OCD - 300.3 (F42)
Obsessive-Compulsive Disorder

- DSM-V® Criteria (own class, no longer under anxiety disorders)
- A. Presence of Obsessions, Compulsions, or Both
- **Obsessions** are defined as 1 and 2:
- 1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
- 2.The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

OCD - DSM cont'd

- **Compulsions** are defined as 1 and 2:
- 1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- 2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

OCD - DSM cont'd

- B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- D. The disturbance is not better explained by the symptoms of another mental disorder

OCD - DSM cont'd

- Specify if:
  - **With good or fair insight**: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
  - **With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true.
  - **With absent insight/delusional beliefs**: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

OCD - Differential Diagnosis:

- Generalized Anxiety Disorder - Worry OR Obsession
- OCPD
- Panic Disorder
- Phobia
- Psychosis - Delusional (reverse - OCD mistaken for psychosis…more common)
- Related Disorders: Hoarding, Excoriation Disorder (skin-picking), Trichotillomania, Body Dysmorphic Disorder.

OCD - A few facts:

- Affects 2-3% of population (lifetime prevalence) although it was once considered to be very rare (less than 1%).
- Affects males and females equally, but boys more than girls and women more than men.
- Boys may outgrow it.
- Women at risk for postpartum OCD typically involving fear of harming their children.

OCD - A few facts:

- Waxes and wanes
- 40% unemployment
- 20% spend more than 5 hrs
- 13% more than 17 hrs at most severe.
- Skoog and Skoog (1999) tracked more than 100 patients for a mean of 47 years. Participants had been hospitalized for OCD between 1947 and 1953 and 40 years later. By the end 83% had improved, with 20% recovering completely and 28% having minimal symptoms.

OCD - Obsessions:

- Contamination
- Fear of being a Victim (checking locks, windows, stoves, curling irons, appliances)
- Order - typically something "bad" will happen if things aren't in order. Can be specific or random. Just a feeling.
- Fear of being a Perpetrator (Guilt/Shame/Loss) - often children physical or sexual harm, Stealing things, Driving and hitting someone, Shouting obscenities
- Scrupulosity - religious, hell, demon possession
- Horrific Images
- "Forgetfulness" - not trusting memory, creating false memories
- Superstitions - Friday the 13th, the number 13, 666, 8

OCD - Compulsions:

- Cleaning
- Checking
- Praying
- Reassurance - self (covert) and from others
- Avoidance
- Compulsions around superstitions - or avoidance.
- Putting in Order or Doing in Order
- Counting - compelled to count something or do something a specific number of times.

Assessment:

- Y-BOCS - The Yale-Brown Obsessive Compulsive Scale - 5 questions each on obsessions and compulsions - 0 to 4 (0 to 40 scores)
- Y-BOCS Checklist - several obsessions and compulsions to indicate past vs. present+
- Hierarchy - assesses anxiety levels of facing fears, guides treatment and can track progress

Heirarchy

8

Not wash hands after garbage can

NotWash hands after pumping gas

Not Wash hands after leaving grocery store

Not Showering after trying on clothing esp. pants

7

Putting away groceries without wiping each item

Allowing grocery bags all over the kitchen without wiping

Not sanitizing hands after being out

Not showering after sitting down in public restroom

Kids touching bottom of their shoes when putting them on

6

Letting book bags around the house

Not sanitizing steering wheel/keys/seatbelt

Not washing hands after loading dirty laundry

Not washing clothes after using public restroom

Sitting on public spaces where feet may be

5

Seeing my kids on bleachers

Not washing hands after touching mail

Shoes touching seats in car

Kids sitting on grass at sporting events

Touching public doors

Clothes shopping – touching clothes others touched

Heirarchy

4

Allowing kids to not wash hands after school

Allowing kids to lay around with dirty clothes

Go to Boy Scouts

Folding laundry on a "dirty surface"

Husband to use ladder w/o washing hands or changing socks

Shake someone's hand w/o washing hands

Use someone's pen w/o washing hands

Watch neighbors take out garbage cans and recycling bins

Kids wanting to play with toys at allergist

Thinking of kids at school sitting on floor

3

Not using sanitize cycle on washing machine

Watching TV shows that have hygiene issues

Not washing hands after loading dirty dishes

Allowing well friends over

Sharing DVDs

Library books

Not washing hands after opening sanitized cans

2

Not washing hands after using credit card

Relaxing in kids' room after dad's visit

Hold objects that have been on a floor

Not washing clothes after putting object on lap after it has been on a floor

Touching postage stamps without washing hands

Exposure and Response Prevention for OCD

- Expose the client to a feared stimulus (exposure) and prevent them from engaging in the compulsion (response prevention).
- Continue Response Prevention (sometimes exposure) until their anxiety comes down
- Choose a moderately fearful stimulus first two ways:
  1. Ask…
  2. Hierarchy

Response Prevention: Stopping Negative Reinforcement

- Provide a rationale for negative reinforcement.
- Simply ask client to stop or wean.
- For example, stop or reduce: searching the internet, calling someone to see if they are ok, cleaning, counting, putting in order.
- Acceptance of discomfort. Getting comfortable with being uncomfortable.
- Practice for 3 minutes being still

Response Prevention with Mindfulness

- In session - set timer for 3 minutes
- Ask client to close their eyes and not move, but notice any urges to move. "You can breathe and swallow, but avoid…"
- Note the similarity between these urges and the urges they have to engage in their compulsion.
- Demonstration...
- Urge surfing

In Vivo Exposure

- Touch and lick things like doorknobs, pens, shoes, floor.
- Purposefully change a routine.
- Purposefully move something askew.
- Say or approach numbers, words, situations.
- Examples:

In Vivo Response Prevention

- **Resist washing**
- **Resist straightening**
- **Resist checking**
- **Resist routine - purposefully change**
- **Resist reassuring - self reassurance by repeating the obsession..What if….and train family members with a set response**
- **Approach instead of avoiding**
- **Resist Prayer - in conjunction with exposures. OK otherwise.**

Contamination Dilemma?

COVID! Flu Season? Do you put your clients at risk for getting the flu and COVID?

- Follow Work, School, and Government Guidelines
- Recontamination!
- "Contaminate" a cloth.
- Touch immediately after washing or sanitizing.

Fear of Being Perpetrator

- Over 90% of women over 85% of men admit to having some type of horrific or untoward thoughts come into their minds
- Difference is most people accept the thoughts and know they won't act on them.
- Those with OCD are horrified and negatively reinforce by…
  1. "White bear behaviors" - i.e. they try to not think of it
  2. Reassure themselves they won't do it.
  3. Engage in avoidance behaviors.
  4. study with people who admitted to having these thoughts, but don't have OCD

Fear of Being Perpetrator

- Normalize these thoughts - Share yours? Usually brings a rapid level of relief.
- Because negative reinforcement has usually strengthened the once normal fear - normalizing is usually insufficient to stop it.
- Thought labeling can be useful sometimes, but exposure is often needed.
- Education that those who have hurt their children did not have OCD. Psychopaths or Schizophrenic. OCD will never make a person do something they don't want to do. Careful.

Verbal Exposure

- Particularly useful when…
  - primarily covert compulsions
  - self-reassurance is high
  - ping-ponging or see-sawing in one's mind
  - exposure to feared event is unethical or impractical.

Verbal Exposure

- Repeat the feared outcome
- Be sure to get to the core fear
- My children will suffer and die from cancer and it will be my fault.
- Repeat feared words; sing them (more when we get to panic). Emetophobia example
- Use audio loops

Cognitive Therapy (CT)

- Fear if I don't check the doors and windows someone will get in and kill me.
- What do you think the likelihood is that if something is left open that someone will come in. And if someone comes in what is the likelihood that something catastrophic will happen?
- Are your thoughts true? Or are they fiction? Thought labeling
- Do you realize that your thoughts are kind of silly?
  - Name the OCD part of the mind - Hugo.
  - You are the wise part; you are not Hugo.
  - "Hugo" is inflating your responsibility to check and overestimating threat.
- Would you be willing to do a behavioral experiment, not check, and see if someone comes in.

Meta-Analysis of CBT for OCD

- 37 RCT of CBT 1993-2014 (Öst, Havnen, Hansen & Kvale, 2015) including those comparing SSRIs.
- CBT yielded very large effect sizes compared to wait list (1.31) and placebo (1.33).
- ERP and CT (.07 for ERP, but NS) always behavioral experiments in CT make it Exposure and Response Prevention - but more socratic
- CBT was significantly better than antidepressants (.55).
- The addition of antidepressants did not potentiate the effect of CBT.

SSRIs vs. ERP/CBT

- *GENERALLY* SSRIs about 60% effective, CBT 70%
- CBT indicated in MOST cases
- SSRIs indicated when depression is severe, as well as when poor or no insight. Maybe when compulsions are strictly covert.
- Anti-psychotics may improve SSRI response.
- While statistically speaking SSRIs do not improve CBT, case by case basis (e.g. severe depression or patient preference) Example my driving guy.

Treatment Overview

1. ERP/CBT Treatment of Choice*
2. SSRIs: 1. Poor Insight or Severe Depression - Fluvoxamine (Luvox), Clomipramine (Anafranil), Zoloft best for kids. Higher dosages than for depression/anxiety. 2. CBT failure
3. Failure of CBT and at least 2-3 medications - TMS Transcranial Magnetic Stimulation
4. TMS Failure: Surgery - most don't want this
   1. Deep Brain Stimulation
   2. Bilateral Cingulotomy - cingulate gyrus and frontal lobe

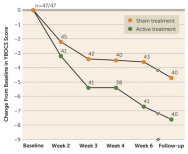
TMS: Transcranial Magnetic Stimulation

- Roth et al., 2021 - 22 clinical sites, 219 patients, 182 included in analysis that had YBOCS scores
  - 72% taking SSRIs, avg 5.8 failed meds
  - ERP NOT mentioned but likely most had it as required for insurance covg.
  - TMS was Well tolerated (18 had transient headaches or similar)

TMS: Transcranial Magnetic Stimulation

- "Most improved within 20 sessions" but 29 is the FDA approved number (121 patients)
- no correlation between treatment response and SSRI or comorbid dx (66%)
- 80% achieved at least a 30% improvement on YBOCS
- Avg score reduction was 52.4%
- Avg pre-test was 27 (24-31 is the severe range) and only 13 at post test (8-15 is mild range). $p < 0.0001$; $t = 45.02$, $df = 4405$

TMS: Controlled Study



4 patients (99 - 5 dropped out) TMS vs Sham (Carmi

creased in both, but TMS significantly more improved:
r TMS -7.7 vs Sham -4.8

Panic Attack - DSM V Definition

An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and includes at least four of the following symptoms:

1) palpitations, pounding heart, or accelerated heart rate
2) sweating
3) trembling or shaking
4) sensations of shortness of breath or smothering
5) feeling of choking
6) chest pain or discomfort...

Panic Attack - DSM V Definition

7) nausea or abdominal distress
8) feeling dizzy, unsteady, lightheaded, or faint
9) chills or hot flushes.
10) paresthesias (numbness or tingling sensations)
11) derealization or depersonalization…..
12) fear of losing control or going crazy
13) fear of dying

NOTE: The abrupt surge can occur from a calm state or an anxious state.

Panic Disorder
DSM-V Criteria - 300.01 (F41.0)

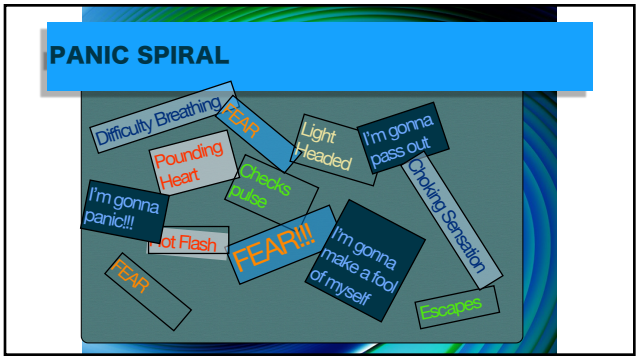
- At least one of the attacks has been followed by at least one month of consistent worry about either:
- having additional panic attacks or the consequences of them (e.g. going crazy, death) OR
- a significant maladaptive change in behavior
- Not solely in response to either physiological effects of a medical or substance abuse issue OR another mental disorder (including anxiety disorders)

New in DSM-V
Panic Attack Specifier

- Panic Attack is not a mental disorder and cannot be coded.
- Panic attacks should be specified when occurring in the presence of another mental disorder (unless panic disorder is present).
- For example, "specific phobia, (feared thing) with panic attacks."

What "Kind" of Panic?

- Quasi Panic Attack: Works way into a "Panicked State."
  - Begins with Worry
  - Little or no fear of symptoms
  - Treat like all worry - Applied Relaxation/SCD
- "True" Panic Attacks
  - Sudden surge or seemingly "out of the blue"
  - Surge triggered by physiological change in the body
  - Fear of Symptoms
  - Treat these with exposure



Meuret et al. (2011)

- 24-hour ambulatory monitoring on clients with panic
- Instructed to hit the panic button immediately.
- Results:
  - Significant decreases in CO_2 and increases in heart rate and respiration a full hour before the panic.
  - Some increases after the panic button, but most of the changes occurred before their awareness.
  - Chronically low CO_2

Panic Assessment

Panic Attack Assessment Form:

When having a panic attack do you experience the following symptoms:

N = never
R = rarely
ST = sometimes
U = usually
A = always

_____heart rate increase _____chest pain or discomfort
_____sweating _____derealization or depersonalization
_____trembling or shaking _____ numbness or tingling sensations
_____difficulty breathing _____chills or hot flushes
_____feeling of choking _____fear of losing control or going crazy
_____ nausea or abdominal distress _____ fear of dying
_____feeling dizzy, unsteady, or faint _____ (other)_____

Circle the symptom or symptoms that usually come first. Underline the worst symptom.

Panic Assessment

Panic Attack Monitoring Form

Time:

Situation (where, who, what):

Background Stress (hours leading up to panic):

Symptoms: Check all that were experienced, Circle the first, Underline the Worst

_____heart rate increase _____chest pain or discomfort
_____sweating _____derealization or depersonalization
_____trembling or shaking _____numbness or tingling sensations
_____difficulty breathing _____chills or hot flushes
_____feeling of choking _____fear of losing control or going crazy
_____nausea or abdominal distress _____fear of dying
_____feeling dizzy, unsteady, or faint _____(other)_____

Intensity on 0-10 scale:

Interoceptive Exposure

- Because physical symptoms potentiate the panic attack in most, we want to find the first symptom(s) of an attack.
- Interoceptive exposure involves "bringing on" those physical sensations with a variety of exercises in the safety of the session and later at home.
- When the client gets comfortable with those symptoms in the session, typically when those symptoms are experienced outside of the session, it is accepted, and the panic doesn't occur.

Interoceptive Exposure

- Breathing through a small straw.
- Rapid breathing - use a metronome
- Head side to side or spin
- Head down and up
- Staring or Flourescent lights
- Running up stairs
- Coat/Hat/Blanket/Hot Drink

Interoceptive Exposure

1. Administer the Assessment....
2. Determine FIRST and WORST symptom
3. Do near the beginning of a session.
4. Try an exercise until you find something that is very similar to "the beginning of" a panic attack.
5. Repeat until anxiety is significantly reduced (3 or 3). Avoid allowing too much relief by stopping.
6. Homework: 2 ways

example (0-8 scale)

Exercise	Symptoms	Anxiety	Similarity
illusion	4	3	2
staring	4	3	6
up at light	2	0	0
flourscent lights/Stare	6	6-7	8
	6	6	
	6	6	
	6	4	
	6	4	
	7	4.5	
	6	3.5	
	5	2	

Interoceptive Exposure Not Working?

- Combine exercises to make them more like the beginnings of a panic attack
- Rapid breathing is the exercise most likely to mimic the symptoms
- If main fear is cognitive, may need to do verbal exposure
- May need to face worst fear (find deepest fear) or worst symptom if not first symptom.

Natural Interoceptive

- Flourescent Lights/Staring
- Exercise*
- Coffee/Caffeine
- Cannabis (other drugs)
- Overheated
- Low Blood Sugar
- Dehydration
- Sleep Deprivation
- More Stress than Usual
- Med side-effects
- Hormones, other Medical Issues

Play Detective;
Be the Hero

Anxiety Sensitivity

- What was under the radar is now noticed.
- Hyper-awareness of normal bodily changes.
- Negative reinforcement of those symptoms exacerbates them.
- Interoceptive exposure desensitizes them.

When Panic Looks Like OCD

- In OCD an individual engages in compulsions to neutralize anxiety caused by obsessions. They also avoid situations that cause anxiety.
- In panic, an individual often engages in compulsions to neutralize the fear of having a panic attack and avoid situations that cause anxiety.

When Panic Looks Like OCD

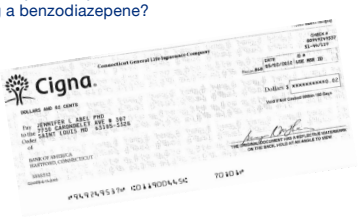
- Checks vitals - most common heart rate; also blood pressure, oxygen, blood glucose. Similarly check eyes, face, etc.
- Checks Phone - charge, people.
- Avoids
  1. naturally occurring interoceptive (e.g.,exercise, coffee)
  2. places where panic has occurred
  3. situations (e.g. parties)

When Panic Looks Like OCD

- Safety Items-person, **drugs** (in case), water
- Reassurance - self or seeking from others.
- Prayer
- Rituals - (case e.g., scrunching)
- Treatment -
  1. Exposure
  2. Response Prevention
  3. Can integrate into the hierarchy

Would you recommend to your client or parent that they use alcohol to deal with their panic?

Then why would you recommend using a benzodiazepene?



Other Panic Treatment

- Use monitoring to learn to predict the unpredictable.
- Use this info to catch anxiety early or prevent.
- Treat the phobia associated with panic.
- Flood the fear verbally….

What is the real fear?

- I'm afraid of heights!
- No - I'm not afraid of heights, I'm afraid of falling
- No - I'm not afraid of falling, I'm afraid of hitting the ground hard and fast.
- No……I'm afraid of the pain immediately after and I'm afraid of dying.

What is the real fear?

- I'm afraid of having panic attacks.
- I'm more afraid an attack will make me go crazy.
- I'm even more afraid of being locked up.
- I'm afraid of being drugged and losing myself.
- I'm most afraid I will lose custody of my kids and that I'll never get to see them. And they won't love me.

Flood the real fear?

- Repeat the fear verbally until anxiety is reduced.
- Rule out poor or absent insight.
- Do not allow reassurance - Know the difference between self-reassurance and reality prevailing.
- Get a SUDS rating after saying it 2-3X - then less often until anxiety is low
- Consider using a mirror.

Example

- "What if I panic and it causes me to go crazy and I'm locked up and lose custody of my kids" "What if I'm locked up in a mental hospital and I never get to see my kids" "I'm afraid that one of these times my panic will be so bad that I'll go crazy, I'll get locked up, get drugged, my kids will stop liking me and won't want to see me."
- Assess difference in you saying it instead: "You're afraid that you will faint in public....
- And the difference between "What IF" and "I'm afraid"

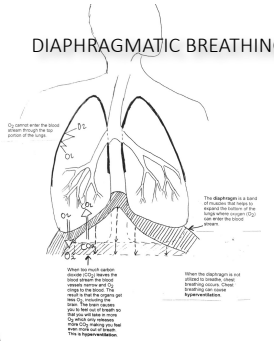
Flood the real fear?

- Flood a word or short phrase.
- "Milk" (Steven Hayes)
- 45 seconds - desensitizes and takes away power by sounding ridiculous.
- e.g. "heart attack" "faint" "suffer" "crash" "turbulence"
- Sing it!

Cognitive Therapy

- What do you think the likelihood is that you will faint if you go to the Piggly Wiggly to do your grocery shopping?
- Behavioral Experiment. Would you be willing to go and see if that happens?
- Would you be willing to fake a faint? What do you think would actually happen if you DID faint in a public place.

DIAPHRAGMATIC BREATHING Dilemma



- Can interfere with effectiveness of exposure, but in subset decreases panic.
- What I do… (win-win)
- Several tricks, but best is hands over head
- Also good to slow breathing despite "brain advising opposite."

When Panic Awakens at Night

- Rule out sleep apnea.
- Have client hold breath as long as possible.
- Nightmares
  - orient to time and place.
  - aromatherapy by the bed.
  - Valuable newer object by the bed.

Research on Panic Treatment

- Interoceptive Exposure (IE) + Cognitive Therapy (CT) - 81% completely panic free at 2 year follow up (Craske, Brown, & Barlow, 1991).
- IE + catching anxiety early and using relaxation and CT
  - Stuart, Treat, and Wade 89% at 1 yr follow-up
  - Craske and Barlow (2006) 90% at 1 and 2 yr follow up.
- Three meta-analyses all show significantly more improvement with CBT than medication (e.g. Westen & Morris, 2001)
  - .88 for CBT
  - .58 for CBT plus Meds
  - .40 for meds (about the same for relaxation/CT)

Research on Panic Treatment

- Benzo dependent - 58% (76% post) able to be benzo free after 3 months f/up with CBT vs. only 24% on taper only (Otto et. al, 1993).
- Dismantling CBT component meta-analysis (Pompoli et al., 2018)
  - Interoceptive most efficacious
  - Cognitive Restructuring 2nd most (often contains exposure)
  - LEAST efficacious - breathing retraining, muscle relaxation, in vivo exposure, virtual reality. STILL USE *IN VIVO* FOR PHOBIAS
  - Breathing retraining DID help "treatment acceptability" PERHAPS use ONLY with clients who are breathing shallow.
  - Dearth of info on mindful acceptance - dissertation???

Medications

SPEAK TO THEIR PHYSICIAN...

- Often best to avoid medication altogether as CBT is significantly more effective and less side effects.
- Avoid prn benzodiazepenes if possible, but if benzodiazepenes are most effective and needed in order to go to work, school, etc. use consistent longer acting (e.g.,Klonipin) to avoid negative reinforcement.
- Beta blockers - very effective for performance anxiety and cardiac focused panic without negative reinforcement.
- SSRIs, SNRIs, Viibryd - all fine. Paxil and Zoloft
- Antihistamines, Buspar, Gabapentine, beyond our scope

Review - Panic

- Treat like worry when working way into panic state.
- Mindful Acceptance
- Stop negative reinforcement.
- Diaphragmatic breathing
- Interoceptive exposure
- Flood "real fear" verbally
- Imaginal Exposure
- In-Vivo Exposure
- Behavioral Experiments.

Agoraphobia

- DSM-V® Criteria 300.22 (F40.00)
- A. Marked fear or anxiety about two (or more) of the following situations:
  1. Using public transportation or cars.
  2. Being in open spaces.
  3. Being in enclosed situations.
  4. Standing in line or being in a crowd.
  5. Being outside of the home alone.

Agoraphobia - DSM cont'd

- B. The individual fears/avoids situations b/c of thoughts that escape will be difficult or help won't be available in the event of panic symptoms or incapacitating or embarrassing symptoms (e.g, fear of incontinence).
- C. The situations always provoke fear or anxiety.
- D. The situations are avoided, "require" a companion, or are endured with intense fear or anxiety.

Agoraphobia - DSM cont'd

E. The fear is out of proportion to the actual danger posed.

F. Persistent - lasting at least 6 months.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

H. If a medical condition is present, the fear, anxiety, or avoidance is clearly excessive.

I. Differential diagnosis

Differential Diagnosis

- Social Anxiety Disorder
- Specific Phobia (e.g. bees, worms)
- Paranoid related disorder
- Depressive disorder - no energy to get out
- Panic Disorder

Agoraphobia - Differences between DSM IV-R and DSM V

- Agoraphobia now requires at least two situations to distinguish from Specific Phobia.
- Panic and Agoraphobia are unlinked in DSM V.
- In DSM IV there were three diagnoses:
  1. panic disorder with agoraphobia
  2. panic disorder without agoraphobia
  3. agoraphobia without history of panic disorder
- #1 now Agoraphobia with Panic Attacks.

Agoraphobia Treatment

- Treatment of Panic often the forefront of treatment+
- Gradual In Vivo Exposure usually best (e.g., sit on your front porch) - May make a Heirarchy
- Flood feared thoughts - Often fear of having a panic attack or consequences of an attack.
- Behavioral experiments
- Fear may prevent the client from coming to therapy.
  - Home Visit
  - Video-Based Online Therapy
  - Phone Therapy

Specific Phobia

• DSM-V® Criteria:

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, an injection, seeing blood). In children may be displayed as clinging, crying, tantrums, or freezing.
B. The phobic object or situation almost always provokes immediate fear or anxiety.
C. The phobic situation(s) is actively avoided or endured with intense fear or anxiety.

Specific Phobia

D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
E. The fear, anxiety, or avoidance is persistent, typically lasting at least 6 months.
F. The fear, anxiety, or avoidance, causes clinically significant distress or impairment in social, occupational or other important areas of functioning (e.g.academic)
G. Differential Diagnoses - not better accounted for by another DSM V Diagnosis.

Specific Phobia - 300.29
Specify if:

- F40.218 - Animal (includes insects) *spiders, dogs*
- F40.228 - Natural Environment *heights, water*
- F40.248 - Situational *planes, elevators*
- F40.298 - Other *emetephobia, clowns*
- F40.23x - Blood-Injection-Injury:
  - F40.230 fear of blood
  - F40.231 fear of injections and transfusions
  - F40.232 fear of medical care
  - F40.233 fear of injury

• note ICD-10-CM codes vary - DSM does not

Specific Phobia - Treatment:

• Cognitive therapy and relaxation are *usually* of very little use: So we do exposure!
  •In-Vivo
  •In imagery
  •YouTube/Images
  •Flood the thoughts/word(s)
  •Flood the thoughts/words In-Vivo etc.
  •May use acceptance
• If the primary fear is fear of having a panic attack,
• what would you do?

Specific Phobia - Acrophobia

- What is the real fear? Not heights, but fear of:
  - **pain/injury/death**
  - jumping
  - falling - lose footing
  - being pushed
  - losing control of vehicle
  - engineering failure
  - natural forces - e.g. earthquake, landslide
- Exposure or Behavioral Experiment

Acrophobia - Exposure

- Video exposure - can vary size.
- In Vivo exposure - gradual approach
- Flood the thoughts - situations more specifically
- Flood thoughts in vivo
- Words - Fall, Jump
- Response Prevention

ACROPHOBIA IN VIVO EXPOSURE

Specific Phobia - Flying

- What is the real fear? Not always crashing:
  - crashing and dying
  - having a panic attack
  - relinquishing control
  - claustrophobia
  - inability to get medical attention

Specific Phobia - Flying

- embarrassing oneself
- irrational fears - ejection; running around; premonition.
- terror
- abandoning my children - missing out.

• Challenge - not practical to face the fear in vivo.

Specific Phobia - Flying

• What is most feared varies greatly between people. Can build a heirarchy including:
- Take off
- Landing
- Stuck on Tarmac - Circling
- Time of day
- Weather
- Turbulence

Flying Phobia - Exposure

1. Search YouTube or Video in search engine.
- Usually start with moderate or easiest - can easily move up the heirarchy.
- Typically 30 sec clip or less

2. Imaginal Exposure
- Make as similar to plane as possible
- Chair (Chair in front/side with claustrophobia)
- Sound

3.Flood fears - All fears, including worst fear

4.Say and sing fear words - crash, turbulence.

Flying Phobia - Education

- 5. Education > Cognitive therapy, but often useless.
  - 8100% more media coverage for plane crashes vs. car WHY? b/c it's rare.
  - Globally, over 3,000 people die in car crashes each day, most major crashes are under 300.
  - If you flew a commercial jet everyday chances are it would take over 19,000 years before you would die in a plane crash.
  - Atlanta: Over 100 million passengers/year
  - Consider Pilots and Flight Attendants - NYC e.g.

Specific Phobia - Emetophobia

- Fear of vomiting and of seeing other people vomit; Considerations:
  - Unethical to purposefully cause someone to vomit - ipecac.
  - Disgust more difficult to treat than fear.
  - OCD? Because germs can cause a stomach flu- not unusual for this to become OCD.
    - Zofran and compazine negatively reinforce; similarly ginger, pepto-bismol other OTC
    - Washing and hand sanitizer
    - Avoiding - touching things, public restrooms, crowds, eating out.

Emetophobia - Treatment of OCD

- **Treat OCD with Exposure and Response Prevention if applicable - Very similar to other contamination related OCD.**
- Differences:
  - worse during flu season
  - response prevention of drugs to prevent nausea
  - otherwise, very similar to any other contamination related OCD.

Emetophobia - Treatment

- Interoceptive Exposure - spinning, head turn, rides.
- Flood the words - mini heirarchy? Sing!
- Flood the fear.
- Photos and Videos
- Goal is not to stop feeling nauseous, but to decrease fear. Expect nausea.

Illness Anxiety Disorder

A. Preoccupation with having or acquiring a serious illness
B. No symptoms, or mild symptoms with exaggerated fears
C. High anxiety about health
D. Excessive checking or avoidance
E. 6 months
F. Not better explained by OCD, GAD, panic, delusional disorder, etc.

Hypochondriasis

- Assess for:
  - Reassurance seeking/Self Reassurance
  - Repeated physician visits (etc.), tests, ER visits
  - Avoiding doctors
  - Internet searches - anecdotally most common reason for compulsive searches
  - Self-Check - mirror, pulse, blood pressure, etc.

Hypochondriasis

- It's natural to want to reassure someone and it's natural for them to reassure themselves.
- Find alternative ways to be supportive.
- Attempts to do cognitive therapy may serve as negative reinforcement.
- Education

Hypochondriasis

- Interoceptive Exposure can be helpful
- Verbal flooding of real fear…death, abandoning children, suffering, getting other people sick
- Stop Negative Reinforcement
- 3 choices - ER, make doc visit, wait & see (postpone).
- Consult with the physician to minimize reassurance.*
- Stop internet searches...then limit them.

Social Anxiety Disorder

DSM-V® Criteria

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others.
B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated.
C. The social situations almost always provoke fear or anxiety.

Social Anxiety Disorder

D. The social situations are avoided or endured with intense fear or anxiety.
E. The fear is out of proportion to the actual threat posed.
F. The fear is persistent, typically lasting for 6 months or more.
G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other areas of functioning.

Social Anxiety Disorder

H. The fear or avoidance is not attributable to the physiological effects of a substance (e.g., drugs, medications) or a medical condition.
I. Not better explained by another mental health disorder
J. Not better explained by a medical condition

Differential Diagnosis

1. Panic Disorder
2. Depression**
3. GAD
4. Body Dysmorphic Disorder (1-2%)
5. Autism Spectrum
6. Medical; e.g.
   a. Parkinsons
   b. disfigurement
   c. tic disorder

Social Anxiety is NORMAL - Zimbardo,Pilkonis, & Norwood, 1975

- 40% of people consider themselves to be shy
- 40% of people consider themselves to have been shy and still shy in some situations.
- an additional 15% consider themselves to be shy in at least some situations.
- So only 5% of people say that they have no social anxiety and….

Social Anxiety Disorder Overview:

- Social Skills Deficit
- Lack of Confidence - Cognitive Distortion
- Physiological Anxiety
- Social Avoidance negatively reinforces the anxiety

Social Anxiety Disorder Assessment

Behaviors:
- Social Skills Deficits
  - eye-contact
  - appropriate affect
  - conversational skills
- Other
  - talk too much - diarrhea of the mouth
  - interrupting
  - inappropriate in any way - TMI, inappropriate comments or questions, unrelated topic or too late.

Social Anxiety Disorder Assessment

Negative Cognitions:
- Unrealistic expectation of performance
  - Exaggeration of the effects of social evaluation
- FNE
- If I'm anxious, I'm failing…

Physiological Anxiety (including fear of panic and fear that someone will notice these symptoms).

Social Anxiety Disorder Treatment Overview:

Teach Social Skills for Skills Deficits

Build Confidence, B3s for Lack of Confidence and Distorted Thoughts

Observation and Acceptance, Relaxation Therapy, Beta Blockers for Physiological Anxiety

Social Anxiety Disorder More Treatment:

EXPOSURE THERAPY - To Practice Social Skills, Desensitize Anxiety, and Build Confidence. Avoid safety behaviors.

Behavioral Experiments/Cognitive Therapy
- How is the experience different from what was expected?
- Guide meaning from a successful exposure.

Address social post-traumatic stress that may have caused or contributed - e.g. Bullying or Valued friends rebuffing.

Social Anxiety Disorder Treatment

Teach Social Skills
- eye contact
- open ended questions including set compliments
- acting for affect - KS
- just listening*
- refrain from interrupting

Group Therapy -

Social Anxiety DisorderTreatment

Just Do It! Tx is designed to provide clients ies to learn that social situations are not as thr ot as dire, and performance deficits are not as unyielding as anticipated. The therapist acts as an expert coach, setting up opportunities for learning, guiding accurate interpretations, joking, encouraging, and providing a context for them to try out new alternatives in feared situations. Hoffmann & Otto (2008)

Public Speaking Treatment

- Normalize - Use Seinfeld Joke.
- Cognitive therapy - Almost everyone empathizes; mostly…everyone wants you to do well.
- Toastmaster's
- Imaginal exposure
- Maybe flood real fear verbally
- First part of the speech - problem solving

Insomnia

Insomnia Disorder - DSM V Criteria

- DSM 4 - Was called Primary Insomnia and was actually more objective - 30 min and < 85% sleep efficiency

A. Dissatisfaction with sleep quantity or quality, with one or more of the following symptoms:

1. difficulty initiating sleep (DFA)
2. difficulty maintaining sleep (DMS)
3. early-morning awakening (EMA)

B. The sleep disturbance causes significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.

C. The difficulty occurs at least 3 nights/week.

Insomnia Disorder - DSM V Criteria

D. The sleep difficulty is present for at least 3 months despite adequate opportunity for sleep

E. The insomnia does not co-occur with another sleep disorder

F. The insomnia is not explained by coexisting mental disorders or medical conditions

- People who have "insomnia" vs. insomnia disorder About 1/3 has no significant psychological symptoms, 1/3 has subclinical, 1/3 has a diagnosable disorder such that insomnia is a symptom (Morin & Espie)

Differential Diagnosis

- OTHER SLEEP DISORDERS:

1. Sleep Related Breathing Disorder - Sleep Apnea - about 1/3 of older adults with insomnia. Male and overweight more prone to it.

2. Narcolepsy - go to REM more rapidly, cataplexy, excessive sleepiness —> involuntary microsleep/naps, sleep paralysis. Typical onset between 15 and 25 progressive problem.

(both of these often no insomnia - rather non-restorative sleep)

3. Restless Leg Syndrome (RLS) Periodic Limb Movement in Sleep (PLMS)

Differential Diagnosis

4. Circadian Rhythm Sleep Disorder - more consistent insomnia and more sleepiness when waking at "normal" hour.

5. Parasomnias - present in childhood or adolescence. Late onset indicative of a serious neurological problem:

   1) Sleep walking

   2) Night Terrors

   3) Sleep Eating Disorder - while sleeping or can't sleep unless they eat

6. Extrinsic Sleep Disorders - Substances - Caffeine, Alcohol, OTC medications

Differential Diagnosis other disorders

7. Medical Problems that are not sleep disorders:

   1) Associated Pain or Discomfort (e.g. arthritis, TMJ)

   2) Medication taken for it (e.g. steroids, pseudophedrine)

   3) Symptom of the Medical Problem - e.g. hormone imbalance

8. Psychological Problems

   1) anxiety disorders - usually GAD or adjustment D/O, PTSD, OCD

   2) depressive disorders

   3) manic (not insomnia - person doesn't want to sleep)

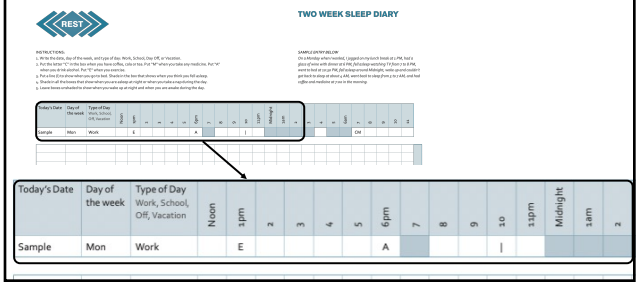
   4) "I wake up in a panic" - Sleep Apnea, Nightmare

facts about Insomnia

- 1 in 4 people say they have difficulty sleeping. Increases with age
- 35% are sleep deprived
- 1 in 4 people take sleep medication at least once/year. National Sleep Foundation.
- 6% have Insomnia Disorder

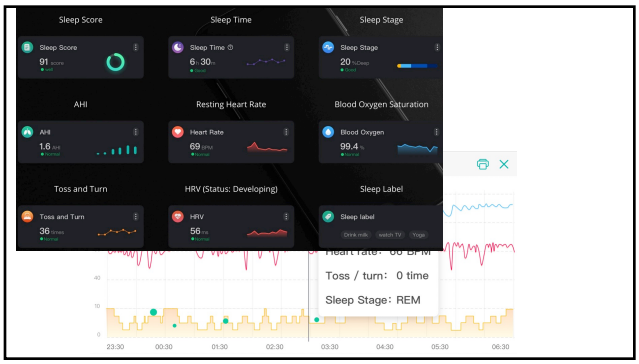
- People overestimate the amount of time awake and underestimate the time asleep in bed.
- Light interferes with melatonin production and sleep.
- People with Insomnia actually look closer to being awake physiologically

Assessment



Sleep On
Go2Sleep Tracker

- Tracks HR and SpO2
- Stages of sleep
- Vibrates to wake upon apnea events
- APP and or computer
- Only $99-$129
- 24 functions



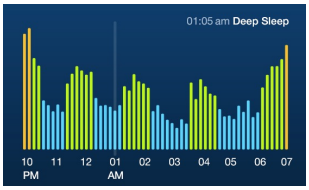
Free APP

sleep score

sleepscore max

Free Assessment

Sleep Time App



Smart Alarm

Assessment

- Polysomnography - recommended to rule out sleep disorders
  1. if standard treatment doesn't help after about 6 weeks.
  2. clear non-restorative sleep in absence of depression
  3. narcolepsy, sleep apnea, myoclonus etc. suspected
- This is often done in a sleep lab - but home sleep studies are becoming more common.
- Measures: EEG (brain waves), EMG (muscle tension), blood oxygen, EKG (heart rate), respiration, EOG (eye movements) as well as leg movements.

Overview of Treatment
For Insomnia

1. Sleep Hygiene - Lifestyle Factors and Bedroom Factors
2. Behavioral Methods
   1. Stimulus Control
   2. Sleep Restriction
   3. Relaxation
   4. Prevent Negative and Positive Reinforcement
3. Cognitive Therapy
4. Education
5. Medication

Treatment
Sleep Hygiene

- Lifestyle Factors:
  1. Caffeine (peak 1-2 hrs, 1/2 life 4-5 hrs)
  2. Nicotine
  3. Alcohol
  4. Diet - too full or too hungry can interfere. Scant evidence for milky warm drinks. Mostly placebo.
  5. Exercise - wearing self out just before bed, not good. Late afternoon/early evening, even in the morning, improves sleep. Fit people sleep better.

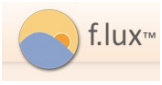
Sleep Hygiene

- Bedroom Factors:
  1. Room Temperature - (65 recommended, but individual), air flow, humidity.
  2. Body Temperature - hot bath 2 hrs before.
  3. Bed Comfort
  4. Noise - may adapt, but may not sleep as soundly.
  5. Lighting -

Sleep Pillow APP
4.9 stars
60K users

Light

- Light interferes with melatonin production
- Blue light in particular, suppresses melatonin.
- Amber light is better. Night Shift (Mac)
- justgetflux.com



- amber goggles/glasses
- Dimmers
- Melatonin supplements?

Wind Down

- Biggest difference between good sleepers and poor sleepers in one study - however, also evidence that many good sleepers don't need a wind down.
- Cut off time of "no work"
- 60-90* minutes before bed - read, meditation/relaxation, knit, etc. TV controversial, reading in bed controversial - pragmatic.
- Pre-Bed Sequence - change into pajamas, brush teeth, etc. Partly Stimulus Control

Naps

- Once considered a bad idea because:
  - Tends to make you more groggy
  - Makes it more difficult to sleep that night
- Power naps can be restorative without interfering with sleep that night
  - Even 10 min can help
  - Under 45 min best
  - 30 min of "sleep opportunity" - set timer/alarm
  - Most effective if done around the same time daily - when your Circadian rhythm dips.

Stimulus Control

- Most cases of insomnia lead to classical conditioning such that the bed becomes a stimulus for being awake and often frustrated and anxious. This includes performance anxiety of trying to sleep.
- Often the initial cause of the insomnia is resolved, but the classical conditioning causes the problem to be maintained.
- Examples: pain, stressful time, environmental (e.g. baby, construction, barking dog)

Stimulus Control

- Goal is to change bed to become a stimulus for relaxation and sleep.
- Classical Conditioning in the other direction - i.e. Bed becomes a stimulus for sleep and feeling relaxed, rather than for being awake and tossing and turning.
- Sleep Hygiene and Wind Down increases likelihood that one will be sleepy when going to bed - so it helps with stimulus control.

Stimulus Control

- Lie down only if sleepy
- Avoid other activity in bed and even in the bedroom if possible.*
- Get up at the same time everyday (up to 1 hr weekend flex once established)
- If unable to sleep after about 15-20 min OR if obvious will not sleep OR if frustrated get up. Repeat as needed.
- Avoid clock watching.

Sleep Restriction

(Spielman, Saskin, & Thorpy, 1987)

- Accomplishes:
  1. increased sleep continuity
  2. reduced wakefulness in bed
  3. increased sleep efficiency.
- Reliable Schedule with Less Frustration in Bed
- It IS a stimulus control strategy of sorts and must include stimulus control.

Sleep Restriction

1. Calculate your current avg sleep time; 10-14 nights (e.g. 5.5 hours).
2. Spend only that amount of time in bed each night.
3. Decide on a rising time. (e.g. 7 a.m.) Regardless of the day of the week.
4. Decide on a threshold time by adding the avg time to the rising time (e.g. 1:30 a.m).
5. Wait to go to bed until *at least* the threshold time. Later if not sleepy…when both sleepy and after the threshold time.

Sleep Restriction

6. If you don't sleep within what seems like 15 min get out of bed, do something relaxing, and go back to bed when feeling sleepy. Repeat as needed
7. IF sleep efficiency is good, add 15 minutes/week…(e.g. either 7:15 a.m. or 1:15 a.m.)
8. Use your bed only for sleep and sex (or if sick)
9. No naps (?)

Sleep Restriction

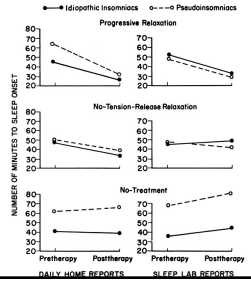
- Morin and Espie (2004) recommend 5 hrs if client is getting less than 5 hrs.
  1. people underestimate how long they sleep
  2. success doesn't depend on sleep deprivation
  3. some safety precaution for patients who experience excessive daytime sleepiness.
- Selling Point - Think of all the time you'll have to do the things you don't have time to do instead of tossing and turning in bed.
- Less frustration - Less suspense of time in bed.

Additional Behavioral Therapy

- Have clients continue to:
  1. Go to work
  2. Go to the gym
  3. Keep social and family engagements
     - If not this gives insomnia more power, reinforcing it and thereby leading to…

  1. secondary gain, and/or
  2. depression
  3. greater anxiety about "need" to sleep.

Results of Progressive Relaxation



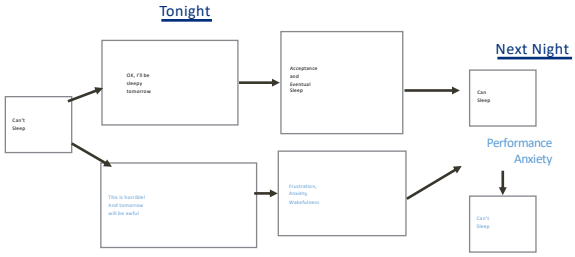
Relaxation

1. Progressive Relaxation has best data.
2. Should NOT be used "like a sleeping pill."
3. Relaxation should NOT be used as a means to fall asleep. Can create performance anxiety.
4. Either use it before bed as part of the wind down OR perhaps to "enjoy" being in bed.

Thoughts That Interfere With Sleep

1. Intrusive thoughts/worries unrelated to sleep.
2. Negative attitudes or worries about sleep.
   - More of a problem.
   - Differ from good sleepers in their negative attitudes about sleep. Good sleepers are more accepting of sleep loss.

Two Ways of Thinking about Not Sleeping



Negative Attitudes about sleep

1. unrealistic expectations about sleep needs and daytime functioning
2. misconception and false attributions about the causes of insomnia
3. disorted perceptions about the consequences of sleep loss
4. faulty beliefs about sleep-promoting practices
5. It doesn't work - I already tried it! I tried counting sheep…

Education

1. Daytime tiredness fluctuates even in people who sleep well.
2. Not feeling well rested is often normal, even after full nights sleep (8 hrs).
3. Yet, sometimes we can feel well rested on much less than 8 hours sleep.
4. Functioning isn't usually impaired much if at all.
5. Sleep strategies take two weeks of persistent application to reach full effectiveness.

Cognitive Therapy

1. Decatastrophize -it's NOT *awful* being sleepy and not *awful* being awake in bed.
2. Attribute appropriate blame - Stop blaming all irritability, poor concentration, and mistakes on insomnia or it really potentiates the problem.
3. Help them to see that their habits contribute substantially to their problem particularly if they've had a sleep study with Polysomnography and there is no evidence that it's a medical issue.

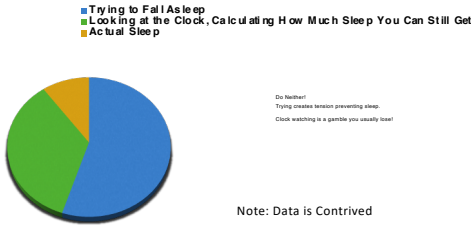
Paradoxical Intent

- Have you ever fallen asleep when you gave up on falling asleep?
- Have you ever fallen asleep when you weren't trying? Reading or watching TV
- Note that people who sleep well do NOT try.
- Trying to sleep does the exact opposite of inducing sleep - the "trying" keeps you awake.

Paradoxical Intent

1. Lie in bed w/dim lights on.
2. Keep your eyes open and try to keep them open "just for a little longer?" That's your catch phrase.
3. Congratulate yourself on staying awake but relaxed.
4. Remind yourself not to *try* to sleep but let sleep overtake you as you *gently* resist.
5. Keep this going and if you get worried at staying awake remind yourself that that is the general idea so you are succeeding.
6. Don't actively prevent sleep - be like a good sleeper - let it come.

Time Spent Awake in Bed



Note: Data is Contrived

Win-Win Trick

1. Some similarity with Paradoxical Intent
2. Works particularly well for people who feel they are too busy to take time to relax.
3. If you sleep, you win! If you don't sleep you win because you get to read, draw, practice relaxation, paint, write, play music, watch TV. etc. Best if low lights/low activity.
4. You may feel sleepy the next day, but it's not so bad because you got to do something you don't normally have time to do.

Vulnerability Factor

1. When you are lying in bed:
   - Your eyes are closed
   - It's dark
   - You're lying down
   - You have on no shoes and less clothes, so *YOU ARE MORE VULNERABLE!*
2. Your body cannot determine the difference between physical and emotional threat so…
3. The threat of the worry seems much worse than it is.
4. Morning clarity "why was that such a big deal?" (Includes fear of being sleepy the next day.)

Problem Solving Sheet
Notes:

1. Best to do ***at least*** an hour before bed, but not too early in the day as things come up, OR
2. Can add to it throughout the day as worries arise.
3. Helps to both resolve the worry before bed AND avoid the vulnerability factor, thereby keeping in perspective AND reducing conditioning - helping stimulus control.
4. Can do as needed if the person realizes that their insomnia is situational with stress and worry.

Medication

- National Sleep - 1 in 4 people take sleep medication
- Benzodiazepines - several, Klonipin (DMS), Xanax (DFA).
- Antidepressants - trazodone, amitriptyline, trimipramine, and doxepin are the most commonly used for sleep. Low dose of Doxepin is preferred for sleep quality.
- SSRIs may interfere with sleep and some may increase periodic limb movements. Not first line for insomnia

Medication

- Antihistamines - most OTC - sometimes paradoxical effect.
- Melatonin - helpful for jet lag and circadian rhythm
- Lunesta and Ambien - hypnotic without anxiolytic. Problem with sleep eating/driving etc.
- Belsomra (suvorexant)- inhibits orexin, a neurotransmitter that promotes wakefulness - less daytime sleepiness more refreshed feelings compared to other soporific meds. New similar Dayvigo (lemborexant)

Medication

- Benzos effective in short term (1-2 wks)
- Problems:
  1. Daytime sleepiness
  2. Dizzy, light-headed, cognitive/motor function impaired
  3. Tolerance
  4. Dependence
  5. Anterograde Amnesia

Medication

- Best used for:
  1. Short term, temporary use*
  2. Intermittent occasional use (e.g. Sun nite, important performance).
- Little evidence for sustained use - but these have best chance: gabapentin, doxepin, trazadone, belsomra, and dayvigo.
- When persistent insomnia should only be used as an adjunct.
- Negative Reinforcement/Psychological Dependence

Combining Meds with CBT

- Medicine best for a week, sometimes up to 8 weeks.
- CBT takes at least 2 weeks to become maximally effective, plus
- Because there are so many behavioral, cognitive, and lifestyle factors it may take time to find things that work the best. Up to 8 weeks.
- CBT continues to work after treatment d/c - not so with meds alone, but sometime combination is most effective.
- Best may be sequential approach of meds+CBT and phase out meds if possible.

Insomnia Treatment in Summary

- Meds can help with stimulus control, but reverse placebo often a problem.
- CBT treatment of choice for chronic insomnia.
- Meds treatment of choice for short term.
  - Typically long-term use of medication is ineffective, but often…
  - effective in combination with CBT
  - Often CBT alone is effective
- Best is sequential approach of meds+CBT and phase out meds.

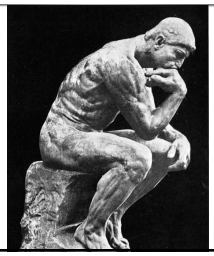
WHEN CBT DOESN'T WORK (OR During CBT)

- R/O Medical Causes
  1. Thyroid
  2. Sex Hormones
  3. Gastrointestinal
- Lifestyle Issues
  1. Sendentary Life Style - Importance of Exercise
  2. Vitamin D (also medical)
  3. Medications (also medical) or other substances
  4. Diet (poor diet or low blood sugar/dehydration) -vicious cycle with appetite.

Treatment Resistant in GAD

Borkovec, Newman, Pincus, & Lytle (2002)

#1.



WHEN CBT DOESN'T WORK (OR During CBT)

- Increase Emotional Processing with:
  - Schema Therapy (case study)
  - Experiential Therapy
  - DBT; Emotion Regulation
- Address Social Issues (interpersonal)
- Consider Medication
- R/O ADHD

WHEN CBT DOESN'T WORK; Medication

- Social Anxiety: Beta-blockers (esp. for performance anxiety Propranolol is FDA-Approved, SSRIs more for pervasive - Zoloft and Paxil only FDA-approved SSRIs)*
- GAD - SSRI's and SNRI's
- Phobias - Beta-blockers following Exposure
- Agoraphobia - SSRIs, Beta-blockers

WHEN CBT DOESN'T WORK; Medication

- Buspar
- MAOIs - work well, but very restrictive (Nardil, Marlin, Parnate) - panic, social anxiety, and depression.
  - Worst side-effects
  - Dietary restrictions - tyromine: beer, wine, cheese, anything fermented - hypertensive crisis and even death in rare cases.
  - Selegiline patch

Other Approaches

- Psychedelics - psilocybin, MDMA, Ketamine, etc.
  - Therapist assisted
  - Microdosing
- Third wave:
  - DBT - Dialectical Behavioral Therapy
  - ACT - Acceptance and Commitment Therapy
  - Metacognitive Therapy
- MISC - CBD, THC, Nutrition, Tapping, Chiropractic…

Quick Summary

- Mindful Observation and Acceptance, including labeling most helpful, quick, painless, when it works.
- Stop or reduce negatively reinforcing behaviors
- Best way to overcome fear is to face it.
- Catch worry early and ALWAYS r/o GAD
- When CBT doesn't work r/o other causes, process emotion, and consider alternative treatments.