Treating Anxiety-Related Disorders in the Context of DBT

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Learning Objectives

• Review evidence-based psychosocial treatments for anxiety-related disorders (anxiety, OCD, PTSD)
• Learn the basic principles and procedures of exposure therapies for anxiety-related disorders
• Review research studies on exposure therapy in the context of DBT treatment for BPD & PTSD

Adapted from Melanie Harned, Ph.D.
Core DBT Dialectic

Acceptance

Change

DBT Target Hierarchy

Stage 1
- Life-interfering behaviors
- Therapy-interfering behaviors
- Quality of life-interfering behaviors
- Skill acquisition

Stage 2
- Decreasing posttraumatic stress

Stage 3
- Increase self-respect
- Achieve individual goals
DBT Change Procedures

1. Contingency Management
2. Skills Training
3. Exposure
4. Cognitive Modification

Why Exposure?

- Dysfunctional behavior patterns have often been reinforced by reducing painful emotions
- Patients’ skills use is inhibited by strong emotions
- Patients are often “emotion-phobic”
- Many patients suffer from unresolved emotional reactions associated with past trauma
Informal vs. Formal Exposure

- **Informal Exposure**
  - Used throughout treatment
  - Usually brief and unstructured
  - Used to target any problematic (unjustified) emotion
    - Shame about crying in front of therapist or sharing vulnerably
    - Fear of being overwhelmed by sadness

- **Formal Exposure**
  - Used during a discrete period of treatment
  - Typically structured, repeated, and prolonged
  - Used to target anxiety-related disorders

Standard DBT Modes

- Outpatient individual therapy
- Outpatient skills training groups
- Telephone coaching
- Team consultation meeting
Why Exposure?

- High rates of current and lifetime anxiety-related disorders among patients with BPD
  - PTSD – 56%
  - Panic – 48%
  - Social Anxiety – 46%
  - Specific Phobia – 32%
  - OCD – 16%
  - Generalized Anxiety – 14%
  - Agoraphobia – 12%
- Anxiety disorders associated with higher risk of suicidal ideation, suicide attempt, suicidal completion, and suicidal behaviors.

Kanwar et al., 2013; Zanarini, et al. 1998

Remission of Axis I Disorders in DBT

Harned, Chapman, Dexter-Mazza, Murray, Comtois, & Linehan, 2008
Why?
What are the barriers to effectively treating anxiety-related disorder in multi-problem BPD patients?

Evidence-based Psychosocial Treatments for Anxiety Disorders
EBT for Anxiety-related Disorders

• Cognitive Behavioral Therapies (CBTs) have the best research support for anxiety-related disorders.

• CBTs typically have multiple components:
  • Psychoeducation
  • Skills training (e.g., relaxation, social skills training)
  • Exposure
  • Cognitive restructuring

Exposure Therapy

• Exposure has been identified as the primary, active ingredient in CBTs for anxiety-related disorders.
  • Exposure alone equally effective as more complex CBTs
    • Particularly true for PTSD, OCD, Social Anxiety
    • Cognitive therapy alone is not as effective as combined CBT treatments

• Exposure is effective for all anxiety-related disorders.
  • Cognitive therapy has only been shown to work for some anxiety disorders (e.g., not specific phobias or OCD).

Kaczkurkin & Foa, 2015
How Effective is Exposure Therapy?

- 60-85% of anxiety disorder patients show clinically significant improvement
  - 68% remission of PTSD
  - 77% remission of panic attacks among panic disorder patients
  - 83% of OCD patient show significant improvement

Other Reasons to Choose Exposure

- Exposure therapy is brief (~12-16) sessions and efficient.
- Exposure therapy can be effectively implemented by clinicians with little prior CBT training or experience.
- Exposure is most consistent with DBT, which emphasizes behavioral over cognitive interventions.
The Basics of Exposure Therapy

When is fear problematic?

**Normal fear**
- Perception of real threat
- Resolves when danger is removed
- No/minimal impairment

**Problematic fear**
- Occurs when minimal risk of actual threat (i.e., unrealistic)
- Causes high distress (i.e., excessive)
- Functional impairment
How is fear acquired?

- **Conditioning**: a negative event is paired with a previously neutral object or situation
  - e.g., a presentation becomes associated with feeling embarrassed
- **Vicarious Learning**: observing another person being hurt or afraid in a specific situation
  - e.g., saw mother panic while driving on the highway
- **Informational Transmission**: being told that specific objects or situations are dangerous (by another person or the media)
  - e.g., read an article on the dangers of not washing hands

How is fear maintained?

- **Avoidance** of things that elicit anxiety
  - Internal cues, e.g., thoughts, memories, emotions, physical sensations
  - External cues, e.g., people, places, objects, smells, situations

- **Avoidance behaviors are anything that decreases anxiety, increases sense of safety, or alleviates uncomfortable sensations**
How else is fear maintained?

- Problematic or unhelpful beliefs

**Overestimate** the likelihood of something catastrophe

**Underestimate** ability to cope or tolerate emotions

Behavioral model of AVOIDANCE

- Patient sees dog
- Patient feels anxious
- Patient avoids
- Others comfort or rescue
- Patient’s anxiety decreases*
- Patient reinforced for avoidance
Rational for Exposure

**Avoidance**

\[ \text{STOP} \]

**Corrective Learning**
- Feared outcomes are unlikely to happen.
- Negative outcomes are unlikely to be catastrophic.
- Anxiety can be tolerated and decreases over time.
- Able to cope effectively with stressful situations.

Exposures: Changing the behavioral model

- Patient feels anxious
- Others praise brave behavior
- Patient looks at dog in shelter
- Patient’s anxiety decreases
- Patient continues looking at dog
- Patient learns “I can handle it!”
Mechanisms of Exposure

• **Habituation-based models:** fear reduction upon repeated exposure to feared stimulus in the absence of aversive event

• **Behavioral testing model:** change threat-laden beliefs and assumptions by testing out beliefs

• **Inhibitory learning approach:** new learning (feared stimulus without aversive experience) competes with old learning

Core Elements of Exposure Therapy

• Orientation and commitment
• Exposure to feared situation or cue
• Corrective learning
• Block action tendencies and expressive tendencies
• Enhance control over aversive events
• Goal: improve *functioning* – may not always reduce anxiety

*Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014*
Types of Exposure

**In Vivo Exposure**

- Exposure to the feared stimulus in real life.
- Designed to counteract avoidance of situations that elicit fear.
- Used in most exposure treatments.
- Typically used for:
  - **People:** strangers, people who resemble abusers
  - **Places:** crowded stores, hospitals, schools
  - **Things:** animals, doorknobs, smell of beer, certain songs
  - **Activities:** public speaking, being hugged, driving
Imaginal Exposure

- Exposure to the feared stimulus in imagination.
- Designed to counteract avoidance of thoughts, memories, and images that elicit fear.
- Clients typically describe the imagined situation out loud and record it or create a script that could be read.
- Typically used for:
  - Past traumatic events
  - Feared outcomes that can’t be simulated in real life (e.g., burning in hell, contracting HIV)
  - Distressing mental images (e.g., of sexually abusing children)
  - As an early step in a fear hierarchy (e.g., imagine flying before actually getting on an airplane)

Interoceptive Exposure

- Exposure to feared physical sensations.
- Designed to counteract avoidance of specific bodily cues that elicit fear.
- Most often used to treat panic disorder.
- Typically done via exercises that induce panic-type sensations:
  - Difficulty breathing (e.g., breathe through a straw)
  - Increased heart rate (e.g., run in place)
  - Dizziness (e.g., spin in a chair)
**In Virtuo Exposure**

- Exposure conducted using virtual reality technology that allows the client to interact with a virtual environment.
- Most often used for fear of flying.
- Has also been applied to other specific phobias (e.g., fear of spiders), PTSD (e.g., combat vets), and social phobia.

**Opposite Action**

- Involves engaging in behavior that is opposite to the “action urge” that is elicited via cue exposure.
- Can be applied to any unjustified emotion.
- Extends response prevention beyond eliminating dysfunctional behavior to also include increasing functional behavior.
  - Opposite action “all the way”
Making Exposure Work

Avoid Avoidance!

**Block avoidance behaviors before, during, and after exposure.**
- Distraction
- Dissociation
- Compulsive behavior
- Mental rituals
- Anti-anxiety medication
- Alcohol/drugs
- Reassurance seeking
- With supportive people
- Avoiding eye contact
- Stopping prematurely
- Chit-chat
- Using DBT skills
- Prayer
- Speaking quietly
- Behavioral outbursts (escape)
Maximizing Inhibitory Learning

• Expectancy Violation (“Test it out”)
  • Maximize discrepancy between expectancy and experience
  • Have patient articulate specific feared expectation
  • Cognitive strategies would not be recommended here

• Occasional Reinforced Extinction (“Face your fear”)
  • Occasionally present the feared outcome during exposures
  • May deepen expectancy violation – patient learns that “disastrous” exposure may be followed by either another disaster or no disaster, decreasing expectancy that all exposures will be disastrous

Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014

Maximizing Inhibitory Learning

• Variability (“Vary it up”)
  • Habituation models emphasize “fear hierarchy,” gradually going in order
  • Exposure therapy with varying cues, for varying duration, at varying levels of intensity, or hierarchy items out of order appear more beneficial long-term
  • Repeat exposures in multiple contexts
    • Internal contexts: medications taken, mood state, hunger level
    • External contexts: location, time of day, presence of others

• “Deepened Extinction” (“Combine it”)
  • Conduct exposure to multiple cues after each have been addressed in isolation

Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014
Maximizing Inhibitory Learning

• Removal of Safety Signals/Behaviors ("Throw it out")
  • Learning only occurs in context of safety signal, limiting generalizability
  • Functions as subtle avoidance
  • Gradually phase out over the course of exposure therapy

• Affect Labeling ("Talk it out")
  • Patients describe emotional experience during exposure
  • May activate higher cortical processing

Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014;
Marks, Walker, Ojalehto, Bedard-Gilligan, & Zoellner, 2019

Do Existing Exposure Treatments Work with Severe BPD Clients?
Standard Exposure Treatments for Anxiety Disorders are...

- Single-diagnosis treatments that target a specific anxiety disorder
- Intended for clients with a primary anxiety disorder without other severe problems

Exposure Treatments for Anxiety Disorders: Common Exclusion Criteria

- Anxiety disorder is not the primary diagnosis
  - Comorbid diagnoses are permitted if they are secondary (i.e., the anxiety disorder must be the most severe and impairing disorder)
- Suicidality
  - Recent suicidal or self-injurious behavior or significant suicide ideation
- Substance use disorder

“[T]he common confluence of exclusion criteria for suicide risk and substance abuse/dependence is likely to exclude many patients with borderline features.”

(Bradley et al., 2005, p. 224)
Prolonged Exposure Therapy (PE) for PTSD: An Example

<table>
<thead>
<tr>
<th>PE Exclusion Criteria</th>
<th>General Recommendation</th>
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</thead>
<tbody>
<tr>
<td>• Imminent threat of suicide or homicide</td>
<td>“In general, we recommend that if another disorder is present that is life threatening or otherwise clearly of primary clinical importance, it should be treated prior to initiation of PE.” (p. 29)</td>
</tr>
<tr>
<td>• Recent serious self-injury</td>
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<td>• Current psychosis</td>
<td></td>
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<tr>
<td>• Current high risk of being assaulted</td>
<td></td>
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<tr>
<td>• Insufficient memory of traumatic event(s)</td>
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Foa, Hembree, & Rothbaum, 2007

Integrating Existing Exposure Treatments into DBT for Severe BPD Patients
Deciding When To Start Formal Exposure

- Not at imminent risk of suicide.
- No recent (past 2 mos.) life-threatening behavior.
- Ability to control life-threatening behaviors in the presence of cues for those behaviors.
- No serious therapy-interfering behavior.
- The anxiety disorder is the highest priority target for the client and the client wants to treat it now.
- Ability and willingness to experience intense emotion without escaping.
Integrating DBT with Prolonged Exposure (PE) for PTSD

- **Standard DBT (1 year)**
  - Individual DBT therapy (1 hour/wk)
  - DBT group skills training (2.5 hours/wk)
  - Telephone coaching (as needed)
  - Therapist consultation team (1 hour/wk)

- **DBT Prolonged Exposure Protocol**
  - Modified Prolonged Exposure therapy for PTSD
  - Occurs concurrently with standard DBT
  - Administered by the individual DBT therapist

Research Progress

- **Pilot cases** (n=7)
  - Harned & Linehan, 2008

- **Open trial** (n=13)
  - Harned, Korslund, Foa, & Linehan, 2012

- **Pilot RCT** (n=26)
  - Harned, Korslund, & Linehan, 2014
Exposure Therapy Works with Severe BPD Clients

Meta-Analysis of Exposure Treatments for PTSD

Completers: 68%
ITT Sample: 53%

Exposure Rarely Causes Increases in Suicide and Self-Injury Urges

<table>
<thead>
<tr>
<th></th>
<th>Urge to Commit Suicide</th>
<th>Urge to Self-Injure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in urges</td>
<td>7.7%</td>
<td>8.2%</td>
</tr>
<tr>
<td>No change in urges</td>
<td>80.5%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Decrease in urges</td>
<td>11.8%</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

*Note.* Urges were rated immediately before and after each exposure task (n=701).
Exposure Therapy Does not Increase Suicidal and Non-Suicidal Self-Injury

Among treatment completers, clients in DBT+DBT PE are 2.4 times less likely to attempt suicide and 1.5 times less likely to self-injure than those in DBT.

And it May Even Decrease Suicidal and Non-Suicidal Self-Injury
Other Outcomes

• In both the open trial and pilot RCT, large and significant improvements were also found for:
  • Suicidal ideation
  • Trauma-related guilt cognitions
  • Shame
  • Dissociation
  • Depression
  • Anxiety
  • Social adjustment

• In the pilot RCT, these effects were larger in DBT + DBT PE than in DBT for treatment completers.

Conclusions

• Existing exposure treatments typically:
  • Exclude severe BPD clients and
  • Postpone treatment if suicidality or other major problems emerge
• Integrating DBT and modified exposure treatments appears to be a safe and effective way to deliver exposure to severe BPD clients.
Thank you!

Questions?