

## Psychosis and Anxiety

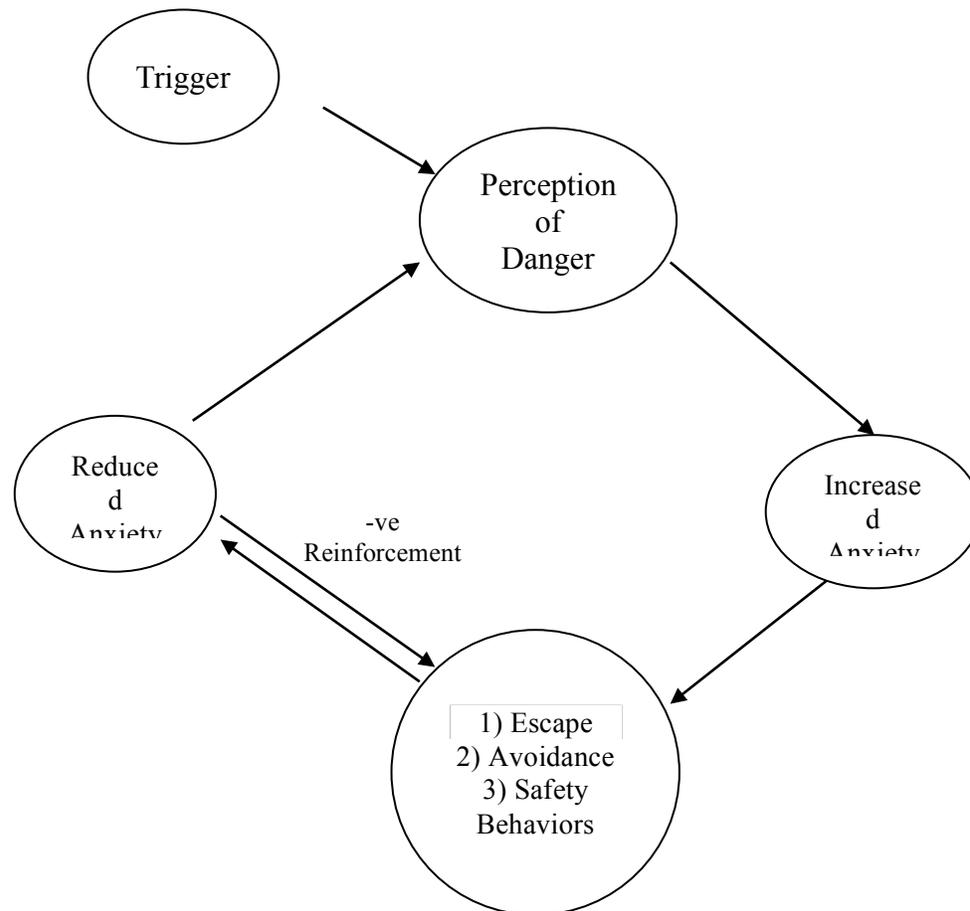
There are multiple reasons why a familiarity with the treatment of anxiety and its disorders is important when we work with individuals with psychosis. First, anxiety and fear are common emotions experienced by individuals experiencing psychosis and, in many cases, may be the predominant presentation of those who seek treatment. Many psychotic symptoms such as paranoia are driven by anxiety-related thoughts that represent a more extreme end of the anxiety spectrum. The person who has beliefs that she is being electronically monitored by the police will undoubtedly respond fearfully when she hears a siren in the distance; the person who has a belief that his body is infested with parasites will understandably be anxious that he is not receiving appropriate medical treatment to rid himself of the infestation. He may even begin to misinterpret his anxiety symptoms (e.g., nausea and sweating) as signs that the infestation is progressing. For us the application of the principles associated with the treatment of anxiety with our clients can help individuals with psychosis live with, and overcome, the fear and anxiety that arise within the context of psychosis. Of equal importance is a thorough knowledge of the principles and practice of treating *anxiety disorders* within the context of psychosis. A recent meta-analysis of the prevalence of anxiety disorders in a large sample of people living with psychosis reveals that anxiety disorders occur at an alarming rate (38.3%) in this population, and the occurrence of three anxiety disorders – Obsessive Compulsive Disorder (OCD), Panic Disorder (PD), and Social Phobia (SP) – is elevated in comparison to general population estimates (Achim et al., 2009). If left unattended, anxiety disorders such as these have been shown to lead to poorer clinical outcomes and quality of life amongst people living with psychosis. Finally, it should be noted that some of the medications that have proven helpful in treating psychotic experiences – namely atypical antipsychotics like clozapine – may exacerbate anxiety-related phenomena. These anxiety symptoms, if untreated, may lead to premature medication discontinuation resulting in increases of both psychotic and negative symptoms.

### Psycho-education: The Anxiety Cycle

Problematic anxiety, and its maintenance, can best be conceptualized as the interplay amongst three domains: cognitive, emotional/physical, and behavioral. We call this the anxiety cycle. As illustrated in Figure 10.1, when confronted with a trigger, the individual will experience anxious feelings (emotional/physical) if he interprets the trigger as dangerous (cognitive). In response to the resulting feelings and physical symptoms of anxiety (emotional/physical), he will attempt to escape from the trigger, or avoid future confrontations (behavioral), and this, in turn, reduces anxious feelings. The experience of relief reinforces the escape/avoidance behavior and therefore the behavior will be repeated in subsequent instances of anxiety.

We recommend that you discuss the anxiety cycle with your clients as soon as possible in therapy. By using their own experiences to illustrate the cycle, clients will better understand the factors that maintain their fears and will gain valuable insight about the domains that they can change to break the cycle.

Figure 10.1: The Anxiety Cycle



Take Stan, for example, who had been suffering with Panic Disorder for many years. Through discussing the three-components of anxiety with his clinician and sharing a number of examples of past panic attacks, he was able to see that most attacks started by experiencing laboured breathing (trigger), which he interpreted as a sign that he was going to suffocate (cognition). This made him understandably anxious – his heart would begin to race, he felt dizzy, and he would start to sweat (emotional/physical). In response, Stan would seek fresh air by quickly fleeing his surroundings to get outside, or he would roll down the window of the car (behavioral). Because these “escape” responses reduced his anxious symptoms (emotional/physical), he quickly learned that he could only venture to places where he could easily get fresh air. Over time, he began avoiding elevators, stuffy rooms, and other places where an easy escape would be difficult. Through examining his anxiety cycle, Stan and his clinician were able to see that therapy aimed at re-interpreting symptoms of breathlessness and exploring alternatives to escape/avoidance behaviors might prove helpful in breaking Stan’s anxiety cycle.

Wendy, on the other hand, is a 40 year-old woman living with OCD and a history of various psychotic experiences. She lived in a group home with 6 other women and was constantly fearful of the home burning down. This fear was especially salient given that Wendy, during an acute

psychotic episode, lit her room on fire when she was in her late 20's and her boyfriend at the time suffered significant burns. In discussing her anxiety cycle with her clinician, she was able to acknowledge that each time she left the house she experienced intrusive doubts about whether the stove was left on, or the iron plugged in (trigger). She worried that if there was a fire, it would be her fault for not having checked the appliances carefully (cognition), and then she felt extremely uncomfortable (emotion/physical). Wendy was often compelled to return home to check that the appliances were turned off (behavioral) - which inevitably they were - and she felt relieved (emotion/physical). As her OCD progressed, Wendy found it difficult to leave the house at all (behavioral) because she felt it was her responsibility to keep the house safe (cognitive). She also began pestering her housemates (behavioral) about turning off the appliances which began to cause friction in the house. Like Stan, Wendy was able to see that her behavioral responses to anxiety were only maintaining her fears. She realized that she would have to change her checking behaviors if she was going to break her anxiety cycle.

## **Psycho-education: Anxiety is Not the Problem**

Too often, clients arrive for therapy having been taught (perhaps even by past clinicians) strategies aimed at distracting themselves from anxiety-provoking triggers, or relaxation training aimed at reducing anxious responses in the heat of the moment. These strategies are rarely helpful in the long term because they reinforce the commonly-held belief that anxiety is somehow dangerous and needs to be harnessed. In fact, anxiety and fear are normal, adaptive human emotions that our bodies are built to produce. In small doses they motivate us to prepare for important tasks (e.g., to study for exams, prepare for a job interview, talk to your roommate about the money he owes you). In larger doses, fear can help us flee from dangerous situations or fight off an attacker. In the early stages of therapy it is imperative to help clients understand that *anxiety is not the problem*. Rather, it is our attempts to control anxiety that cause impairment and suffering. In Stan's case, his frequent need for escape and subsequent avoidance began making his world smaller and never allowed him to experience his anxiety as a set of experiences that were not harmful and, if left alone, would eventually pass. Similarly, Wendy's compulsive checking made her feel trapped and her reassurance seeking was causing undue stress at home. Both were trying to control their anxiety instead of living their lives.

## **Addressing Anxious Thinking**

Many of the techniques and strategies already discussed throughout the book will prove helpful in allowing your clients to re-appraise their anxious thinking, or at least re-appraise the value of their anxious thinking. Perhaps the most valuable tool for addressing anxious thoughts is to allow your clients the experience of acting in a manner that defies their thinking. For example, after much coaching, Wendy allowed herself to leave the house without checking appliances *despite* her OCD trying to create doubts in her mind. She did this, in part, by realizing that her doubts were just her mind at work creating thoughts that were getting in the way of her living her life. Stan, on the other hand, was helped by learning that breathlessness was just that, shortness of breath or a symptom of anxiety and could in no way harm him. He still had the thought that he may suffocate quite often but he was able, through mindfulness practice, to accept these anxious thoughts and continue to focus on his valued goals, without letting the thoughts about suffocation rule his behavior.

## Overcoming Avoidance: Exposure Therapy

One of the most powerful tools for dealing with anxiety is exposure to fear-provoking stimuli. In fact, many argue that exposure therapy is necessary, and - on its own – sufficient, for overcoming most anxiety disorders. Exposure therapy involves your client repeatedly, or continuously, confronting feared triggers without escaping, to achieve the end goal of the trigger no longer eliciting anxiety. The traditional behavioral model of anxiety posits that exposure works on the principle of *extinction* in which the repeated, or prolonged, presence of a feared stimulus (e.g., talking in front of a group at a meeting) in the absence of a feared consequence (e.g., being ridiculed by others) will result in the reduction of fear, as long as the individual does not escape or avoid the situation (e.g., leave the meeting early; attend the meeting but being silent). Viewing exposure therapy from this narrow lens, however, does not do justice to the experientially-rich learning opportunities that exposure provides. You and your client can use exposure exercises to: 1) test out assumptions about fear-provoking stimuli (e.g., “somebody at the meeting disagreed with my point of view, but it wasn’t so bad”); 2) promote emotional regulation and coping with strong emotions (“I was very anxious at the meeting but I was able to speak despite this”); and 3) practice commitment toward value-driven behaviors and goals (e.g., “the meeting is an important opportunity to speak my mind, which is consistent with my value of being an assertive, caring person”). If done collaboratively and with utmost respect to your client’s integrity, exposure therapy can become an essential tool for promoting personal and therapeutic growth across many areas of our client’s lives.

Despite the fact that exposure therapy is seen as a first-line treatment of anxiety disorders, very much less is known about the use of exposure with people experiencing psychosis and co-morbid anxiety disorder(s). This is, in part, due to the belief that the increase in anxiety (albeit short-term) arising from exposure therapy may destabilize clients and increase the risk of psychotic symptoms worsening. Such beliefs have led to the systematic exclusion of people with psychosis from research investigating exposure therapy, which, in turn, contributes to the general dearth of outcome data about its efficacy in this population. In deciding about whether to engage in exposure therapy with a client, it is often helpful for you and her/him to question whether the short-term anxiety produced by exposure therapy is any more dangerous/harmful than the anxiety and avoidance that your client experiences every day, and will continue to experience daily if left untreated. If the pros outweigh the cons, you can also take the following precautions when considering exposure:

- Exposure therapy should not proceed if your client is in the acute stages of a psychotic experience. Symptom stability and the ability to cope with strong emotions are an important precondition for exposure.
- Assess psychotic symptoms at regular intervals during the course of exposure therapy and have a care plan available if symptoms worsen.
- If possible, include family members, or those cohabitating with your client, in exposure planning so that they understand the rationale, know what to expect, and can watch for signs of psychotic symptom change.
- Discuss the benefits and drawbacks of exposure therapy before commencing. Your client should be aware that confronting fear-provoking stimuli will undoubtedly increase anxiety symptoms in the early stages of therapy but reduce these same symptoms in the long-term. It may be helpful to couch this discussion using relevant examples from your

client's life where he/she has undergone short-term discomfort in order to achieve long term rewards (e.g., exercising to lose weight; studying to pass an exam).

- Discuss and model the collaborative nature of exposure therapy. Reinforce that your client *always* has the final say in the types of exposure exercises that he/she will engage in, and that he/she can stop the exercise at any time.
- If necessary, employ strategies aimed at titrating fear responses during exposure exercises (see below).

### *Developing a Plan for Behavioral Change: The Exposure Hierarchy*

Before embarking on a journey we typically need a map. In preparing to engage your client in exposure therapy, the exposure hierarchy serves as an important tool for collaboratively setting objectives, breaking these objectives into manageable goals, and monitoring progress. We have found it helpful to engage in a discussion about values with clients as a backdrop for setting goals and creating hierarchies related to anxiety. Clients whose goals are not clearly aligned with their life values will be far less likely to be motivated to achieve them.

Callie was referred to her clinician for treatment of severe social phobia. She had also struggled with psychotic experiences much of her adult life. Although she had been socially anxious since she was a child, her difficult experiences with psychosis had exacerbated her fears of being negatively evaluated by others. During the early stages of therapy, Callie's clinician struggled to find a way to engage her in any sort of exposure-based intervention. All of the clinician's suggestions for social activities were met with a resounding "no". It was only in re-discussing values and related goals that the clinician was able to engage Callie. Callie was quite passionate about helping animals and wanted to eventually become an advocate for animal rights. When her clinician asked Callie what was standing in the way of her ability to act on these values and goals, she noted that her fear of interviews was holding her back from securing a volunteer position at the local shelter. When her clinician asked if she would like to work on overcoming her fear of interviews, Callie agreed.

Creating a hierarchy involves breaking your client's goal into manageable, yet anxiety-provoking steps. It would obviously be too difficult for Callie to "just go" and do the interview. Through collaborative examination of the goal, Callie and her clinician were able to identify five distinct components of the interview process that were anxiety provoking: phoning to inquire about the volunteer position; introducing herself at the shelter; asking a friend's mother if she would be a reference; answering any questions about her mental health status; and engaging in the interview itself. It is important that all feared situations be included on the hierarchy even if they are unlikely to occur (e.g., being asked about mental health status). Next Callie and her clinician created a scale to rate these situations, and approximations of these situations, based on the amount of anxiety Callie perceived she would feel if she were in each situation. Commonly you can introduce a Subjective Units of Discomfort Scale (SUDS) ranging from 0 (completely calm) to 100 (worst anxiety imaginable) to do this - although some clients may prefer a 0 to 10 scale. Others who are less cognitively flexible may find it easier to rate the situations as low, medium, or high anxiety. After rating the situations, they were ordered from most to least anxiety-provoking. The completed hierarchy is presented in Form 10.1, and a blank form that you may use with your own clients is presented in Form 10.2.

Over the course of therapy Callie started with the least anxiety-provoking situation and gradually worked her way up the list. As she did so, she monitored her progress by acknowledging the situations she had “conquered” along the way. It should be noted that some of the situations on the list did not lend themselves well to repeated exposure (e.g., calling the shelter, asking for a reference, engaging in the interview). In these cases, the clinician set up proxy situations (role plays) that Callie could practice in session over and over again until she felt more comfortable and was able to confront the actual feared situation. Callie’s clinician monitored her discomfort throughout the sessions using the SUDS ratings.

Despite the best efforts on the part of you and your client, they may find some of the situations on their hierarchies too overwhelming. In these cases, it may be important to break the overwhelming situation into smaller steps. For example, Callie found introducing herself to multiple people at her clinician’s office very difficult so she agreed to practice with one person multiple times until she was ready to move on to others. In some cases, the clinician may need to moderate the client’s emotional response during exposure in other ways. Below are some tips that can help with this.

**Form 10.1. Example Exposure Therapy Hierarchy – Callie**

<u>Exposure Hierarchy</u>		
<b>Goal:</b> <u>To interview for volunteer position at animal shelter</u>		
<b>Situation</b>	<b>SUDS (0-100)</b>	<b>Accomplished? (Yes/No)</b>
Attend interview	100	
Role play interview with my clinician’s colleague	80	
Role play interview with my clinician asking about my illness	80	
Call Ms. Callahan and ask if she will be a reference	70	
Go to shelter to pick up application and introduce myself	70	
Role play interview with my clinician	65	
Practice introducing myself to people at my clinician’s office	60	

Phone animal shelter to inquire about position	55	
Role play phoning animal shelter with my clinician	45	

### **Tips for Titrating Emotional Responses during Exposure Exercises**

- Collaborate with your client to decide upon a SUDS value that defines his/her emotional threshold (i.e., the maximum level of anxiety that can be tolerated without feeling overwhelmed).
- Agree upon a brief “escape plan” that your client can use when SUDS level surpasses threshold with the agreement that (s)he will re-engage when SUDS reduces to a tolerable level. Examples may be withdrawing from a social situation temporarily, or distracting one’s self – briefly – during an exposure to contamination. Your clients may also benefit from the judicious use of safety behaviors early on in therapy (e.g., initially touching a “contaminated” door handle while wearing gloves).
- Proceed *slowly* through items on your client’s hierarchy. It’s not a race... It is particularly important to ensure that your client has mastered his/her anxiety at each level of the hierarchy before moving on.
- Allow ample time during an exposure session for SUDS to reduce and to debrief about the exposure exercise. It is important that your client does not leave the session in a state of high anxiety. This may require that you schedule longer sessions with your clients during exposure therapy.
- Before assigning independent exposure exercises as homework, ensure that your client is “comfortable” tolerating anxiety in session.

### **Conclusion**

In this chapter, we have discussed the presence and overlap of anxiety with psychosis. In this session(s) a normalizing approach to the experience of anxiety and psycho-education about the anxiety cycle is important. Re-visiting mindfulness- and acceptance-based strategies for noticing and addressing anxiety symptoms is critical. Motivation to engage in exposure-based models to address anxiety can be enhanced by linking exposure to previously identified values and goals while keeping in mind the ultimate goal of the client working towards living a more meaningful and enriched life.

Blank Exposure Hierarchy

<b><u>Exposure Hierarchy</u></b>		
<b>Goal:</b> _____		
<b>Situation</b>	<b>SUDS (0-100)</b>	<b>Accomplished? (Yes/No)</b>

## **Between Session Practice**

Collaboratively decide on the between session practice, clarify understanding, and troubleshoot any potential barriers to practice. Example handouts are given to the client as well as corresponding blank handouts to fill out.

## **Feedback From Client on the Session**

Solicit feedback from your client during and at the end of each session as well as when processing emotion regulation exercises. Feedback increases collaboration and responsiveness on the part of the therapist and helps to clarify any misunderstandings or concerns that can impact on engagement and the therapeutic relationship.

## **Summary of session**

Ask your client to read over the session handout at home and share this handout with family, friends or caregivers if (s)he wants to. Model a strengths-focused approach by asking the client to identify one personal strength, quality or accomplishment from the session. If your client finds it difficult to do so you can cue with examples (s)he has noticed or ask what a friend or family member might say. This reinforces your client's effort, strengths, accomplishments, and progress, and introduces the coping/grounding exercise.

## **Coping Exercise (Optional)**

See appendices for a selection of coping/grounding exercises.

## **Additional Resources**

See appendices.