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Should art be integrated into cognitive behavioral therapy for anxiety disorders?

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ABSTRACT

Although cognitive behavioral therapy (CBT) is the preferred treatment method for anxiety disorders, it is underutilized and has been critiqued for being too verbal or abstract. Due to the role of imagery in maintaining anxiety disorders, art may be a useful addition to CBT for anxiety disorders. Art was incorporated into a brief CBT model in two quantitative case studies: Case 1 for panic disorder with agoraphobia (PDA) and Case 2 for generalized anxiety disorder (GAD). The A-B, single-subject experimental design included a two-week baseline period and a seven-week intervention period in both cases. The participant with PDA recorded her symptoms of PDA and her level of general anxiety throughout the baseline and intervention periods using a panic diary, whereas the participant with GAD recorded her level of general anxiety. In Case 1 for PDA, the intervention resulted in statistically significant reductions in panic frequency and some features of panic anxiety and agoraphobia. In Case 2 for GAD, the decrease in general anxiety was marginally significant.

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Cognitive behavioral therapy (CBT) is more effective in reducing the symptoms of anxiety disorders, including panic disorder with agoraphobia (PDA) and generalized anxiety disorder (GAD), than any other psychotherapy (Marchand, Todorov, Borgeat, & Pelland, 2007). The symptoms of PDA include panic attacks, anxiety about future attacks and their ramifications, and a phobia of situations where escape may be difficult; the symptoms of GAD include disproportionate worry that is difficult to control (American Psychiatric Association [APA], 2000). Although some antidepressants are equal to CBT in short-term treatment of PDA and GAD, CBT has longer-lasting effects on panic frequency and generalized anxiety than these medications (Barlow & Durand, 2005; Barlow, Gorman, Shear, & Woods 2000). Despite these findings, CBT is underutilized in treatment for these disorders. Deacon (2007) stated that only 10% of people with PDA had engaged in CBT.

Several theories exist as to why clients with PDA do not receive CBT at a higher rate. Traditional CBT for anxiety disorders can require as many as 20 weeks of sessions and is chiefly offered in urban areas (Deacon, 2007). Therefore, clients with PDA with lower incomes or living in rural areas may not be able to complete a full course of CBT (Deacon & Abramowitz, 2006). Brief versions of CBT, including 7-week courses of treatment and intensive full-day sessions, have been implemented to address some of these concerns (Deacon & Abramowitz, 2006; Marchand et al., 2007). In addition to the physical and financial inaccessibility of CBT, however, it may also be difficult for some clients cognitively and verbally. CBT requires clients to think abstractly for a variety of tasks, including visualization and ranking exercises; these exercises may be challenging for some clients with lower verbal skills or more concrete thinking (Craske, Barlow, & Meadows, 2000; Perry, 2002).

Conducting Internet video sessions could supplement briefer protocols in addressing issues of accessibility and expense (Klein et al., 2009), whereas integrating art into CBT could provide a concrete foundation to the more abstract tasks of CBT and offer visual and tactile routes to learning and expression. For example, visual representation of thoughts could be used during cognitive restructuring to help a client scale down an irrational worry to a more rational thought. Drawing feared situations could be used as imaginal desensitization. Craske and Barlow (1988) discussed the importance of facing avoided imagery through visualization when treating chronic anxiety. Creating artwork would also require CBT clients to engage actively in their treatment. Craske, Barlow, & O'Leary (1992) advised therapists not to merely "spoon-feed" psychoeducational information to clients.

The goal of this study was to test the efficacy of a brief cognitive behavioral art therapy (CBAT) intervention in treating the symptoms of PDA and GAD. Live Internet video sessions were also used

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in Case 2 for GAD. In Case 1 for PDA, it was hypothesized that CBAT would (a) reduce the symptoms of PDA, including panic frequency, panic anxiety, and agoraphobia and (b) increase overall quality of life, defined here as a decrease in general anxiety and increase in general feelings of goodness (participant rating of "how good they felt that day"). In Case 2 for GAD, it was also hypothesized that CBAT would increase overall quality of life. In Case 1, art activities were integrated into Marchand et al.'s (2007) seven-session model condensed from the 21-session Panic Control Treatment (PCT) (Craske et al., 2000). The foci of the protocol were altered slightly for Internet video sessions in Case 2 to address the symptoms of GAD as recommended in Craske et al. (1992). Quantitative results and case vignettes will be discussed following a review of related literature.

Related literature

PDA is a relatively common psychological disorder with a lifetime prevalence of 3.5% (APA, 2000). The most identifiable symptoms are panic attacks, defined by the rapid onset of at least four out of 14 psychophysiological symptoms. Examples include increased heart rate, dizziness, nausea, and feelings of depersonalization. In addition to recurrent panic attacks, a person must experience at least one month of anxiety about future attacks and their results to receive a diagnosis of PDA. These panic attacks and anxiety must cause significant distress or impairment in functioning. Initial panic attacks become panic disorder when the person develops a learned fear of the psychophysiological symptoms, which become panic triggers (Barlow & Durand, 2005). Agoraphobia is a separate diagnosis that can develop before or after panic disorder in 30–50% of cases (APA, 2000). People with agoraphobia avoid difficult-to-escape situations where a panic attack would be embarrassing, such as a crowded shopping mall. At times, these situations trigger initial or subsequent panic attacks.

GAD is more common than PDA, with a lifetime prevalence of 5% (APA, 2000). It is characterized by excessive worry about a variety of aspects of life occurring on most days for at least six months (APA, 2000). Worrisome thoughts are difficult to cease or control. Psychophysiological symptoms, including muscle tension, fatigue, and agitation, accompany these worries. Although PDA and GAD may co-occur if criteria for both are met, there are important physiological distinctions between the experience of panic attacks and anxiety. While panic involves autonomic arousal – i.e. increased heart rate – and the activation of the Flight/Fight System (FFS) in the brain, generalized and specific anxiety results in autonomic restriction and the activation of the Behavioral Inhibition System (BIS) in the brain (Gray & McNaughton, 1996). Borkovec and Inz (1990) found that people with GAD exhibit high levels of EEG beta activity in the frontal lobes of the brain, especially the left hemisphere. The lack of right hemisphere brain activity may suggest that people with GAD partake in worrisome thoughts to avoid imagery associated with negative emotions that might result in greater autonomic arousal and/or panic.

CBT uses a theoretical approach and methodology that combine components of cognitive therapy and behavioral therapy. Cognitive behavioral theory posits that our behavior is a result of our cognitions—our perceptions and beliefs about our environment, and, therefore, these cognitions must be restructured in order for behavior change to occur (Perry, 2002). The situational antecedents, associations, and consequences of a behavior that reinforce its reoccurrence can then be altered so a behavior can be reduced or changed. Rosal (2001) discussed three types of CBT in practice today: (1) cognitive restructuring therapies, (2) coping skills therapies, and (3) problem-solving therapies (p. 212). As previously stated, CBT has been found to be the most effective and long-lasting treatment for anxiety disorders over other psychotherapies and medications; at least 13 controlled studies have demonstrated significant benefits for GAD (Borkovec & Ruscio, 2001) and at least 25 studies have also demonstrated its efficacy for PD and PDA (Marchand et al., 2007).

According to Craske et al. (2000), seven techniques are implemented in the most effective CBT interventions for PDA: psychoeducation, breathing retraining, cognitive restructuring, interoceptive exposure, imaginal exposure, in vivo exposure, and relapse prevention. Marchand et al. (2007) condensed these seven techniques from Craske et al.'s (2000) PCT, a 21-session treatment, into seven sessions. Psychoeducation about PDA helped clients understand their cycle of panic, including physiological, cognitive, and behavioral components. Breathing retraining taught clients to deescalate the psychophysiological symptoms of an attack. Cognitive restructuring addressed catastrophic thinking during panic attacks as well as anxious periods between attacks. Interoceptive exposure used behavioral conditioning techniques to break negative associations with bodily cues experienced during panic attacks. Finally, imaginal and in vivo exposure exercises gradually desensitized clients to agoraphobically avoided situations or activities. The majority of these techniques are also employed in the most effective CBT protocols for GAD; cognitive restructuring approaches can address underlying biases in cognition (Barlow & Durand, 2005) and desensitization exercises can help clients confront previously avoided images (Craske et al., 1992).

Brief or intensive versions of CBT protocols have been effectively used to treat panic and anxiety (Deacon and Abramowitz, 2006; Deacon, 2007; Marchand et al., 2007) compared to traditional CBT, and therapist-assisted online therapy is another effective alternative that increases accessibility and reduces costs. Richards, Klein, and Austin (2006) found that interactive online CBT sessions supplemented by email support from therapists significantly reduced symptoms of panic disorder compared to control groups. Klein et al. (2009) then established that frequency of therapist emails does not necessarily improve end-state functioning in these clients. According to Andersson, Carlbring, Berger, Almlov, and Cuijpers (2011), these therapist-assisted, online interventions are most effective when diagnoses are verified beforehand and the treatment is clear, thorough, and easily usable. In a meta-analysis of 92 studies, Barak, Hen, Boniel-Nissim, and Shapira (2008) found no significant difference in the effectiveness of various forms of online therapy for different disorders when compared to face-to-face therapy.

Although the Internet therapy in Case 2 was also intended to increase accessibility for the participant with GAD, they were live, therapist-guided video sessions and, therefore, perhaps closer to face-to-face CBT than therapist-assisted online CBT or "etherapy." However, the ethical considerations relevant to etherapy were still considered in the reported study. Alders, Beck, Allen, and Mosinski (2011) discussed the importance of art therapists password protecting digital files on external hard drives and fully informing clients about the risks of publicizing their own images on social media sites. With respect to live online supervision, or "telesupervision," Brandoff and Lombardi (2012) also recommended that art therapists use encrypted video communication to protect client confidentiality.

Art interventions were integrated into Marchand et al.'s brief CBT protocol for PDA in Case 1 of the reported study with slight variations for Internet video sessions in Case 2 for GAD. Although the author is unaware of any previous studies implementing a full course of CBAT for either disorder, a variety of studies have shown the efficacy of other types of art therapy for anxiety in general (Curry & Kasser, 2005; Chambala, 2008; Sandmire, Gorham, Rankin, & Grimm, 2012; van der Vennet & Serice, 2012). Sandmire et al. (2012) found that art therapy, including mandalas, collage,

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