

The Importance of Automatic Thought's Evaluation Through cognitive – Behavioral Therapy in Patients with Generalized Anxiety Disorder.

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Abstract:

This study will analyze the positive value of automatic thoughts' assessment in patients with Generalized Anxiety Disorder, to improve the symptoms associated with thinkings and emotions. For a disorder "unorganized" as Generalized Anxiety Disorder, where the patient feels anxious from almost any situation and knows not where and when to feel secure, the Cognitive – Behavioral Therapy chooses to use a more structured framework to put in front of reality's evidence. This therapy is considered as one of the most used and highly appropriate to treat Generalized Anxiety Disorder. One of the main principles of Cognitive-Behavioral Therapy is that patients learn to identify, evaluate and respond to their automatic thoughts and dysfunctional beliefs. The aim of this study is to show the importance of automatic thoughts's evaluation mode in patients with Generalized Anxiety Disorder. In this study will be provided essential elements for the selection of these thoughts, to indicate their nature. The research methodology is based on case study, where the basic datas are taken for 5 patients diagnosed with Generalized Anxiety Disorder and treated through Cognitive-Behavioral Therapy techniques. In conclusion it resulted that patients that properly examined the validity of an automatic thought, were able to understand the nature of their thoughts, if they were true or not.

Keywords: Cognitive-Behavioral Therapy, Generalized Anxiety Disorder, automatic thoughts, cognitive conceptualization, adaptive response.

1. Introduction.

Anxiety is a special kind of fear. It is an emotional signal that we sense some type of threat. Generalized Anxiety Disorder (GAD) is a diagnosis that describes people who experience strong, persistent and damaging anxiety. While, everyone experiences some anxiety, GAD means that the anxiety has to some extent taken control of you (White, 1999)¹. The term GAD first emerged with the publication of the DSM-III (American Psychiatric Association, 1980)². At the time GAD was viewed essentially as a residual disorder because the diagnosis was not made if symptoms of panic disorder, obsessive-compulsive disorder, or phobia were present. The fundamental feature of the disorder was "persistent anxiety" for at least one month, with clients also required to endorse symptoms from three out of four categories, including motor tension, autonomic hyperactivity, apprehensive expectation and vigilance/scanning (Dugas; Robichaud, 2007)³.

The term GAD is used in the official psychiatric Diagnostic and Statistical Manual of Mental Disorders (DSM-5), where the following diagnostic criteria are outlined:

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The individual finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).

Note: Only one item is required in children.

- (1) restlessness or feeling keyed up or on edge
- (2) being easily fatigued

- (3) difficulty concentrating or mind going blank
- (4) irritability
- (5) muscle tension
- (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia, or delusional disorder) (DSM-5, 2013).⁴

Cognitive- Behavior Therapy has broad evidence as a powerful intervention for mental health problems in adults. Cognitive – behavior treatments have an empirical base and majority of practitioners, at least in North America, are trained in a scientist-practitioner model (Dobson, 2009).⁵

Automatic thoughts are a stream of thinking that coexists with a more manifest stream of thought (Beck, 2011).⁶ These thoughts are not peculiar to people with psychological distress; they are an experience common to us all. Most of the time we are barely aware of these thoughts, although with just a little training we can easily bring these thoughts into consciousness. When we become aware of our thoughts, we may automatically do a reality check if we are not suffering from psychological dysfunction (Beck, 2011).⁷

It is very important distinguishing automatic thoughts from emotions. Many patients do not clearly understand the difference between their thoughts and their emotions. Emotions are of primary importance in cognitive- behavior therapy. People with psychological disorders, however, often misconstrue neutral or even positive situations and thus their automatic thoughts are biased. By critically examining their thoughts and correcting thinking errors, they often feel better (Beck, 2011).⁸

2. Understanding anxiety and thinking in GAD.

Anxiety is a prolonged complex emotional state that is often triggered by an initial fear. Fear is at the heart of all anxiety states. Fear is the underlying psychological state that drives the anxiety (Clark&Beck, 2012).⁹

To understand the anxiety it is important to know some of the common effects of anxiety:

Psychical symptoms

- Increased heart rate, palpitations
- Shortness of breath, rapid breathing
- Chest pain or pressure
- Choking sensation
- Dizziness, lightheadedness
- Sweating, hot flashes, chills
- Nausea, upset stomach, diarrhea
- Trembling, shaking
- Tingling or numbness in arms, legs
- Weakness, unsteadiness, faintness
- Tense muscles, rigidity
- Dry mouth

Cognitive symptoms

- Fear of losing control, being unable to cope
- Fear of physical injury or death
- Fear of “going crazy”
- Fear of negative evaluation by others
- Frightening thoughts, images, or memories
- Perceptions of unreality or detachment
- Poor concentration, confusion, distractibility
- Narrowing of attention, hypervigilance for threat
- Poor memory
- Difficulty in reasoning, loss of objectivity

Behavioral symptoms

- Avoidance of threat cues or situations
- Escape, flight
- Pursuit of safety, reassurance
- Restlessness, agitation, pacing
- Hyperventilation
- Difficulty speaking

Emotional symptoms

- Feeling nervous, tense, wound up
- Feeling frightened, fearful, terrified
- Being edgy, jumpy, jittery
- Being impatient, frustrated, (Clark&Beck, 2012).¹⁰

The common thinking errors in interpretation are : Catastrophizing, faulty estimates, gross generalizations, polarization, minimization. Catastrophizing is evident when the individual's thoughts focus exclusively on the worst possible outcomes of events. Faulty estimates are evident when the probability of danger is assessed at inaccurately high levels, particularly when the actual probability of danger is ambiguous. Gross generalizations are evident when the danger perceived in one event is applied to other events, without any differentiation between events. polarization is evident when are perceived in all-or-nothing terms of extreme danger or safety. Factors that indicate protection or safety may be minimized or ignored (Rygh&Sanderson, 2004).¹¹

The cognitive component of GAD can be modulated with a wide variety of techniques. These techniques include psychoeducation, cognitive restructuring, hypothesis testing, positive imagery, worry exposure, improving problem orientation, cost-benefit analysis of coping and two cognitive response prevention techniques:scheduled worry time and worry-free zones. The cognitive components of GAD are: psychoeducation, cognitive restructuring, worry episode log, guided discovery, decatastrophizing, developing alternative viewpoints, hypothesis testing, positive imagery, worry exposure, improving problem orientation, cost-benefit analysis of coping, cognitive response prevention, scheduled worry time and worry-free zones (Rygh&Sanderson, 2004).¹²

People with GAD haveinconsistent thoughts and can not control them. Therefore, it is important to apply strategies to control thisthoughts. Most of the time, strategies used to control the thoughts from individuals themselves are not effective.

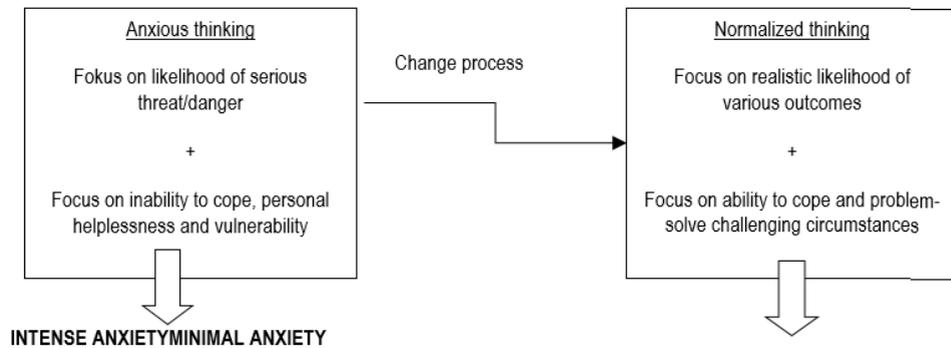
There is a little available research on the nature of thoughts control strategies used by individuals with GAD. However, evidence from other sources suggests that some such strategies may be ineffective and perhaps countproductive. Research with thought control Questionnaire suggests that worry and punishment, when conceptualized as thought control strategies, are associated with emotional disturbances (Heimberg&Turk&Mennin, 2004).¹³

The treatment of thinking through Cognitive-Behaviour Therapy (CBT), theoretical and practical models.

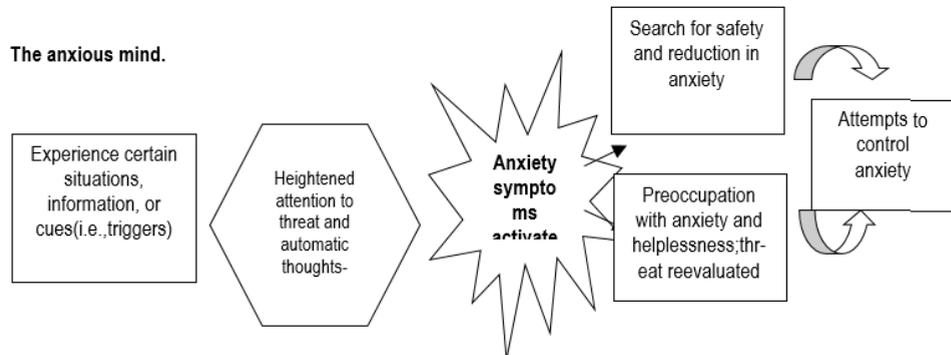
The majority of people experiencing GAD do not seek treatment. They tend to regard themselves as chronic worriers and assume that nothing can really help them. Untreated, GAD tends to last longer and impact a greater portion of a person's life. The traditional treatment stems from Freud's work and maintains that the cause of anxiety is usually rooted in childhood. It is believed that by returning to these earlier issues the client's fundamental conflict can be brought to the surface and resolved. The cognitive part of CBT refers to the power of our beliefs. What we believe about ourselves, our world and our future has a strong influence on what actually happens. The behavior part of CBT acknowledges that real change happens in our life only when we do things differently. There needs to be some kind of action that brings the new direction to life (White, 1999).¹⁴

One important step of CBT is to identify the negative thoughts. The clients must become aware of their thoughts, the act of metacognition. Some clients are quite "psychologically minded" and understand these ideas fairly quickly, whereas others struggle with some of these notions and exercises. Some clients may object to terms such as dysfunctional or distorted thoughts. The onus is on the therapist to find substitutions that have the same meaning but are more palatable to clients. For example, we may use the phrase "thoughts that make us feel bad" or "thoughts that lead to negative emotions" (Dobson, 2009).¹⁵

There are many techniques to change the anxiety thinking. From anxious thinking to normalized thinking we must use skills to understand the anxious mind. There are some diagrams to illustrate this shift in thinking (Clark & Beck, 2012).¹⁶



The anxious mind.



Exercise for thought monitoring (Clark & Beck, 2012).¹⁷

A two-step process for learning to catch core anxious thoughts:

- 1- Monitoring the anxious thoughts
- 2- Threat assessment diary.

Anxiety work plan

Targeted anxiety symptoms	Interventions exercises	Self-help schedule	Outcome
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PART I. ANXIETY TRIGGERS (situations, etc.)

1.			
2.			
3.			

From the Anxiety and worry workbook, Clark&Beck, 2012).¹⁸

3. The importance of evaluating Automatic Thoughts (AT).

Our thoughts are created by our mind, which is constantly helping us to interpret the world around us, describing what's happening, and trying to make sense of it by helping us interpret events, sights, sounds, smells, feelings. Automatic thoughts can be words, an image, a memory, a physical sensation, an imagined sound, or based on 'intuition' – a sense of just 'knowing'(Vivyan, 2009).¹⁹

Automatic thoughts seem to pop up spontaneously, they become fairly predictable once the patient's underlying beliefs are identified. Automatic thoughts are usually quite brief and patient are often more aware of the emotion they feel as a result of their thoughts than of the thoughts themselves. Automatic thoughts are often in "shorthand" form, but can be easily spelled out when the patient ask for the meaning of the thought. These can be evaluated according to their validity and their utility. To summarize, automatic thoughts coexist with a more manifest stream of thoughts, arise spontaneously and are not based on reflection or deliberation. People are usually more aware of the associated emotion, but with a little training, they can become aware of their thinking (Beck, 2011).²⁰

To evaluate appropriately the automatic thoughts, the clinician first must learn the patient to identify them. There are some important steps to identify automatic thoughts and than to evaluate them.

Eliciting AT – how to identify steps:

1. Heightening the Emotional and Physiological response.
2. Eliciting a detailed description
3. Visualizing the situation.
4. Re- creating an interpersonal situation through role play.
5. Eliciting an image.
6. Suggesting an opposite thought.
7. Uncovering the meaning of the situation.
8. Phrasing the question differently (Beck, 2011).²¹

To conduct a correct automatic thought's evaluation, the clinician must know to identify additional AT, the problematic situation and to recognize the situations that can evoke AT. This could be able with the client's help.

4. Method.

The basic datas are taken for 5 patients diagnosed with Generalized Anxiety Disorder and treated through Cognitive-Behavioral Therapy techniques.

Table 1. Patients characteristics.

	All Patients (n = 5)	Treatment with CBT (n = 5)	Practice for AT evaluating (n=4)
Number female	4	3	3
Self anxiety measured	3	3	3
Stabilized on medication at start of treatment	2	1	1
Age	40	40	40
Additional diagnose except GAD Mood disorders	2	2	2

Measures.

The Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5) - Adult and Lifetime Version (Timothy A. Brown and David H. Barlow, 2014), was used to determine current and lifetime DSM-5 diagnostic status (an abbreviated version focusing on current diagnoses was given for post- and follow-up assessments). The ARDIS-5 includes a clinical severity rating (CSR) for each diagnosis. All assessments were administered by clinic psychologists in their clinic practice.

To the five patient was applied the Self-Evaluation Questionnaire, STAI form Y-1 and Self-Evaluation Questionnaire, STAI form Y-2 (White 1999).²²

With all the patient were used the techniques for AT evaluation. The questioning to help patients evaluate their thinking:

- Examine the validity of AT.
- Explore the possibility of other interpretations or viewpoints.
- Decatastrophize the problematic situation.
- Regognize the impact of believing the AT.
- Gain distance from the thought.
- Take steps to solve the problem.

The AT are collected by the patients in spontaneous way during the sessions. The important AT distinguished because are in a strong relation with the initial patient's complaint. Very important is to distinguish the true facts. The clinician has to keep in mind that AT are rarely completely erroneous. Usually they content a grain of truth (Beck, 2011).²³

Example for one case, to see the way how the AT effect all the cognitive construct of the person.

Case 1, female, 38 years old.

AT identified – *"My husband is not interested for my career"*.

1. What is the evidence tha supports this idea?
2. *"He don't ask me what I do every day in my job."*
3. Is there an alternative explanation or viewpoint?
4. *"I don't think so."* – negative
5. What is the worst that could happen?
6. *"If my husband will not be worried if I let the job."*
7. What is the effect of my believing the AT?
8. *"I feel anxious and pessimist."*
9. What would I tell to a specific person?
10. *"I will tell to my husband that I don't care about him."*
11. What should I do?

"I have to tell him that my career is very important for me."

After has been seen how the AT effect the patient thinking and believing, the clinician must understand the difference between true or untrue AT. For this aim it can be used the version of A.T.Beck, for typical mistakes in thinking:

1. All-or-nothing (also called black and white, polarized or dichotomous thinking).
2. *Example case 1: "If my husband doesn't ask about my job, he doesn't love me."*
3. Catastrophizing (also called fortune-telling)
4. *Example case 1: "I will be so upset, I won't talk to my husband all day."*
5. Disqualifying or discounting the positive.
6. *Example case 1: "My husband call me many times a day, but he never ask me if I have any problem at job."*
7. Emotional reasoning.
8. *Example case 1: "I have a good relationship with my husband, but I still feel that I'm not very important for him."*
9. Labeling.
10. *Example case 1: "I'm upset, he is disgraceful."*
11. Magnification/minimization.
12. *Example case 1: "When he doesn't ask me about my career, makes me feel very worthless. Having good relationship with him, doesn't mean he's interested in me."*
13. Mental filter (also called selective abstraction).
14. *Example case 1: "Because he doesn't make me many questions about my job, it means he doesn't love me."*
15. Mind reading.
16. *Example case 1: "He think I'm not capable in my job."*
17. Overgeneralization.
18. *Example case 1: "These dissadisation can make unfavorable our relationship."*
19. Personalization.
20. *Example case 1: "He doesn't care about my career because I did something wrong."*
21. "Should and Must" statements (also called imperatives).
22. *Example case 1: "It's terrible for me if I don't have my husband's attention all the time."*
23. Tunnel vision.

Example case 1: "My husband doesn't like my professionalism."

To registrate the AT is used the Thought record (White, 1999):²³

Triggering situation
Anxiety and other feelings
Automatic thoughts
Worst outcome
Rerate feelings and thoughts

The uncertainty is one important cause for the appearance of AT. Acceptance of uncertainty can be addressed by working to do the following (William & Knaus, 2008):²⁵

1. Accept facts and reality.
2. Accept that you can progressively master methods for overcoming uncertainty fears.
3. Accept that a prime solution involves for uncertainty may prove uncomfortable but is instrumental to positive change.
4. Accept that overpreparation, such as repeatedly going over every possible scenario, supports a misguided view that perfection is the solution for controlling tension.

5. Results.

After this process the patient were able to evaluate their AT. Not all of them were able initially to identify them, but after a guided help they could evaluate appropriately their AT. Evaluating the At was helpful for the identifying of emotions too. This was helpful too for the patient's interaction when they play themselves through role play. After identifying and evaluating AT, additional questioning brings to light other important thoughts. The patients, in addition, have other automatic thoughts not about the same situation itself, but about their reaction about that situation. They may perceive their emotion, behavior, or physiological reaction in a negative way.

Among this process it had been seen that the AT could appear before a situation, in anticipation of what might happen, during a situation and/or after a situation, reflecting on what had happened. In addition to being unable to identify automatic thoughts associated with a given emotion, patients have difficulty even identifying a particular situation or issue that is most troublesome to them. Many patient among this process reported interpretations, which may or may not reflect their actual thoughts. The best way in this cases is to guide the patients to report their thoughts. Patients often report thoughts that are not fully spelled out. It was difficult to evaluate a telegraphic thought, so the best way was to guide the patients to express the thoughts more fully. The patients had thoughts about their cognitions, their emotions, their behavior or their physiological or mental experiences. Any of these stimuli engendered initial AT followed by an initial emotional, behavioral, or physiological reaction.

To summarize, the patients was learned to identify their dysfunctional thinking, then to evaluate and modify it. The process started with the recognition of specific AT in specific situations and than evaluate the AT and situation itself.

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