commonly occur in clients who present with anxiety (Fava et al., 2000). Substance use disorders may also be comorbid (Michael et al., 2007).

Anxiety disorders often develop in childhood and may last through to adulthood if not treated, with later onsets being associated with higher levels of comorbidity (Kessler et al., 2005). As with many mental health problems, anxiety disorders are more common amongst those with a lower socioeconomic status, so factors such as low income, low education and unemployment may be risk factors for developing clinical anxiety (Michael et al., 2007). Socioeconomic position is also linked to poorer outcomes in psychiatric treatment, perhaps because of factors such as chronic stress (Roy-Byrne et al., 2009), which is likely to be linked to social deprivation.

Maintenance processes

When we experience anxiety in the context of actual threat, the ‘fight, flight or freeze’ response enables us to deal with the danger by reducing or eliminating the threat, which results in a corresponding fall in the level of anxiety. However, for those with clinical anxiety, some of these same responses can serve to maintain the person’s anxiety. Within the CBT model, this can be explained via the typical cognitive and behavioural responses exhibited by those with clinical anxiety. Cognitive responses refer to how the

person views those situations that cause them anxiety, for example in clinical presentations this might involve overestimating the level of risk or underestimating the capacity to cope. Behavioural responses refer to actions carried out in an attempt to reduce anxiety. These responses will be examined in more detail below.

Cognitive bias

Human beings strive to make sense of the world. We constantly examine our experiences and try to understand them as best we can. Sometimes the basis for our understanding is well informed and accurate, but often we have to make use of less than complete information or adapt knowledge from other areas that may not be well suited to the current needs. In the absence of full information, or perhaps due to prior negative experiences, our thoughts can often be biased. The various forms of cognitive bias, which appear to be important in helping us to understand clinical anxiety, are described below.

Overestimating the likelihood of danger

This refers to the person's perception of how probable it is that their feared outcome will occur. For example, a person who is worried about giving a speech at a social event may fear that their mind will go blank midway through and that they will be unable to continue. The more likely they believe this outcome to be, the higher their anxiety which may then result in avoidance.

Overestimating the awfulness of the consequences

As well as overestimating the likelihood of a feared outcome, people usually consider the possible consequences if it were to happen. So, for example, whilst plane crashes are rare in comparison to road traffic accidents, the consequences are usually much more catastrophic, which is why many people are much more afraid of flying than driving. In addition, personal meanings are often attributed to feared outcomes occurring. In the earlier example, the prospect of going blank in the middle of a speech might be particularly upsetting if the person were to view this as an indication that they were inadequate in some way or that they will be judged very harshly. Thus, even when the likelihood of a feared outcome is low, where the person perceives that the consequences would be particularly awful, this is also likely to contribute to their anxiety. Careful questioning can help to elicit this information, such as 'If [the feared event] were to happen, what would be the worst thing about that for you?', 'What might it say about you?' and 'What are you worried that others might think?'

Exercise 9.2 Cognitive processes in anxiety

Can you think of an anxiety-provoking situation that you are likely to face, or something you could plan to do in the near future that might cause anxiety? For example: give a presentation; attend a social event with unfamiliar people; go on a first date; or try out something new. What is it about the situation that makes you feel anxious? What is your worst fear about what might happen? How likely is this to occur? What would be the worst thing about this if it were to happen?

Underestimating ability to cope

A further cognitive bias involves the tendency to underestimate one's ability to cope in a threatening situation. Where a person views themselves as poor at dealing with setbacks or unable to manage when things go wrong, they may be more likely to avoid the anxiety provoking situation. Unfortunately, avoidance resulting from an underestimation of coping skills means that the person has little opportunity to draw on existing skills and resources in challenging situations, practice problem-solving skills or learn that they can function effectively even when anxious.

Focus of attention

When we are faced with threat, our levels of alertness increase and we become more aware of any cues that might signal danger. For example, a person who is anxious about walking alone in an alley after dark may be extra alert to sounds or signs that someone may be following them. When in the presence of actual threat, this can be highly adaptive as it helps us to stay alert to danger and protect ourselves. However, where there is an exaggerated perception of threat, this may only serve to reinforce biased thinking. This is because we often have limited information, thus ambiguous or neutral signals can be misinterpreted and used to support anxious predictions. Indeed there may be a tendency to focus exclusively on those cues that may indicate threat, whilst ignoring alternative sources of information, a process known as *selective attention*. Consider, for example, the person who is nervous about public speaking and is highly alert to cues that members of the audience are bored, hostile or mocking. Noticing someone yawn or smile may only confirm their worst fears, and so further exacerbate their anxiety and reinforce biased thinking.

Exercise 9.3 Selective attention

Think back to a situation that made you anxious. What cues did you pick up on in the situation that may have reinforced your anxious predictions? In retrospect, can you see how you might have been selectively attending to particular aspects of the situation that then reinforced your anxiety?

Emotional reasoning

A final cognitive process that can maintain anxiety is the tendency to interpret experiences based purely on emotional reactions. Our emotions are powerful responses that we use to help us make sense of what is happening in any given situation. However, they can also bias our thought processes. For example, when a person's mood is low they can feel more hopeless about their situation. Similarly, when a person *feels* frightened this may lead them to assume that the situation must indeed be dangerous.

Behavioural responses

As described previously, the anxiety response drives us to try to eliminate or minimise danger and thus reduce the associated anxiety. Unfortunately, where the person's perceptions of threat are exaggerated, the actions they take may provide a short-term reduction in their anxiety but prevent them from learning that their fears were over-exaggerated. This can lead to a vicious cycle where the person believes that through their actions they have successfully avoided the perceived danger, but means they are prevented from learning that the event was either unlikely to occur or the consequences would be less awful than they anticipated, and so their exaggerated beliefs remain intact. In addition, they are more likely to carry out these same behaviours in the future both because of the short-term reduction in anxiety and because they believe that these are what prevented the perceived danger from occurring. The types of actions that people may take are described below.

Safety-seeking behaviours

In order to protect themselves from perceived danger, clients will often engage in behaviours designed to keep them safe. Salkovskis (1991) labels these strategies as *safety-seeking behaviours* or more simply, *safety behaviours*. The most obvious safety behaviours

tend to be avoidance and escape, whereby the person either avoids the feared situation or, once in it, tries to find a means of escape. A person with a fear of spiders, for example, may try to avoid any situations where they are likely to encounter spiders, such as basements. If they come across a spider, for example in the bathroom, they may leave the room or ask a housemate to remove the spider, thus eliminating possible contact. Whilst this may result in a reduction to the person's anxiety, it means that they don't have the opportunity to learn corrective information about the actual threat (or lack of threat). For example, they might find out that the spider is not a danger to them or that their discomfort or anxiety would likely reduce if they remained in its presence over time. These types of behaviours can also prevent the person from developing a capacity or tolerance for challenging situations. Recall the first time that you ever spoke in front of a group (or imagine what this would be like if you have never done this). For most people, this can be a very anxiety-provoking experience. After some practice, a bit of encouragement and a few good outcomes, however, your confidence may go up, your skills are likely to improve and the intensity of the anxiety you experience will likely reduce.

Often we don't have the option of avoiding or escaping a feared situation. Indeed, many clients may try to stay in situations that cause them high anxiety, recognising that avoidance doesn't help them in the long term. One way to cope may be to use safety behaviours designed to manage the threat. For example, a person who fears flying might restrict themselves to short flights, only travel when accompanied by a close relative, take a tranquiliser beforehand, use alcohol to relax or book a seat by the emergency exit. Their safety behaviours may even be very subtle or serve no obvious function in keeping them safe such as using distraction during the safety announcements, repeating a mantra or carrying a lucky charm. Unfortunately, by engaging in such behaviours, the person is likely to draw the conclusion that they only coped with or avoided danger by carrying these out. As a result, their beliefs about the perceived risk remain intact and they are very likely to continue to engage in using the same safety behaviours in the future.

It will be important for the practitioner and client to become aware of the use of such behaviours. The practitioner can help the client to recognise these through the use of careful questioning. Effective questions include: 'What do you normally do to stop yourself from getting anxious?', 'What did you do to prevent (the feared event) from happening?', 'What did you do to keep yourself safe in the situation?' and 'What sorts of things did you do to reduce/manage your anxiety when you were in the situation?'

The use of safety behaviours may also result in unintended consequences, for example focusing the person's attention more heavily on the perceived threat and keeping them in a state of high alert, thus maintaining their anxiety. Such safety behaviours then become a powerful maintaining factor in the anxiety cycle.

Exercise 9.4 Safety-seeking behaviours

Can you think of a time when you might have used safety behaviours to cope with a situation where your fears were over exaggerated? What did you do to avoid the perceived danger? As well as avoidance or escape, consider some of the more subtle safety behaviours that you might have used. What might have been the unintended consequences of your actions? What impact might these have had on your perceptions of the threat?

Scanning/hypervigilance

As described earlier, when we perceive ourselves to be in danger our focus tends to narrow as we selectively attend to cues associated with the threat. For the anxious client this can lead them to actively scan the environment for signs of threat, when in a situation perceived of as threatening. Since many neutral or ambiguous pieces of information can be interpreted as evidence that the perceived threat exists, looking for signs of danger can in itself become a self-fulfilling prophecy. Scanning for signs of danger can also keep the person in a state of high alert so maintaining their anxious state.

In conclusion, in order to understand the factors maintaining anxiety we need to explore both the cognitive responses, in other words the way in which the person makes sense of perceived threat, as well as behaviours which serve to prevent the person from disconfirming exaggerated beliefs. How we understand these processes can be demonstrated using a diagrammatic formulation, also known as a *conceptualisation* of the problem.

Formulation

Formulation in CBT is a means of describing the problem, understanding how the problem developed and explaining how the problem is currently being maintained (see Chapter 3). In the LICBT approach, the focus is on the processes currently maintaining the person's anxiety. Five key areas are considered in relation to this and can be captured using a five areas formulation model. This shows broadly how each of the areas we have previously discussed: the situation, thoughts, emotions, physiological responses and behaviours, interact with each other to maintain the problem (see Figure 9.1).

This model can provide a useful way to socialise clients to the CBT model. By breaking down the different areas, analysis of the problem becomes more manageable and

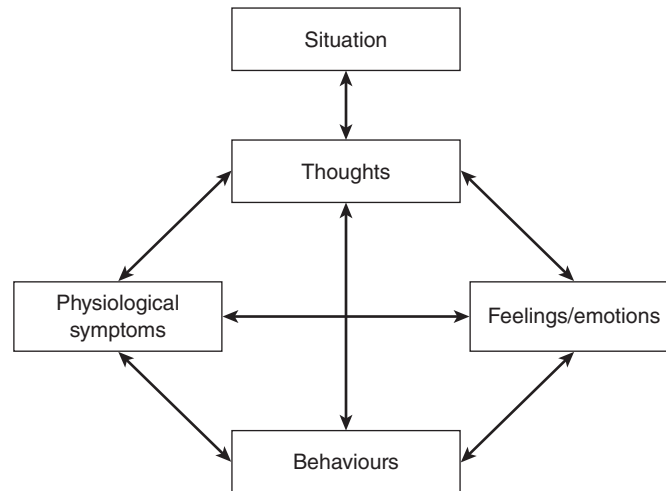


Figure 9.1 Five areas maintenance cycle

can help the person to feel less overwhelmed. It may then be useful to focus more specifically on particular maintenance processes as a way of targeting areas for change. We will consider this further below, in the context of those anxiety disorders which are recommended for treatment using the LICBT approach, namely specific phobias, panic disorder, GAD and OCD. Case studies are provided for illustration.

Specific phobia

Box 9.2 Case study: Specific phobia

Helen is a 25-year-old woman with a phobia of rats. She can't pinpoint when this started but remembers reading the George Orwell novel, *Nineteen Eighty-Four* (1949), at school, in which the main character is tortured with rats. She believes that if she encountered a rat it would run up her legs under her clothes and go up to her face. She also has images of baby rats running around her feet looking for their mother. The problem has become particularly marked recently since Helen moved into her own flat. She reports finding it difficult to take her refuse out to the shared waste disposal area as the bins are often overflowing with rotting vegetables and fast food containers.

(Continued)

(Continued)

Her neighbour helps out some of the time by taking her rubbish out for her. However, Helen is now starting to feel distressed about living in her flat. She has started to avoid going to places where she fears she might encounter a rat such as streets with a lot of fast-food outlets. She also avoids walking along the riverbank, which she used to enjoy, going to parks and walking near bins or skips.

Phobias are characterised by a persistent fear of a specific object or situation, which leads the person to avoid that object or situation. The fear is out of proportion to the actual level of threat posed. Often the person recognises that their fears are exaggerated or irrational. However, they nevertheless experience high levels of distress in the presence of the phobic stimulus or even just when thinking about it. Phobias are very common, with prevalence rates of 6–9 per cent in Europe and the United States, and around 2–4 per cent in Asian, African and Latin American countries (APA, 2013). The most common phobias are of heights, spiders, enclosed spaces, flying, dental treatment, snakes and injections (Oosterink et al., 2009). Many sufferers have multiple phobias (APA, 2013). Whilst it is not uncommon for most people to experience some level of fear about specific objects or situations, in order to reach a clinical threshold there should be significant impairment to the person's functioning.

It may be difficult to ascertain what the person fears will happen if they encounter the phobic stimulus as the primary focus of fears tend to vary across phobias (LeBeau et al., 2010). Frequently, people worry about being harmed, being trapped or losing control. With some phobias, the main reaction is one of disgust or revulsion, particularly in blood-injury phobia or with animal phobias. For those who experience panic attacks in the presence of their feared object, their primary fear may be about the anxiety symptoms produced. Others may find it difficult to pinpoint exactly what might happen if they remain in the presence of the feared object. For treatment purposes, eliciting the primary focus of the fear may not be necessary and it is often sufficient to know that the person is highly fearful in the presence of the phobic stimulus.

Whereas phobias typically involve a surge in adrenaline, resulting in an increase in blood pressure and heart rate, blood-injury phobia is unusual in that it is associated with the opposite bodily response. Sufferers experience an initial increase in their blood pressure, which is quickly followed by a sudden drop, which can then lead to fainting. People with this type of phobia tend to fear and avoid

situations involving direct or indirect exposure to blood, injuries, wounds, injections or other invasive health procedures, such as dental treatment or having blood taken. Around 4 per cent of the population appear to have this type of phobia; many having acquired it in childhood, and a high proportion have a history of fainting (Öst, 1992).

Avoidance of the feared object is very common in phobias. This may generalise beyond the specific object or situation that is feared, for example avoidance of parks in case of encountering dogs (dog phobia); avoidance of waste (rat phobia); avoidance of gardens or cellars (spider phobia). This avoidance prevents the person from learning that their fears are exaggerated and so serves to maintain their fear (see Figure 9.2).

In addition, hypervigilance may be common, with the person constantly scanning the environment for signs that indicate the presence of the phobic object, for example checking weather reports frequently (thunder phobia); constantly checking for signs that other drivers are too close (driving phobia); being alert to dog walkers from a long distance away (dog phobia). As described previously this may serve to keep the person alert to perceived danger or encourage avoidance.

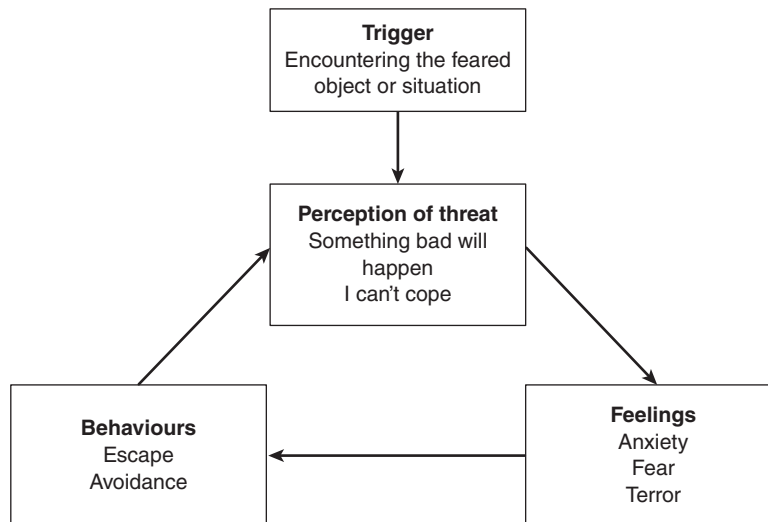


Figure 9.2 Maintenance cycle for specific phobia

Panic disorder

Box 9.3 Case study: Panic disorder

Angela is a 48-year-old woman who started having panic attacks three months ago. She reported to her primary care physician that during the panic attacks she is very aware of her heart beating rapidly. She also experiences shortness of breath, saying that however deeply she tries to breathe it feels as though she can't get enough air into her lungs. Angela was terrified when she had her first panic attack and believed that her lungs were collapsing. Her friend became worried and called an ambulance. Angela attended the emergency department of her local hospital, where a doctor diagnosed that she was having a panic attack. She said that he didn't really explain what this is, 'just something to do with being anxious' and she has continued to have panic attacks ever since. She had her first attack when out shopping. She now avoids going into town when it is busy and will only go shopping when her husband goes with her, buying small amounts so that she doesn't have to stay in the shop for very long. Whenever she feels anxious, she tries to slow down her breathing or breathe more deeply to ensure that she is taking in enough oxygen.

Panic disorder is characterised by the presence of recurrent or unexpected panic attacks. A panic attack is defined as a sudden surge in anxiety that reaches a peak within minutes and is associated with a number of physical symptoms such as breathlessness, palpitations, shaking, feelings of choking and dizziness. There may also be a sense of being outside of oneself (*depersonalisation*) or of being dissociated from the environment (*derealisation*). According to the CBT model (Clark, 1986), panic attacks are thought to result from *catastrophic misinterpretations* that the person makes about these symptoms. In other words, the person is terrified of what their symptoms might mean, believing, for example, that a racing heart indicates that they are going to have a heart attack, difficulty swallowing means they are going to choke, feeling lightheaded will result in them passing out or that the symptoms won't stop, leading them to go mad or lose control. This then serves to increase their anxiety, increasing or maintaining their symptoms, leading to a vicious cycle (see Figure 9.3).

When formulating panic disorder, it is important to elicit these catastrophic misinterpretations as they are a key factor in the maintenance of the panic attack. Questions should focus around these symptoms to explore the meaning that has been attributed to them, for example: 'When you noticed your heart beating fast what did you fear might happen?', 'When you struggled to catch your breath what were you frightened might happen?' and 'What is the worst thing that might have happened

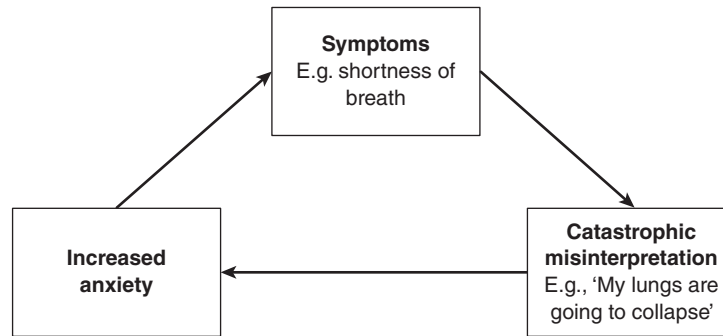


Figure 9.3 Maintenance cycle for panic: catastrophic misinterpretation

if the symptoms had continued or you hadn't been able to get out of the situation?' Sometimes panic attacks may appear to come out of the blue. In these situations, it is useful to ask the person what the first sign was for them that they were having a panic attack. It is often the case that those experiencing panic disorder are hypervigilant to any indications of the symptoms occurring, for example noticing their heart beating faster or their breathing becoming more shallow. The person may misinterpret this as the sign of an impending panic attack, so raising their anxiety and further exacerbating the symptoms.

As a result of the attributions made about the symptoms, the experience of having a panic attack can be extremely distressing and so avoidance is common. This may include avoiding situations where the person has had panic attacks previously or anticipates having a panic attack (e.g. crowded places), or leaving situations as soon as they start to feel anxious. Where avoidance or escape are difficult, the person may engage in more subtle safety behaviours as an attempt to prevent or manage the panic attacks (such as carrying medication, only going shopping at quiet times, always being accompanied by a friend or relative, or checking for possible exits to enable a quick getaway). Such behaviours keep the person's focus on their fears of having a panic attack and, crucially, prevent them from learning that panic attacks are harmless (see Figure 9.4) and that anxiety symptoms tend to disappear of their own accord in much the same way that the body eventually calms down after physical exertion.

Unfortunately, clients often try to manage the symptoms in ways that are unhelpful, for example, by trying to slow down breathing or by taking deep breaths. As described earlier, the anxiety response leads to increased heart rate and breathing, allowing more oxygen into the body, which, in turn, enables the muscles to produce more energy. By breathing more deeply, the person only increases the level of oxygen in their blood,

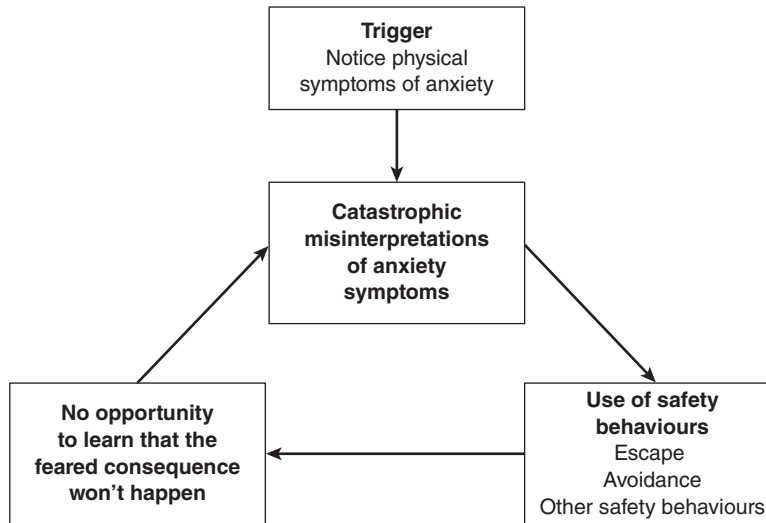


Figure 9.4 Example of maintenance cycle for panic: safety behaviours

which maintains the anxiety symptoms and can also exacerbate other symptoms such as feeling light-headed, so feeding into the vicious cycle. Useful questions to elicit these behaviours may include: ‘What actions did you take to try to reduce your anxiety?’ or ‘What kinds of things did you do to try to prevent (the feared consequence, e.g. heart attack) from happening?’

Agoraphobia

Agoraphobia is a disorder that often accompanies panic disorder. The person has a fear of getting trapped in particular situations such as enclosed spaces, crowds or travelling on public transport, or alternatively being far from a place of safety. In the case study provided in Box 9.3, for panic disorder, we can see that Angela has become avoidant of going to places that are busy. As time goes on, she has become avoidant of more and more places where she fears that she might have a panic attack. In assessing whether agoraphobia is also present, useful questions may include: ‘Are there any situations you avoid in order to prevent having a panic attack?’, ‘What kinds of things have you stopped doing since you started having panic attacks?’ and ‘If you didn’t have panic attacks what would you do more of?’

Generalised anxiety disorder (GAD)

Box 9.4 Case study: Generalised anxiety disorder

Martin is a 46-year-old man who lives with his wife and two teenage children. He would describe himself as always having been a worrier, however over the past year he has been experiencing increasing levels of anxiety after a number of redundancies were made in his workplace. His worries primarily revolve around fears of being made redundant. He also worries about interest rates rising and not being able to pay his mortgage, his elderly parents becoming ill, his children getting bullied at school, and household appliances or his car breaking down. He finds it difficult to get to sleep and often wakes up in the night in a state of high anxiety. He constantly feels restless and irritable, is smoking heavily and has lost his appetite. His wife is becoming increasingly concerned about him and has urged him to get some help.

The ‘cardinal’ feature of GAD is worry (Wilkinson et al., 2011: 5). For those who experience GAD, the tendency to worry is persistent and excessive. Whilst the content of their worries is typical of the usual things most people worry about such as family, finances, work and relationships, the worries associated with this clinical condition tend to be disproportionate and are present for most of the time, despite the absence of a specific triggering event.

Those who present with GAD tend to perceive their worrying as being outside of their control. However, the CBT model suggests that they are actively engaging in worry in an attempt to reduce uncertainty. In other words, they try to anticipate all of the possible worst-case scenarios. This may be because they hold *positive beliefs* about the benefits of worry of which they are not fully aware, believing, for example, that worrying helps them to find solutions to problems, shows they are a responsible person or prevents bad things from happening (Wilkinson et al., 2011). In this sense, worrying can be seen as a misguided attempt to mentally problem-solve. Thus, when a problem arises the person engages in an endless series of ‘what if’s, as they try to prepare for all of the worst-case scenarios and anticipate all possible outcomes. Unfortunately, each ‘what if ...’ leads to another potential worst outcome in the person’s mind, and as the process continues, the worries become less and less related to the immediate problem. This is sometimes referred to as *hypothetical* worry as opposed to *real* worry. So, for example, in Martin’s case, when the boiler breaks down his worries may start with the actual problem (how will he get it fixed? – the *real* worry), but very quickly escalate to

concerns that he won't be able to afford the repair, he will fall behind with the mortgage payments, lose his house and end up living on the streets (*hypothetical* worry). This results in the person feeling overwhelmed and increases their anxiety, making it more difficult to engage in actively solving the immediate problem and so keeps the person focused on their worries (see Figure 9.5). The chronic state of anxiety that this creates results in restlessness, fatigue, problems with concentration, muscle tension, irritability and sleep disturbance. A longer-term consequence may be the reinforcement of beliefs that the person cannot manage difficulties, which further reinforces their avoidance of tackling problems as they occur.

When formulating GAD with clients, the practitioner should gather information about the client's tendency to worry. Useful questions include: 'Would you characterise yourself as a worrier?', 'Do other people in your life describe you as a worrier?', 'Have you always been a worrier?', 'If you weren't worried about this particular situation (e.g. job uncertainty), is there anything else you would be worrying about?' and 'If this particular worry resolved itself would you find other things to worry about?' These types of questions help to focus the client on the key aspect of their anxiety which is a propensity to worry, rather than the particular stresses they may be experiencing at

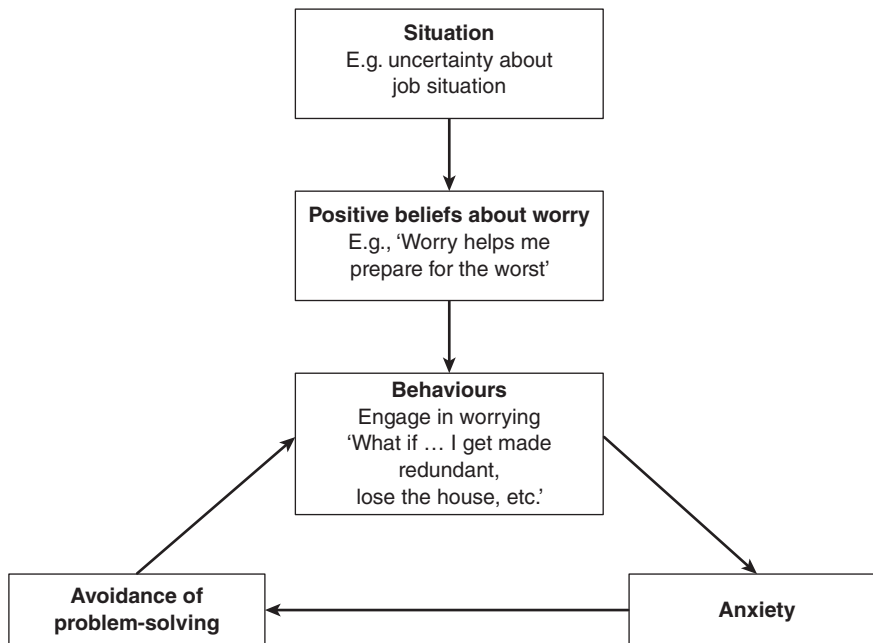


Figure 9.5 Maintenance cycle for GAD

the current moment. In this way, the practitioner can also distinguish between stress, which tends to be a short term reaction to factors in the environment which the person may not have sufficient resources to deal with (e.g. over work, too many caring responsibilities, being in debt), as opposed to a long-term tendency to worry which would exist regardless of environmental stressors (though may be heightened by them). These types of questions can also prove helpful in distinguishing GAD from acute adjustment disorder, where the person has become markedly distressed and their functioning is impaired as a result of an identifiable stressor occurring within the previous three months (APA, 2013).

When working with GAD, it is important to maintain a focus on worry as a process rather than getting caught up in trying to deal with the content of every worry the client brings. Often clients will present with a particular worry that is consuming them that week. Their tendency to catastrophise about the worry may lead them to engage in subtle or overt reassurance-seeking which is usually counterproductive. Thus, working successfully with clients with GAD involves keeping a focus on the process of worrying rather than the content of the worries.

Obsessive compulsive disorder (OCD)

Box 9.5 Case study: Obsessive compulsive disorder

Ayesha is a 32-year-old woman with obsessive compulsive disorder. She carries out numerous checking behaviours when leaving the house or before going to bed. Her fear is that if she hasn't done sufficient checks she may be responsible for something bad happening such as causing a fire (through leaving on electrical appliances), causing a flood (by leaving her taps open) or allowing burglars to get in if she hasn't locked up properly. Her checking rituals take up hours each day, making it difficult for her to lead a normal life.

OCD is a condition characterised by recurrent obsessions and compulsions. Central to the development of OCD is an inflated sense of responsibility for preventing harm coming to others (Salkovskis, 1985). This may include fears about putting others in danger by being careless or doubts about having carried out a necessary activity such as turning off taps or electrical appliances, locking up the house, fears about contaminating others through the transmission of germs, or fears of behaving in an unacceptable manner as a result of having inappropriate thoughts or *obsessions*. The person may experience thoughts that they find distressing or may be contrary to their own morals or

values (sometimes termed *ego dystonic* thoughts). This may include thoughts about harm coming to others, unacceptable sexual thoughts or blasphemous thoughts. The fleeting occurrence of such thoughts has been found to be common in the general population (de Silva & Rachman, 2004) and most people are untroubled by them. Difficulties occur when the person is excessively worried about what it means to have such thoughts, seeing them as a sign of their poor morals, a wish for bad things to happen to others or even that they may act out the thoughts, which causes high levels of distress. This results in various behaviours (which are termed *compulsions*) which are carried out to prevent the feared outcome. Examples include repeatedly checking that household appliances have been turned off, excessive cleaning or hand-washing, or attempts to cancel out or *neutralise* unacceptable thoughts. Often the latter involves the use of superstitious rituals such as tapping a piece of furniture or repeating a phrase. Although the person may recognise that their behaviours are excessive, unhelpful or even irrational, the potential consequences of not carrying out these behaviours are predicted to be so disastrous that not engaging in them is seen as too high a risk. Unfortunately, engaging in such behaviours has the unintended consequence of keeping the person's attention focused on the thoughts and imbuing them with more legitimacy. This also prevents the person from learning that their feared outcome is highly unlikely to occur or that the obsessional thoughts, if not attended to, are likely to disappear by themselves.

Figure 9.6 shows an example maintenance cycle for Ayesha, referred to in the case study in Box 9.5. In formulating OCD, it is important to gather information about the nature of the obsessional thoughts, the feared consequence for the person if they don't respond to their doubts, urges or intrusive thoughts and the checking behaviours or rituals they engage in as a result. Useful questions for eliciting this information include: 'What do you think it means that you have this thought?', 'What are you worried might happen if you couldn't dismiss this thought?', 'What do you do in response to these

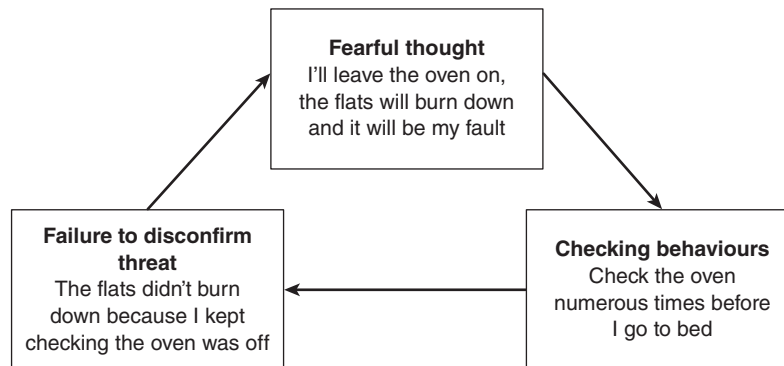


Figure 9.6 Maintenance cycle for OCD: safety behaviours

thoughts?’ and ‘What is the worst thing that might happen if you don’t carry out the behaviours?’ Where thoughts are perceived of as unacceptable, it can be very difficult to elicit their content as clients may fear that the practitioner will judge them negatively or there may even be a worry that voicing such thoughts might make them more likely to occur. This requires sensitivity on the part of the practitioner.

Exercise 9.5 Formulating anxiety

Using the case studies provided for all the disorders covered in this section, draw up some more possible formulations to explain how the person’s difficulties may be maintained.

Use of self-help materials

When working with clients using an LICBT approach, the practitioner should help the client to understand the maintenance processes during the assessment and initial treatment sessions. It is important to focus on a typical example of a situation where the problem occurred in order to help them to draw out their responses and understand how the problem is kept going. A recent example is likely to be easier for the client to remember and will provide more accurate details. Clients should then be encouraged to gather more examples themselves. This will help them to recognise their responses and how these may be feeding into the problem as well as begin to identify what they need to do to break out of unhelpful cycles. Useful templates are provided on self-help websites and in self-help books to enable them to do this; see for example:

- Get Self Help website: www.getselfhelp.co.uk.
- *How to beat panic disorder one step at a time* (Farrand and Chellingsworth, 2016).
- *How to beat worry and generalised anxiety disorder one step at a time* (Chellingsworth and Farrand, 2016).
- *Break free from OCD: Overcoming obsessive compulsive disorder with CBT* (Challacombe et al., 2011).

Conclusion

As we have seen, a number of maintenance processes are involved in keeping anxiety disorders going. At the heart of each anxiety disorder are thoughts or beliefs about the

nature of the threat. These are seen to drive the anxiety response and the actions the person takes as a result. Behaviours that clients engage in to prevent the feared outcome result in them failing to learn that the feared consequence has been exaggerated or that if it did occur they would be able to cope, and thus serve to maintain the problem. The treatment of anxiety disorders using an LICBT approach will involve guiding the patient with the use of detailed self-help materials to both build their understanding of these maintenance factors and to learn techniques which help them to break the cycles of maintenance. These will be explored in Chapter 10.

Summary

- The anxiety response is normal, appropriate and necessary for us to function safely.
- The CBT model proposes that anxiety disorders are maintained by exaggerated beliefs about potential threat, and result in the person engaging in behaviours that are designed to keep themselves or others safe, but which maintain the problem by preventing them from learning corrective information about the situation they fear.
- Anxiety disorders are very common in the population and a thorough assessment requires that practitioners have a good understanding of their diagnostic features.
- LICBT can be used effectively to treat specific phobias, panic disorder, GAD and OCD.
- During the assessment, the practitioner should start to explore key cognitions and behaviours, and map these out with the client using formulation diagrams that are usually embedded in self-help materials. These can help the client begin to understand how their difficulties are being maintained and so help to prepare them for change techniques that are designed to help them break unhelpful cycles.

Further reading and activities

As with all new knowledge and skill sets, much of this information and advice will only make clear sense when you start to practise it. Becoming familiar with the diagnostic criteria for each anxiety disorder will help you when making decisions regarding the appropriateness of LICBT for the client and the specific treatment protocols that should be followed. You should spend some time making yourself familiar with the NICE guidelines for the treatment of anxiety disorders and the diagnostic criteria in DSM-5. You may also find it useful to refer to Morrison (2014) when determining diagnoses. For further reading regarding formulation using the five areas approach, read Williams and Chellingsworth (2010). For those interested in furthering their understanding of anxiety disorders it may be helpful to read Kennerley et al. (2017), although bear in mind that this is designed for high intensity CBT.