Collaborative Case Formulation Is Key in Cognitive-Behavioral Therapy for Anxiety and Panic

A Review of

Cognitive–Behavioral Therapy for Clients With Anxiety and Panic
with Bunmi O. Olatunji
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Cognitive–behavioral therapy (CBT) is highly efficacious and has been established as the first-line psychosocial treatment of choice for anxiety disorders (Norton & Price, 2007; Tolin, 2010). On the basis of Aaron T. Beck’s pioneering cognitive model of anxiety disorders (Beck, Emery, & Greenberg, 1985) with recent updates (Clark & Beck, 2010), anxiety problems are proposed to arise from faulty learning such that individuals misinterpret benign triggers or situations as dangerous or threatening and underestimate their ability to cope with the consequences. This maladaptive thinking pattern may affect individuals at the physiological level in which autonomic hyperarousal (e.g., panic attacks) develop to prepare the individual for the fight, flight, or freeze response.

At the behavioral level, individuals may avoid the anxiety-provoking triggers or situations, or develop strategies (e.g., safety behaviors) that prevent them from learning that the feared triggers or situations are not as dangerous as they had thought. While avoidant behaviors may temporarily relieve anxiety and the perceived danger, they never fully remediate these feelings and thoughts. As a result, symptoms of the anxiety are maintained.

CBT is a structured form of psychotherapy that helps individuals with anxiety problems change maladaptive thinking patterns and decrease avoidant behavior. CBT features several components, beginning with psychoeducation and self-monitoring to help clients understand what triggers and maintains their anxiety.

The cognitive restructuring component involves identifying and modifying erroneous beliefs about panic and anxiety. Exposure and behavioral experiments expose clients systematically to feared activities (e.g., driving), situations (e.g., at work), physiological sensations (e.g., increased heart rate), or cognitions (e.g., memories) to help them reduce avoidant behaviors that prevent safety learning.

Since the advent of Beck’s CBT model of anxiety, other researchers have developed specific cognitive–behavioral models and interventions that map onto specific anxiety disorders. As a result, there have been a growing number of manualized treatments for various anxiety disorders, including panic disorder, social anxiety disorder, obsessive-compulsive disorder, generalized anxiety disorder, posttraumatic stress disorders, and specific phobias.

However, a manualized approach does not adequately address comorbidity and other complications often encountered in clinical practice. An alternative is the individualized case formulation approach to the delivery of CBT. This approach is illustrated in Cognitive–Behavioral Therapy for Clients With Anxiety and Panic, a new training DVD in the Specific Treatments for Specific Populations video series released by the American Psychological Association (APA).

In this DVD, expert clinician Bunmi O. Olatunji, of Vanderbilt University, collaborates with a real female client with panic
attacks and comorbid anxiety problems to provide her with a new way of understanding her symptoms. CBT principles guide the selection, focus, and sequence of subsequent interventions.

As an overview, Olatunji is first interviewed by host Jon Carlson and briefly discusses several key learning objectives, including the basic tenets and structure of CBT, the conceptualization of anxiety in the CBT model, and challenges that clinicians may face when using this type of therapy in treating anxiety disorders. In particular, he observes that for some clients, the idea of being exposed to the very trigger or situation they fear may be a "hard message to sell," as they may expect the therapist "will make me feel better without making me feel worse."

As such, he contends that clinicians need to provide a proper and convincing conceptualization and treatment rationale so that clients will be receptive to engaging in treatment. Olatunji later demonstrates in the session how he reframes the client’s expectancies of experiencing anxiety and addresses the client’s ambivalence about treatment via a cost–benefit analysis.

A full-length introductory therapy session between Olatunji and the client is presented after the interview. An option is presented in the menu for the viewer to watch the therapy session with voice-over commentary by Olatunji. This feature is helpful in capturing Olatunji’s observations, reactions, and thoughts on the client and the therapeutic intervention being used upon subsequent viewing(s) of the therapy session.

The single session presented in this DVD is ambitious, with a great deal of content jam-packed into 45 minutes. Olatunji was able to (a) set an agenda for the session; (b) gather some relevant history from the client that informs understanding of her current symptoms; (c) formulate the client’s anxiety model by eliciting her catastrophic beliefs about anxiety, as well as behavioral and cognitive avoidance strategies; (d) provide psychoeducation about anxiety; (e) use the client’s real-life examples to introduce the idea of exposure therapy and habituation; (f) develop a preliminary exposure hierarchy; (g) use cognitive reframing and motivational interviewing techniques to address ambivalence in trying exposure therapy; and (h) elicit commitment to specific therapy homework.

For illustrative purposes, Olatunji was able to demonstrate these therapy components seamlessly over the span of the session without leaving the client (or the viewer) feeling overwhelmed. However, he acknowledges that these therapy components would typically be introduced over a span of several sessions and that it would likely take 20 sessions or more to address fully the client’s anxiety concerns.

The DVD ends with a second interview with Olatunji with his final thoughts on the therapy session and CBT. As the viewer is being led through a review of clips of the session in the follow-up discussion, he or she is reminded of the importance of the relationship between the therapist and the client in CBT. Olatunji not only exhibits warmth, genuineness, curiosity, and enthusiasm throughout the session, but he also demonstrates true collaboration with his client. Each has a role (i.e., she is the expert on her anxiety symptoms, and he is the expert on ways of reducing anxiety) that complements the other as they jointly decide on how to carry out the exposure assignments.

APA has previously released several training DVDs in the Specific Treatments for Specific Populations series on the use of the cognitive–behavioral approach in the treatment of specific anxiety disorders, including generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, and social anxiety disorder. The current DVD is a valuable addition to the series in that it showcases the importance of case conceptualization for a client with a complex and comorbid presentation of anxiety symptoms. Clients with a singular or “clean” diagnosis of a particular anxiety disorder do not necessarily reflect what clinicians typically see in their practice.

With that said, we add that this DVD may be more suitable for clinicians with some familiarity with CBT. Students or clinicians new to CBT may benefit by watching demonstrations of specific cognitive restructuring techniques and the delivery of exposure therapy (e.g., interoceptive exposure) with the aid of other training DVDs because Olatunji’s DVD does not provide in-depth demonstrations of techniques.

On the other hand, those who are more advanced in their training and more familiar with basic techniques may find Olatunji’s demonstration of collaborative case conceptualization particularly helpful. In our opinion, individualized case conceptualization is key to guiding therapy and relieving client distress with many of the more complicated cases seen
References


