CBT Protocols for Anxiety Disorders

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Objectives:

At the completion of this session, the participant should be able to:

1. Discuss the disadvantages and advantages of structured empirically-supported CBT protocols.
2. Develop a basic understanding of the conceptual models and treatment components for two promising CBT protocols:
   » Cognitive Processing Therapy (CPT) for PTSD
   » Acceptance & Commitment Therapy (ACT) for a broad range of clinical problems.
3. Understand the empirical foundation these protocols.
4. View recorded segments of protocols to observe important elements and processes of CBT in general and of the particular protocols that you view.
Objective 1a:

Discuss Disadvantages of Treatment Protocols; Common Arguments against Treatment Manuals

1. Factors common to all therapies are more important than specific techniques
   »“Dodo bird” effect
   »Qualities of the therapist
   »Therapy is about a relationship
   »Therapy is an art form.

2. Manuals are rigid/inflexible & do not meet important needs of the patient.

3. CBT manuals were validated with samples that were not representative of community patient populations.

4. Dissemination – intimidating for clinicians to think they need to master a large # of protocols; easier to stick with training & have a generalized approach.
Responses to Arguments Against CBT Manuals

1. Common Factors
   » Anxiety D.O.s typically respond best to CBT
   » Qualities of the therapist necessary but not sufficient
   » If therapy is an art form, than it is not likely to advance over time.

2. Protocols rigid/inflexible
   » Even within the most structured of protocols, there is some tailoring of the interventions.

3. CBT outcome studies now more generalizable.

4. Dissemination – CBT making this a priority.
Objective 1b: Advantages of Empirically-Supported CBT Protocols

1. Truism – empirically validated methods are empirically validated vs. therapist not using a manual.

2. Treatment manuals facilitate the advancement of behavior change research
   » Increase treatment uniformity
   » Outcomes become more likely to reflect the effects of the treatments vs. differences in the individual therapists.
Objective 1b (cont):

Advantages of Empirically-Supported CBT Protocols

3. CBT treatment manuals include reliable and valid questionnaires for tracking symptoms & progress
   »Studies have found that therapists’ typically overrate improvement as compared to patient ratings of progress; therapists’ confidence unrelated to effectiveness.

4. Therapists not using empirically supported treatments vulnerable to:
   »Fads and charismatic leaders,
   »Biased information processing & heuristics, &
   »Patient’s avoidance of therapy tasks.
Objective 2

Cognitive Processing Therapy (CPT) Conceptual Model and Treatment Components

- PTSD is a disorder of natural recovery.
- What interferes with or facilitates recovery after a trauma?
  - Escape and avoidance of strong negative affect & the situations that trigger them:
    - Prevents developing adaptive beliefs and perspectives on the trauma,
    - Prevents natural dissipation of those feelings.
Objective 2
Develop a Basic Understanding of the Cognitive Processing Therapy (CPT) Conceptual Model and Treatment Components

• What interferes with or facilitates recovery after a trauma?
  - “Stuck Points” - Maladaptive beliefs develop in response to the trauma or pre-existing beliefs are reinforced by the trauma. For example,
    • “The event was my fault, I should have known something terrible would happen (hindsight bias)”
    • “Nobody (no men) is trustworthy.”
    • “I have no control over anything that happens to me.”
Cognitive Processing Therapy

Characteristics & Goals

• 12 or 13 sessions (depending on whether patient needs Traumatic Bereavement module).

• Highly structured – down to 5 & 10 minute blocks!

• Goals:
  – Changing thinking about meaning of event
    • Decreasing hindsight bias & self-blame, &
    • Learning to not over-generalize their thinking about a single traumatic event to all people or themselves as people.

  – Eliminating avoidance and escape allowing the dissipation of natural emotions.
Cognitive Processing Therapy
Protocol Components

1. Psychoeducation about PTSD, emotions, “stuckpoints.”

2. Impact statement--Writing & processing statement of how PTSD/trauma has negatively affected life.

3. Written account of worst trauma & processing it.

4. Learning & practicing Cognitive Therapy worksheets (ABCs, Challenging Questions, Patterns of Problematic Thinking).

5. Modules that cover key areas: Safety, Trust, Power/Control, Esteem, Intimacy.

Objective 3: Understand the empirical foundation of:

Cognitive Processing Therapy (CPT) for PTSD
• Random assignment to 
  -CPT or MA (minimal attention WL; 5-10 min call/wk).

• Combination of group & individual format 
  -17 weeks of group meetings; first 9 also met with individual therapist.

• Drop out rate 
  -CPT 18% 
  -MA  21%

• ITT MANCOVAS taking into account dropouts, improvement across assessments remained significant.
## Scores of CPT-SA Treatment Group versus MA Group at Pre- and Posttreatment

<table>
<thead>
<tr>
<th>Measure and group</th>
<th>Pretreatment</th>
<th>Posttreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>CAPS-SX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT-SA</td>
<td>65.46</td>
<td>26.39</td>
</tr>
<tr>
<td>MA</td>
<td>68.30</td>
<td>23.67</td>
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<tr>
<td>MPSS</td>
<td></td>
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<tr>
<td>CPT-SA</td>
<td>57.57</td>
<td>22.85</td>
</tr>
<tr>
<td>MA</td>
<td>57.52</td>
<td>24.74</td>
</tr>
<tr>
<td>BDI-II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT-SA</td>
<td>24.43</td>
<td>10.81</td>
</tr>
<tr>
<td>MA</td>
<td>24.52</td>
<td>11.55</td>
</tr>
<tr>
<td>DES-II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT-SA</td>
<td>18.17</td>
<td>12.68</td>
</tr>
<tr>
<td>MA</td>
<td>20.83</td>
<td>17.04</td>
</tr>
</tbody>
</table>

*Note.* CPT-SA = cognitive processing therapy for sexual abuse (n=28); MA = minimal attention (n=27); CAPS-SX = Clinician-Administered Post-Traumatic Stress Disorder (PTSD) Scale, 1-Week Symptom Status Version; MPSS = Modified PTSD Symptom Scale; BDI-II = Beck Depression Inventory-II; DES-II = Dissociative Experiences Scale-II.
Percent of Cognitive Processing Therapy Participants Meeting PTSD Dx Crit After Treatment (ITT)

<table>
<thead>
<tr>
<th></th>
<th>Post test</th>
<th>3 Mo FU</th>
<th>1 Yr FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-CSA</td>
<td>7</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>MA</td>
<td>74</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Good End State Functioning (Completers)

<table>
<thead>
<tr>
<th></th>
<th>CPT</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posttest</td>
<td>79%</td>
<td>4%</td>
</tr>
<tr>
<td>3 Mo FU</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>1 Yr FU</td>
<td>75%</td>
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</table>

Good End State Functioning ITT

<table>
<thead>
<tr>
<th></th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posttest</td>
<td>60%</td>
</tr>
<tr>
<td>3 Mo FU</td>
<td>62.8%</td>
</tr>
<tr>
<td>1 Yr FU</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

»No patient experienced a worsening from pre to post-treatment
Cogn Proc Tx for Military related PTSD


• CPT vs. WL, RCT
• N=60
• Intent-to-Treat Analyses
Figure 2. Random regression analysis of change in Clinician-Administered PTSD Scale (CAPS) severity scores for the cognitive processing therapy (CPT) and wait-list (WL) conditions over time (Week 0 = baseline).
Cogn Proc Tx for Military related PTSD


• Condition X Time interactions (p < 0.01) - groups not different at pretreatment but CPT group improved differential compared to baseline & compared to WL at post treatment & follow up (ITT):

  - CAPS Total
  - CAPS Re-experiencing
  - CAPS Numbing
  - PCL
  - STAI

• No differences in outcome of CPT between those with or without service-related disability!

• At posttreatment, the ES’s were large but by 1 mo follow up they were in the medium range.

• Nonsignificant trend for BDI-2

• Not CAPS avoidance or CAPS hyperarousal.
Cognitive Proc Tx vs. Prolonged Exposure vs. Wait-list for Female Rape Victims


PARTICIPANTS

- PTSD dx, female rape victims.
- Exclusion criteria included current psychosis, developmental disabilities, suicidal intent, current parasuicidal behavior, current dependence on drugs or alcohol, and illiteracy.
- N=181 women; 85% had other traumas in addition to index rape (average of 6.4 adult crime incidents).

Randomized to 3 conditions

2. Prolonged Exposure (PE) - 1) education-rationale, 2) breathing retraining, 3) behavioral exposures, & 4) imaginal exposures. Exposure homework.
3. Minimal Attention (MA, brief phone calls & invitation for them to call)
Cognitive Proc Tx vs. Prolonged Exposure vs. Wait-list for Female Rape Victims

• ASSESSMENT
  - Interviews
  - Clinician-Administered PTSD Scale (CAPS)
  - SCID-IV - Patient Version
  - Standard Trauma Interview (see above)
  - Self-Report Scales
  - PTSD Symptom Scale (PSS)
  - BDI
  - Trauma-Related Guilty Inventory

• EXPERIMENTAL DESIGN
  - Random assignment to CPT, PE or MA (WL)
  - 6 weeks of 2x/week treatment
  - [At the end of 6 weeks, the MA participants were assigned to one of the active treatments.]
CPT vs. PE vs. WL for Female Rape Victims
Resick, et al. '02, JCCP, v. 70(4).
CPT Dismantling: CPT vs. CT vs. WA

• Full CPT = CPT-C + Written Account (WA)
• N= 150 sexually or physically women assaulted as children or adults & meeting PTSD criteria; highly traumatized & chronic sample
• Victims, Randomly Assigned to 1 of 3 conditions
  • Full CPT vs. Cognitive Therapy (CPT-C) Component only vs. Written Account (WA) Component
    – 2 hr/wk x 6 wk
    – Blind Assessment
• Primary measures
  – PTSD (CAPS)
  – SCID-IV
  – Standard Trauma Interview
CPT Dismantling: CPT vs. CT vs. WA

Posttraumatic Diagnostic Scale
CPT Dismantling: CPT vs. CT vs. WA

Beck Depression Inventory – II
1. CPT, CPT-C, WA all resulted in significant improvement in PTSD and Depression- main measures.

2. All groups also significantly improved on all other measures - anxiety, anger, guilt, shame & cognitive distortions.

3. Large effects at post treatment and maintained at 6 month follow up.
Objective 4
View recorded segments of protocols to observe important elements and processes of CBT in general and of the particular protocols that you view.

CPT Video
ACCEPTANCE AND COMMITMENT THERAPY
Why Acceptance and Commitment Therapy was selected for this presentation?

• Innovative CBT approach– focus on acceptance, mindfulness, valued life directions, meta-cognitive awareness.

• Growing empirical base
  – Several RCTs.

• Outstanding approach to development and testing of a therapeutic method
  – Theory; basic science; theory
  – Early component analysis studies
Why Acceptance and Commitment Therapy was selected for this presentation?

• Outstanding approach to development and testing of a therapeutic method
  – Meditational analysis are almost always included in outcome studies.

• Other end of the continuum –
  – CPT highly structured;
  – ACT encourages flexible application of ACT principles in response to particular treatment context.
Objective 2:

Develop a basic understanding of the conceptual model and components of: Acceptance & Commitment Therapy (ACT)

- ACT is a type of CBT rooted in basic research on language and cognition & integrated with well-established behavioral analytic principles.
- Rather than attempting to eliminate unpleasant thoughts & feelings, ACT aims to increase “psychological flexibility” in the service of living a fulfilling, vital life.
- Techniques include using metaphors and a wide range of brief experiential mindfulness exercises, values clarification tasks, and standard behavioral interventions.
Acceptance and Commitment Therapy: Processes that Contribute to Poor Quality of Life and Problems of Living

- Unwillingness
- Cognitive Fusion
- Preoccupation with Rumination & worry
- Lack of purpose & life direction
- Persistent inaction, impulsivity or avoidance
- Self-as-Content

Psychological Inflexibility
Acceptance and Commitment Therapy: Treatment Components

- Present Moment Awareness
- Acceptance/willingness
- Cognitive Defusion
- Valued Life Directions
- Committed Action
- Self as Context
- Psychological flexibility
Objective 3:

Understand the empirical foundation of the:

- Acceptance and Commitment Therapy Protocol
### NREPP’s Review of Acceptance & Commitment Therapy Studies

**Quality of Research Ratings by Criteria (0.0-4.0 scale)**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Reliability of Measures</th>
<th>Validity of Measures</th>
<th>Fidelity</th>
<th>Missing Data/Attrition</th>
<th>Confounding Variables</th>
<th>Data Analysis</th>
<th>Overall Rating</th>
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<tbody>
<tr>
<td>1: Obsessive-compulsive disorder symptom severity</td>
<td>4.0</td>
<td>4.0</td>
<td>3.5</td>
<td>4.0</td>
<td>2.5</td>
<td>4.0</td>
<td><strong>3.7</strong></td>
</tr>
<tr>
<td>2: Depression symptoms</td>
<td>4.0</td>
<td>4.0</td>
<td>3.5</td>
<td>4.0</td>
<td>2.5</td>
<td>4.0</td>
<td><strong>3.7</strong></td>
</tr>
<tr>
<td>3: Rehospitalization</td>
<td>2.5</td>
<td>2.5</td>
<td>1.5</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td><strong>2.6</strong></td>
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<tr>
<td>4: General mental health</td>
<td>4.0</td>
<td>4.0</td>
<td>2.0</td>
<td>2.0</td>
<td>4.0</td>
<td>4.0</td>
<td><strong>3.3</strong></td>
</tr>
</tbody>
</table>
### Follow up Change Outcomes; Post Mediators

*(3 studies no follow-up; 3 no post)*

<table>
<thead>
<tr>
<th>Study</th>
<th>Problem</th>
<th>Comparison</th>
<th>Mediator</th>
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<tbody>
<tr>
<td>Tapper, 2009</td>
<td>Weight</td>
<td>Diet</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Woods, 2006</td>
<td>Trichotillomania</td>
<td>Wait list</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Gaudiano, 2009</td>
<td>Psychosis</td>
<td>Enhanced TAU</td>
<td>Defusion</td>
</tr>
<tr>
<td>Bond, 2000</td>
<td>Work stress</td>
<td>Wait list</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Wicksell, 2009</td>
<td>Pain</td>
<td>MDT + medication</td>
<td>Defusion</td>
</tr>
<tr>
<td>Wicksell, 2008</td>
<td>Pain</td>
<td>TAU</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Lazzaroni, 2009</td>
<td>Work stress</td>
<td>Wait list</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Zettle, 1986</td>
<td>Depression</td>
<td>CT</td>
<td>Defusion</td>
</tr>
<tr>
<td>Hayes, 2004</td>
<td>Stigma</td>
<td>Psychoeducation</td>
<td>Defusion</td>
</tr>
<tr>
<td>Lappalainen, 2007</td>
<td>Outpatient misc</td>
<td>CBT</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Lillis, 2009</td>
<td>Weight</td>
<td>Wait list</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Lillis, 2007</td>
<td>Ethnic prejudice</td>
<td>Education</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Gifford, under review</td>
<td>Smoking</td>
<td>Medications</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Lundgren, 2008</td>
<td>Epilepsy</td>
<td>Supportive treatment</td>
<td>PF/EA</td>
</tr>
<tr>
<td>Gregg, 2007</td>
<td>Diabetes</td>
<td>Education</td>
<td>PF/EA/Self-Manage</td>
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<tr>
<td>Varra, 2008</td>
<td>Resistance to ESTs</td>
<td>Psychoeducation</td>
<td>PF/EA/Defusion</td>
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<tr>
<td>Zettle, in press</td>
<td>Depression</td>
<td>CT</td>
<td>Defusion</td>
</tr>
<tr>
<td>Gratz, 2006</td>
<td>BPD</td>
<td>TAU</td>
<td>PF/EA</td>
</tr>
</tbody>
</table>

**Average Proportion Mediated:**

.53 (unweighted by n); .47 (weighted); Total n = 903
Accept & Commit Tx for GAD

Roemer et al. ‘08, JCCP, Vol. 76, No. 6.

- N=31
- ADIS-IV
- Randomly assigned to ACT or WL
- 16 sessions (4 individual, 12 grp)
### Effect Sizes for Full Sample of Participants Who Began Treatment (N = 26), All Variables at Pretreatment, Posttreatment, and 3- and 9-month Follow-Up

<table>
<thead>
<tr>
<th>Variable</th>
<th>Post</th>
<th>3-month</th>
<th>9-month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD CSR</td>
<td>2.97</td>
<td>2.83</td>
<td>2.34</td>
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<tr>
<td>PSWQ</td>
<td>1.58</td>
<td>1.94</td>
<td>1.86</td>
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<tr>
<td>DASS-Anxiety</td>
<td>1.23</td>
<td>1.47</td>
<td>1.30</td>
</tr>
<tr>
<td>DASS-Stress</td>
<td>1.77</td>
<td>1.58</td>
<td>1.61</td>
</tr>
<tr>
<td><strong>Secondary outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDI</td>
<td>1.74</td>
<td>1.57</td>
<td>1.24</td>
</tr>
<tr>
<td>QOLI</td>
<td>0.81</td>
<td>0.71</td>
<td>0.79</td>
</tr>
<tr>
<td>No. of additional di.</td>
<td>0.76</td>
<td>1.07</td>
<td>0.69</td>
</tr>
<tr>
<td><strong>Mechanism of change</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAQ</td>
<td>1.65</td>
<td>1.63</td>
<td>1.80</td>
</tr>
<tr>
<td>MAAS</td>
<td>0.57</td>
<td>0.83</td>
<td>0.74</td>
</tr>
</tbody>
</table>
Percentage of Treated Participants (N = 23) Meeting Criteria for Diagnostic Change, Responder Status, and High End-State Functioning at Posttreatment and 3-Month and 9-Month Follow-Up

<table>
<thead>
<tr>
<th></th>
<th>Post</th>
<th>3-month</th>
<th>9-month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic change</td>
<td>78.26 (18 of 23)</td>
<td>84.21 (16 of 19)</td>
<td>76.47 (13 of 17)</td>
</tr>
<tr>
<td>Responder status</td>
<td>77.27 (17 of 22)</td>
<td>83.33 (15 of 18)</td>
<td>80.00 (12 of 15)</td>
</tr>
<tr>
<td>High end-state</td>
<td>77.27 (17 of 22)</td>
<td>94.44 (17 of 18)</td>
<td>86.67 (13 of 15)</td>
</tr>
</tbody>
</table>

Note. Italic type indicates the last available values carried forward for the percentages.
ACT vs. MTAU for Ppl at Risk for LTD Resulting from Chronic Pain & Stress


- Sweden very high rates of disability
- Ss were public employees at high risk for disability and medical utilization.
  - Pain or stress symptoms; missed work for at least 3 periods of 7+ days over last year.

- Groups Randomized to:
  - MTAU
  - ACT + MTAU

- Dependent Measures
  - 6 months BL, 6 mo following intervention
  - Sick leave utilization
  - Medical utilization
  - Quality of Life
ACT vs. MTAU for Ppl at Risk for LTD Resulting from Chronic Pain & Stress

ACT vs. MTAU for Ppl at Risk for LTD Resulting from Chronic Pain & Stress


• At posttest and over FU, ACT+MTAU group significantly fewer sick days & medical utilization than MTAU-alone; large group differences
• At post-test & FU, no group differences in level of pain, stress or quality of life.
PARTICIPANTS

• OCD (DSM-IV); few exclusion criteria
  – Active psychosis
  – Or cognitive deficits that would make it difficult to participate (e.g., Autism)

• Randomized to:
  – ACT (n=41) – 8, 1 hr sessions, no in-session exposure or hw intended to systematically expose to achieve desensitization to OCD triggers; hw practice ACT skills when encounter triggers in everyday experience
  – Progressive Relaxation Training (n=38) – prior studies, credible tx to OCD

• Dependent Measures
  – PRIMARY -- YBOCS; BDI-2
  – SECONDARY-- QoL; AAQ; Thought-Action Fusion Scale; Thought Control Q; Tx Eval Inventory
Accept & Commit Tx vs. Progr Relax for OCD
Twohig 2010, JCCP, 78 (5).

ITT/LOCF; Significant Time X Condition interaction; For those at pretreatment with at least mild depression, there was a significant Condition x Time interaction; ACT group improved significantly more than the PRT group.
Accept & Commit Tx vs. Progr Relax for OCD
Twohig 2010, JCCP, 78 (5).

- Results
  - Clinically Significant Improvement (ITT) ACT significantly higher rates for the various outcome measures

<table>
<thead>
<tr>
<th></th>
<th>Post</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>46-56%</td>
<td>46-66%</td>
</tr>
<tr>
<td>PRT</td>
<td>13-18%</td>
<td>16-18%</td>
</tr>
</tbody>
</table>
Accept & Commit Tx vs. TAU to Prevent Rehospitalization for Psychotic Pts

Bach & Hayes, ‘02, JCCP, 70(5).

<table>
<thead>
<tr>
<th></th>
<th>ACT+TAU</th>
<th>TAU-Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Schizoaffective</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Mood DO w Psychosis</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36</td>
<td>38</td>
</tr>
</tbody>
</table>

- Randomized to:
  - ACT + TAU
  - TAU-Alone
  - Only Public hospital in 200 miles – therefore rehospitaliz would be in that hospital; no drop outs
Accept & Commit Tx vs. TAU to Prevent Rehospitalization for Psychotic Pts

Bach & Hayes, '02, JCCP, 70(5).

Graph showing the proportion not rehospitalized over days following initial release, comparing Treatment as Usual and ACT groups.
Accept & Commit Tx vs. TAU to Prevent Rehospitalization for Psychotic Pts
Bach & Hayes, '02, JCCP, 70(5).

- Symptom reporting at follow-up in the ACT and TAU
Self-rated believability of hallucinations and delusions for participants in the acceptance and commitment therapy (ACT) and treatment-as-usual conditions during baseline and follow-up.
Objective 4: Observe important elements and processes of CBT in general and of the particular protocols that you view.

ACT video clip: Cognitive Defusion
Conclusions

1. Numerous empirically-validated CBT protocols exist for anxiety disorders.

2. These protocols have many advantages.

3. Clinicians would benefit from learning one or more protocol for disorders they are interested in treating; when beneficial to do so, they can make modifications based on the patients’ needs.
Conclusions

4. CPT is a highly efficacious treatment for PTSD patients who experienced various types of traumas (sexual assault, combat, or childhood sexual abuse).

5. ACT is broadly and flexibly applicable & typically results in significant and clinically-meaningful improvement in functioning in important life domains.
Bibliography


Websites:

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