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Emotional Schemas and Resistance to Change in Anxiety Disorders

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Cognitive-behavioral treatment for all anxiety disorders involves exposure to feared situations and feared emotions. Dropout from therapy is a continued problem for final treatment effectiveness. A meta-emotional model of fear of negative emotions (and anxious sensations and thoughts) is advanced that can be used as a transdiagnostic treatment model for anxiety disorders. According to this model, anxious individuals hold theories of anxiety that interfere with effective treatment. Specific treatment recommendations are developed from this model to counter roadblocks in cognitive-behavioral therapy of the various anxiety disorders.

Although there is considerable evidence that cognitive-behavioral therapy is highly effective in the treatment of anxiety disorders, many prospective patients do not complete the recommended course of treatment (Leung & Heimberg, 1996; van Minnen, Arntz, & Keijsers, 2002; Vogel, Stiles, & Gotestam, 2004). Since CBT requires continued exposure with response prevention for anxiety-provoking behavior, patients understandably may be reluctant to continue in treatment—or, if they do continue, they may be reluctant to comply with direct exposure. Indeed, effective exposure necessitates the activation of sufficient fear (Foa & Kozak, 1986). Each of the anxiety disorders that I will discuss—panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, social anxiety disorder, and posttraumatic stress disorder—is characterized by a fear of the consequences of one's own anxiety or sensations. It is proposed here that each anxiety disorder consists of a theory of emotional dysregulation that underpins resistance to engage in exposure.

All of us have experiences of uncomfortable or unpleasant emotions—such as sadness, anxiety, fear, or anger—but not everyone develops a diagnosable psychiatric disorder. Anxiety disorders have been linked to early temperamental differences, anxiety sensitivity, hypervigilance for threat, and other cognitive dispositions. It is proposed here that noncompliance in CBT for anxiety disorders is partly related to the role of emotional avoidance and fear of anxiety. Exposure implies emotional dysregulation to the anxious patient.

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Emotional Schemas

The role of emotional processing in anxiety disorders has been a focus of a number of studies. Of specific interest has been the construct of "alexithymia"—that is, the difficulty in labeling or identifying one's own emotions. Alexithymia has been viewed as a "meta-emotional" deficit reflecting difficulties recalling emotions or identifying the situations that give rise to emotions (Taylor, Bagby, & Parker, 1997). Overall levels of anxiety are positively related to alexithymia (Culhane & Watson, 2003; Eizaguirre, Saenz de Cabezon, Alda, Olariaga, & Juaniz, 2004). In a study of 85 combat veterans, alexithymia was predictive of PTSD (Monson, Price, Rodriguez, Ripley, & Warner, 2004), while in another study alexithymia was found to be essentially a *symptom* (that is, emotional numbing) characteristic of PTSD (Badura, 2003). Alexithymia is related to maladaptive coping with anxiety, such as drinking (Stewart, Zvolensky, & Eifert, 2002) and the search for perfectionism (Lundh, Johnsson, Sundqvist, & Olsson, 2002).

Although recognizing, labeling, and differentiating emotions are part of an essential first-step in emotional processing, individuals also differ in their interpretations and strategies of their own emotions once they recognize they have an emotion. I have proposed a model of emotional schemas that identifies a set of interpretative processes and strategies that are activated once an "unpleasant" emotion is experienced (Leahy, 2001b, 2003a). Once an emotion is activated, the first step is to attend to the emotion. This first step can include both noticing the emotion and labeling the emotion, a process underlying alexithymia. Of course, more than one emotion may be activated, thus adding further to the complexity of this first step. The next step can involve emotional and cognitive avoidance of the emotion, as

reflected by dissociation, bingeing, or alcohol consumption. For example, individuals with social anxiety disorder rely on alcohol or drugs to manage their emotions so that their emotional arousal will be diminished, thereby decreasing the likelihood that they will be humiliated because they might appear anxious. Similarly, individuals with PTSD also rely on alcohol and drugs to reduce the emotional impact of their intrusive images.

Each of the anxiety disorders entails emotional schemas (interpretations and strategies) of the sensations, emotions or intrusive thoughts and images that are experienced. Negative emotional strategies and interpretations include validation ("Other people understand the way I feel"), comprehensibility ("My emotions don't make sense to me"), guilt and shame ("I shouldn't have these feelings" or "I don't want anyone to know I feel this way"), simplistic thoughts ("I should not have mixed feelings"), higher values ("My feelings reflect my higher values"), control ("I am afraid my feelings will go out of control"), rationality ("I should be logical and rational—not emotional"), duration ("My feelings will last a long time"), consensus ("Other people have the same feelings"), acceptance ("I can accept the feelings I have"), rumination ("I sit and dwell about how bad I feel"), expression ("I can allow myself to cry"), blame ("Other people cause me to feel this way"). The emotional schema model is shown in Figure 1.

We have found that these negative emotional schemas are related to depression, anxiety, PTSD, metacognitive aspects of worry, alcohol abuse, marital discord, and personality disorders (Leahy, 2001a, 2002a,2002b, 2003b; Leahy & Kaplan, 2004) Of interest in the current paper is the relation between emotional schemas and specific anxiety disorders. For example, individuals with panic disorder are expected to believe that their sensations and emotions are not comprehensible, will go out of control, will last a long time, are not experienced by others, cannot be accepted, and cannot be expressed. Indeed, CBT addresses many of these interpretations by using bibliotherapy, explanation of the nature of panic disorder, setting up experiments, and testing specific predictions. Similarly, the treatment of OCD entails addressing the patient's beliefs in thought-action fusion (loss of control), responsibility for neutralizing intrusions (control and guilt), and the personal implication of intrusions (guilt and shame) (Clark, 2004). These cognitive elements of OCD are also "emotional schemas" in that they constitute a rule-book that these individuals use for handling "unwanted" thoughts, images, and emotions.

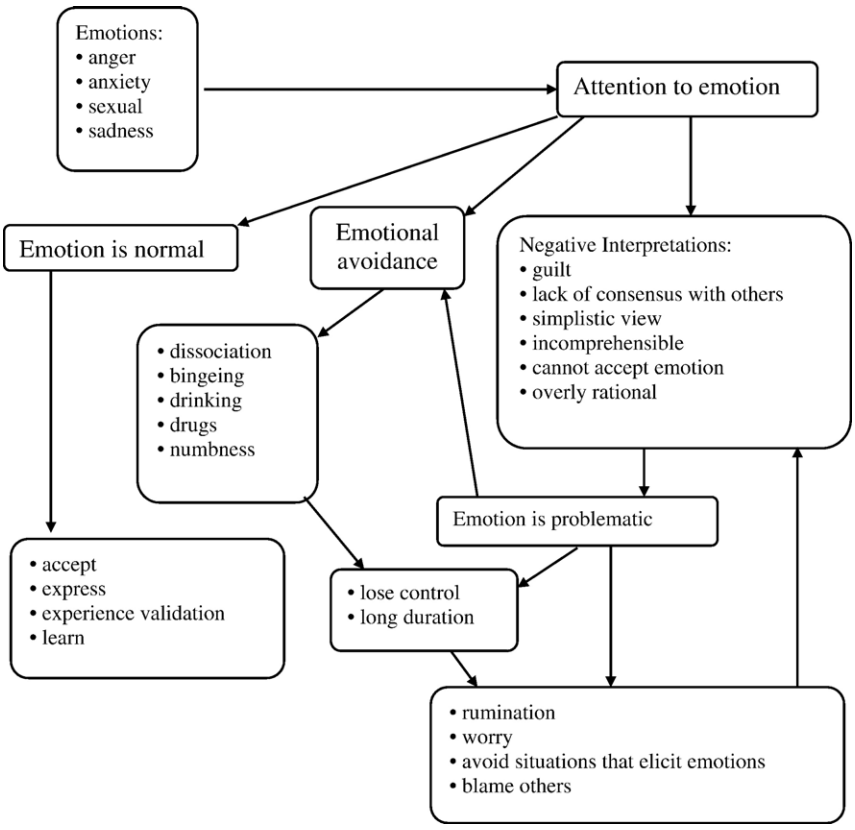

Figure 1. Model of emotional schemas.