Treating Anxiety Within the Collaborative Care Model (Part 2)

Zachary Bodenweber, LMSW
Implementation Specialist
Collaborative Care Clinician
zbodenweber@outlook.com

Please write your name, position, and organization in the chat box!

Acknowledgements

- Virna Little, LCSW-R, SAP, PSYD
- Amy Jones-Renaud, MPH
- Rita Haverkamp, MSN, PMHCNS-BC, CNS
- Cynthia Kim, LCSW-R

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Content for this presentation was adapted from the presentation *Modular Anxiety Treatment©* by:

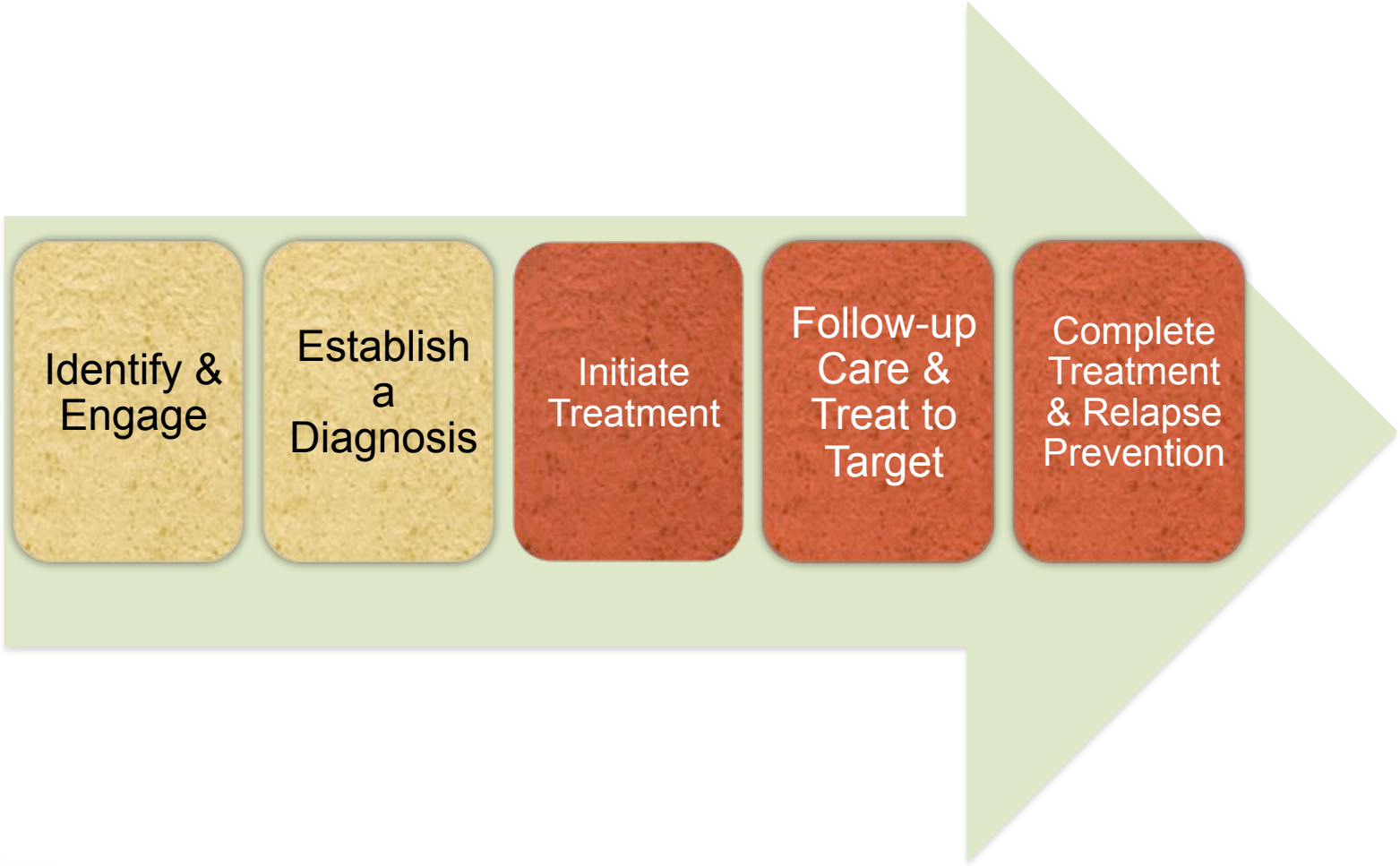
Stacy Shaw Welch, PhD
Anxiety & Stress Reduction Center of Seattle

Kari Stephens, PhD
University of Washington
Department of Psychiatry & Behavioral Sciences

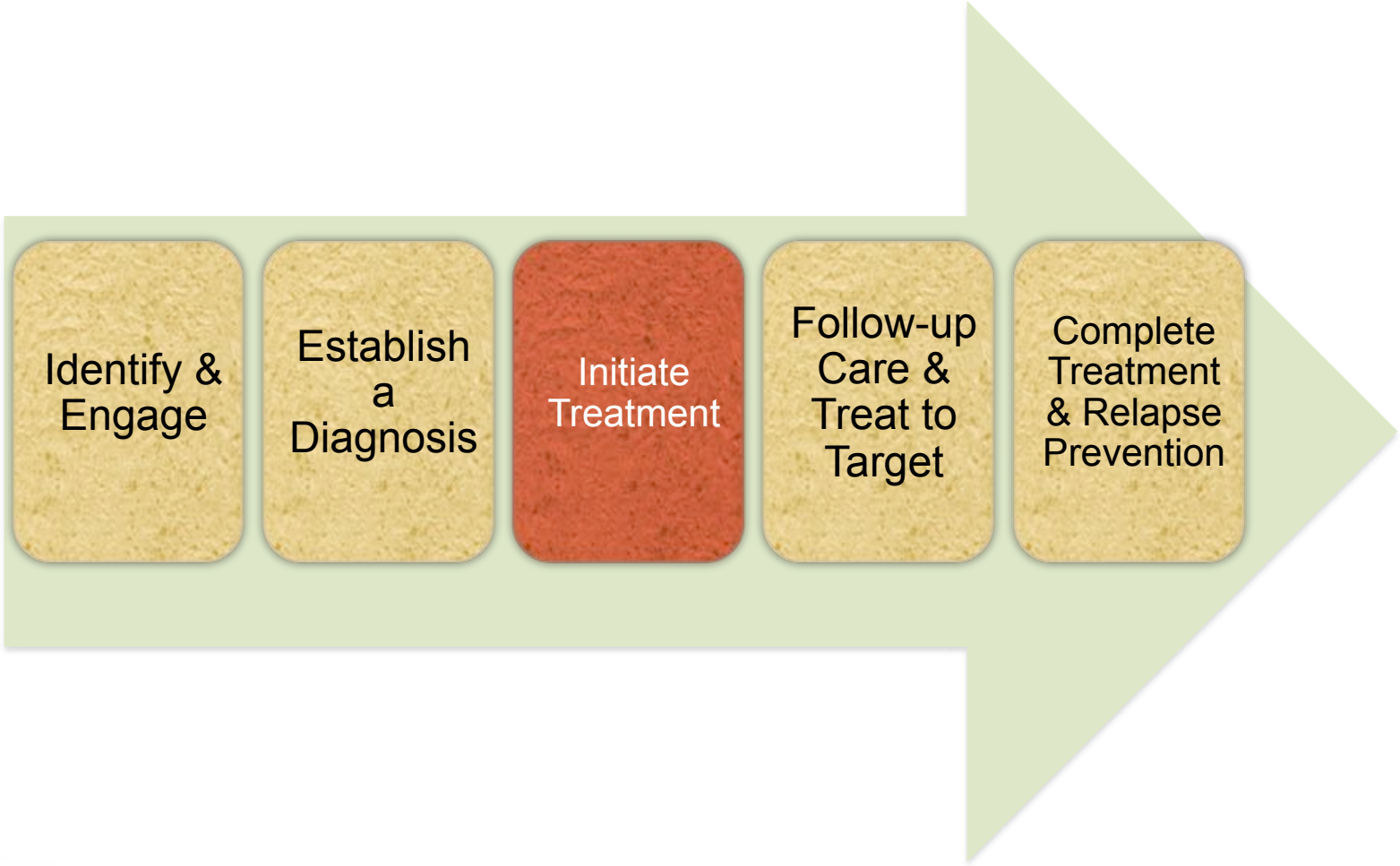
We will learn about…

- Management and treatment of anxiety in Collaborative Care
  - Best Practices
  - Talk Treatment
  - Psychopharmacology
  - Treatment-to-Target + Stepped Care
  - Relapse Prevention

Care Manager Workflow



Initiate Treatment



Initial Treatment Planning

- **Patient**
  - Learns about anxiety disorder and treatment options. Works with team to develop plan that reflects goals. Agrees to level of engagement in treatment.
- **PCP**
  - Completes medical assessment as needed. Initiates appropriate treatment with care manager. Prescribe initial medication trial. Provide encouragement and support regarding treatment and working with new team member
- **Behavioral Health Care Manager**
  - Provided psychoeducation about anxiety. Coordinates with team to create integrated treatment plan. Provides brief behavioral intervention. Engages patient in follow-up plan.
- **Psychiatric Consultant**
  - Supports treatment planning. Guides treatment decisions as needed. May support team's medication or diagnostic concerns.

Treatment Principles

- Psychoeducation
- Safety Planning
- Behavioral approaches should be top priority
- Shared decision-making
  - Pharmacotherapy decisions should be collaborative and patient-centered
  - Final decision is always determined by the PCP

Treatment

1) Talk Treatment
   - Modular Anxiety Treatment
   - CBT-Based
2) Medication
   - Serotonergic Antidepressants

GAD has shown to be effectively treated with Cognitive Behavioral Therapy (CBT), medication, or a combination of both.

Why Talk Treatment?

- Talk treatment is meant to be a learning experience where your clinician acts much like a teacher or a guide to help you understand where your symptoms come from and what to do about them so that you can regain control of your life.
- Good intervention is about knowledge, empowerment, and positive change so that patients can learn the tools and strategies for **independent symptom management and improvement**.
- Language use: talk treatment, therapy, counseling
  - Implications and connotations of each
  - How can this effect patient engagement?

Patient Readiness

- Some engagement and rapport
- Likelihood to return to treatment consistently
- Stable from immediate crises
- Assess mental status
  - High doses of opioids, benzodiazepines, or sleep/ memory disruptive agents may interfere
- BHCM should prioritize engagement and crisis management before structured interventions

Modular Anxiety Treatment

- Distills the most active and effective components of effective treatments
- Consists of behavioral interventions to reduce and treat anxiety disorders in adults, regardless of the anxiety disorder
- First-line treatment to be customized to the patient and therapist

Modular Treatment

Treatment Approach

TREAT

- ***Medications***
- Anxiety can be reduced if the fear is not actually as dangerous as it seems (brain as an oversensitive alarm going off too soon) through ***exposure***

And/Or

MANAGE

- Anxiety can be tolerated and managed with ***coping skills*** if:

1. fear has evidence of real danger, or
2. the client is not ready to face the fear head-on

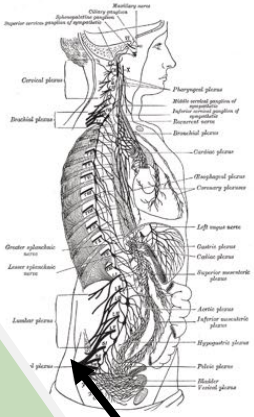
CBT Model of Anxiety

- **The Three B's**
  - Body
    - Physical response to fear
  - Brain
    - Set of negative and/or irrational thoughts
  - Behavior
    - Avoidance patterns to run away from perceived danger
- Framing it in this way helps patients see anxiety as controllable and promotes an understanding of treatment

CBT Model of Anxiety

Physical sensations

(physiological arousal)



Anxiety

Thoughts

(perception of threat)

Behaviors

(avoidance, safety behaviors)

Interactional Model of CBT

- Thoughts: Images, self-talk, memories, beliefs (including core beliefs), interpretations, meaning
- Feelings: Emotional and physical
- Behavior: Observable things that happen
- Dynamic relationship between these three things
  - Responses in the face of stressful events
- Cognitive Schema

Talk Treatment: CBT

- Clinical trials have found CBT to effectively reduce GAD symptoms compared with control conditions and with other psychotherapies
- Clinical trials of other psychotherapies for GAD have not shown sufficient evident of efficacy to recommend their use
- CBT provides a multimodal intervention that includes:
  - Education
  - Self-monitoring
  - Cognitive restructuring
  - Exposure
  - Relapse Prevention

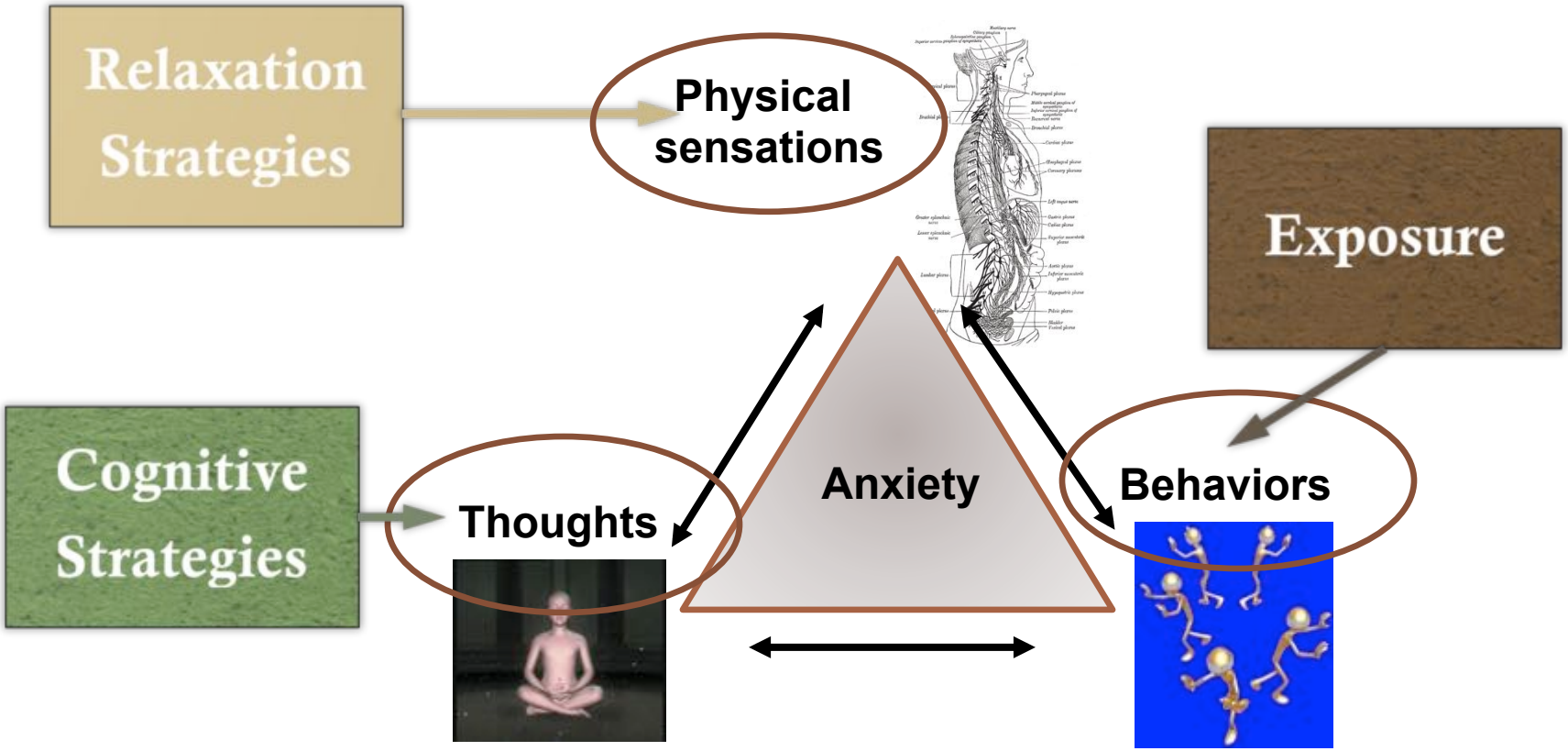
CBT: Theoretical Foundation

- Based on evidence that persons with generalized anxiety disorder (GAD) experience (Craske, 2003):
  - **Cognitive symptoms** of excessive and uncontrollable worry about a number of life domains
  - **Physical symptoms** of motor tension, vigilance, restlessness, inability to relax, poor sleep, and poor concentration
  - **Behavioral symptoms** of excessive preparation, procrastination, poor decision making, and avoidance
- These elements of GAD can be effectively targeted through Cognitive Behavioral Therapy

CBT and GAD

1. Overestimating and catastrophizing negative events are addressed through cognitive skills that encourage evidence-based thinking
   - This decreases attentional bias to threat
2. Deficits in problem solving are targeted through cognitive coping skills and behavioral strategies
3. Behavioral practices challenge avoidant behavior and involve repeated exposure to feared situations
   - This reduces emotional response and autonomic arousal
4. Relaxation skills aim to reduce excessive muscle tension and vigilance

Targeting Interventions



Physical Sensations

- Relaxation skills target physiological reactivity associated with anxiety and worry
- Two main skills are
  - *Diaphragmatic breathing* – targets acute panic / anxiety reactions
  - *Progressive muscle relaxation* – targets chronic muscle tension associated with ongoing anxiety / worry
- Important to be realistic about how effective these skills are in reducing anxiety
- Skills are taught and applied similarly across the anxiety disorders

Diaphragmatic Breathing

- Eupnea: natural and relaxed form of breathing in all mammals. Occurs in a state of relaxation.
  - When there is no clear and present danger in environment
- Babies breathe this way. It's natural, but we forget overtime.
- Balances out Carbon Dioxide and Oxygen
- Stimulates the Vagus nerve, activating relaxation response

Diaphragmatic Breathing

Target symptoms

- Increased heart rate
- Rapid or shallow breathing
- Lightheadedness/ dizziness
- "Butterflies" in the stomach

How to practice

- Take slow, controlled breaths into the diaphragm
- Inhale and exhale about the same length (3 sec)
- Can take a lot of practice to feel natural
- Practice when not stressed first!

Diaphragmatic Breathing

- When we are under stress (acute or chronic), we unwittingly change the way we breathe (we often make the mistake of using our chest muscles to help control the breath). This does not allow the lower portion of our lungs to expand with good, oxygenated air, and can accidentally trick our brain and body into entering a more stressful state
  - "We are going to learn a new way of deep breathing called diaphragmatic or abdominal breathing"

Diaphragmatic Breathing

- Instructions: Imagine that there is a balloon just behind your belly-button. When you inhale, you will breathe in through your nose and imagine the breath filling the balloon slowly and gently with the air that you breathe in. When you exhale, imagine the balloon slowly and gently deflating.
- Do not try to hold on to the breath: As soon as your lungs are full, release the breath completely and slowly.
- Practice this breathing at least 2x/day when you are already relatively relaxed, about 5 breath cycles each time

Deep Breathing Log

Day	Morning	Mood	Mid-day	Mood	Evening	Mood
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Breathing Break

Progressive Muscle Relaxation

- The human musculature system acts like a pendulum: the more you push it in one direction, the more it swings back in the opposite direction
- If you have had recent surgery, chronic pain, or other soreness in any part of your body, you can skip those areas during the tensing segment of the exercises.

Progressive Muscle Relaxation

Target symptoms

- Chronic muscle tension
- Headaches
- Problems falling asleep

How to practice

- Systematically tense (10 sec) and relax (30 sec) various muscle groups in the body
- Tensing muscles creates a stronger relaxation response
- Helps with identifying early indicators of muscle tension in different parts of the body
- Requires frequent practice to be effective

Progressive Muscle Relaxation

- To begin, get into a comfortable position and spend a moment just "settling in." We are going to first tense, and then release various muscle groups in a sequence. For each exercise, hold the tension component for approximately 10 seconds on each exercise, then relax for approximately 20 seconds. Focus on the difference between tension and relaxation: the feelings of tightness compared to the warm, heavy sensation of relaxation…

Progressive Muscle Relaxation

- Get into a comfortable position and close your eyes,
- Make fists with your hands and bring your arms up to your shoulders, tensing the bicep muscles, then release and let your arms hang at your sides.
- Flex your feet, lifting them off the floor and hold your legs straight out, then point your toes, and focus on the feelings of tightness running up your calves. Repeat, then let your legs drop back down onto the floor and feel the difference.
- Suck in your abdomen, as if to absorb a punch. Feel the tightness in your stomach area. Then, push your stomach out. Now release.

Progressive Muscle Relaxation

- Breathe in deeply and sharply, holding your breath. Then push your arms back to intensify the sensations. Hold for a few seconds, then release.
- Pretend that your shoulders are on strings, being pulled up toward the ceiling. Hold for several seconds, then let them drop back down,
- Press your head back against the chair and your chin down, feeling the tightness in your jaw and neck. Hold for ten seconds, then release.

Progressive Muscle Relaxation

- Close your eyes tightly and hold, focusing on the tension in your face. Now, relax your facial muscles.
- Wrinkle your brow downward as if scowling and hold for several seconds; then push your eyebrows up into a high arch. Repeat, then relax.

Progressive Muscle Relaxation

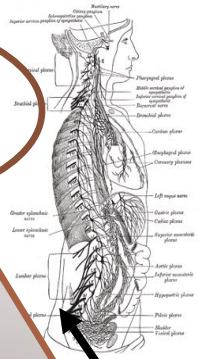
- Now focus on your breathing. Breathe deeply and slowly. Feel the cool air as you breathe in and the warm air as you breathe out. Try to relax all of the muscles in your body and focus on the warm, heavy, pleasant sensations of relaxation. Count from 1 to 5, and with each step, try to achieve a deeper state of relaxation. Once you have done this, picture a pleasant scene in your mind; perhaps a beautiful sunset, a beach, or a colorful garden. Keep focusing on this nice image for the rest of this time. After staying in a deeply relaxed state for approximately two minutes, gradually bring yourself out of this deep relaxation by counting backward from 5 to 1.

Other Physiological Strategies

- Yoga
- Meditation
- Massage
- Exercise
- Good sleep habits
- Good nutrition
- Attending to physical illness
- Avoiding substances

Relaxation Strategies

Physical sensations



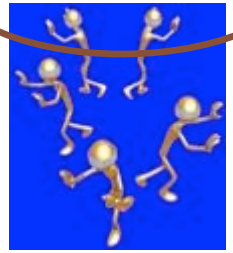
Exposure

Cognitive Strategies

Thoughts

Anxiety

Behaviors



Thoughts

- Cognitive Strategies to build metacognition
  - Awareness of thoughts
  - Thinking about our thinking
  - Making the subjective objective
- Helps us objectively view thoughts so that we can manipulate and change them
  - You don't have to believe everything you think
  - Thinking happens

Three-Part Worksheet

- Also used for Independent Practice (homework)
- Instructions: Think back over the past few days and pick a situation that was stressful for you
- Describe the context of the situation
  - Helps identify triggers or things that can be modified environmentally
- Write down any thoughts, beliefs, images, or self- talk
- Write down how you were feeling when this happened, both emotionally and physically
- Write down what happened next

Context	Thoughts	Feelings	Behavior
What happened? Where were you? What were you doing? When was this during the day?	Self-talk Images or memories Beliefs Interpretations	Emotions Physical Sensations	What happened next? Was there anything you said or did/did not do but wanted to?

Review with Patient

- Review of deep breathing: What worked, what was difficult, how many times each day/week?
- Consider starting and ending each session/module with deep breathing to reinforce skill and help patient/client feel centered
- Review of three part worksheet
  - Clarifying differences between thoughts and feelings
  - Make sure thoughts are captured without any editing
  - Reflect on process of completing worksheet
  - Identify trends, patterns, and relationships

Automatic Thoughts

- Unhelpful thoughts are sometimes obvious but are often very subtle and we find them popping into our minds almost automatically
- These tend to come from deeply reinforced patterns of what we have told ourselves or what we have heard from others over time
- Core Beliefs
- Over time, repeated patterns of negative dynamics with thinking and belief can create and be reinforced by cognitive distortions

Core Beliefs

- Core beliefs tend to capture recurrent or central themes that underlie negative automatic thoughts
- Examining repeated patterns of negative automatic thoughts can lead to the identification of core beliefs
  - Do this with patients
- Common Themes
  - Worth
  - Ability to be loved
  - Self-efficacy

Process of Cognitive Distortions

- Emotional reasoning: Trying to understand a situation and make decisions based on how you feel instead of what you really know about the situation
- Ignoring important information
- Ignoring positive information in favor of the negative
- Misattribution of cause
- Mistaking correlation with causation

Cognitive Distortions "Thinking Errors"

- Overgeneralizing: Thinking that one bad thing will always happen in a similar kind of situation
  - Assuming temporal causality: If it's been true in the past it will always be true, mistaking correlation for causation
- Selective abstraction: Exaggerating negative aspects of a situation to be worse than they actually are, or thinking good things aren't as good or important as they actually are.

Cognitive Distortions "Thinking Errors"

- Excessive responsibility: Thinking you are responsible for all negative things that happen
- Dichotomous (all or nothing) thinking: Thinking that something is only one way or the other.
- Catastrophizing: Thinking of the worst possible scenario or outcome for any given situation
- Mind reading/Magical thinking: Thinking you know what other people are thinking about the situation even though you can't read their thoughts or that your very thoughts influence what will happen

Anxiety Cognitive Distortions

General

- Overestimating the likelihood of negative outcomes → **"jumping to conclusions"**
- Catastrophizing → **"worst case"**

Disorder specific

- Social phobia → **mind reading**
- OCD → **thought action fusion**

Cognitive Restructuring

What is it?

- Process of identifying, evaluating, and changing unhelpful or maladaptive thoughts
- Goal is to generate more balanced, accurate coping thoughts that are less anxiety provoking but still believable to the client

Why do it?

- Clients can rehearse these coping thoughts before anxious situations to decrease anticipatory anxiety, as well as during anxious situations to decrease in-the-moment anxiety
- With repeated practice, clients generally start to think in a more balanced way more automatically and with less intentional effort
- *** This is NOT just thinking positively!

Cognitive Restructuring

Overestimating likelihood of negative outcomes

Identify all other possible outcomes to help determine the "real odds" of the feared outcome

Catastrophizing

Make a list of ways to cope with the worst case scenario. What would you do?

Cognitive Restructuring

- Uses a structured and measured approach to identify negative thoughts, feelings, and behavior
- That allows us to gently but purposefully challenge aspects of that process that are toxic, hurtful, or at least unhelpful
- Cognitive reframing or cognitive processing – the ability to reflect on cognitive, emotional, and behavioral states in the moment and challenge anything problematic so that we can think, feel, and do something different to improve over time

Challenging Cognitive Distortions

"Cognitive Distortions" is a term from cognitive-behavioral therapy that refers to biased ways of thinking about oneself and others. Most people experience these to varying degrees, and unfortunately, they can lead to problematic emotional and behavioral states. Learning how to identify and challenge these automatic thoughts can help increase psychological wellbeing and rational behavior. For this exercise, refer to the list of cognitive distortions at: http://www.healthypsych.com.

Thoughts (Write down the repetitive thought)	**Feelings** (List any emotions that you feel when thinking those thoughts)	**Cognitive Distortions?** (Is there a cognitive distortion(s) in your thought? If so, write it down; there may be a few.)	**Alternative, Rational Response** (Think of a more rational response to your cognitive distortion (CD) and write that here. If there isn't a CD in your thought, leave this row blank and move on to another example.)
Example: "I know I'm going to fail that exam"	Anxious, discouraged, tense	Fortune telling/Predicting the future	"Actually, I've passed many exams before and I'm pretty confident that if I study enough, I'll do fine"

Quality Questions

- Use Socratic method of questioning to help patients systematically analyze their beliefs and move them in a more helpful direction when they get stuck
  - It is most beneficial when they arrive at the answers themselves
- Similar "Thought-challenging" questions can be provided to patients for independent practice
- These strategies help craft a more neutral, balanced, and healthy thought

Socratic Questioning

- **Clarification**
  - What does it mean when you/I say…?
  - What exactly does this mean?
  - What do we already know about this?
  - Can you give me an example?
  - Can you say that another way?
- **Probing Assumptions**
  - How did you/I come to this conclusion?
  - Given that, what else might be the case?
  - If this happened to a friend or family member, what would you tell them about this?

Socratic Questioning

- Probing Reasons, Evidence, and Perspective
  - Can you show me…?
  - Are these the only explanations?
  - What is the evidence to prove what you are thinking?
  - Has anyone else expressed a different opinion?
  - Is there another way to look at this?

Socratic Questioning

- Analyzing Implications and Questions
  - Then what would happen?
  - What would that then mean?
  - How helpful is it to emotionally or behaviorally invest in that thought/belief ?
  - What would it mean to give up that belief?

Challenging Anxious Thought

- If you get stuck during cognitive reframing, you can use the following questions to prompt completing the exercises
  - What is some evidence for and against this idea?
  - How helpful is the interpretation or belief?
  - Are interpretations of the situation based in fact or emotion, past experience?
  - Is thinking all or nothing?
  - Are you using extremes or shameful language (always, forever, never, need, should, can't)?

Challenging Questions

- Challenging Questions continued…
  - Are you taking the situation out of context or only focusing on one aspect?
  - Are you discounting other important pieces of information?
  - Is the source of the information reliable?
  - Are you mistaking possibility for probability?
  - Are you using your feelings rather than facts? (emotional mind versus wise mind)

Thought Record

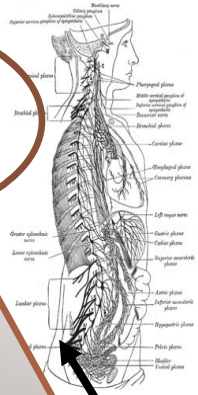
Context & Behavior	Feelings	Automatic Thoughts	Evidence for? How Helpful?	Evidence Against? Consequences?	Alternative Thoughts and Behavior	Re-rate Mood
Who were you with/what were you doing? When was it?	Describe Mood and rate its intensity (1-10), physical feelings AND emotions	What does this mean to me? What are my beliefs about this? What are the images or memories related to this?	Provide objective examples that others could say are true . How helpful is it for me to invest in this?	What are some objective examples of times/situations where this was not the case? What are the results of investing in this?	Reframe thought leaving out value judgments and including information that is more neutral or positive and helpful to tell yourself	Repeat the balanced thought and describe your mood now, rate the intensity of the previous mood

Other Thought Interventions

- Mindfulness
- Problem solving improves scattered thinking / forgetfulness as well as indecision
- Addressing habits of poor / impulsive decisions
- Thought stopping for worried / anxious thoughts
- Motivational Interviewing
  - Capitalizing on cognitive dissonance and ambivalence

Relaxation Strategies

Physical sensations



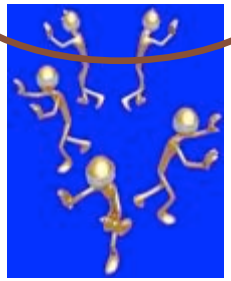
Exposure

Cognitive Strategies

Thoughts

Anxiety

Behaviors



Behaviors

- Approach > Avoidance
- We are wired to seek pleasure and avoid pain
- Short-term benefits of avoidance do not outweigh long term consequences
  - It only works temporarily
  - It reinforces anxiety over time
- In order to work through our worries and problems, it is important to approach or confront our problems with purpose, using coping skills, and in "safely" measured doses

If anxious responses (emotions and behaviors) are learned through experience,
then lasting change must occur by creating new learned behavior… also by experience.

This will ultimately uproot old associations (anchors of pain/pleasure) and replace them with new ones that reduce anxiety and promote functioning.

This is about creating new meaning.

Exposure

Process of exposure is similar across the anxiety disorders, ***what varies is the fear trigger***

Disorder	Trigger
Separation anxiety	separation from caregiver (children)
Specific phobia	feared object / situation
Social phobia	social / performance situations
Panic / agoraphobia	physical sensations of panic / avoided activities and situations
GAD	worry scenarios / images and worry triggers
PTSD	trauma memories and triggers
OCD	obsessions and obsessive thoughts themselves

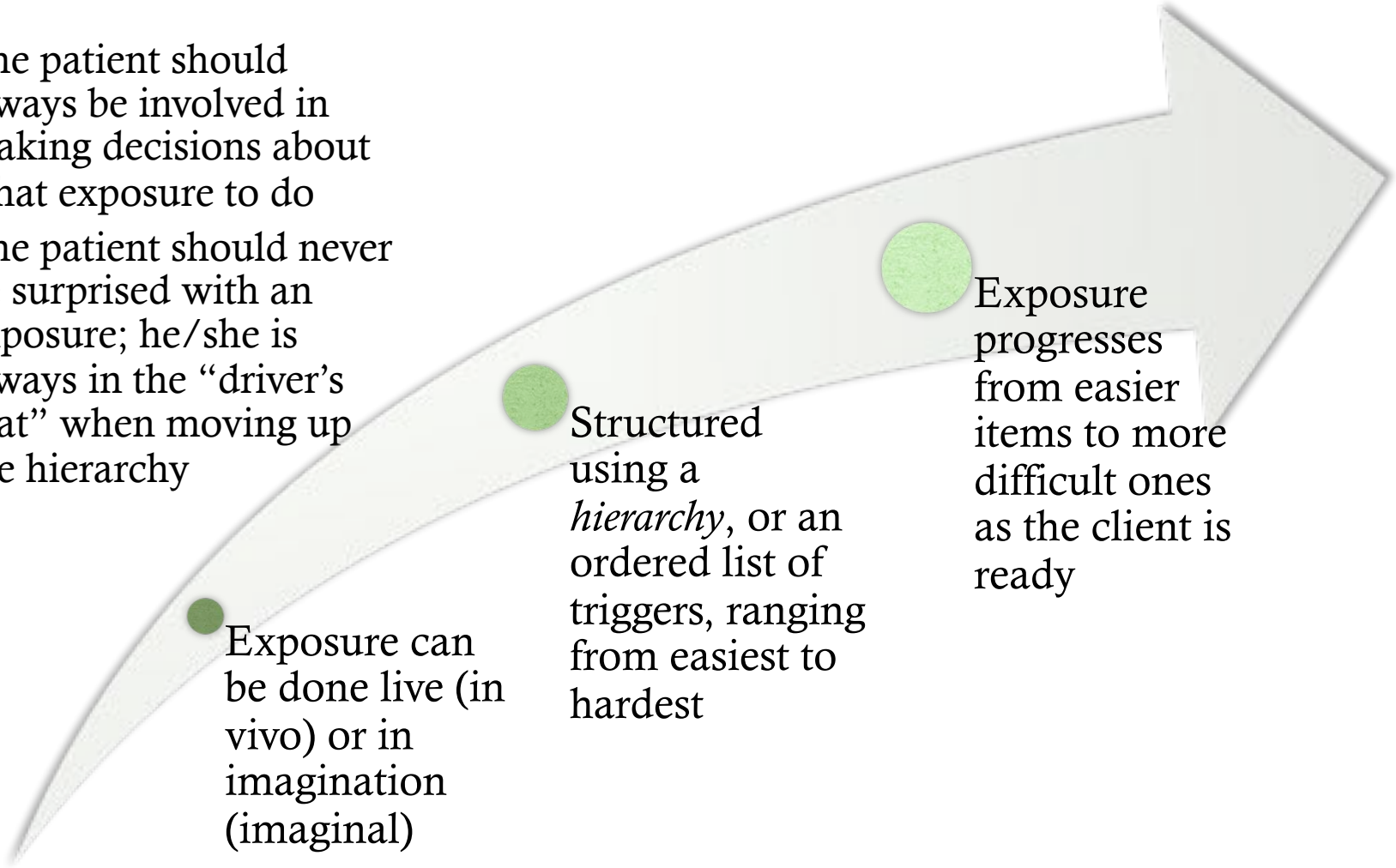
Exposure

Ask: *What does the brain need to learn to not fear a stimulus that isn't truly dangerous?*

- Exposure is the process of systematically approaching feared situations and triggers
- Approaching these triggers *without trying to escape or engage in safety behaviors* leads to a reduction in anxiety over time
- Usually requires multiple exposures to the same trigger for anxiety to decrease and new learning to occur
- The amount of time it takes for anxiety to decrease can vary widely across clients

Exposure

- The patient should always be involved in making decisions about what exposure to do
- The patient should never be surprised with an exposure; he/she is always in the "driver's seat" when moving up the hierarchy



Exposure can be done live (in vivo) or in imagination (imaginal)

Structured using a *hierarchy*, or an ordered list of triggers, ranging from easiest to hardest

Exposure progresses from easier items to more difficult ones as the client is ready

Exposure: Care Manager Role

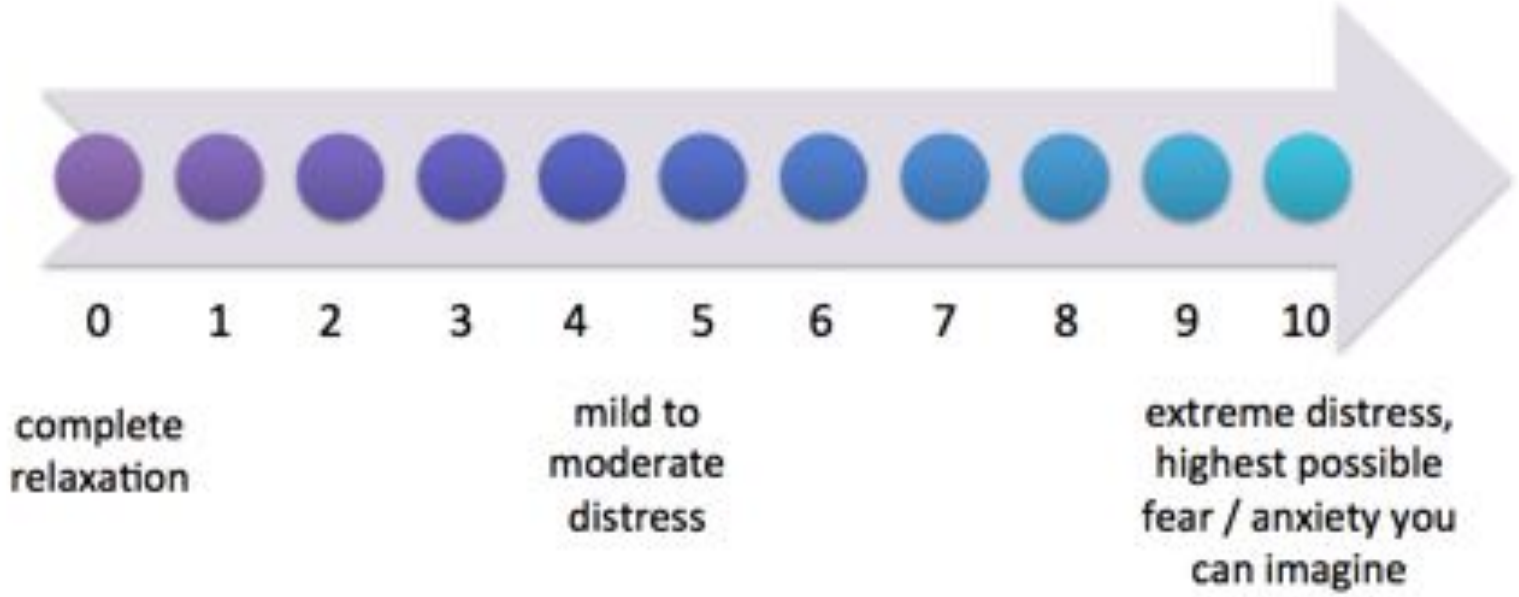
What Do You Do?

- Encourage the client to engage in the exposure
- Assist the client in maintaining focus on the trigger
- Assess internal reactions (SUDs ratings) before and after exposure to determine whether the strategies are working
- Point out avoidance and help the client refocus on the trigger
- Provide encouragement and validation during exposure and praise/reinforcement afterward
- Choose targets patient can tolerate
- Inform team of potentially increased anxiety

Psychoeducation

- The approaches we discussed up until now may not be adequately effective for patients with moderate to severe symptoms of anxiety
- Exposure-based strategies can reduce the power of triggers and bring about lasting recovery from anxious symptoms
- Important to support and encourage the continued exposure to something that is feared in order to actually stop the fear. "Going through it"
- "What's on the other side of fear?"

Subjective Units of Distress (SUDS)



Describe specific situations related to your anxiety that make you feel varying levels of discomfort. On a scale of 0 to 10 (0 being not at all anxious, and 10 being extremely anxious), rate how much each situation affects you.

Anxiety-Producing Situation	0 - 10

Internal Change and External Change

All effective interventions change the way feel or the way we behave…

The two are interrelated

Behavioral Activation

- Anxiety and Depression have symptoms of functional avoidance, which can both be addressed with BA
- BA targets patterns of **avoidance**, **withdrawal**, and **inactivity**
- Can be targeted to treat anxious symptoms through behavioral change
- The intervention strategies discussed, such as utilization of relaxation skills or exposure practice, can be applied to the behavioral activation process

Problem Solving Treatment (PST)

- Three goals
  - Help patient understand the link between current life problems and current symptoms
  - Develop a systematic problem solving strategy to solving "here and now" stressors
  - Engage in pleasant social and physical activities
- PST engages patient in creating action to resolve what is most pressing/important to them
  - Promotes mastery over environment
  - **Encourages approach rather than avoidance**
  - Trains brain to solve problems and look for solutions

Psychopharmacology

- Most clearly indicated in patients with severe symptoms, significant functional impairment, and/or safety issues
- Generally serotonergic antidepressants are the first-line therapy (except for patients with bipolar disorder)
- Benzodiazepines should be used with caution, as they are associated with multiple problems: dependence, decreased behavioral treatment effectiveness, cognitive impairment, street value
- Think long-term time frame, , such as how and when medications will be discontinued. Clarify expectations.
- Encourage patients to continue medications despite tolerable side effects, which may resolve after 1-2 weeks. Note that anxiety can limit adherence and tolerability of these effects
- Wellbutrin is usually avoided due to activating properties

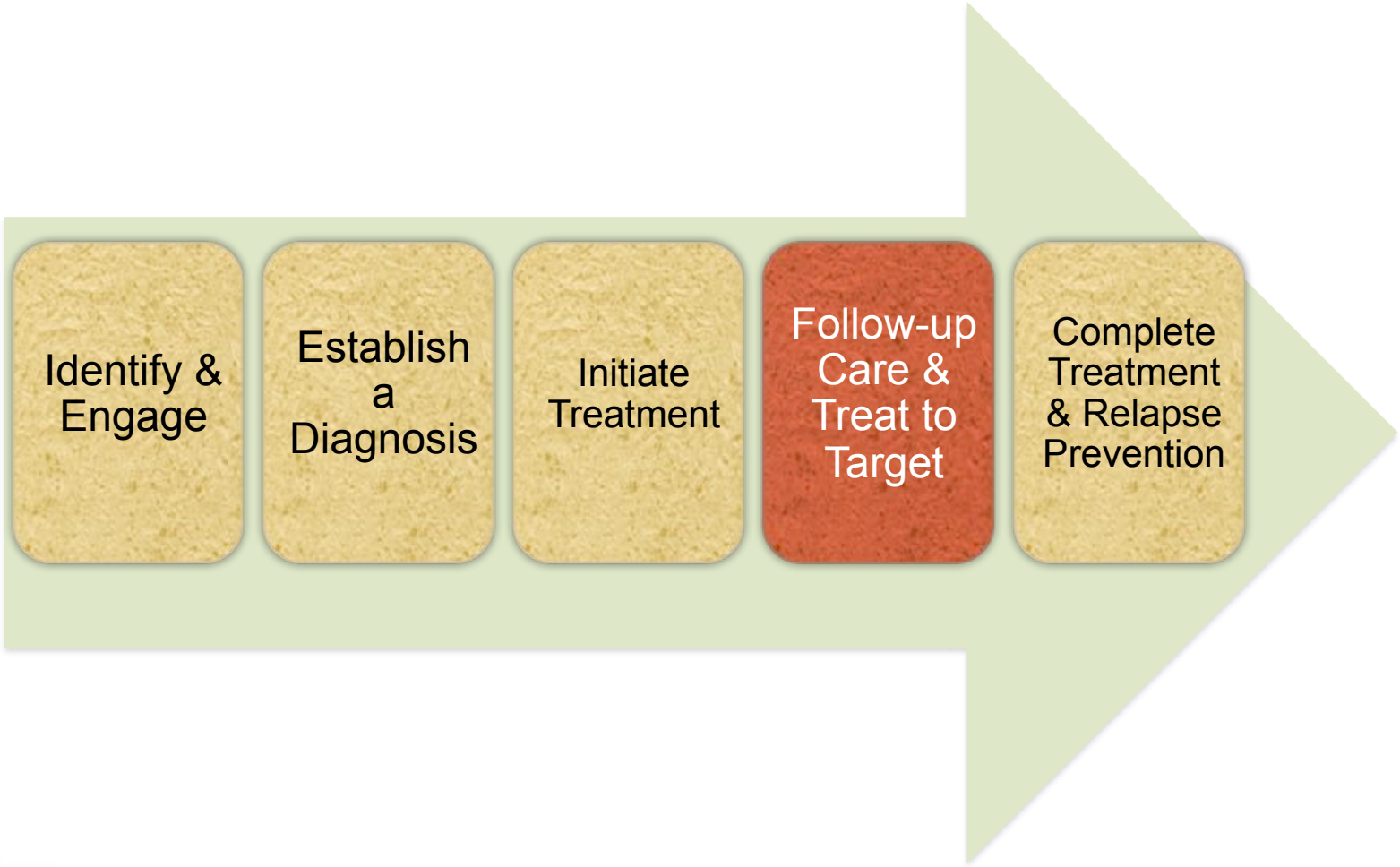
Commonly Prescribed for Anxiety

- SSRIs
  - Citalopram
  - Escitalopram
  - Fluoxetine
  - Paroxetine
  - Sertraline
- Mixed Receptor Antidepressants
  - Duloxetine
  - Mirtazapine
  - Effexor
- Other
  - Buspirone
  - Hydroxyzine
  - Prazosin

Benzodiazepines

- May be considered for:
  - Severe functional impairment
  - Brief situational anxiety
- Aim for gradual reduction for patients with long-term use
- Use your Expert: The psychiatric consultant

Follow-up Care & Treat-to-Target



Follow-up

- More frequent contacts during beginning stages of treatment
  - Check for medication adherence
  - Medication side effects
  - Barriers
  - Concerns
  - Symptom response
    - Anxiety
    - Depression
    - Suicidal ideation
- Close follow-up after warm hand-off is effective for patient engagement and treatment adherence

Medication Management

- Methods for Telephonic Medication Management include:
  - Explaining rationale of treatment
  - Identifying side-effects
  - Countering demoralization/hopelessness
    - "It's been one week"
  - Address fears
  - Reinforce instructions
  - Provide PCP recommendations
  - Administer PHQ-9 + GAD-7 to track symptoms

Treat-to-Target

- GAD-7 is used to monitor treatment response
- GAD-7 Target:
  - Below 10
  - Drop in 50%
- Improvement as Expected = Target in 10 weeks
- Stepped Care
  - If not improved as expected, initiate Psychiatric Consultation and/or Change in Treatment

Psychiatric Consultation

- GAD-7 at Enrollment
- GAD-7 currently
- Medication (Duration + dosing)
- Side effects
- Symptoms + Symptom response
- Interventions used
- Medical conditions/problems

Treat-to-Target

- **No Response**
  - Consider optimal dosage
  - Taper off medication and try a different medication following same titration principles
  - An inadequate response to one SSRI does not predict failure of a second in GAD
- **Partial Response**
  - Talk Treatment
    - Continue CBT if partial reduction in symptoms
  - Medication
    - Initiate adjunctive treatment with second-line medication or with CBT
    - Augmentation of pharmacotherapy with CBT has led to a greater reduction in GAD symptoms compared with medication alone

Treat-to-Target

- **Poor Response**
  - Evaluate for and address:
    - Co-occurring conditions in need of treatment
    - Ongoing life stress in need of a greater focus on problem-solving
    - Consideration of including family members to assist in application of skills in home environment
    - Family interactional styles reinforcing GAD
    - Potential benefit of augmenting CBT with medication

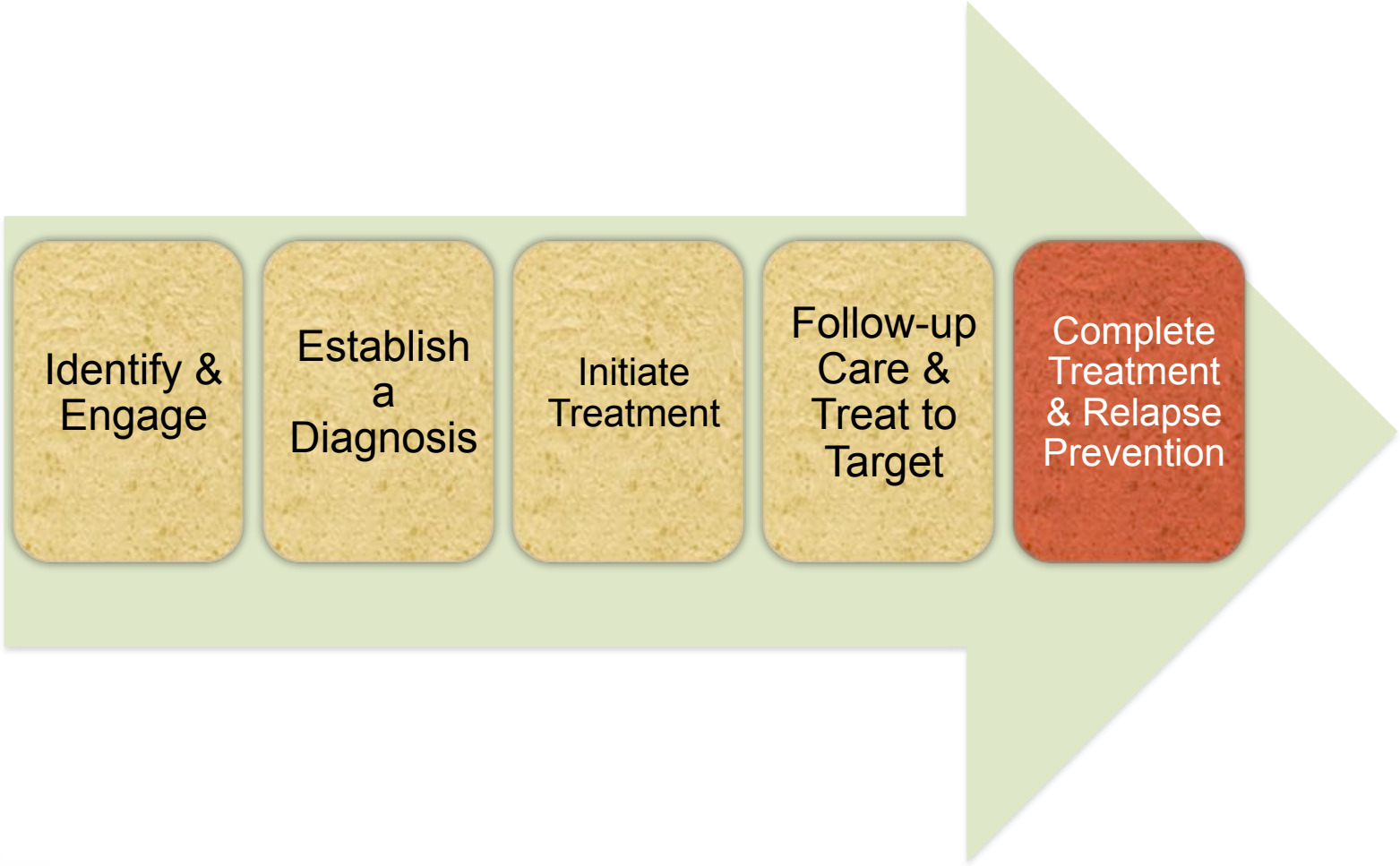
CBT + Medication

- CBT and Medication can have counterproductive interactions in some cases
- Patients should be on stable, tolerable medication dose
- Avoid large doses of benzodiazepines
  - Numbing response limits effect of exposure, which aims to intentionally elicit anxious symptoms
- Medications with sedative effects can disrupt the learning of new coping strategies

Follow-Up

- **Positive Response**
  - If improved as expected:
    - Evidence that "booster sessions" or monthly maintenance sessions following CBT is associated with greater sustained benefits
    - Monthly GAD-7 + Brief intervention/ Med Management

Complete Treatment & Relapse Prevention



Relapse Prevention Planning

- Consider both anxiety and depression signs when identifying warning signs
- Identity and use techniques that reduce symptoms and improve functioning
- Encourage patients to independently monitor symptoms through completion of GAD-7 (provided with relapse prevention plan)

Relapse Prevention Planning

- Effective Relapse Prevention Planning will be seen as the continued, independent use of skills and strategies developed throughout treatment
- Continued Self-monitoring
- Continued use of relaxation skills
- Continued use of cognitive restructuring
- Continued exposure and approach through positive confrontation of anxiety-provoking situations

Relapse Prevention Planning

- Inform patient that recurrence of worry, anxiety, or avoidance behavior are likely to occur in future
- Anticipated and expected
- Not a failure or setback
- Chance to reapply coping skills and newfound knowledge
- Personalize plan to patient's response and preferences
  - Identify most helpful strategies
  - Use key words, phrases, or metaphors

Relapse Prevention Plan

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Patient Name: _____ **Date:** _____

Maintenance medications

1. _____: _____tablet(s) of _____mg _____Take at least until_____
2. _____: _____tablet(s) of _____mg _____Take at least until_____
3. _____: _____tablet(s) of _____mg _____Take at least until_____
4. _____: _____tablet(s) of _____mg _____Take at least until_____

Call your primary care provider or your care manager with any questions (see contact information below).

Other treatments

1. _____
2. _____
3. _____

Personal warning signs

1. _____
2. _____
3. _____
4. _____

Things that help me feel better

1. _____
2. _____
3. _____
4. _____

If symptoms return, contact: _____

Primary Care Provider _____ Phone: _____ Email: _____
Care Manager _____ Phone: _____ Email: _____

Next appointment Date: _____ Time: _____

Sources

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, Arlington, VA 2013.
- Baldwin, D. Generalized anxiety disorder: epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis. UpToDate 2013.
- Beck, J. S. (2011). Cognitive therapy: basics and beyond. New York: Guilford Press.
- Bernes GA, Danhaur SC, Lyles MF, et al. Telephone-delivered cognitive behavioral therapy and telephone-delivered non-directive supportive therapy for rural older adults with generalized anxiety disorder: a randomized clinical trial. JAMA Psychiatry 2015; 72: 1012
- Boswell, James F.,Iles, Brittany R.,Gallagher, Matthew W.,Farchione, Todd J. Behavioral activation strategies in cognitive-behavioral therapy for anxiety disorders.
- Psychotherapy, Vol 54(3), Sep 2017, 231-236
- Bourne, E.J. (2011). The anxiety and phobia workbook, Fifth Edition.
- Burns, D.D. (2012). Feeling Good: The new mood therapy.

Sources

- Craske MG. Origins of phobias and anxiety disorders: Why more women than men, Elsevier, Oxford 2003.
- Craske MG. Cognitive behavior therapy, American Psychological Association, Washington, DC 2009.
- Craske MG & Bystritsky, A. Approach to treating generalized anxiety disorder in adults. UpToDate 2017.
- Cujipers P, Sijbrandi M, Koole S, et al. Psychological treatment of generalized anxiety disorder: a comparison with pharmacotherapy. Psychol Rev 2014; 34: 130
- Durham, RC, Fisher PL, Treliving LR, et al. One year follow-up of cognitive therapy, analytic psychotherapy and anxiety management training for generalized anxiety disorder: symptom change, medication usage and attitudes to treatment. Behav Cogn Psychother 1999; 27:19
- Hofmann SG, Smits JA. Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. J Clin Psychiatry 2008; 69: 621
- Hopko, D.R., Lejuez, C.W., & Hopko, S.D. Behavioral activation as an intervention for coexistent depressive and anxiety symptoms. Sage Journals. 2004, 3(1): 37-48.
- Hopko, D. R., Robertson, S. M. C., & Lejuez, C. W. (2006). Behavioral activation for anxiety disorders. The Behavior Analyst Today, 7(2), 212-232.

Sources

- Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. Arch Gen Psychiatry 1994: 51(8).
- Kessler RC, Berglund P, Dealer O. et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Get Psychiatry 2005: 62(593)
- Mogg K, Bradley B. Attentional bias in generalized anxiety disorder versus depressive disorder. Cognit Ther Res 2005: 29:29.
- Mitte K. Meta-analysis of cognitive-behavioral treatments for generalized anxiety disorder: a comparison with pharmacotherapy. Psychol Bull 2005; 131: 785.
- Norton PJ, Price EC. A meta-analytic review of adult cognitive behavioral treatment outcome across the anxiety disorders. J Nerf Meant Dis 2007; 195: 521.
- Paul M. Lehrer and Richard Gevirtz. Heart rate variability biofeedback: how and why does it work? Frontiers in Psychology. July 2014. https://doi.org/10.3389/fpsyg.2014.00756
- Resick, P.A. (2008). Cognitive Processing Therapist's Manual. Boston, MA: WHSD.

Sources

- Shu-Zhen Wang, Sha Li, Xiao-Yang Xu, Gui-Ping Lin, Li Shao, Yan Zhao, and Ting Huai Wang. Effect of slow abdominal breathing combined with biofeedback on blood pressure and heart rate variability in prehypertension. The Journal of Alternative and Complementary Medicine. October 2010, 16(10): 1039-1045. doi: 10.1089/acm.2009.0577

- S Chen, P Sun, S Wang, G Lin and T Wang. Effects of heart rate variability biofeedback on cardiovascular responses and autonomic sympathovagal modulation following stressor tasks in prehypertensives. Journal of Human Hypertension. February 2016. doi:10.1038/jhh.2015.27

- Spitzer RL, Kroenke K, Williams JB, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med 2006; 166: 1092.

- Stanley MA, Wilson NL, Amspoker AB, et al. Lay providers can deliver effective cognitive behavior therapy for older adults with generalized anxiety disorder: a randomized trial. Depress Anxiety 2014; 31:391

- Wells A, Matthews G. Attention and Emotion: A clinical perspective, Erlbaum, Hove, UK 1994.

Questions?

Always feel free to email me at
zbodenweber@outlook.com