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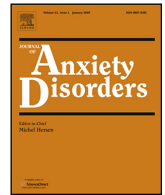

False Safety Behavior Elimination Therapy: A randomized study of a brief individual transdiagnostic treatment for anxiety disorders

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ABSTRACT

In response to the ever-growing number of CBT based therapy protocols, transdiagnostic approaches to anxiety treatment, based on models of anxiety emphasizing common elements across anxiety disorders, have been increasingly explored. The aim of the current study was to test the efficacy of an individually administered, brief (5-session) transdiagnostic treatment for anxiety disorders. The current treatment (called F-SET) focuses chiefly on the elimination of anxiety maintaining behaviors and cognitive strategies (so-called "safety" aids) among individuals suffering from a range of anxiety disorders including generalized anxiety disorder (GAD), social anxiety disorder (SAD) and panic disorder (PD). Patients ($N = 28$; mean age = 28.5 years; 75% female; 71% White) were randomly assigned to F-SET or waitlist control conditions. Participants were assessed prior to, immediately after, and 1-month following treatment. In addition to independent assessments of diagnostic status, standardized self-report measures and assessor ratings of severity and distress associated with anxiety symptoms were used. Participants in the F-SET condition experienced significantly less anxiety (Cohen's $d = 2.01$) and depression (Cohen's $d = 2.16$) than those in the WL condition. Mediational analysis showed that change in avoidance strategies mediated the group changes in anxiety symptoms. The results from the current study are an important first step in identifying a simpler, focused form of CBT that can be delivered with minimal therapist training, at a low cost and with minimal client contact time.

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1. Introduction

Anxiety related psychopathology represents one of the most prevalent and debilitating forms of mental illness (Kessler, Berglund et al., 2005; Weissman, 1990). Epidemiological studies suggest that approximately 25% of the population will suffer from clinically significant anxiety at some point in their lives with a 12-month prevalence rate of approximately 18% (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Anxiety disorders generally maintain a chronic course when untreated (Pine, Cohen, Gurley, Brook, & Ma, 1998) and result in substantial impairment across the lifespan (Ferdinand, van der Reijden, Verhulst, Nienhuis, & Giel, 1995). In addition to the immense personal suffering created by clinically significant anxiety syndromes, these disorders create a considerable public expense that includes treatment costs, lost work time, and mortality (Greenberg et al., 1999). Anxiety psychopathology is also associated with increased utilization of non-psychiatric medical services (Greenberg et al., 1999), further amplifying the associated public health burden.

Research focused on individual cognitive behavioral therapy (CBT) for anxiety began in the 1980s (e.g., Barlow, Hayes, & Nelson, 1984). As this line of research developed, so did the creation of detailed therapy manuals necessary for researchers to replicate therapeutic procedures. Consequently, psychological treatments were increasingly characterized by individual protocols that contained specific strategies targeting particular forms of psychopathology (Barlow, Allen, & Choate, 2004). Treatment studies employing these techniques demonstrated marked improvements in 60–90% of patients with anxiety disorders (Beck, Sokol, Clark, Berchick, & Wright, 1992; Heimberg & Juster, 1995; Deacon & Abramowitz, 2003). However, the creation of numerous protocols is likely to limit training and dissemination of these treatments.

The growing number treatment manuals creates an increasing need for the development of theoretically driven and evidence based treatments that are accessible and easy to disseminate (Office of the Surgeon General, 1999; Persons, 2003). As a result, researchers have begun to explore transdiagnostic approaches to

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anxiety treatment based on models of anxiety emphasizing a single common pathway across diagnostic categories. Unlike manuals for specific disorders, a transdiagnostic treatment approach is applicable to a range of anxiety disorders using a single treatment protocol.

One approach to treating multiple anxiety disorders using a single protocol is to focus on "safety" aids. Safety aids are behavioral or cognitive strategies used to reduce anxiety (Korte, Norr, & Schmidt, in press). Safety aids tend to temporarily alleviate anxiety, usually through avoidance strategies, but in the long term are believed to exacerbate and maintain anxiety disorders. Individuals suffering from anxiety disorders perceive safety aids as protecting them from feared stimuli or situations (Salkovskis, Clark, & Gelder, 1996). The importance of these strategies in anxiety disorders is well documented; however, the particular pattern of safety aid use varies across different anxiety disorders. For example, people with social anxiety may take slow breaths and grip objects tightly to avoid shaking while reading to a group, speak quickly or rehearse sentences in their mind to counter the fear of talking funny, or avoid eye contact to deal with the fear of freezing up while making conversation (Wells et al., 1995). On the other hand, individuals with panic disorder and agoraphobia engage in safety behaviors such as being accompanied by a friend or partner, carrying safety aids (e.g., cell phone, water, or medication) or checking for exits and restrooms (Rachman, 1984). Those with generalized anxiety may avoid risks, repeatedly seek reassurance from others including doctors, family and friends, and engage in overprotective and checking behaviors (Woody & Rachman, 1994).

Safety aids may contribute to anxiety in a number of ways. Foa and Kozak (1986) developed an emotional processing model for fear reduction that outlined two essential factors required to correct pathological fear including elicitation of fear and acquisition of corrective information. Use of safety aids hampers the ability to correct the fear by limiting fear activation. For example, someone with social anxiety may avoid social situations and thus not experience the fear associated with that situation. Additionally, the use of safety aids in feared situations may reduce the ability to acquire corrective information. An individual with panic disorder who interprets weak or tingling feelings in her legs as a sign that she will pass out may prevent collapsing by holding on to a nearby object or tensing her legs. By using this safety aid she prevents the disconfirmation of her fear and the ability to acquire corrective information (Salkovskis et al., 1999). Thus, her anxiety is maintained through the inability to obtain evidence disconfirming her fear.

Some research suggests the use of safety aids has a negative effect on the efficacy of exposure. Salkovskis et al. (1999) reported that individuals with agoraphobia who sought to decrease safety aids during exposures experienced greater belief change and fear reduction than an equivalent exposure where safety aids where maintained. Safety aid use also interfered with fear reduction among individuals with claustrophobic fears (Sloan & Telch, 2002). Kamphuis and Telch (2000) reported individuals with claustrophobia using mental distraction as a safety aid showed lower fear reduction during exposure than those instructed to focus on the perceived threat.

Treatments focusing on safety aids have demonstrated greater efficacy for specific anxiety disorders, such as social anxiety disorder and panic disorder, relative to those that did not specifically address safety aids (Wells et al., 1995; Salkovskis et al., 1999). Recently, Schmidt, Buckner, Pusser, Woolaway-Bickel, and Preston (2012) developed a transdiagnostic treatment, False Safety Behavior Elimination Therapy (F-SET), in which the elimination of safety aids is a key therapeutic focus. Consistent with prior theory, in F-SET, safety aids are conceptualized as behavioral and cognitive strategies that an individual engages in as a result of their anxiety, which may help relieve anxiety in the short term but likely contribute to anxiety in the long term (Salkovskis et al., 1999). Thus, the majority of the F-SET protocol involves the identification and fading of safety aids that maintain anxiety.

The other main strategy emphasized in F-SET is the development of an "anti-phobic" approach which is similar to exposure exercises that are part of many established disorder-specific treatments. The anti-phobic approach consists of behavioral experiments that involve engaging in behaviors that directly oppose the individual's phobic tendencies (i.e., doing the opposite of the person's anxious response). As such, being "anti-phobic" necessarily involves giving up all safety aids relevant to a particular situation. It is recognized that anti-phobic behaviors are often difficult for patients. However, they provide effective disconfirmation of false threats that maintain anxiety problems (Schmidt et al., 2012). For example, anti-phobic behaviors for a patient with social anxiety disorder would focus on activities that make them the center of negative attention (e.g., wearing funny clothes, stumbling over their words or stuttering, pretending to faint or throw up in public).

Given that safety behaviors occur among all anxiety disorders, F-SET appears to be viable for any anxiety diagnosis. The goal of F-SET is to eliminate phobic behaviors (i.e., safety aids) and increase anti-phobic behaviors regardless of the specific anxiety disorder diagnosis. F-SET is comprised of simplified versions of the basic elements common to most empirically validated CBT treatments for anxiety disorders. A key strength of the F-SET protocol is the use of a transdiagnostic approach, which allows for the use of this treatment across multiple anxiety disorders. Further, the F-SET protocol is a relatively streamlined approach to treating anxiety. Many CBT protocols for anxiety include education, cognitive reappraisal, and exposure exercises. In F-SET, patients receive general psychoeducation, though training in cognitive therapy and exposure are not specifically covered. Nonetheless, the focus on eliminating safety aids and developing an anti-phobic approach commonly leads patients to complete exposure exercise during the course of treatment (Schmidt et al., 2012).

With the aim of increasing the parsimony of transdiagnostic treatments, the current study was a modification of the group F-SET program developed by Woolaway-Bickel and Schmidt (unpublished treatment manual) into a five week individual therapy format. Consistent with group F-SET, the individual format focused on the identification of safety aids that maintain and exacerbate anxiety (e.g., avoidance of situations or sensations, substance use, medication, etc.) and the elimination of those behaviors. F-SET has demonstrated efficacy in a group format (Schmidt et al., 2012) and the current study was designed to use these techniques in an individual therapy format. We expected that the individual F-SET format would allow for shorter treatment duration since we could focus on the safety aids used most frequently by the client, rather than the broader range safety aids which were covered in the group format. Four primary hypotheses were evaluated in the current study: (1) the F-SET protocol would produce better overall outcome relative to a waitlist control, (2) the F-SET protocol would yield clinically significant improvement of primary diagnosis symptoms as well as secondary diagnosis symptoms, (3) the F-SET protocol would create treatment improvement that is maintained during a one month follow-up interval and (4) given that reduction of safety aid use is the key mechanism of change in the F-SET treatment, a reduction in safety aid use will mediate the relationship between pre and post treatment.

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