Treatment and management of anxiety disorders and fear-related disorders

Lesson 3.4.3 | Clinical psychology

Core ideas

CBT helps people identify anxious thoughts, test threat predictions and practise more helpful responses to feared situations.

Exposure-based treatments reduce avoidance by helping the person face feared cues in a planned and supported way.

Gradual exposure can use a fear hierarchy, moving from less frightening to more frightening situations while coping skills are practised.

Good management plans include relapse prevention, support systems and adaptations for the specific anxiety pattern.

Behavioural therapy: systematic desensitisation combines a graded fear hierarchy with a learned incompatible response such as relaxation. It is more specific than exposure alone; the rationale is to weaken the anxiety response gradually.

Applied tension is included for blood/injection/injury phobia because some sufferers show a fall in blood pressure and fainting. Its rationale is to counter that fall; do not assume ordinary relaxation and muscle tension are interchangeable.

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Key terms

CBT: A therapy that works on thoughts, beliefs and behaviour.

Exposure therapy: Treatment involving planned contact with feared cues or situations.

Fear hierarchy: A ranked list of feared situations from easier to harder.

Gradual exposure: Step-by-step exposure to feared situations.

Systematic desensitisation: Gradual exposure paired with relaxation or calmer responding.

Relapse prevention: Planning to reduce the chance of symptoms returning.

Applied tension: Muscle-tension training used to counter fainting responses associated with blood/injection/injury phobia.

Further detail and evidence

Key study - Chapman and DeLapp (2013): this case examined nine sessions of manualised CBT with applied tension for "T", a self-referred 42-year-old White man whose long-standing blood/injection/injury phobia prevented medical care.

Chapman/DeLapp method: interviews and symptom questionnaires informed an individual formulation. Sessions used psychoeducation, monitoring, cognitive restructuring, graded exposure and applied tension; subjective distress ratings tracked change. Exposure progressed towards blood tests and routine medical procedures.

Chapman/DeLapp findings: T resumed medical procedures and reported lasting gains at follow-up. At about 12 months his Beck Anxiety Inventory score had fallen from 41 to 7, and blood/injection sensations were reduced. This supports feasibility for this case, not proof that one component alone caused improvement.

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Continued

Systematic desensitisation begins with a graded hierarchy, teaches an incompatible response and progresses through increasingly feared situations. Improvement should involve reduced fear/avoidance, not just being able to recite the hierarchy. Exposure alone does not necessarily include the incompatible-response component.

CBT adds work on predictions and beliefs: identify an expectation, consider evidence, test it safely and review what happened. Applied tension specifically targets the fainting tendency in BII phobia; its physiological purpose differs from reducing arousal through relaxation.

Applying the ideas

Chapman and DeLapp combined cognitive and behavioural components with applied tension. A lower BAI score and renewed medical attendance provide different kinds of outcome evidence. Because the components were combined, the case cannot tell us whether tension, exposure, cognitive change or their interaction was responsible.

Evaluation and connections

Chapman/DeLapp evaluation: detailed longitudinal evidence supports real-world application, but one motivated self-referred man limits generalisation. Combined treatments and self-reports cannot isolate causal mechanisms. Confidentiality, consent and managing distress are important; compare idiographic understanding with nomothetic treatment claims.

Individual formulation supports idiographic usefulness, while a manual supports consistency and later replication. Long follow-up tests maintenance, but one motivated self-referral cannot establish average effectiveness. Exposure requires informed agreement and distress monitoring; avoiding all short-term discomfort would also prevent testing the feared prediction.