THE AGORAPHOBIA TREATMENT GROUP

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Focal Group Psychotherapy

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Table of Contents

Introduction

Agoraphobia is one of the most disabling of the anxiety disorders, affecting approximately 5 percent of the adult population in the United States. The term *agoraphobia* was originally coined by Westphal (1871) to describe a fear of walking in open spaces. However, the principal fear in agoraphobia involves apprehension about having a panic attack in situations where escape is perceived to be difficult. Common phobic situations include driving, stores and restaurants, elevators, planes and other public transportation, and being alone. Agoraphobia usually develops after an individual has been experiencing panic attacks and begins to avoid situations previously associated with panic or perceived as likely to bring on panic. The fear can, in some cases, progress to the point where a person is entirely housebound. Agoraphobia frequently involves dependency on a spouse, partner, or support person who must accompany the agoraphobic on forays away from their safe place. It also may involve depression: agoraphobics feel helpless and hopeless in avoidance of routine activities which they formerly accomplished easily. Some agoraphobics also experience obsessive, intrusive thoughts, warranting a dual diagnosis of agoraphobia and obsessive-compulsive disorder.

About 75 to 80 percent of agoraphobics are women, and the disorder typically begins in the early twenties. There is some evidence for a hereditary

basis, as concordance rates for identical twins are three to four times higher than for fraternal twins (Torgersen, 1983; Slater & Shields, 1969). Predisposing family history factors are also involved: parents who are overly protective, overcritical and perfectionist, or phobic themselves may set the stage for their children to later develop agoraphobia or another anxiety disorder.

The most effective treatment for agoraphobia is *in vivo* exposure—a process in which the client directly but gradually confronts a phobic situation in small increments. Typically, the agoraphobic and a support person will go together to confront a situation, such as a grocery store, continuing to the point where anxiety becomes slightly unmanageable. The client temporarily retreats from the situation at that point, allowing the anxiety to subside. After doing some breathing and relaxation exercises, the client proceeds with the exposure and then reenters the situation until anxiety rises to a certain criterion level again. Frequently, the agoraphobic will have desensitization to the situation in imagination (following Wolpe's systematic desensitization techniques—see Wolpe, 1958, 1973) prior to undertaking *in vivo* exposure.

Recent research indicates that self-paced exposure, carried out over a longer period of time and utilizing a support person, is superior to intense exposure (also known as *flooding)* over a short period of time (Barlow & Waddell, 1985). It is also critical that clients receive extensive training in

learning to cope with panic attacks prior to engaging in *in vivo* exposure (Barlow, 1988, Chapter 11, and Bourne, 1990, Chapter 6). Current treatment protocols emphasize training clients to control panic symptoms that are deliberately provoked during treatment sessions (Barlow & Craske, 1989).

Another critical area to address in treating agoraphobia is the client's anxious self-talk and underlying core beliefs or cognitive schemata that predispose this self-talk. Clients are taught to identify anxiety-provoking thinking patterns, as described by Beck (1979) and Beck & Emery (1985). They learn to rationally dispute distorted thoughts and replace them with more rational, supportive self-statements based on direct experience. Core beliefs that perpetuate anxiety are also identified. Their origins are explored in the context of the client's developmental history, and then the client learns to evaluate their validity and work with more rational, self-supportive affirmations.

Agoraphobia can be treated through individual therapy, or in a group format as described in this chapter. There are advantages to each approach. It is important, in initially evaluating a client, to explore his or her preferences as well as ability to be comfortable in a social situation (see next section). Groups can provide considerable *interpersonal support* for recovery as well as *incentive* to do homework and practice self-paced exposure between sessions. It may be asking a lot from individual therapy to be able to generate the same

degree of support and motivation to practice that is possible within a group, although clients who prefer individual therapy tend to do better in that mode.

The approach to group treatment presented in this chapter draws considerably from TERRAP—a group treatment program for agoraphobia developed by Arthur Hardy more than 20 years ago. TERRAP (a contraction derived from "territorial apprehensiveness") currently offers treatment groups throughout the United States and is operated by TSC Corporation in Menlo Park, California. This chapter also draws heavily from *The Anxiety and Phobia Workbook* (Bourne, 1990), which is based on the author's clinical experience with individual and group therapy treatment approaches.

An adequate recovery program for agoraphobia can be achieved in ten weeks by a group covering the main treatment iInterventions described above, namely

- The Causes of Panic and Agoraphobia (Weeks 1 and 2)
- Relaxation Training (Week 3)
- Physical Exercise (Week 4)
- Coping with Panic Attacks (Week 5)
- Imagery Desensitization (Week 6)
- Real-Life Desensitization (Week 7)

- Field Trip 1 (to practice *in vivo* exposure) (Week 8)
- Self-Talk (Week 9)
- Mistaken Beliefs and Affirmations (Week 10)

These are core ingredients of recovery that constitute the main focus of this chapter and need to be addressed in any effective treatment program.

Additional treatment components that might be included in a more comprehensive program would include:

- Identifying and Expressing Feelings (one session)
- Assertiveness Training (two sessions)
- Self-Esteem Training (two sessions)
- Nutrition and the Use of Medication (one session)
- Anxiety and Life Meaning (Existential-Spiritual Perspective) (one session)

A longer, 18-week treatment format incorporating the above elements constitutes, in my opinion, an ideal program for recovery. Space limitations prohibit detailed discussion of these components in this chapter. Relevant chapters of *The Anxiety and Phobia Workbook* cover them in some depth, however.

Selection and Screening

A pre-group evaluation is necessary to determine the suitability of prospective clients for the group. Generally, only those clients who meet DSM-III-R criteria for Panic Disorder with Agoraphobia or Social Phobia are appropriate for inclusion. Since so much of the work of the group focuses on desensitization to phobias, clients presenting with other types of anxiety disorder—such as "pure" panic disorder, generalized anxiety disorder, or obsessive-compulsive disorder—are likely to feel misplaced. Individuals dealing with a simple phobia, for example, who are *only* fearful of freeways or flying, and who do not have panic attacks, can utilize the group, although they may find the section on coping with panic attacks to be irrelevant to their problem.

Clients who are motivated to overcome their difficulties and are willing to make a 10- to 18-week commitment are most likely to benefit from the group. It's important to ask clients about their motivation and commitment at the outset. A moderately to severely phobic person may have no conception of the discipline needed, nor the commitment it really takes, to recover. Many phobics say "yes" emphatically, that they are ready and willing to work toward recovery. Yet when it comes right down to doing the work required, they will rationalize and avoid to extremes.

Another issue is clients' social anxiety level. Certain individuals are so

phobic about being in any group that they are likely to do better by completing a course of individual therapy focusing on communication skills such as self-disclosure and desensitization to social situations prior to entering a group. It is important to raise the issue of comfort level in a social situation with all prospective clients.

Two additional variables predict outcome in group treatment: depression and marital adjustment. Agoraphobic clients who concurrently meet DSM-III-R criteria for dysthymic disorder or major depression may be too depressed to do the homework necessary for recovery—in particular, real-life exposure to phobic situations. The moderate to severely depressed client is likely to gain support from the group, but may make little real progress until the depression abates. Individual psychotherapy helping a client to resolve life crises or interpersonal issues causing depression may be a necessary adjunct to effective group work. Sometimes these issues get resolved in the latter sessions of the extended group, which focus on feelings, assertiveness, and self-esteem.

Research has repeatedly demonstrated that clients with a spouse or partner tend to do very well when the partner is supportive of their recovery. (Munby & Johnston, 1980; Barlow, O'Brien & Lust, 1984) Conversely, when the partner is indifferent or in opposition to the treatment, the chances of success are significantly diminished. This is the reason for including clients'

partners or support persons in the group during the first seven sessions and in subsequent sessions on assertiveness and communication. It is most useful at the stage of the pre-group evaluation to explore the possibility of collusions between client and partners against recovery.

Time and Duration

Groups can be run either for 10 or 18 weeks. The shorter version focuses on providing training in relaxation, panic-reduction, desensitization, and cognitive skills and includes one field trip where clients practice *in vivo* exposure. These are the "bare essentials" for beginning recovery. The longer version adds an emphasis on interpersonal skills (assertiveness and communication, self-esteem, nutrition, medications, and personal meaning). The advantage of the 18-week group lies not only in providing clients with additional relevant skills, but in giving them a longer period of time for practicing real-life desensitization within the structured context of the group. (A second field trip, where clients practice exposure during the regular time of the group meeting, is offered in this extended version).

Group sessions typically last between one-and-a-half and two hours.

Structure

The agoraphobia treatment group works best as a closed group

consisting of eight to ten clients. When there are more than ten clients, group members don't have enough opportunity to share their experiences on a week-to-week basis. Partners or support persons of clients are included in the group during the first seven sessions to help make the group a "safe place." In the longer format, partners return for later sessions on assertiveness and communication to engage in role-plays with clients.

Attendance at all sessions is stressed. This is reinforced by having the client pay in advance for each month (or for each of three six-week segments) of the group. Clients sign agreements at the outset that they will pay for the groups at the beginning of each month or six-week segment.

The group leader takes responsibility for presenting the lesson for each week, handling clients' questions, stimulating discussion, and conducting exercises and role-plays. For the group to be successful, the leader must provide guidance and instruction to clients individually, confronting them when necessary. At the same time, he or she needs to create a supportive atmosphere, impart enthusiasm to the group, and inspire commitment in each group member to do the homework.

In addition to the leader, there is a group assistant who is preferably a recovered agoraphobic. The group assistant takes minutes of the meeting each week, reinforce the lesson discussed, and writes up a one- to two-page

summary that is mailed out to clients a day or two after each meeting. The most important function of the group assistant is to be available to clients between group meetings. Clients are encouraged to call the assistant if they have any questions or concerns during the week.

If the assistant is unavailable or unable to answer the client's questions, the group leader may be contacted instead.

Goals

The goals of the agoraphobia treatment group are fourfold:

1. To provide clients with strategies and skills for coping with panic attacks—specifically, abdominal breathing, muscle relaxation, grounding skills such as physical exertion, and cognitive skills emphasizing the use of coping statements (sessions 3 and 5).

2. To provide clients with a knowledge of how to practice both imagery and real-life desensitization as a means to overcoming their phobias. In addition, clients are given support and encouragement to practice desensitization on a regular basis at home (sessions 6 and 7).

3. To assist clients in identifying and modifying unhelpful self-talk and mistaken beliefs that contribute to their anxiety on an ongoing basis (sessions 9 and 10).

(sessions 11-14).

Ground Rules

The following ground rules are presented to clients during the first week of the group:

1. Assigned homework is to be completed and turned in each week. Homework consists of a self-monitoring form on which clients check off whether they practiced relaxation, exercise, desensitization, and cognitive restructuring or affirmations on a daily basis. Additional written homework assignments relevant to each component of the program are given each week. Completed homework is turned in to the group assistant, who takes it home and provides written comments to the client. It is given back to the group leader prior to each group meeting and is reviewed by the leader at the outset of that meeting. Both the leader and assistant repeatedly emphasize to group members during the first few weeks that completing homework is *essential* to their progress toward recovery.

2. Clients are told that the door to the group room is always left open and that anyone who feels the need to leave can do so at any time. Clients are encouraged to leave the group only *temporarily* if they are feeling anxious, to allow themselves time to calm down and recover, and then to make every effort to return to the group, if possible, for the remainder of the session. However, it's OK to leave for the day and call the

assistant afterwards if they feel that doing so is absolutely necessary.

3. Clients are encouraged to share with the group on a weekly basis what is going on in their life and any progress they're making in their recovery program. However, they are asked not to talk about specific anxiety or panic symptoms (such as heart palpitations, sweaty hands, feeling dizzy, disoriented, out of control, or fearful of something terrible happening). Agoraphobics tend to be very suggestible and are susceptible to "swapping" symptoms.

4. Clients are told to avoid watching television programs or reading newspaper articles that focus on violent or fearful themes. This only serves to aggravate their proclivity to view the outside world as an unsafe place.

5. Each week after the second session, every client is to call one other person in the group. During the second week, clients are given a list of group members with their telephone numbers and are told to call a different person each week. When they call, they are to discuss how their week has been going and any progress they've made with their program, but to avoid talking about symptoms. If clients feel shy or awkward about calling someone, it's OK for them to share that they're feeling that way—or that they can't think of anything to talk about—and to stay on the phone for just a minute or two.

   The purpose of this exercise is to help clients give and receive support, reduce their social anxiety, and foster

group cohesion.

6. It is emphasized from the outset that everything that goes on in the group is to be kept strictly confidential. If a client's partner or support person has participated in the group, it's OK to discuss the group's process with that particular person (even on weeks when they aren't in attendance), but with nobody else. Clients are permitted to record group sessions if they choose.

Starting the Group

The group needs to begin with the leader and group assistant introducing themselves. Then clients introducing themselves. I've found it helpful to have clients break up into dyads afterwards (not with their support person) for more extensive introductions. This begins the process of group members getting acquainted. Additional "get-acquainted" periods of five or ten minutes each during the first three weeks of the group, in which each client meets a new person each time, will help build an atmosphere of support and cohesiveness.

Following introductions, the ground rules mentioned in the previous section should be discussed. The leaders should acquaint clients with basic policies and procedures of the group, and distribute handouts describing ground rules, policies, and procedures.

It is very important when starting a group to emphasize the importance of doing the assigned homework. This is a good place to present anecdotal evidence that the most successful "graduates" of previous groups were the ones who consistently did homework and practiced real-life exposure.

Main Concepts and Skills

A. Concept: Development of Agoraphobia

"Agoraphobia is a complication that develops in some individuals who have experienced panic attacks. A panic attack is a sudden intense surge of anxiety that seems to be coming out of the blue, involving such symptoms as: 1) heart palpitations, 2) chest constriction and difficulty breathing, 3) dizziness or vertigo, 4) faintness, 5) sweating, 6) trembling, 7) feelings of unreality (sometimes called *depersonalization),* and 8) fears of imminent danger, such as dying, going crazy, or losing complete control. Panic attacks are so uncomfortable that when one has occurred, you may become fearful of ever again entering the situation that provided its context—especially if this is a situation you can't easily exit, such as driving on the freeway, being in an elevator, or standing in line at the checkout stand in the grocery store. Because you want to avoid future panic attacks, you start avoiding those situations in which you're afraid one might occur. It's this avoidance that really marks the beginning of agoraphobia. What you're *really* afraid of is not

so much the specific situation—the grocery store or the freeway—but of having a panic attack in such situations.

"Agoraphobia can be mild, moderate, or severe, depending on the number of situations you avoid and the degree of restriction this imposes on you. In the most severe cases, you can become housebound altogether. All agoraphobics need a "safe person" and a "safe place" where they can feel at ease and free of fear about panic. In the most extreme case, an agoraphobic cannot leave this safe place at all without panicking. In many cases, though, there are a variety of situations and places you can still deal with outside your home, and you have only a few, select phobias.

"Two secondary problems that develop with agoraphobia are *dependency* and *depression.* Being with someone you can trust—your 'safe person'—enables you to engage in activities or go places you wouldn't try alone. So you become dependent on that person, typically to a greater degree than you'd like. Depression develops because of the feelings of helplessness you get from not being able to control your panic reactions—and especially from being unable to go places and do things you used to negotiate with ease. In recovering from agoraphobia, you will gain both a greater sense of self-sufficiency and a more optimistic, hopeful outlook toward life."

B. Concept: The Agoraphobic Personality Profile

"Agoraphobia affects one in every 20 people in the United States, or about 5 percent of the population. As an agoraphobic, you have a number of special personality characteristics, many of which are quite positive, that set you apart from the 'average' person:

- You're very sensitive. You are sensitive to environmental stimuli such as temperature, light, smells, and sounds. And you are also often sensitive to other people and their feelings. Many agoraphobics have a heightened sense of intuition—some are 'psychic.'

- You probably have an above-average IQ.

- You're creative. Being both intelligent and creative, you have the best of both worlds. Typically, you have a very rich and vivid imagination. In this group, you'll learn to use your imagination positively, instead of against yourself, by magnifying your fears.

- You have intense emotions and often a high degree of emotional reactivity. This is usually an inborn trait, and it makes your experience of life more vivid and poignant. In this group, again, you can learn to make this trait work for rather than against you.

"Many famous people have this profile of characteristics and have struggled with phobias, including Johnny Carson, Barbra Streisand, Carly Simon, Bob Dylan, and Vladimir Horowitz.

"Some of the *less* positive traits you may have include:

- A lot of negative thinking—particularly 'what-if' and 'should' thinking.
- A tendency to be compulsive (doing things compulsively) or obsessive (having recurring, repetitive thoughts).
- A tendency to be a perfectionist—you can become very upset if things don't work out exactly the way you'd like them to.
- A tendency to procrastinate—you put off things you don't want to deal with. You're also very adept at avoidance and have great skill at coming up with excuses for getting out of what you don't what to do.
- You're a 'people pleaser'—from an early age you have sought others' approval and often believe that pleasing others is more important than taking care of yourself. (The modern term for this characteristic is co-dependency.)
- You're secretive—it's often difficult for you to tell anyone else about your problem. You feel ashamed of your problem and fear that others will make fun of you or regard you as 'crazy' if you talk about it.

These less positive traits are 'learned' and can therefore be unlearned and replaced with more positive patterns of thought and behavior."

C. Concept: The Causes of Agoraphobia

"There are three *levels* of causes which contribute to developing agoraphobia:

1. Long-term, predisposition causes

2. Recent causes, such as the conditions and circumstances that trigger a first panic attack

3. Maintaining causes, conditions such as negative self-talk and withheld feelings that keep the problem going

"There are three types of long-term, predisposing causes: 1) heredity, 2) your childhood environment and upbringing, and 3) cumulative stress over time. Agoraphobia tends to run in families. About 20 percent of children of an agoraphobic parent develop panic attacks or agoraphobia, while the incidence of agoraphobia in the general population is about 5 percent. More compelling evidence for the role of heredity comes from the fact that if one identical twin has problems with phobias, the other twin is up to three times more likely to have problems as well than would be the case with a pair of fraternal twins. Researchers believe that you do not inherit agoraphobia *per se* but rather a volatile, reactive nervous system that is more easily sensitized to anxiety-provoking situations. The particular type of anxiety disorder you develop, given this personality, depends on other factors.

"Apart from heredity, there are several types of dysfunctional family

circumstances that show up in the background of agoraphobics. The most common ones are as follows:

- *Your parents communicate an overly cautious view of the world.* Parents of agoraphobics—even when not explicitly phobic themselves—often are excessively concerned about potential danger to their children. They frequently attribute danger to normal childhood activities that aren't really dangerous. The child of such parents, unfortunately, learns to regard the world outside the home as a dangerous place.

- *Your parents are overly critical and set excessively high standards. A* child growing up with critical, perfectionist parents is never quite sure of his or her acceptability. As an adult, such a person may be overly eager to please, look good, and be nice at the expense of his or her needs and feelings. Having grown up feeling insecure, you have a tendency as an adult to depend on a safe person or safe place and to restrict yourself from activities involving public, performance, or social situations where there is a possibility of losing face or 'looking bad.'

- *You've grown up with emotional insecurity and dependency.* There are many kinds of disfunctional family situations that can generate deep-seated insecurity. Loss of a parent due to death or divorce can precipitate strong fears of abandonment in a child. Neglect, rejection, physical or sexual abuse, or family alcoholism also leave a child feeling very insecure. When that child responds to this insecurity with excessive dependency, the stage is set for over-reliance on a

safe person or place later in life. While agoraphobia isn't the only type of problem that can develop when a child has learned to be overly dependent, it's a common outcome.

"The third long-term, predisposing factor that contributes to the onset of panic and agoraphobia is cumulative stress. Stress can accumulate over months or years as a result of long-standing psychological problems. Or it can accumulate as the result of too many 'major life changes' (such as marriage or divorce, a change of jobs, geographical moves, health problems, a financial reversal, and so on) within a short period of time. [It's very helpful to have clients fill out the Homes-Rahe "Life Events Survey" at this point to get an estimate of their current level of cumulative stress—see Chapter 2 of *The Anxiety and Phobia Workbook.]*

"When stress isn't managed well, it tends to accumulate. The long-term effects of stress are varied. Some people develop chronic tension headaches, ulcers, or high blood pressure. Others become depressed. In those who have a genetic vulnerability to anxiety, panic attacks may be the outcome in place of a psychosomatic illness. An important implication of this is that good stress management—including relaxation, exercise, good nutrition, time management, social support, and adopting low-stress beliefs and attitudes toward life—should help reduce or eliminate your vulnerability to panic attacks."

Recent Causes

"A first panic attack is often triggered by some kind of stressful event or situation. This acts as a 'last straw,' since in most cases stress has been accumulating for many years beforehand. Among the most common precipitating events are

- *A significant personal loss*—This can be the loss of a significant person through death or divorce, the loss of employment, a financial loss, or the loss of physical health.

- *A significant life change*—Any turning point in your life cycle qualities, such as getting married, having a baby, going off to college, changing jobs, making a geographical move, and so on.

- *Stimulants or recreational drugs*—It's not uncommon for a first panic attack to develop after excessive ingestion of caffeine. Even more common is the appearance of panic attacks in people using cocaine. Amphetamines, LSD, high doses of marijuana, and withdrawal from sedatives and tranquilizers can also jolt a person into a first panic attack."

Maintaining Causes

"Maintaining causes operate in the here-and-now to keep panic attacks and agoraphobia going. Most of the skills you will be learning in this group will help you to deal with maintaining causes. The primary maintaining

causes are

1. *Phobic Avoidance*

> "Continuing to avoid facing your phobia is what maintains its hold over you. Obviously, it's very rewarding to continue this avoidance; the reward is that you're saved from having to experience anxiety. Trying to think or reason your way out of a phobia won't work as long as you continue to avoid confronting it directly.

2. *Anxious Self-Talk*

> "Self-talk is what you say to yourself in your own mind. You engage in an internal monologue much of the time, although it may be so automatic and subtle that you don't notice it unless you step back and pay attention. Much of your anxiety is created by statements you make to yourself beginning with the words 'What if'—such as 'What if I have another panic attack?' 'What if I lose control of myself while driving?' 'What will people think if I get anxious while standing in line?' This type of self-talk *anticipates* the worst in advance. The more common term for this type of thinking is simply 'worry.' You can learn to recognize anxiety-provoking self-talk, stop it, and replace it with more supportive and calming statements to yourself.

3. *Withheld Feelings*

> "Holding in feelings of anger, frustration, sadness, or even

excitement can contribute to a state of *free-floating* anxiety. Free-floating anxiety is when you feel vaguely anxious without knowing why.

"You may have noticed that after you let out your angry feelings or have a good cry, you feel calmer and more at ease. Expressing feelings seems to have a distinct physiological effect that results in reduced levels of stress and anxiety.

4. *Lack of Assertiveness*

"To express your feelings to other people, it's important that you develop an assertive style of communicating. Assertiveness, in a few words, is expressing yourself in a direct, forthright manner. It involves a healthy balance somewhere between submissiveness, where you are afraid to ask for what you want at all, and aggressiveness, where you demand what you want through coercion or threats. People who are prone to anxiety and phobias frequently tend to act submissively. They avoid asking directly for what they want and are afraid to express strong feelings, especially anger. Often they are afraid of imposing on others or of not maintaining their self-image as a pleasing and nice person. They may be afraid that assertive communication will alienate their safe person, on whom they feel dependent for their basic sense of security.

"Learning to be assertive, and to directly communicate your needs and feeling, is essential to overcoming

agoraphobia.

5. *Lack of Self-Nurturing Skills*

"Common to the background of many people with anxiety disorders is a pervasive sense of insecurity. This is especially apparent in agoraphobia, where the need to stay close to a safe place or safe person can be so strong. Such insecurity arises from a variety of conditions in childhood, including parental neglect, abandonment, abuse, overprotection, perfectionism, as well as from patterns of alcoholism or chemical dependency in the family. Since they never received consistent or reliable nurturing as children, adult survivors of these various forms of deprivation often lack the capability to properly take care of their own needs. Unaware of how to love and nurture themselves, they suffer from low self-esteem and may feel anxious or overwhelmed in the face of adult demands and responsibilities. This lack of self-nurturing skills only serves to perpetuate anxiety.

"The most lasting solution to parental abuse and deprivation is to become a good parent to yourself. In session 13 of this group, you will learn how to gain awareness of your needs and develop a nurturing relationship with your 'inner child.'" (It would be useful for ten-week group leaders to briefly discuss the relevance of self-esteem to recovery from agoraphobia and refer clients to Chapter 14 of *The Anxiety and Phobia Workbook.)*

6. *High-Stress Lifestyle*

> "Managing your stress will help reduce your vulnerability to panic attacks and anxiety in general. Mastering the concepts and skills taught in this group in connection with relaxation, exercise, nutrition, self-talk, mistaken beliefs, feelings, and assertiveness will all contribute to helping you reduce the sources of stress in your life. Other stress management skills such as time management, delegating, and pacing are described in such books as *Life after Stress,* by Martin Shaffer, and *The Relaxation and Stress Reduction Workbook,* by Martha Davis, Matthew McKay, and Elizabeth Eshelman.

7. *Lack of Meaning or a Sense of Purpose*

> "It has been my repeated experience that people experience relief from anxiety as well as phobias when they feel that their life has meaning, purpose, and a sense of direction. Until you discover something larger than personal self-gratification—something that gives your life a sense of purpose—you may be prone to feelings of boredom and a vague sense of confinement because you are not realizing all you can be. This sense of confinement can be a potent breeding ground for anxiety, phobias, and even panic attacks.
>
> "We will explore various ways of creating meaning and a broader sense of life purpose in the next-to-last session of this group.

D. Concept: Relaxation

"Relaxation is one of the most powerful tools at your disposal for overcoming anxiety and a predisposition to panic. It is at the very foundation of any program undertaken to overcome agoraphobia. The type of relaxation that really makes a difference is the *regular daily* practice of some form of *deep* relaxation. Deep relaxation refers to a distinct physiological state that is the exact opposite of the way your body reacts under stress or during a panic attack. This state was originally described by Herbert Benson (1975) as the 'relaxation response.' It involves a number of physiological changes, including:

- a decrease in heart rate
- a decrease in respiratory rate
- a decrease in blood pressure
- a decrease in skeletal muscle tension
- a decrease in metabolic rate and oxygen consumption
- a decrease in analytical thinking
- an increase in alpha-wave activity in the brain

"If you are willing to practice deep relaxation for 20 to 30 minutes per

day on a regular basis, a *generalization* of the state of relaxation to the rest of your life will occur. After several weeks of practicing deep relaxation on a regular basis, you will feel more relaxed all of the time.

"Some of the more common forms of deep relaxation include: abdominal breathing, progressive muscle relaxation, visualizing a peaceful scene, medication, autogenic training, guided imagery, biofeedback, and sensory deprivation. For the purposes of this group, we'll be focusing on the first three."

E. Skill: Abdominal Breathing

"Abdominal breathing means breathing fully from your abdomen or from the bottom of your lungs. It is exactly the reverse of the way you breathe when you're anxious or tense, which is typically shallow and high in your chest. If you're breathing from your abdomen, you can place your hand on your stomach and see it actually *rise* each time you inhale. To practice abdominal breathing, observe the following steps:

1. Place one hand on your abdomen right beneath your rib cage.

2. Inhale slowly and deeply through your nose into the bottom of your lungs (the lowest point down in your lungs you can reach). Your chest should move only slightly, while your stomach rises, pushing your hand up.

3. When you've inhaled fully, pause for a moment and then exhale fully through your mouth. As you exhale, just let yourself go and imagine your entire body going loose and limp.

4. In order to fully relax, take and release ten abdominal breaths. Try to keep your breathing *smooth* and *regular* throughout, without gulping in a big breath or exhaling suddenly. You might count each breath on the exhale, as follows:

   Slow inhale—Pause—Slow exhale (count 1)

   Slow inhale—Pause—Slow exhale (count 2)—and so on

   If you start to feel light-headed while practicing abdominal breathing, stop for 30 seconds and then start up again.

"You'll find that abdominal breathing will help to slow you down any time you feel symptoms of anxiety or panic coming on. Three or more minutes of abdominal breathing can abort a panic attack if you initiate it before the panic has gained momentum. Abdominal breathing will also counteract hyperventilation symptoms, which can be mistaken for symptoms of panic." *(Note:* An explanation of hyperventilation and how it can contribute to panic attacks may be in order here.)

F. Skill: Progressive Muscle Relaxation

"Progressive muscle relaxation is a time-honored relaxation technique

that is very helpful in reducing skeletal muscle tension, which is one of the principal contributing causes of anxiety. To best utilize it, practice the technique

- for at least 20 minutes
- at a regular time
- preferably before or one hour after a meal
- in a quiet setting
- with your head supported

"While practicing, make a decision to let go of your worries and concerns. Refrain from judging your performance or the results of the exercise. Follow these steps:

1. Clench your fists tightly. Hold them clenched for 7 to 10 seconds. You may want to count one-thousand-one, one-thousand-two, and so on, to mark off seconds.

2. Concentrate on what's happening. Feel the buildup of tension in the muscles of your hands. It may be helpful to visualize the muscles tensing.

3. After 7 to 10 seconds, release the muscles in your hands abruptly, imagining them going loose and limp. Allow relaxation to develop for at least 10 to 20 seconds before proceeding. Use

the same time intervals for all the other muscle groups in your body.

4. Tighten your biceps by drawing your forearms up toward your shoulder and "making a muscle" with both arms. Hold for 10 second, then relax for 15 to 20 seconds.

5. Tighten your triceps (the muscles on the undersides of your upper arms) by extending your arms out straight and locking your elbows. Hold and then relax.

6. Tense up the muscles in your forehead by raising your eyebrows up as far as you can. Hold...and then relax. Imagine your forehead muscles becoming smooth and limp as they relax.

7. Tense up the muscles around your eyes by clenching them tightly shut. Hold ...and then relax. Imagine sensations of deep relaxation spreading all around the area of your eyes.

8. Tighten your jaw by opening your mouth so wide that you stretch the muscles around the hinges of your jaw. Hold...and then relax. Let your lips part and allow your jaw to hang loose.

9. Tighten the muscles in the back of your neck by pulling your head way back, as if you were going to touch your head to your back. Focus only on tensing the muscles in your neck. Hold...and then relax. Since this area is often especially tight, it is good to do the tense-relax cycle twice.

10. Tighten your shoulders by raising them up as if you were going to touch your ears. Hold...and then relax.

11. Tighten the muscles around your shoulder blades by pushing your shoulder blades back, as if you were going to touch them together. Hold the tension in your shoulder blades...and then relax. Since this area is often extra tense, you might repeat the tense-relax sequence twice.

12. Tighten the muscles of your chest by taking in a deep breath. Hold for up to 10 seconds...and then relax slowly. Imagine any excess tension in your chest flowing away with the exhalation.

13. Tighten your stomach muscles by sucking your stomach in. Hold...and then release. Imagine a wave of relaxation spreading through your abdomen.

14. Tighten your lower back by arching it up. You can omit this exercise if you have lower back pain. Hold...and then relax.

15. Tighten your buttocks by pulling them together. Hold...and then relax. Imagine the muscles in your hips going loose and limp.

16. Squeeze the muscles in your thighs all the way down to your knees. You will probably have to tighten your hips along with your thighs, since the thigh muscles attach at the pelvis. Hold...and then relax. Feel your thigh muscles smoothing out and relaxing completely.

17. Tighten your calf muscles by pulling your toes toward you. Hold...and then relax.

18. Tighten your feet by curling your toes downward. Hold...and then

relax.

"The entire progressive muscle relaxation sequence should take you about 20 to 30 minutes the first time. With practice, you may decrease the time needed to as little as 15 to 20 minutes."

G. Skill: Visualizing a Peaceful Scene

"While progressive muscle relaxation is useful for relaxing your muscles, visualizing a peaceful scene will help you to relax you mind. Any scene that feels very calming to you will do. It could be a remote beach, a mountain stream, a calm lake, or an indoor scene such as a cozy fireplace or your own bedroom. It's very important in visualizing a peaceful scene to take time to see it in as much detail as possible. Focus on all the objects you can see—their colors, shapes, and sizes. Also be aware of any sounds, smells, or things in the situation you can touch." A suggested script for visualizing a peaceful scene is as follows:

> Close your eyes and imagine you're in a very peaceful, comfortable setting. It can be outdoors or indoors. It can be realistic or imaginary. You find that you feel very safe and supported there...this is a safe place. (Pause) Now look all about you and notice the colors of everything in this particular scene. (Pause) You might focus on one color in particular ...and you find this color to be very relaxing. As you feel more and more relaxed, take notice of any sounds that you can hear in this special place. (Pause) You might now focus on one sound in particular, and you find this sound to be very relaxing. Now become aware of anything that you're touching on the ground or elsewhere. How does it feel? Let these tactile sensations help to

relax you still more. Just continue allowing yourself to settle in, feeling very relaxed and at peace in this wonderful place. You're feeling very safe, secure, and at ease.

Remember that the more you picture yourself in this peaceful scene, the easier it will be to return there whenever you like. You can learn, after a while, to retreat to your own special scene—the safe place in your mind—whenever you're feeling anxious or tense.

H. Concept: Physical Exercise

"A program of regular physical exercise will help you to reduce your vulnerability to panic attacks and anxiety in general. Exercise provides a natural outlet for the excess adrenalin and physiological arousal that accompany anxiety states. It also releases muscle tension and stimulates production of endorphins in the brain, resulting in a state of increased calmness and well-being. There is some evidence that regular exercise helps to correct some of the neurophysiological imbalances associated with panic attacks.

"To optimize the anxiety-reducing effects of exercise, it is best to do an *aerobic* form of exercise at least *four times per week* for *at least 20 to 30 minutes.* Aerobic exercises include brisk walking, jogging, aerobic dancing, bicycling or riding a stationary bike, swimming, jumping rope, running in place, and ice or roller skating. If you do brisk walking, you'll want to double

the minimum time, for example, from 20 to 40 minutes, to obtain the best results.

"If you haven't been doing any type of exercise for some time, it is best to start with walking for only very short periods (from 5 to 10 minutes) of more vigorous exercise. If you have any medical conditions that might limit exercise, and experience such symptoms as high blood pressure, diabetes, chest pains, fainting spells, or joint stress—or if you are forty or older—be sure to consult with your doctor before undertaking an exercise program.

"Some people avoid exercise because they fear it will aggravate a panic attack. The state of physiological arousal accompanying vigorous exercise reminds them of the symptoms of panic. If this applies to you, you might want to do 40 to 60 minutes of walking on a daily basis; or you can very gradually build up to a more vigorous level of exercise.

"Many people find it helpful to vary the type of exercise they do. This can help reduce boredom, as well as give you the chance to exercise different body parts. Popular combinations include doing an aerobic type of exercise such as jogging or cycling three to four times per week, and a socializing exercise such as tennis, volleyball, or bodybuilding exercise twice per week.

"If you're starting an exercise program or are otherwise not used to vigorous exercise, observe the following guidelines:

1. Approach exercise gradually. Start out by exerting only 10 minutes (or to the point of being winded) every other day for the first week. Add 5 minutes to your workout time each successive week until you reach 30 minutes.

2. Give yourself a one-month trial period. Make a commitment to stay with your program for at least a month despite aches, pains, inertia, or resistance. By the end of a month, you may find exercise to be sufficiently rewarding so that you will want to continue.

3. Expect some discomfort initially. Aches and pains are normal when you start out, but disappear as you gain strength and endurance.

4. Find ways to reward yourself for maintaining a commitment to your exercise program.

5. Warm up before exercising by doing some toe-touches and jumping jacks. When you're finished with vigorous exercise, cool down by walking around for 2 or 3 minutes.

6. Avoid exercising within 90 minutes of a meal or when you feel overstressed.

7. Stop exercising if you experience any sudden, unexplainable body pains or other symptoms.

8. If you find yourself getting bored with exercise, find a partner to go with you or a form of exercise requiring a partner.

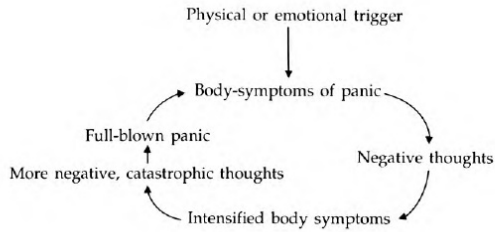
9. Exercise more than once per week. It's stressful to your body to exert vigorously then fall out of shape before you exert again.

10. Work toward the goal of doing aerobic exercise four to five days per week for 20 to 30 minutes each session."

I. Concept: The Panic Cycle

"A panic attack is a sudden surge of mounting physiological arousal that can occur out of the blue or in response to encountering—or merely thinking about—a phobic situation. Physical symptoms include: heart palpitations, tightening in the chest, shortness of breath, dizziness, faintness, sweating, trembling, shaking, or tingling in the hands and feet. Psychological reactions that accompany these bodily changes include: intense desire to run away, feelings of unreality, and fears of having a heart attack, going crazy, or doing something uncontrollable.

"The panic cycle involves a reciprocal interaction between bodily symptoms of panic and fearful thoughts. The cycle looks like this:



"Hyperventilation may, in some cases, be added to the loop. Rapid, shallow breathing during early stages of panic may produce hyperventilation symptoms such as tingling in the hands and feet, dizziness, disorientation, and feelings of unreality. Be aware, however, that panic attacks can produce these symptoms in the absence of hyperventilation."

The following concepts are very useful for learning to cope with panic attacks:

J. Concept: Panic Attacks Are Not Dangerous

"Recognize that a panic attack is nothing more than the well-known fight-or-flight response occurring out of context. This is a natural bodily response that enables you (and all other mammals) to be alerted to and quickly flee a truly life-threatening situation. What makes a panic attack hard to cope with is that this intense reaction occurs *in the absence of any immediate or apparent danger.* Or, in the case of agoraphobia, it occurs in

situations that have no immediate life-threatening potential (standing in line at the grocery store or being at home alone). Because there is no apparent, external danger in a panic attack, you tend to *invent or attribute danger* to the intense bodily symptoms you're going through. Your mind can very quickly go through the process: 'If I feel this bad, I must be in some danger. If there is no apparent external danger, the danger must be inside of me.'

"In short, you may imagine that heart palpitations will lead to a heart attack, that your constricted breathing will lead to suffocation, that dizzy sensations will result in fainting, or that you will lose control and 'go crazy.' In fact, none of these ever occurs. You can't have a heart attack from a panic attack. Your heart is made of very strong and dense muscle fibers. According to Dr. Claire Weekes, a noted authority on panic, a healthy heart can beat 200 beats per minute for days—even weeks—without sustaining any damage. Electrocardiogram tracings of panic attacks show rapid heartbeat, but none of the types of abnormalities seen in individuals with heart conditions. By the same token, you can't suffocate from a panic attack. Your brain has a built-in reflex mechanism that will *force* you to breathe if you're not getting enough oxygen. Feelings of faintness or dizziness may come on because of reduced circulation to the brain during panic, but you won't faint. These sensations can be relieved by slow, abdominal breathing. It's also important to know that agoraphobics *never* lose control or 'act crazy.' It's unheard of.

"The upshot of all this is that a panic attack is not dangerous. If you can convince yourself of this at the time panic occurs, you may significantly reduce the intensity of your reaction."

K. Concept: Don't Fight Panic

"It's important to avoid fighting a panic attack, for example, tensing up against panic symptoms or trying to 'make' them go away. This only creates more muscle tension, which is one of the contributing causes of panic. In her books, *Hope and Help for Your Nerves* and *Peace from Nervous Suffering,* Claire Weekes describes a four-step process that many people have found very helpful:

1. *Face panic symptoms* rather than running from them. Instead of telling yourself, 'I can't handle this,' you might say, 'This will pass...I've handled it before and I'll manage it this time, too.'

2. *Accept* what your body is going through. Again, don't fight panic. Work on adopting an attitude of acceptance. Ideally, learn to *observe* your body's state of physiological arousal, no matter how uncomfortable it may be, instead of reacting to it.

3. *Float* with the 'wave' of a panic attack, instead of forcing your way through it. You might imagine that you are literally riding a wave, moving with the upsurge and gradual fading out of panic. Realize that it takes only a few minutes for most of the adrenalin produced by panic to be reabsorbed, so that the

worst will be over quickly.

4. *Allow time to pass.* Realize that reactions you're going through are time-limited. Say to yourself, 'This will pass,' and engage in some distracting activity such as conversation, moving around, abdominal breathing, or repeating positive statements until the reaction subsides."

L. Concept: Separate First From Second Fear

"Claire Weekes makes a distinction between first fear and second fear. First fear consists of the physiological reactions underlying panic; second fear involves making yourself afraid of these reactions by saying such scary things to yourself as: 'I can't stand this!' 'I'm going to have a heart attack!' 'I've got to get out of here right now!' Try to keep this distinction in mind when panic symptoms come on. Instead of scaring yourself (second fear) about your body's reactions, you can move with them and make such reassuring statements as: 'These are just exaggerated bodily symptoms. I can go with them until they pass' or 'I've handled this before, and I can do so now.'" A list of positive coping statements that clients can use to help them float through a panic attack is on the next page. This can be used as a handout.

M. Skill: Learn To Distinguish the Early Stages of Panic—The Anxiety Scale

"With practice you can learn to identify the preliminary signs in yourself

that a panic attack may be imminent. For some people this may be signaled by a sudden increase in heartbeat. For others it might be a tightening in the chest, sweaty palms, or queasiness in the stomach. Most people experience some type of preliminary symptoms before a 'point of no return' is reached beyond which a significant panic attack is inevitable.

"It's possible to distinguish different levels or degrees of anxiety by using a ten-point scale:

The Anxiety Scale[1]

7-10	*Major Panic Attack*	All of the symptoms in Level six exaggerated; terror; fear of going crazy or dying; compulsion to escape
6	*Moderate Panic Attack*	Palpitations; difficulty breathing; feeling disoriented or detached (feeling of unreality); panic in response to perceived loss of control
5	*Early Panic*	Heart pounding or beating irregularly; constricted breathing; spaciness or dizziness; definite fear of losing control; compulsion to escape
4	*Marked Anxiety*	Feeling uncomfortable or "spacey"; heart beating fast; muscles tight; beginning to wonder about maintaining control
3	*Moderate Anxiety*	Feeling uncomfortable but still in control; heart starting to beat faster; fast breathing; sweaty palms
2	*Mild Anxiety*	Butterflies in stomach; muscle tension; definitely nervous
1	*Slight Anxiety*	Passint'twinge' of anxiety; feeling slightly nervous
0	*Relaxation*	Calm, a feeling of being undistracted and at peace

Coping Statements

Use any or all of the following positive statements to help you cultivate attitudes of acceptance, "float," and allow time to pass during a panic attack. You may find it helpful to repeat a single statement over and over again—in conjunction with deep, abdominal breathing—during the first minute or two when you feel panic symptoms coming on. If one statement gets tiresome or seems to stop working, try another.

This feeling isn't comfortable or pleasant, but I can accept it.

I can be anxious and still deal with this situation.

I can handle these symptoms or sensations.

This is not an emergency. It's okay to think slowly about what I need to do.

This is not the worst thing that could happen.

I'm going to go with this and wait for my anxiety to decrease.

This is an opportunity for me to learn to cope with my fears.

I'll just let my body do its thing. This will pass.

I'll ride this through—I don't need to let this get to me.

I deserve to feel okay right now.

I can take all the time I need to let go and relax.

I can always leave if I need to.

There is no need to push myself. I can take as small a step forward as I choose.

I've survived this before and I'll survive this time, too.

I can do what I have to do in spite of anxiety.

This anxiety won't hurt me—it just doesn't feel good.

This is just anxiety—it won't hurt me.

This is just anxiety—I'm not going to let it get to me.

Nothing serious is going to happen to me.

Fighting and resisting this isn't going to help—so I'll just let it pass. These are just thoughts—not reality.

I don't need these thoughts—I can choose to think differently.

This is not dangerous.

So what.

"Although the level of symptoms at the various levels of this scale are typical, they may not correspond exactly to the specific symptoms that you experience. The important thing is to identify what constitutes a Level 4 for you. This is the point where—whatever symptoms you're experiencing—you feel that your control over your reaction is beginning to drop out. Up to and through Level 3, you may be feeling very anxious and uncomfortable, but you still feel that you're managing what's going on. Starting at Level 4, you begin

to wonder whether you can control what's happening, which leads you to panic even further. With practice you can learn to catch yourself—to abort a panic reaction—before it reaches this point of no return. The better you become at recognizing the early warning signs of panic—up through Level 4 on the scale, the more control you will gain over your panic reactions."

N. Skill: Learning To Retreat

"When your anxiety reaches Level 4 on the Anxiety Scale and you associate that anxiety with a particular situation, *retreat* from the situation. Staying in a situation when anxiety begins to get out of control (Level 4 or above) will *sensitize* you to that situation. If you aren't phobic toward the situation, you could become so. If you already have a phobia about the situation, that phobia will be reinforced. *Retreating is not escaping.* Retreat simply means that you temporarily withdraw from a situation, allow your anxiety to subside down to Level 1 on the Anxiety Scale, and then *return* to the situation. If your anxiety reaches Level 4 while driving, retreat by pulling off the road as soon as you can, getting out of your car, and walking around. If your anxiety reaches Level 4 while standing in line at the grocery store, put your groceries down and retreat outside until you feel better, then return. Work on letting go of concerns about what other people will think about your actions.

"Learning to retreat is *essential* to your recovery from agoraphobia. You will use this skill again and again when you start practicing real-life desensitization."

O. Skill: Using Diversion Techniques To Reduce Panic

"Any technique that helps to redirect your attention away from bodily symptoms as well as from fear-evoking thoughts during the early stages of panic will stop the reaction from gaining momentum. Many people have found that the following techniques will abort a panic attack before it reaches Level 4 or 5 on the Anxiety Scale:

- Talk to another person
- Move around or engage in physical activity
- Engage in a simple, repetitive activity (in a grocery store, for example, count the number of cans on the shelf or count the money in your wallet)
- Do something requiring concentration (read a magazine, solve puzzles, knit or sew, calculate or compute, or play a musical instrument)
- Express angry feelings (pound a pillow or hit your bed with a plastic bat—do *not* vent anger on people)
- Experience something immediately pleasurable (for example,

receive a hug, have sex, soak in your bathtub)

- Practice thought stopping. Shout 'stop' several times and/or visualize a large stop sign. This will help disrupt a chain of negative thoughts. Follow this by repeating a positive affirmation."

P. Skill: Use Abdominal Breathing To Reduce Panic

"When panic symptoms come up to Level 4 on the Anxiety Scale, use the abdominal breathing skill previously described. Continue with slow, regular abdominal breathing—inhaling through your nose and exhaling through your mouth—for two to three minutes. This practice alone will help reduce the intensity of your physiological reactions. At Level 4, it's also helpful to use progressive muscle relaxation techniques, but confined to the arms, head, neck, and shoulders only. Focus on the areas that hold the most tension."

Q. Skill: Use Coping Statements To Reduce Panic

"Negative self-talk always aggravates panic, creating the 'second fear' that was described earlier. If you can learn to replace negative self-talk with positive coping statements, you will eliminate or at least diminish the severity of your panic reactions. Select three or four coping statements from the list in Section L. Write these down on a 3 by 5 card and keep it in your purse or wallet. When symptoms come on, pull out the card and repeat one of the

coping statements again and again. It may be necessary to do this for three or four minutes—but with practice, you'll find the technique to be effective.

"You may want to combine this skill with the abdominal breathing skill previously described."

R. Concept: Desensitization

"Sensitization and desensitization are important concepts in understanding phobias. *Sensitization* is a conditioning process in which you learn to associate anxiety with a particular situation (or with an internal thought, sensation, feeling, or memory). For example, if you were to panic while sitting in an airplane or in a restaurant, you might acquire a strong association between being in these situations and being anxious. Thereafter, being in, near, or perhaps just thinking about the particular situation might trigger your anxiety again. An automatic connection between the situation and a strong anxiety response is established—a connection that is seemingly beyond your control. To avoid experiencing anxiety, you also avoid the situation to which you've become sensitized: and so a phobia is established.

"Desensitization is the process of unlearning an unwanted connection between anxiety and a particular situation (or object, animal, person, and so on). For desensitization to occur, you need to experience a different kind of response to a situation that initially causes you to feel phobic, a response that

is *incompatible* with anxiety. One such response is *relaxation.* If you can experience relaxation (or a relative state of relaxation) in the presence of a situation or object that typically elicits anxiety for you, you will *unlearn* your anxiety response and replace it with another. This response can simply involve having *no* adverse reactions; or may be characterized by a relative degree of relaxation.

"There are two kinds of desensitization: *imagery desensitization* and *real-life desensitization.* In imagery desensitization, you *visualize* while you're deeply relaxed being in a situation that makes you feel phobic. Should any anxiety arise, you retreat from the phobic scene in your mind and imagine yourself in a peaceful scene instead. When you're fully relaxed, you return in your imagination to the phobic scene. In real-life desensitization, you confront a phobic situation directly, but retreat to a safe place if your anxiety exceeds Level 4 on The Anxiety Scale. Other terms for real-life desensitization are *in vivo desensitization, exposure therapy,* or simply *exposure.* In both types of desensitization, the idea is to: 1) unlearn the connection between a particular situation and an anxiety response, and 2) re-associate feelings of calmness and relaxation with that situation.

"It's generally a good idea to practice imagery desensitization first with a particular phobia before undertaking real-life desensitization. Much of your anxiety about a phobia is attached to internal thoughts and fantasies about

the situation anyway; desensitizing in fantasy initially will help make it easier for you to confront the situation in real life. Also, there are some phobic situations (such as airplane travel or taking a professional exam) for which it would be inconvenient or expensive to practice your desensitization in real life."

S. Concept: The Phobia Hierarchy—Facing What You Fear in Small Increments

"You can construct a series of scenes (or real-life situations) relating to your phobia which are graduated as a hierarchy, ranging from scenes that are mildly anxiety-provoking to those that produce full-blown panic. The hierarchy makes the task of facing a phobia much easier by breaking it down into many small steps. You begin by facing a very mild instance of your phobia, and do not proceed to confront the next step up in the hierarchy until you're completely comfortable with step one. Continue this process of getting used to each step in the hierarchy, all the way up to the most anxiety-producing step at the top. This is *incremental desensitization.* Two examples of hierarchies follow. Note that a good hierarchy contains at least 8, and as many as 20 steps.

"Phobia About Driving on Freeways

Visualize:

1. Watching cars on the freeway from a distance.

2. Riding in a car on the freeway with someone else driving. (This could be broken into several steps, varying the distance or time on the freeway.)

3. Driving on the freeway for the distance of one exit with a friend in the car at a time when there is little traffic.

4. Driving for the distance of one exit with a friend when the freeway is busier (but not at rush hour).

5. Repeat Step 3 alone.

6. Repeat Step 4 alone.

7. Driving for the distance of two exits with a friend when there is little traffic.

8. Driving for the distance of two exits with a friend when there is moderate traffic.

9. Repeat Step 7 alone.

10. Repeat Step 8 alone.

"In steps above Level 10, you would increase the distance you drive and also include driving during rush-hour conditions.

"Phobia About Getting Injections

Visualize:

1. Watching a movie in which a minor character gets a shot.

2. A friend talking about her flu shot.

3. Making a routine doctor's appointment.

4. Driving to a medical center.

5. Parking your car in the medical center parking lot.

6. Thinking about shots in the doctor's waiting room.

7. A woman coming out of the treatment room rubbing her arm.

8. A nurse with a tray of syringes walking past.

9. Entering an examination room.

10. The doctor entering the room and asking you about your symptoms.

11. The doctor saying that you need an injection.

12. The nurse entering the room with injection materials.

13. The nurse filling a syringe.

14. Alcohol being applied to a cotton ball.

15. Seeing the hypodermic poised in the doctor's hand.

16. Receiving a penicillin shot in the buttocks.

17. Receiving a flu shot in the arm.

18. Having a large blood sample taken."

T. Skill: Constructing an Appropriate Phobia Hierarchy

"A well-constructed hierarchy allows you to approach a phobic situation gradually and incrementally. Use these guidelines:

1. Choose the particular phobic situation you want to work on—for example, going to the grocery store, driving on the freeway, giving a talk in front of a group.

2. Imagine a very mild instance of having to deal with this situation, one that hardly bothers you at all. You can create a mild instance by imagining yourself somewhat removed in space or time from full exposure to the situation—for example, parking in front of the grocery store without going in, or imagining that it is one month before you have to give a presentation. Or you can diminish the difficulty of the situation by visualizing yourself with a supportive person. Try to create a very mild instance of your phobia and designate it as the first step in your hierarchy.

3. Now imagine what would be the strongest or most challenging scenario relating to your phobia and place it at the opposite

extreme—the highest step in your hierarchy. For example, if you're phobic about grocery stores, your highest step might be waiting in a long line at the checkout counter by yourself. For air travel, such a step might be taking off on a transcontinental flight, or encountering severe air turbulence midflight. For public speaking, you might imagine giving a presentation to a *large crowd,* giving a *long presentation,* or speaking on a very *demanding topic.* See if you can identify what specific parameters of your phobia make you more or less anxious, and use them to develop scenarios of varying intensity.

4. Now take some time to imagine six or more other scenes of varying anxiety-provoking potential relating to your phobia. Place these in ascending order between the two extremes you've already defined. Use the sample hierarchies to assist you.

5. Generally, 8 to 12 steps in a hierarchy are sufficient, although in some cases you may want to include as many as 20. Having fewer than 8 steps is usually insufficient.

6. Sometimes you may find it difficult to go from one step to the next in your hierarchy. You may be able to relax within the scene you placed at Step 5; but become very anxious when you visualize Step 6. In this instance you need to construct an *intermediate* scene (at 5V2) that can serve as a bridge between the two original scenes.

If you have difficulty getting over anxiety in reaction to the initial scene in your hierarchy, you need to create a still less

anxiety-provoking scene to start out with."

U. Skill: Practicing Imagery Desensitization

"Success with imagery desensitization depends on four things: 1) your ability to enter into a deep state of relaxation, 2) the vividness and detail with which you visualize phobic scenes as well as your peaceful scene, 3) having enough steps—or small enough increments—in your hierarchy, and 4) your willingness to practice on a regular basis.

"In practicing imagery desensitization, follow these steps:

1. *Relax.* Spend 10 to 15 minutes getting very relaxed. Use progressive muscle relaxation or any other relaxation technique that works for you.

2. *Visualize yourself in your peaceful scene.* Get comfortable in the peaceful scene you learned to visualize in the previous session on relaxation.

3. *Visualize yourself in the first scene in your phobia hierarchy.* Stay there for 30 seconds to 1 minute, trying to picture everything with as much vividness and detail as possible, as if you were 'right there.' If you feel little or no anxiety (below Level 2 on the Anxiety Scale), proceed to the next scene up in your hierarchy.

4. If you experience *mild to moderate* anxiety—a Level 2 or 3 on the

Anxiety Scale—spend 30 seconds to 1 minute in the scene, allowing yourself to relax within it. You can do this by breathing away any anxious sensations in your body or by repeating a soothing affirmation such as 'I am calm and at ease.' Picture yourself handling the situation in a calm and confident manner.

5. After about a minute of exposure, retreat from the phobic scene to your peaceful scene. Spend about 1 minute in your peaceful scene or long enough to get fully relaxed. Then *repeat* your visualization of the same phobic scene as in Step 4. Keep alternating between a given phobic scene and your peaceful scene (about 1 minute each) until the phobic scene loses its power to elicit any (or more than very mild) anxiety. You are then ready to proceed to the next step up in your hierarchy.

6. If visualizing a particular scene causes you strong anxiety, Level 4 or above on the Anxiety Scale, do not spend more than 10 seconds there. Retreat immediately to your peaceful scene. Accustom yourself gradually to the difficult scene, alternating short intervals of exposure with retreat to your peaceful scene. If a particular step in your hierarchy continues to cause difficulty, you probably need to add an additional step, one that is intermediate in difficulty, between the last step you completed successfully and the one that is troublesome.

7. Continue progressing up your hierarchy step by step in imagination. Generally, it will take a minimum of two exposures to a scene to reduce your anxiety within it. Keep

in mind that it's important not to proceed to a more advanced step until you're completely comfortable with the step before. Practice 15 to 20 minutes each day, and begin your practice not with a new step, but with the last step that you successfully negotiated. Then proceed to a new step."

V. Skill: Practicing Real-Life Desensitization

"In practicing real-life desensitization, observe the following steps:

1. *Use the hierarchy you developed for imagery desensitization. Note that it may be* necessary to add some additional intermediate steps in your hierarchy when exposing yourself to a phobia in real life.

2. *Enter and/or stay in your phobic situation (whatever step in your hierarchy* you're on) *up to the point where your anxiety reaches Level 4* on the Anxiety Scale—the point where your anxiety *first begins to feel a little unmanageable.* Even if you are uncomfortable in the situation, *stay with it* as long as your anxiety does not go beyond Level 3.

3. *Retreat* from the situation at the point where your anxiety reaches Level 4. Retreat means *temporarily* leaving the situation until you feel better, and then *returning.* Retreat is *not* escaping or avoiding the situation. It is designed to prevent you from 'flooding' and risking the possibility of re-sensitizing yourself to the situation.

4. *Recover.* After you have temporarily pulled back from your phobic

situation wait until your anxiety goes back down to Level 1 or 2 on the Anxiety Scale.

5. *Repeat.* After recovering, reenter your phobic situation and 1) keep going into it or 2) stay with it up to the point where your anxiety once again reaches Level 4. If you are able to go further or stay longer in the situation than you did before, fine. If not—or if you can't even go as far as you did the first time—that's fine, too. Progression and regression in terms of what you can tolerate are all part of the exposure therapy.

6. Continue going through the above cycle—Expose—Retreat - Recover—Repeat—until you begin to feel tired, then stop for the day. Your daily practice session can take from 30 minutes to 2 hours. The limit as to how far you go in any practice session can be determined by the point where your anxiety reaches Level 4 on the Anxiety Scale."

W. Concept: Utilize a Support Person

"It's often very helpful to rely on a person you trust (spouse, partner, friend, helping professional) to accompany you into the phobic situation when you first begin *in vivo* work. The purpose of the support person is to provide 1) reassurance and safety, 2) distraction (the person usually is talking with you), 3) encouragement to persist with practice, and 4) praise for small successes.

"Your support person should *not* push you. It's good for him or her to

encourage you to enter a phobic situation without running away. Yet it is up to you to decide on the amount of exposure you want to undergo, and when you have reached Level 4. Your support person should not criticize your practice or tell you to try harder. Yet it is good if he or she can recognize any resistance on your part and help you ask yourself whether any resistance is present. Mainly the support person's job is to provide encouragement and support without judging your performance." Guidelines for the support person can be found in Section CC.

X. Concept: Dealing With Resistance

"Undertaking exposure to a situation you have been avoiding may bring up resistance. Notice if you start procrastinating or putting off getting started with your exposure sessions by saying, 'I'll do it later.' The mere thought of actually going into a phobic situation may elicit strong anxiety, a fear of being trapped, or self-defeating statements to yourself such as: 'I'll never be able to do it/ or 'This is hopeless.' Instead of getting stuck in resistance, regard it as a major therapeutic opportunity to learn about yourself and to work through long-standing avoidance patterns or excuse-making that has held up your life."

Y. Concept: Tolerating Some Discomfort

"Facing situations that you have been avoiding for a long time is not particularly comfortable or pleasant. It is inevitable that you will experience some anxiety. In fact, it's common to feel *worse initially* when undertaking exposure therapy before you feel better. Recognize that feeling worse is *not* an indication of regression, but rather that exposure is really *working.* Feeling worse means that you are laying the foundation to feel better. As you gain more skill in handling symptoms of anxiety when they come up during exposure, your practice sessions will become easier, and you'll gain more confidence about following through to completion."

Z. Concept: Reward Yourself for Small Successes

"People going through *in vivo* exposure often fear that they're not moving fast enough. There is no standard or 'correct' speed for progress. What's important is to consistently reward yourself for small successes. For example, being able to go into a phobic situation slightly further than the day before is worthy of giving yourself a reward such as a new piece of clothing or dinner out. So is being able to stay in the situation a few moments longer—or being able to tolerate anxious feelings a few moments longer. Rewarding yourself for small successes will help substantially to maintain your motivation to keep practicing."

AA. Concept: Practice Regularly

"Regular practice—rather than hurrying or pressuring yourself—will produce the most time-efficient results. Optimally, it is good to go out and practice three to five times per week. Longer practice sessions, with several trials of exposure to your phobic situation, tend to produce more rapid results than shorter sessions. As long as you retreat when appropriate, it's impossible to practice too much exposure in a given session (the worst that can happen is that you might end up somewhat tired or exhausted).

"The *regularity* of your practice will determine the rate of your recovery. If you're not practicing regularly, notice the excuses you're making to yourself and sit down with someone else to discuss their legitimacy. Regular practice of exposure is *the key* to a full and lasting recovery."

BB. Concept: Expect and Know How To Handle Setbacks

"Having a setback—in other words, not being able to tolerate as much exposure to a situation as you did in a previous session—is a *normal* part of recovery. Recovery simply doesn't proceed in an upward linear fashion—there are plateaus and regressions, as well as times of moving forward. It's very important not to let a setback discourage you from further practice. Simply chalk it up to a bad day or bad week and learn from it. Appreciate that nothing can take away the progress you've made up to the point of the setback. You can use each setback as a learning experience that will tell you

more about how to best proceed in mastering a particular phobic situation. A setback can be a good learning experience. It only means you went too far, too fast."

CC. Skill: Support Person Skills

The following skills are taught by the group assistant to clients' support persons during Week 7. In this session, support persons split off from the rest of the group.

1. Before practicing, communicate clearly about what the phobic expects of you during practice. Does she want you to talk a lot to her? Stay right with her? Follow behind her? Wait outside? Hold her hand?

2. Let your phobic partner pick the goal she wishes to work on during a practice session—not the goal you're interested in.

3. Be familiar with the phobic's early warning signs of anxiety. Encourage her to verbalize when she's becoming anxious. Be willing to ask her from time to time how she's doing.

4. Don't allow your partner's distress to rattle you. Remember that reason isn't always present when someone panics. If your partner panics, quietly lead her to safety, end the practice session for the day, and go home with her. Above all, don't leave her alone.

5. Be where you say you're going to be during a practice session. Don't move to another location because you want to test your partner. It can be very frightening for the phobic to return to a prearranged meeting place to find you gone.

6. Don't push a phobic person! She knows what is going on in her body and may panic if pushed further than she's ready to go at the moment.

7. On the other hand, encourage your partner to make the most out of practice. It's better to attempt to enter a situation and have to retreat than not to try at all. If you feel that your partner's resistance is preventing her from undertaking practice or from making progress with practice, ask: 'Do you think something is getting in the way of your progress?' Assist her in identifying and exploring any resistance.

8. Let the phobic have responsibility for her own recovery. Be supportive and encouraging, but avoid trying to step in and do it all for her. This will only undermine her confidence.

9. Try to see things from the phobic's point of view. Things that seem insignificant to others, such as walking down a street or eating in a restaurant, may involve a great deal of work and courage for the phobic to achieve for even a short period of time. These accomplishments, and the efforts leading to them, should be recognized.

10. Phobics generally are very sensitive and need a great deal of praise for every step they take. Be sure to give your partner recognition for small achievements. Praise her for whatever

she accomplishes and be understanding and accepting when she regresses.

11. Encourage practice with rewards. For example, you might say: 'When you can handle restaurants, let's have lunch together somewhere special.'

12. Accept the phobic's bad days and reinforce the idea that she can't have a perfect day every time. It's natural that there will be times of backsliding.

13. It may be necessary to readjust you own schedule in order to facilitate your partner's practice. Be sure that you are willing to make a commitment to work with your partner regularly over a sustained period of time before offering to be a support person.

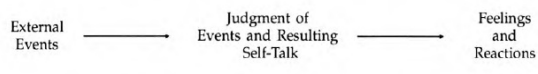
14. Know your own limits. If your capacity to be supportive has been stretched to the limit, take a break. Avoid expecting yourself to be perfect."

DD. Concept: Self-Talk and Anxiety

"What we say to ourselves in response to any particular situation is what mainly determines our mood and feelings. Imagine two individuals sitting in stop-and-go traffic at rush hour. One perceives himself as trapped and says such things to himself as 'I can't stand this,' 'I've got to get out of here,' 'Why did I ever get myself into this commute?' He feels anxiety, anger, and

frustration. The other perceives the situation as an opportunity to lay back, relax, and put on a new tape. He says such things to himself as 'I might as well go with the flow,' or 'I can unwind by doing some deep breathing.' What he feels is a sense of calmness and acceptance. In both cases, the situation is exactly the same, but the feelings in response to that situation are vastly different.

"What you tell yourself happens so quickly and automatically that you don't even notice it, and so you get the impression that the external situation 'makes' you feel the way you do. But it's really your judgments and thoughts about what is happening that lead to your feelings. This sequence can be represented as



"In short, you are largely responsible for how you feel. This is a profound and very important truth—one that it takes many individuals a long time to fully grasp. It's often much easier to blame the way you feel on something or someone else than to take responsibility for your reactions. Yet, it is precisely through your willingness to accept that responsibility that you will be able to take charge and have mastery over your life.

"People who have phobias, panic attacks, and general anxiety (or

depression) are especially prone to engage in negative self-talk. Anxiety can be generated on the spur of the moment by repeatedly making statements to yourself by repeatedly making statements to yourself that begin with the two words 'What if.' Whenever you experience anxiety in advance of confronting a difficult situation, it's likely that you have 'what-ifed' yourself into it. If you finally decide to avoid a situation, it may be because you've asked yourself 'What if I panic?' 'What if I can't handle it?' or 'What will other people think?' Just noticing when you fall into 'What if' thinking is a first step in the direction of gaining control over negative self-talk. The real change occurs when you begin to *counter* and *replace* negative 'What if' statements with positive, self-supportive statements such as 'So what,' 'These are just thoughts,' 'This is just scare talk,' 'I can handle this,' 'I can breathe, let go and relax,' and so on. There are several basic points about self-talk to keep in mind:

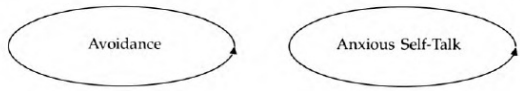
1. Self-talk is usually so *automatic* and *subtle* that you don't notice it or the effect it has on your moods and feelings. You react without noticing what you told yourself right before you reacted.

2. Self-talk often *appears in telegraphic form.* One short word or image contains a whole series of thoughts, memories, or associations.

3. Self-talk is typically *irrational but almost always believed.* For example, anxious 'what if' thinking leads you expect the worst possible outcome, one that is highly unlikely to

happen. Yet, because it occurs so quickly, it goes unchallenged and unquestioned.

4. Self-talk *perpetuates avoidance.* You tell yourself that a situation such as the freeway is dangerous, and so you avoid it. By continuing to avoid it, you reinforce the thought that it is dangerous.



5. Negative self-talk is a series of bad habits. You aren't born with a predisposition to fearful self-talk—you learn it. Just as you can replace unhealthy behavioral habits, such as smoking or drinking excess coffee, with more positive, health-promoting behavior, so can you replace unhealthy thinking with more positive, supportive mental habits."

EE. Concept: Self-Talk Sub-personalities

"Not all negative self-talk is the same. Human beings are complex, with different aspects or facets that are sometimes referred to as 'sub-personalities.' These different voices or parts of yourself can defeat you with different types of negative inner dialogue. Four of the more common sub-personalities that are prominent in anxiety-prone people include: the *Worrier,* the *Critic,* the *Victim,* the *Perfectionist.*

1. The Worrier (promotes anxiety)

> "Often this is the strongest subpersonality in people who are prone to anxiety. Playing a greater role in directly generating anxiety than the critic, victim, or perfectionist described below. The Worrier's dominant tendencies include: a) anticipating the worst, b) fearing the future, and c) creating grandiose images of potential failure or catastrophe. The Worrier is always vigilant, watching with uneasy apprehension for any small symptoms or signs of trouble.
>
> "By far the favorite expression of the Worrier is 'What if....'"

2. The Critic (promotes low self-esteem)

> "The Critic is that part of you that is constantly judging and evaluating your behavior. It tends to point out your flaws and limitations whenever possible. It jumps on any mistake you make to remind you that you're a failure. It likes to compare you with others, and usually sees them coming out favorably.
>
> "The Critic's favorite expressions include: 'You stupid....' 'Can't you ever get it right?' 'Why am I always this way?' 'Look at how capable _____ is.' 'You could have done better.' 'You'd better do it over.'"

3. The Victim (promotes depression)

> "The Victim is that part of you that feels helpless or

hopeless, and plays a major role in depression. It has a tendency to believe that there is something inherently wrong with you—you are in some way deprived, defective, or unworthy. The Victim always perceives insurmountable obstacles between you and your goals. Characteristically, it bemoans, complains, and regrets things as they are at present.

"The Victim's favorite expressions include: 'I can't.' 'It's useless.' 'I'll never be able to.' 'Why bother?' 'I don't care anymore.'"

4. The Perfectionist (promotes chronic stress and burnout)

"The perfectionist is a close cousin of the critic, and may make self-critical remarks. However, its concern is less to put you down than to push and goad you to do better. It is the hard-driving part of you that wants to be best, and is intolerant of mistakes or setbacks. It has a tendency to try to convince you that your self-worth, rather than being inherent, is dependent on external qualities such as: a) vocational achievement, b) money and status, c) being accepted by others, d) being pleasing and nice to others. It is common for the Perfectionist to push you into stress, exhaustion, and burnout, despite warning signals from your body.

"Some of the Perfectionist's favorite expressions include: 'I should.' 'I have to.' 'I must.' 'If you can't do it right, don't do it at all.'"

FF. Skill: Identifying and Countering the Self-Talk of Sub-personalities

"Take some time to reflect on how each of the sub-personalities plays a role in your thinking, feelings, and behavior. Which of the four is strongest and which is weakest for you? What does each characteristically say to you? How might you begin to counter the negative statements used by each against you?

"To get started, here are some examples of positive counterstatements that you can use with each of your sub-personalities:

The Worrier

"Instead of 'What if ...,' you can say:

'So what.'

'I can handle this.'

'I can be anxious and still do this.'

'This may be scary, but I can tolerate a little anxiety, knowing that it will pass.'

'I'll get used to this with practice.'

'I can retreat if necessary.'"

The Critic

"Instead of putting yourself down, you can say:

'I'm okay the way I am.'

'I'm lovable and capable.'

'I'm a unique and creative person.'

'I deserve the good things in life as much as anyone else.'

'I accept and believe in myself.'

'I'm worthy of others' respect.'"

The Victim

"Instead of feeling hopeless, you can say:

'I don't have to be all better tomorrow.'

'I can continue to make progress one step at a time.'

T acknowledge the progress that I've made and will continue to improve.'

'It's never too late to change.'

'I'm willing to see the glass as half-full rather than half-

empty.'"

The Perfectionist

"Instead of demanding perfection, you can say:

'It's okay to make mistakes.'

'Life is too short to be taken so seriously.'

'Setbacks are part of the process and a necessary learning experience.'

'I don't have to always be .'

'My needs and feelings are at least as important as anyone else's.'"

GG. Concept: Cognitive Distortions

"Anxious people actually think in distorted, unrealistic, or illogical ways, in the same manner as people who are depressed. Cognitive therapists such as Aaron Beck and David Burns have described in considerable detail these distorted modes of thinking and their effect on mood and behavior. All of these distortions tend to skew the way you perceive and evaluate yourself, others, and innumerable situations in everyday life. This distortion is responsible for creating and *sustaining* much of the anxiety, depression, guilt,

and self-criticism that you experience. Learning to recognize and counter these distorted modes of thinking with more rational, positive affirmations will go a long way to help you view yourself and life in a more balanced, objective fashion. And this, in turn, will significantly reduce the amount of anxiety, depression, and stress you experience. I will describe seven cognitive distortions that have special relevance for people dealing with anxiety disorders:

1. *All-or-Nothing Thinking:* The hallmark of this distortion is an insistence on black-or-white choices. You tend to perceive everything in terms of extremes, with very little consideration of the middle ground. Either the day was terrific, or it was the worst day of your life. Either he loves you or he hates you. If you can't be brilliant, you're stupid.

2. *Ignoring the Positive:* When you're anxious or depressed, you have a tendency to overlook all indications of your ability to cope successfully. You forget positive experiences and accomplishments of the past, and anticipate insurmountable problems in the future. You focus on the problem rather than considering steps toward a solution.

3. *Catastrophizing:* When you think about something that is somewhat challenging or risky, you perceive total disaster as the probable outcome. For example, you've been making progress and then have a setback. Instead of seeing the setback as inconvenient and a normal part of recovery, you feel as though you're back at the beginning. Or you anticipate

the very worst even when it is highly improbable. In short, you project a catastrophe.

4. *Overgeneralizing:* One negative experience, such as being turned down for a promotion, will be translated into a law governing your entire existence—'I'll never get anywhere in life' or 'I just can't make the grade.' Or one stranger is rude to you and you conclude that all strangers are unkind. Or you have a problem in one store, therefore all stores should be avoided. Overgeneralizing is betrayed by *absolute statements* such as 'I'll *never* be able to trust anyone again,' or *'No one* would remain my friend if they really knew me.'

5. *Personalizing (taking things personally):* This is a tendency to relate everything to yourself, thinking that everything people do or say is some kind of reaction to you. A stranger frowns at you, thus you have done something wrong. Your spouse snaps at you, so you reason that it must be your fault. You enter a room and conversation ceases: they must have been talking about you. When you personalize, you fail to recognize that other people's negative behavior probably reflects *their* mood. Instead, you imagine it as a personal reaction to you.

6. *Emotional Reasoning:* You believe that you are what you feel. If you feel stupid, then you must *be* stupid. If you feel like a loser, then you must be a loser. If you feel guilty, then you must have done something wrong. The problem with emotional reasoning is that emotions by themselves have no validity as definitions of who you are.

7. "'Should' Statements: You try to motivate yourself by insisting on what you should do or be, without reference to what you actually want to do or be. The word 'should' is a telltale sign of the Perfectionist subpersonality described earlier. 'Should' can be part of a healthy ethical concern. But it can also reflect self-imposed standards that are excessively high or unrealistic."

HH. Skill: Identifying and Countering Cognitive Distortions

1. "'Catch yourself in the act' of negative self-talk. Be aware of situations that are likely to be preceded or accompanied by negative self-talk. For example:

   - Any occasion when you're feeling anxious, upset, or depressed
   - Occasions when you've made some kind of mistake or have failed to meet your own expectations
   - Situations in which you feel under scrutiny or criticized
   - Occasions when you're angry at yourself or others

2. "Ask yourself, 'What have I been telling myself that led me to feel this way?' 'Do I really want to do this to myself?'

   "If you're feeling too upset to undertake the task of identifying and countering self-talk, at least give yourself the opportunity to acknowledge and release your feelings.

When you've calmed down and are ready to relax, you can proceed with the steps below. (See Chapter 12 of *The Anxiety and Phobia Workbook* for ideas and guidelines for expressing feelings.)

3. "*Relax* or *distract* yourself. *Disrupt* the train of negative thoughts by taking some deep abdominal breaths or using some method of distraction. The point is to *slow yourself down and relax.* Negative self-talk is so rapid, automatic, and subtle that it can escape detection if you're feeling tense, speeded up, or unable to slow down. In extreme cases, it may take 15 to 20 minutes of deep relaxation, using breathing, progressive muscle relaxation, or meditation, to slow yourself down sufficiently to be able to identify your self-talk. If you're not excessively wound up, you can probably do this step in a minute or two.

4. "*Write dozen* the distorted self-talk or inner dialogue that led you to feel anxious, upset, or depressed. It's often difficult to decipher what you're telling yourself by merely reflecting on it. It can be confusing to try to think about what you've just been thinking. The act of writing your thoughts down will help to clarify the specific statements you made to yourself.

"This is the step that may take some practice to learn. It's important in identifying self-talk to be able to disentangle thoughts from feelings. One way to do this is to write down just the feelings first and then deduce the thoughts which led to them. For example, the statement 'I feel stupid and irresponsible' is one where thoughts and feelings are still

entangled. It can be broken down into a particular feeling —'I feel upset' or 'I feel disappointed in myself'—and the thought (self-talk) that logically produces such a feeling—'I am stupid' or 'I am irresponsible.' As another example, the statement 'I'm too scared to undertake this' mixes a feeling of fear with one or more thoughts. It can be broken down into the feeling 'I'm scared,' which arises from the negative self-statement 'This is unmanageable' or 'I can't undertake this.' You can ask yourself first, 'What was I feeling?' Then ask yourself, 'What thoughts went through my mind to make me feel this way?'

5. "*Challenge* your distorted self-talk with questions that ask for evidence or proof of their validity. Good questions to ask might be:

    - What is the evidence for this?
    - Is this always true?
    - Has this been true in the past?
    - Am I looking at all sides of this—the whole picture?
    - Am I being fully objective?
    - What's the very worst that could happen? Would that be so very bad?

6. "*Counter* your distorted self-talk with positive, supportive affirmations. Write these down in a column next to the

distorted self-statements. Your positive affirmations should be believable and feel 'right' to you (avoid mere positive thinking that you don't really believe in)." Two examples follow of the process of challenging distorted thinking and writing counterstatements:

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Example 1

Catastrophizing:	"People will think I'm weird or crazy if I start to panic during the meeting."
Questioning:	"How often has this happened in the past?" (Answer: Probably never.) "What are the odds of this really happening?" (Answer: Very unlikely.)
Counterstatement:	"If I start to feel panicky in the meeting, I can excuse myself, saying that I have to go to the bathroom. Even if people do see me panicking, it's much more likely that they'll express concern than that they'll think I'm crazy or weird."

Example 2

Overgeneralization:	"That panic attack I had on the freeway yesterday was so bad that I'll *never* be able to drive on freeways again."
Questioning:	"What are the odds of this being really true?" "Has this been true in the past?"
Counterstatement:	"I may need to lay off driving freeways for a while. After some time has passed, I'll feel good enough to try it again, and I believe I can succeed if I break the task down into small enough steps.

After all, I was able to drive freeways in the past, so I know I can do it again."

II. Concept: Rules for Writing Positive Counterstatements

1. "Avoid negatives in writing your counterstatements. Instead of saying 'I'm not going to panic when I board the plane,' try 'I am confident and calm about boarding the plane.' Telling yourself something will *not* happen is more likely to create anxiety than giving yourself a direct affirmation.

2. "Keep counterstatements in the present tense. 'I can breathe and let these feelings pass' is preferable to 'I will feel better in a few minutes.' Since much of your negative self-talk is in the here-and-now, it needs to be countered by statements in the present tense.

3. "Whenever possible, keep your statements in the first person. Begin them with T or refer to T somewhere in the statement. It's okay to write a sentence or two explaining the basis for your counterstatement, but try to end with an *I*-statement.

4. "It's important that you have some belief in your positive self-talk. Don't write something down just because it's positive if you don't actually believe it."

JJ. Skill: Working With Positive Counterstatements

1. "Read through your lists of positive counterstatements slowly and carefully for a few minutes each day for at least two weeks.

This will help you integrate them more deeply into your awareness.

2. "Make copies of your worksheets and post them in a conspicuous place. Take time once a day to read through your positive counterstatements.

3. "Put your counterstatements on tape, leaving a pause of about 5 seconds after each one, so that it has time to 'sink in.' You can significantly enhance the effect of such a tape by giving yourself 15 minutes to become very relaxed before listening to it.

4. "If you're having a problem with a particular phobia, you might want to work with positive counterstatements that are specific just to that phobia. For example, if you're afraid of speaking before groups, make a list of all your fears ('What-ifs') about what could happen, and develop positive statements to counter each fear. Then read through your list of counterstatements carefully each day for two weeks or make a short tape, as previously described."

KK. Concept: Mistaken Beliefs

"Where does negative self-talk come from? In most cases, it's possible to trace negative thinking back to deeper-lying beliefs, attitudes, or assumptions about ourselves, others, and life in general. These basic assumptions have been variously called 'scripts,' 'core beliefs,' 'life decisions,' 'fallacious beliefs,'

or 'mistaken beliefs.' We learned them from our parents, teachers, and peers, as well as from the larger society around us while growing up. These beliefs are typically so basic to our thinking and feeling that we do not recognize them as *beliefs* at all—we just take them for granted as 'the true nature of reality.' Examples of mistaken beliefs might be: 'I'm powerless/ 'Life is a struggle/ or 'I should always look good and act nice, no matter how I feel.'

"Mistaken beliefs are at the root of much of the anxiety you experience. Underlying your anxious patterns of self-talk are basic destructive assumptions about yourself and the 'way life is.' You could spare yourself quite a bit of worrying, for example, by letting go of the basic assumption, 'If I worry about this problem enough, it will go away.' Similarly, you would feel more confident and secure if you would let go of the mistaken beliefs, 'I'm nothing unless I succeed' and 'I'm nothing unless others love and approve of me.' Once again, life would be less stressful if you would let go of the belief, 'Either do it perfectly or don't bother.' You can go a long way toward creating a less anxious way of life by working on changing the basic assumptions that tend to perpetuate anxiety."

LL. Skill: Identifying Mistaken Beliefs

"Recognizing your own particular mistaken beliefs is the first and most important step toward letting go of them.

"The following questionnaire will help you to identify some of your own unconstructive beliefs. Rate each statement on a l-to-4 scale according to how much you think it influences your feelings and behavior. Then go back and work with the beliefs that you rated 3 or 4." (This questionnaire can be used as a handout.)

MM. Skill: Countering Mistaken Beliefs With Affirmations

"Attempt to come up with a positive affirmation to counter each of the unproductive beliefs you rated 3 or 4 on the Mistaken Beliefs Questionnaire.

"Use the following guidelines for constructing affirmations:

1. An affirmation should be *short, simple,* and *direct.* 'I believe in myself' is preferred to 'There are a lot of good qualities 1 have that I believe in.'

2. Keep affirmations in the *present tense* ('Em prosperous') or *present progressive tense* (T am becoming prosperous').

3. Try to *avoid negatives.* Instead of saying 'I'm no longer afraid of public speaking/ try 'I'm free of fear about public speaking' or 'I'm becoming free of fear about public speaking.' Similarly, instead of the negative statement 'I'm not perfect/ try 'It's okay to be less than perfect' or 'It's okay to make mistakes.'

4. Start with a direct declaration of a positive change you want to

make in your life ('I'm making more time for myself every day.'). If this feels a little too strong for you at first, try changing it to, 'I'm willing to make more time for myself.' *Willingness* to change is the most important first step you need to take toward achieving substantial change in your life. A second alternative to a direct declaration is to affirm that you are *becoming* something or *learning* to do something ('I'm learning to make more time for myself.').

5. It's important that you have some belief in—or at least a willingness to believe—your affirmations. It's by no means necessary, however, to believe in an affirmation 100 percent when you first start out. The whole point is to shift your beliefs and attitudes in the direction of the affirmation."

Mistaken Beliefs Questionnaire

How much does each of these unconstructive beliefs influence your feelings and behavior? Take your time to reflect about each item.

1. -Not At All

2. -Somewhat/Sometimes

3. -Strongly / Frequently

4. -*Very* Strongly

Place the appropriate number in the box by each statement:

- ▫ I feel powerless or helpless.

- Often I feel like a victim of outside circumstances.
- I don't have the money to do what I really want.
- There is seldom enough time to do what I want.
- Life is very difficult—it's a struggle.
- If things are going well, watch out!
- I feel unworthy. I feel I'm not good enough.
- Often I feel that I don't deserve to be successful or happy.
- Often I feel that it's useless to bother.
- My condition seems hopeless.
- There is something fundamentally wrong with me.
- I feel ashamed of my condition.
- If I take risks to get better, I'm afraid I'll fail.
- If I take risks to get better, I'm afraid I'll succeed.
- If I recovered fully, I might have to deal with realities I'd rather not face.
- I feel like I'm nothing (or I can't make it) unless I'm loved.
- I can't stand being separated from others.
- It's very hard to be alone.
- What others think of me is very important.
- I feel personally threatened when criticized.
- It's important to please others.
- People won't like me if they see who I really am.
- I need to keep up a front or others will see my weaknesses.
- I have to achieve or produce something significant in order to feel okay about myself.

- ▫ My accomplishments at work/school are extremely important.
- ▫ Success is everything.
- ▫ I have to be the best at what I do.
- ▫ I have to be somebody—somebody outstanding.
- ▫ To fail is terrible.
- ▫ I can't rely on others for help.
- ▫ I can't receive from others.
- ▫ If I let someone get too close, I'm afraid of being controlled.
- ▫ I can't tolerate being out of control.
- ▫ I'm the only one who can solve my problems.
- ▫ I should always be generous and unselfish.
- ▫ I should be the perfect: (rate each)

  ▫ employee ▫ professional

  ▫ spouse ▫ parent

  ▫ lover ▫ friend

  ▫ student ▫ _____
- ▫ I should be able to endure any hardship.
- ▫ I should be able to find a quick solution to every problem.
- ▫ I should never feel tired or lazy.
- ▫ I should always be efficient.
- ▫ I should always be competent.
- ▫ I should never be angry or irritable.
- ▫ I should always be pleasant or nice no matter how I feel.
- ▫ I often feel: (rate each)

- ▫ ugly
- ▫ slow-witted
- ▫ inferior or defective
- ▫ guilty or ashamed

- ▫ I'm just the way I am—I can't really change.
- ▫ The world outside is a dangerous place.
- ▫ Unless you worry about a problem, it just gets worse.
- ▫ It's risky to trust people.
- ▫ My problems will go away on their own with time

NN. Skill: Ways To Work With Affirmations

"Once you've made a list of affirmations, decide on a few that you would like to work with. In general, it's a good idea to work on only two or three at a time, unless you choose to make a tape containing all of them. Some of the more helpful ways you can utilize affirmations are to

1. Write an affirmation repetitively, about five or ten times every day for a week or two. Each time you doubt you can believe it, write down your doubt on the reverse side of the paper. As you continue to write an affirmation over and over, giving yourself the opportunity to express any doubt, you'll find that your degree of belief in it increases.

2. Write your affirmation in giant letters with a magic marker on a blank 8-1/2-by-11-inch or larger sheet of paper. The words should be visible from at least 20 feet away. Then affix it to your bathroom mirror, your refrigerator, or some other

conspicuous place in your home.

3. Put a series of affirmations on tape. If you develop 20 or so affirmations to counter statements on the Mistaken Beliefs Questionnaire, you may wish to put all of them on tape. You can use either your own voice or have someone else make the recording. Make sure that the affirmations are in the first person, and that you allow about 10 seconds between them so that each one has time to 'sink in.' Listening to the tape once a day for 30 days will lead to a major shift in your thinking and the way you feel about yourself. It's okay to play the tape any time, even while cleaning the house or driving in your car. However, you can expedite the process by giving the tape your full attention in a very relaxed state when you've slowed yourself down enough to deeply feel each affirmation."

For the sake of brevity, concepts and skills utilized during Weeks 11 through 18 of the agoraphobia treatment group are not presented separately here. See the discussion of iInterventions for each of these weeks in the following section. Also refer to the appropriate chapters in *The Anxiety and Phobia Workbook* for detailed presentations of relevant concepts and skills.

Main Interventions

Because the main iInterventions used in the agoraphobia treatment group consist of didactic presentation and group discussion, these

iInterventions are not specifically labeled each time they appear. All other iInterventions are listed as exercises.

Week 1: Introduction

Procedures

Begin with the group leader's and group assistant's personal introductions. Let the group know about how you got involved in working with agoraphobia. Explain to group members how they can get in touch with you and the assistant.

Have group members introduce each other. They can pair up for five minutes to get acquainted; then each member of a dyad introduces the other. Many agoraphobics actually find this process less threatening than introducing themselves.

Go over the basic ground rules of the group, as specified in the previous section on ground rules. To help reduce anxiety, emphasize that clients are free to bring support persons during the first five weeks of the group and that each group member is free to leave the room at any time. Explain that homework will be required each week and that keeping up with it is essential to making progress toward recovery.

Concepts A and B: The Development of Agoraphobia

The Agoraphobic Personality Profile

Present and discuss the material in the Concepts and Skills section. Make sure that clients understand the causal sequence between panic attacks and subsequent development of phobic avoidance, dependency, and depression. When discussing the personality profile, have group members share about the specific traits with which they identify.

Procedures

If the group runs two hours, introduce a ten-minute break in the middle. Many agoraphobics prefer not having to sit still for long periods of time. (Do this in all subsequent sessions.) During the break, group members are encouraged to spend time getting to know each other.

Emphasize before the group is over that clients are not to put themselves into unnecessarily anxiety-provoking situations. Briefly explain the concept of desensitization (to be covered in detail in Week 6) and instruct clients not to enter phobic situations, unless they have to, for the time being. They need to master skills of relaxation, exercise, and coping strategies for minimizing panic before they undertake exposure to phobic situations.

Have clients fill out the self-evaluation form that can be found in the

subsequent section of this chapter, Measuring Change. They will complete it a second time at the end of the group to track their progress.

Homework

- Clients should read Chapter 2 of *The Anxiety and Phobia Workbook.*

- Hand out the reading list of popular books on panic attacks and agoraphobia (see References at the end of this chapter) and encourage clients to read at least two books of their choice during the course of the group. *The Anxiety and Phobia Workbook* is required reading for the group; assignments from various chapters will be given in subsequent weeks.

- Group members should write out their personal goals for the group. These should include specific phobias they would like to overcome and any other behaviorally defined goals (such as fewer panic attacks, finding gainful employment, upgrading communication with their spouse, driving, coping with medical appointments).

- Clients are to make a list of their questions about the program and bring them in for discussion the following week.

Week 2: The Causes of Panic and Agoraphobia

Homework Review

Review homework from the preceding week, beginning with a discussion of clients' questions about the group. Encourage clients to call the group assistant or leader as questions arise during the course of the program.

Have clients share, for no more than three minutes each, their personal goals for the group.

Concept C: The Causes of Agoraphobia

Present and discuss material in the Concepts and Skills section. Emphasize the distinction between predisposing, short-term, and maintaining causes of panic/ agoraphobia. Reassure clients who are concerned about panic attacks being hereditary or physically caused that these links do not compromise recovery.

Procedures

At this point, clients often raise issues about medication—both whether they should be taking drugs and what drugs to take. Indicate that the two criteria for deciding to take medication are: a) *severity of symptoms*—in other words, the more severe, frequent, and disabling panics attacks are, the more appropriate it is to consider medication, and b) *personal values*—the client's

individual views and feelings about medication ultimately determine the choice about whether to utilize them. A discussion of the pros and cons of the two major classes of drugs used to treat panic disorder—antidepressant medications and minor tranquilizers—is in order here. See Chapter 16 of *The Anxiety and Phobia Workbook* for a detailed discussion of these issues.

Pass out a list of group members' phone numbers. Each member of the group should call a different person on the list every week. The purpose of this assignment is to foster an atmosphere of support and interpersonal closeness in the group. Each client starts by calling the person below her or his name on the list and advances one name each week. Calls should focus on getting acquainted and discussing what individuals have been doing to work on recovery—not on a discussion of symptoms. (Symptoms and other problems can be discussed with the group assistant.) If a client has difficulty coming up with something to say, it's OK to share that fact and keep the phone call brief. (For example, "Hi, I'm just calling to say hello. I can't talk any longer, though, because this is hard for me now.") Emphasize the importance of making each call each week, because group members can tend to feel rejected if they don't receive a call.

Homework

- Chapter 4 of *The Anxiety and Phobia Workbook* is the assigned reading.

- Clients should list any additional questions they have about the program and bring them in the following week.

- Have clients cut pictures out of magazines that remind them of their phobia or otherwise produce anxiety, and bring them in as well.

- Clients are to call another member of the group, as discussed above under Procedures.

Week 3: Relaxation Training

Homework Review

Go over clients' questions from the homework. Ask about whether everyone received a phone call from someone in the group. Spend 10 to 15 minutes having clients share and talk about pictures from magazines that remind them of their phobias.

Concept D: Relaxation

Present and discuss the material in the Concepts and Skill section. Emphasize that relaxation is at the foundation of everything else clients will be doing toward their recovery. Distinguish deep relaxation techniques such as abdominal breathing, progressive muscle relaxation, and meditation from more passive forms of relaxation such as watching TV, stressing that the

former are more effective in achieving the "relaxation response." A daily commitment to practice some form of deep relaxation will greatly expedite recovery.

Skill E: Abdominal Breathing

Explain that even though abdominal breathing may feel unusual at first, it's the natural way that babies, small children, and relaxed adults breathe. Have clients hold their right hand over their stomach as they practice. Their hand should rise if they are doing abdominal breathing correctly. Emphasize that a minute or two of abdominal breathing is an efficient way to diminish anxiety or the early symptoms of panic on the spur of the moment.

Skill F: Progressive Muscle Relaxation

After 5 minutes of practice with abdominal breathing, introduce progressive muscle relaxation. Turn down the lights in the room, have clients remove uncomfortable outer clothing and remain seated (they may lie on the floor if they prefer). Model tensing and relaxing the 15 muscle groups in sequence with clients watching, so that they will have a good idea of how to do each muscle-tensing exercise. Before starting progressive muscle relaxation, explain to clients that occasionally during relaxation, fears of falling or losing control may come up. Emphasize that neither of these

outcomes is in fact possible, and that if anyone feels uncomfortable, it's okay to stop doing the exercise. Sometimes it's necessary for some clients to desensitize to relaxation. Now read the script for progressive muscle relaxation contained in the Concepts and Skills section. Clients should receive a copy of this script for home practice, or, even better, a tape of recorded instructions.

Skill G: Visualizing a Peaceful Scene

Instruct clients to create in their mind a peaceful scene of their own choosing. Use the script provided in the Concepts and Skills section or devise your own script. At the end of the exercise, bring clients back to an alert state by counting from 1 up to 5. On the count of 5, suggest that they will feel awake and alert.

It's important that clients relax sufficiently to experience their peaceful scene in detail, using all of their senses. Afterwords, ask group members to individually describe their scene and any problems they might have had visualizing it. If someone doesn't have a scene, it's part of their homework for next week to develop one. If some group members have difficulty visualizing, instruct them to ask themselves such questions as "What are the main objects in the scene?" "What colors are visible?" "What sounds are present?" "What time of day is it?" "What is the temperature?" and so on. (A handout listing

questions designed to evoke multisensory imagery might be helpful.) Mention that developing a reliable peaceful scene—a sort of "safe place" in the mind—is a prerequisite for imagery desensitization, a skill for overcoming phobias that you will teach to the group 3 weeks later. Also indicate that regular practice will improve group members' ability to visualize.

Homework

- Chapter 5 of *The Anxiety and Phobia Workbook* is assigned reading.

- Clients are to practice abdominal breathing for at least 5 minutes each day. They are also to try practicing this form of breathing at times when they feel anxiety or the early symptoms of panic coming on.

- Clients should practice the complete progressive muscle relaxation sequence, which will take from 20 to 30 minutes, at least once (preferably twice) each day, seven days per week. They should find a quiet place to practice where they won't be distracted. During practice, they should be free of uncomfortable clothing with their head supported. Practice should be avoided on a full stomach—the best times for practice are upon awakening in the morning, during lunch break, after getting home from work, or before retiring. It's best to maintain a regular practice time each day.

- After completing progressive muscle relaxation, clients are to

visualize going to their peaceful scene and stay there for a least 3 minutes. If they have problems identifying a peaceful scene or visualizing it, they are to call the group assistant.

- *Note:* Clients who find active progressive muscle relaxation uncomfortable or otherwise objectionable may substitute passive muscle relaxation or a guided visualization for their daily deep-relaxation practice. Scripts for these alternative forms of relaxation may be found in Chapter 11 of *The Anxiety and Phobia Workbook.*

- Starting with this week, clients will fill out the Weekly Practice Record (from Chapter 3 of *The Anxiety and Phobia Workbook)* to monitor their practice of skills and competencies taught in the program. (For Week 4, they should check off Used Deep Breathing Technique and Used Deep Relaxation Technique Monday through Sunday.) Clients turn in their Weekly Practice Record, along with any other assigned homework, at the beginning of each group meeting.

Week 4: Physical Exercise

Homework Review

Collect homework.

Procedures

Ask clients about their experiences with practicing progressive muscle relaxation (or alternative) and visualizing their peaceful scene. Were they able to practice each day? If not, what types of barriers got in the way? Have a discussion about the types of self-talk and excuses that people can use to talk themselves out of activities promoting their recovery. In the case of practicing relaxation, ask clients whether they can identify with any of the excuses listed under Some Common Obstacles To Implementing a Daily Program of Deep Relaxation at the end of Chapter 4 of *The Anxiety and Phobia Workbook.* Reiterate the importance of practicing all three relaxation skills—abdominal breathing, active or passive deep-muscle relaxation, and visualizing a peaceful scene—on a daily basis.

Ask how phone calls are going. If calls aren't being made, this is the time to explore reasons why and to mildly confront group members who are remiss.

Present and discuss the concept of physical exercise as a means of reducing vulnerability to panic and anxiety. Explain how physical exercise reduces anxiety through release of muscle tension, metabolism of excess adrenalin, production of endorphins, and so on.

Have clients determine their level of fitness, using the worksheet in Chapter 5 of *The Anxiety and Phobia Workbook.* Also have them take their

resting pulse rate. They can use both indices as a measure of their fitness level.

Concept H: Exercise

Discuss material presented in the Concepts and Skills section. Ask clients what types of exercise, if any, they are doing and how often. For those who aren't exercising, what forms would they consider? For clients who are housebound, emphasize that there are several forms of aerobic exercise that will meet their needs, such as stationary cycling, jumping on a rebounder, or aerobic workouts on video.

By the end of this discussion, each client who is not already exercising regularly should have made a commitment—before the group—to undertake an exercise program. "Commitment" means exercising a minimum of 4 times per week for a minimum duration of 20 minutes.

Go over the guidelines in the section Getting Started from Chapter 5 of *The Anxiety and Phobia Workbook* for the benefit of any clients who are contemplating beginning an exercise program. Emphasize the importance of starting off gradually. Clients who have not exercised in a while and are over forty should consult with their physicians before undertaking any exercise program.

Some clients may be phobic about exercise; the increased heart and respiratory rate associated with exercise may seem all too much like a panic attack. Encourage these clients to begin by walking 30 to 45 minutes per day or to do a milder form of aerobic exercise, such as swimming (using the breaststroke) or light jogging. An exercise program can progress gradually: clients can begin with very short sessions (as little as 5 minutes per day for several days) and then increase the duration by minute increments.

Homework

- Chapter 6 of *The Anxiety and Phobia Workbook* is assigned reading.
- Clients should continue practicing relaxation techniques learned the preceding week and monitor their practice on the Weekly Practice Record.
- All group members should engage in physical exercise—either brisk walking or a more vigorous, preferably aerobic, exercise—on at least 4 days of the following week. They can track their practice on the Weekly Practice Record.

Week 5: Coping With Panic Attacks

Homework Review

Collect homework from the preceding week and ask clients how they did with exercise. For those who've just begun exercising, did they find a form they can enjoy? How many times did they do exercise during the week? It's likely that some clients will resist getting started with exercise—so this is a good time to explore self-talk and excuses that maintain their resistance. Go over the common types of excuses for not exercising listed in the section Obstacles To Implementing an Exercise Program in Chapter 5 of *The Anxiety and Phobia Workbook.* (Spend no more than 15 to 20 minutes on this, as there are several concepts to be presented this week.)

Procedures

Introduce and discuss the following concepts:

Concept I: The Panic Cycle

Concept J: Panic Attacks Are Not Dangerous

Concept K: Don't Fight Panic

Concept L: Separate First Fear From Second Fear

It's important to emphasize that panic is nothing other than the "fight-or-flight" response—a response necessary to our survival—that simply

occurs in the absence of any life-threatening situation. Because panic makes you feel like you do when there's real danger, you imagine danger where there isn't any. Go over the various illusory dangers commonly associated with panic (heart attack, suffocation, and so on) and present scientific data to refute each danger.

In discussing Claire Weekes's four attitudes for managing panic, emphasize the importance of learning to observe and go with bodily symptoms rather than fighting or reacting to them. When presenting the distinction between first and second fear, ask clients to come up with their own examples of self-talk that could instigate or aggravate panic. Then pass out copies of the list of coping statements (see Concept L in the previous section) and instruct clients to find a few statements they like. They should practice rehearsing those when they feel symptoms of panic coming on.

Skills M and N: Distinguishing Early Forms of Panic and Learning To Retreat

Introduce and discuss the material in the Concepts and Skills section. Hand out a copy of the Anxiety Scale (presented in Section M) to the group, pointing out that the symptoms described on various levels of the scale are not universal. Each individual will in fact have her or his own unique set of symptoms that define the point where a sense of control starts to diminish. This point where control first seems to drop out is defined as Level 4. Panic

can usually be aborted if action is taken at this level. Ask clients in the group each to try to define what would constitute a level 2, 3, or 4 *for them.* Those clients who haven't thought this through are asked to do it as homework for the following week.

Distinguish three basic skills for coping with panic:

Skill O: Distraction Techniques

Skill P: Abdominal Breathing and Muscle Relaxation

Skill Q: Replacing Self-Talk With Positive Coping Statements

Discuss the material in the respective Concepts and Skills section. Take a survey of the group, asking people what techniques they've used in the past to counter an oncoming panic attack, and how well those techniques have worked. Then present skills associated with the use of distraction, breathing, muscle relaxation (progressive muscle relaxation exercises involving arms, head, neck, and shoulders only), and coping statements. Have clients rehearse three minutes of breathing or muscle relaxation in combination with the use of one coping statement. They should practice this same combination for a few minutes each day during the following week.

Discuss options for dealing with panic attacks *above* Level 4 in intensity

on the Anxiety Scale. These include: a) retreating from the situation if possible, b) walking about or engaging in some simple physical activity, c) calling someone if a phone is available (some clients who have difficulty driving like to have a cellular phone in their cars), d) continuing slow abdominal breathing and inhaling through the nose (to stop hyperventilation), e) breathing into a paper bag (also to stop hyperventilation), f) "floating past" the panic (see Concept K), g) "grounding" by touching the floor or physical objects in the surrounding environment, h) crying or screaming into a pillow to discharge arousal, or i) with the approval of their doctor, taking an extra dose of a minor tranquilizer (sometimes the mere act of doing this will offset panic). Ask clients which strategies they would consider trying should they experience above a Level 4 during the next few weeks.

Homework

- Clients are to continue practicing deep relaxation (progressive or passive muscle relaxation) for 20 minutes every day and to engage in vigorous exercise at least 4 times per week.

- During the following week, clients should keep a log of their panic attacks, where they note:

  - The date and time when panic occurred

- Any antecedents or triggers that might have brought on panic

-The maximum intensity of panic on the Anxiety Scale

- Coping technique(s) used to abort or limit the panic reaction

This log will be turned in the following week.

- Clients should rehearse the combination of abdominal breathing (or progressive muscle relaxation) and repeating a coping statement for 3 minutes each day. They are to use this combination when actual symptoms of panic arise.

- Chapter 7 of *The Anxiety and Phobia Workbook* is the assigned reading.

Week 6: Imagery Desensitization

Homework Review

Collect clients' logs monitoring panic reaction during the preceding week and have the group discuss different types of antecedents that may instigate panic. Clients often gain insights from each other about various factors (such as lack of sleep, too much caffeine, failure to act assertively) that can predispose them to a panic reaction.

Procedures

Ask clients to share what coping statements they've been using to reframe their response to the bodily symptoms of panic. Encourage them to continue practicing the combination of abdominal breathing and repetition of a coping statement every time they feel the onset of panic symptoms.

Concept R: Desensitization

Present and discuss the material in the Concepts and Skills section. Contrast desensitization with the notion of sensitization. Clarify the distinction between imagery and real-life desensitization and how the former provides a good preparation for the latter.

Concept S and Skill T: The Phobia Hierarchy

Discuss the material from S and T of the Concepts and Skills section. The process of confronting a phobic situation is made easier by breaking it down into small steps. Here it is helpful to have clients give examples of their phobias and actually write out 2 or 3 hierarchies on a blackboard. Teach them the skill of constructing a proper hierarchy, defining extremes at the low and high ends of the continuum first, and then filling in 7 or 8 intermediate steps of varying difficulty.

Skill U: Practicing Imagery Desensitization

Introduce and discuss the material from the Concepts and Skills section. I've found it useful to have a prerecorded tape that leads clients through the process—alternately asking them to visualize a phobic scene and then retreating to their peaceful scene. It's essential that everyone has a good grasp of the Anxiety Scale presented the week before and understands the importance of "switching off" a phobic scene if it causes anxiety to rise above Level 4. Otherwise, they are to stay with the phobic scene for about one minute and imagine breathing away any anxiety and/or repeat a calming affirmation. It also helps to instruct clients, while visualizing a phobic scene, to see themselves in the scene handing it with composure and confidence. Finally, make sure group members understand that they are not to advance to the next scene in a hierarchy until the preceding scene has lost its capacity to elicit anxiety above Level 1 on the Anxiety Scale.

Emphasize that success with imagery desensitization depends on the ability to relax and to visualize both phobic scenes and a peaceful scene or safe place in multisensory detail. It's useful here, if you haven't already, to give clients a handout with a list of questions they can ask themselves to evoke more detailed imagery.

Remind clients not to be concerned if they do *not* feel any anxiety while doing imagery desensitization. You might make the comparison between

their brain and a tape recorder and emphasize that they are rerecording positive images over an old negative image. Clients often feel they have failed to do imagery desensitization correctly unless phobic scenes evoke anxiety. Reinforce the importance of practicing desensitization in fantasy over the next few weeks, whether or not clients experience any anxiety with the procedure.

Instruct clients that they are to practice *only* imagery desensitization during the subsequent week and not to begin real-life exposure. If they have any questions about details of the imagery desensitization process, they are to contact the group assistant. (Here again, a prerecorded tape leading clients through imagery desensitization can be quite helpful.)

Homework

- Clients continue exercising, having a daily session of deep relaxation, and using their preferred coping strategies to deal with panic reactions.

- Have clients construct hierarchies for three phobias they wish to work on. They should turn in copies of these the following week. Refer group members to Appendix 3 of *The Anxiety and Phobia Workbook* for several examples of hierarchies.

- Following each daily session of deep relaxation, clients are to

practice 15 to

- 20 minutes of imagery desensitization, beginning with the first step of their hierarchy. They should work with only one phobia (one hierarchy) at a time. If they feel no anxiety with the first step, they are to expose themselves to it twice and then proceed to the next step, exposing twice to this scene and progressing to any scenes further up in their hierarchy in a similar fashion until they reach a scene that causes mild anxiety. They should practice imagery desensitization with this last scene until it no longer elicits anxiety, then stop. During any given practice session, individuals are to work with no more than two scenes at a time if these scenes are eliciting anxiety.

- Chapter 8 of *The Anxiety and Phobia Workbook* is assigned reading for the following week.

Week 7: Real-Life Desensitization

Homework Review

Collect clients' hierarchies assigned from the previous week and point out examples of properly and improperly constructed hierarchies. Make sure that everybody understands at this point how to construct a hierarchy.

Procedures

Have clients share how imagery desensitization practice went during the past week. Did anyone encounter resistance to practicing? Did anyone have problems getting sufficiently relaxed? Were there problems with visualization? Reassure clients that even though they may feel like they're not getting much out of the process (especially if phobic scenes don't elicit anxiety), continuing to practice over the next few weeks will make it easier for them to undertake real-life desensitization.

Skill V: Practicing Real-Life Desensitization

Present and discuss the material in the Concepts and Skills section. Emphasize that real-life exposure is the single most important component of a recovery program, but that it is effective only if practiced properly.

Go over the notion of retreating from exposure when anxiety reaches or exceeds Level 4 on the Anxiety Scale (Skill M). This concept needs special attention because clients are typically not used to the idea of retreating and tend to take an all-or-nothing approach to dealing with phobias. Either they have to "tough it out" and deal with a situation no matter how anxious they feel, or else avoid the situation altogether. Emphasize that neither approach works. Excessive or too rapid exposure will only increase their sensitization to a given phobia. Continued avoidance will only keep them from dealing with the problem. Get across the idea that retreating is not "cowardly"—it is the

most efficient way possible to succeed with real-life exposure to any phobic situation. Also emphasize the distinction between retreating and escaping. Escaping or running away from a phobia only serves to reinforce it, while retreating and then returning to the same situation after anxiety has subsided accomplishes desensitization. *[Note:* Clients who are highly anxious much of the time—near Level 4 on the Anxiety Scale even when not engaged in exposure—should be taught initially to retreat to the first increment of anxiety they feel when confronting a phobic situation.]

Concept W: The Support Person

Discuss the importance of having a support person along when first undertaking real-life desensitization. The support person provides a sense of safety, encouragement, and also a distraction from bodily symptoms of anxiety. It's best to have the support person go along for the first few exposures to a given step in a hierarchy and then to try the step out alone (or with the support person at a distance). Alternatively, the support person can accompany the client through most or all of a hierarchy before the client tries any of the steps alone.

During this session, the group assistant usually meets with support people in a separate room for about half an hour and discusses guidelines for working with their phobic partners (as described in Section CC: Support

Person Skills).

Concepts X and Y: Dealing With Resistance and Tolerating Discomfort During Real-Life Exposure

Present and discuss the material in the Concepts and Skills section. It's important that clients fully understand and are prepared to accept the reality that exposure is hard work and seldom comfortable in the early stages. It will not be intolerably uncomfortable if retreating is handled properly. These ideas should be reiterated several times during subsequent weeks.

Expect clients to offer considerable resistance to practicing real-life desensitization. They will need frequent exhortations to practice and in many cases individual attention on the part of the group leader to assist them in overcoming long-standing avoidance patterns. I recommend an individual session—or at least a phone call to each group member at the end of the first eight to nine weeks—to explore feelings and resistance around the practice of *in vivo* exposure.

Concept Z: Reward Yourself for Small Successes

Explain the material from the Concepts and Skills section.

Concept AA: Practice Regularly

Emphasize that success with real-life desensitization is fostered by regular practice, at least three times per week. One practice session per week is not enough.

Homework

- Clients are to continue practicing exercise, relaxation, and imagery desensitization four to seven times per week.

- For the coming week, clients should select one phobia for practicing real-life desensitization. They can use the same hierarchy for real-life exposure that they constructed for imagery desensitization, but in some cases they may want to add some extra steps. Very small steps are often necessary for real-life desensitization. Individuals should practice at least three times, approximately one hour each time. If possible, they should work with a support person and be sure that they retreat whenever their anxiety reaches Level 4 on the Anxiety Scale. If they have any difficulties or questions in regard to the exposure process, they are to call the group assistant.

- Chapter 9 of *The Anxiety and Phobia Workbook* is assigned reading for the following week.

Week 8: Field Trip 1

Homework Review

Collect Weekly Progress Records and ask clients what progress they made with real-life exposure. At this point, simply have them share what progress (if any) they made toward a specific goal, rather than getting into a detailed discussion of resistance to exposure. It's necessary to dedicate most of this two-hour session to the field trip.

Procedures

Announce that the group will be taking a field trip today to a nearby shopping center or small shopping mall. The announcement needs to be a surprise in order to ensure attendance and to cut down on clients' anticipatory anxiety. Expect moans, groans, and other expressions of fear or not wanting to go. You and the group assistant need to encourage and reassure everybody that you will be available to help as much as they need help, and that no one will be forced to do anything they don't want to do. Insist that all clients go. Avoid spending more than a few minutes listening to complaints, as this will only increase the general anxiety level for the entire group.

Explain the purpose of the field trip as follows:

- To learn and practice, step-by-step, the real-life desensitization process discussed last week.
- To learn, in particular, how to retreat when anxiety reaches

Level 4.

- To give clients an opportunity to go as a group and thus feel safer with each other.

Keep the trip short—no more than an hour in duration. The group can caravan in three or four cars to a pre-assigned spot in front of one of the stores in the shopping mall. Clients who are very phobic about riding in a car may be given the alternative of walking, with someone accompanying them, provided the shopping center is close by. When you arrive at the shopping center, divide into two groups—those who are ready to practice exposure *inside* a store and those who aren't yet ready to go inside. The leader and assistant each take a group. Clients ready to go into a store should start with a smaller store and progress toward a department store with several floors (exposure to elevators or escalators can be included, if appropriate). Throughout the field trip, the leader and assistant watch carefully and *ask* clients for indications that anxiety has risen to Level 4. When this happens, the client is exhorted to retreat, recover, and return to exposure only after anxiety has subsided to Level 1. The retreating client should leave the store with another group member for support. Have them remain outside until anxiety has reduced to Level 1, when they should again attempt exposure.

After one hour of practice, return to where the group meeting is regularly held and have clients discuss their experiences and reactions. If

there is any time left, have them talk more about any resistance that came up during the field trip or during their weekly practice of *in vivo* desensitization. Emphasize that a willingness to take risks is *essential* to their recovery. Then add that the way risk-taking is made possible is by ensuring that risks are kept *small.*

Homework

- Clients are to continue practicing on a daily basis deep relaxation and imagery desensitization relevant to the phobias they're working on. All members of the group should be exercising at least four days per week. Clients track all of this in the Weekly Progress Record.

- *In vivo* exposure should be practiced at least three or four days per week, preferably with a support person. Clients will be asked during the remaining weeks of the group how they're doing with their *in vivo* goals.

- Clients should finish reading Chapter 9 of *The Anxiety and Phobia Workbook* for the following week (but shouldn't yet do the exercises).

Week 9: Self-Talk

Homework Review

Collect Weekly Progress Records.

Procedures

Ask how *in vivo* exposure has been going. Go around the group and make sure that everyone has gotten started with exposure practice. This is the time to review clients' reasons for resisting practice. Clients need to understand that exposure isn't necessarily a comfortable process. Feeling uncomfortable and wanting to resist are a *normal* part of the process. If they weren't feeling *any* discomfort, you would have doubts about whether they were really practicing exposure. In short, exposure is not always supposed to feel good. Next, ask clients whether they've all identified Level 4 for themselves and are retreating when anxiety begins to reach this point. Letting anxiety get too high during exposure will defeat the purpose. Reemphasize the importance of rewarding themselves every time they go out and practice, even if progress is nominal. This will increase the likelihood of their continuing to practice.

Concept BB: Expect and Know How To Handle Setbacks

Emphasize that setbacks are a *normal* part of the process. All phobics have their good and bad days. On good days, they'll make great strides with exposure—on bad days, they may be unable to do what they did two weeks

ago. Ups and downs during recovery are expected. Over the long-term (it takes, on the average, six months to two years to recover) they will experience *gradual* progress.

Concept DD: Self-Talk and Anxiety

Present and discuss the concept of self-talk and its role in perpetuating anxiety (see the Concepts and Skills section). Clients should already be somewhat familiar with the concept from the previous discussion, in Week 5, of self-talk and panic attacks. Make sure that everyone understands that self-talk frequently is so automatic and subtle that it goes unnoticed if there is not a deliberate effort to identify it.

Concept EE and Skill FF: Identifying and Countering Sub-personalities

As described in the Concepts and Skills section, these are the Worrier, the Critic, the Victim, and the Perfectionist. Clients can use a blackboard to write down examples of typical statements made by the four sub-personalities. Have group members offer their own examples and share which sub-personalities they feel to be most dominant for them.

Allow 15 minutes during which clients try to identify and write down self-talk that served to aggravate an upsetting incident during the preceding week. This can be a time when they felt anxious, depressed, angry, self-

critical, or guilty. Emphasize the importance of learning to distinguish *thoughts from feelings.* 'This is frightening" is not a pure example of an internal thought, because it contains a feeling word—"fright." It is necessary to deduce from the feeling of fright the thoughts one had to instigate that fear, for example: "What if they see me start to panic while I'm standing here?" From this, follow the statement of feeling, "This is frightening." Both the instigating thought and the resulting feeling statement are a part of the negative self-talk, but only the former gets at the root of the problem. Go around the group and have each client share her or his examples of self-talk, correcting any cases where thoughts have not been differentiated from feelings.

Concept GG: Cognitive Distortions

If time permits, present the concept of cognitive distortions and the seven distortions that are particularly relevant to anxiety (from the Concepts and Skills section). Alternatively, clients can be instructed to review the section on distortions with examples in Chapter 9 of *The Anxiety and Phobia Workbook* and identify during the next week which ones are prominent in their own thinking. (Don't spend too much time on this segment, since learning to counter anxiety-provoking self-talk should be the exclusive focus of this week).

Present the various steps involved in countering self-talk:

Skill HH: Identifying and Countering Cognitive Distortions

Concept II: Rules for Writing Positive Counterstatements

Skill JJ: Working With Positive Counterstatements

It's important here to take two or three examples of negative self-talk from clients, create a refutation, and have the client come up with oral counterstatements. It may also be helpful to write out Socratic questions to use in the refutation, and at least one of the resulting counterstatements, on a blackboard. A typical refutation might go like this:

Therapist: What did your worrier tell you that time?

Client: What if I had a heart attack from panicking while trying to learn to drive again?

Therapist: What is the evidence that panic attacks cause heart attacks?

Client: I don't know.

Therapist: Go back and read Chapter 6 of *The Anxiety and Phobia Workbook* where it explains that a panic attack can't cause a heart attack. There's simply no evidence for any relationship between cardiovascular disease and panic. Now, what would be a good counterstatement to your original 'What if' statement?

Client: A panic attack, however uncomfortable, is not dangerous to my heart. I can

let panic rise, fall, and pass, and my heart will be fine.

An example of a refutation involving the cognitive distortion of catastrophizing might go as follows:

Client: What if I'm home alone and start to panic? That would be *terrible*—I don't think I could handle it.

Therapist: Is it really the case that panicking alone at home would be utterly terrible? What's the absolute worst that could happen? Would you actually die?

Client: No, of course I couldn't die. I'd just be very frightened.

Therapist: Is it absolutely true that there is nothing you could do? That you'd be completely helpless, without recourse?

Client: No, I guess not. I would try and call John or else my friend, Cindy. I could also call the group assistant. If no one was available, I could call the local crisis hotline.

Therapist: Would it help to make a list of people who you could contact if you ever find yourself panicking while alone?

Client: Probably, yes.

Therapist: So what would be a counterstatement to your original negative self-statement?

Client: So what if I did panic while I'm alone at home. I'd probably feel pretty uncomfortable for a while, but it's just not true that I couldn't handle it.

After illustrating the process of refutation and developing counterstatements, have the group break into dyads and repeat the process.

Person A in the dyad finds an example of negative self-talk while Person B challenges the example and asks A to develop a counterstatement. Then the roles are reversed.

Go over the rules for writing positive counterstatements and suggest various alternatives for working with positive counterstatements described in II and JJ.

Homework

- Clients should continue to chart their practice of exercise, relaxation, imagery, and real-life desensitization, using the Weekly Progress Record.

- Hand out a copy of the Daily Record of Dysfunctional Thoughts (see Chapter 9 of *The Anxiety and Phobia Workbook).* Clients are to make 50 copies of it for future use. For next week, they should spend 15 to 20 minutes a day tracking, challenging, and countering instances of negative self-talk that arise. Although clients may not be able to write out self-talk (and counterstatements) at the very time it occurs, they should try to do so within the same day. If possible, they are to indicate the sub-personality and any cognitive distortions involved in their negative self-statements. Completed worksheets should be turned in the following week. Clients should call the group assistant if they have any questions that come up during the week on any aspect of the process of identifying and countering self-talk.

- Clients should read Chapter 10 of *The Anxiety and Phobia Workbook.*

Week 10: Mistaken Beliefs

Procedures

Have clients share examples of countering anxiety-provoking self-talk. They can use the Daily Record of Dysfunctional Thoughts worksheets from the preceding week. Discuss examples and then have group members share about how they are doing with the process of countering unconstructive inner dialogues. Some individual attention may be necessary here to ensure that everyone understands the various steps of the process. Request that clients continue to write down everything on the Daily Record of Dysfunctional Thoughts for another week. Writing out self-talk and refutations will help them *internalize new habits* of noticing and countering the unhelpful things they tell themselves. Eventually, they will be able to do this automatically, without writing it all out.

Concept KK: Negative Beliefs

Present and discuss the concept of mistaken beliefs, including basic assumptions about self, others, and life in general that underlie negative self-talk.

Skill LL: Identifying Mistaken Beliefs

Hand out the Mistaken Beliefs Questionnaire presented under LL in the Concepts and Skills section, and tell group members to take their time in completing it. Give them from 10 to 15 minutes. Ask clients to share examples of mistaken beliefs they rated 3 or 4, then use these to illustrate how to counter mistaken beliefs and to develop constructive affirmations.

As in the preceding week, engage in dialogue with a few clients to challenge a mistaken belief, using Socratic questions. Then ask a client to come up with an affirmation to counter the mistaken belief. An affirmation is a short, terse statement that summarizes an entire belief or attitude, as distinguished from the positive self-talk that clients learned about last week.

In challenging mistaken beliefs, there are two additional questions—besides Socratic questions, which challenge the logical basis of such beliefs—that are very helpful:

- "Does this belief promote my well-being?"
- "Did I freely choose this belief, or did it develop out of my experiences in childhood?"

[Chapter 10 of *The Anxiety and Phobia Workbook* provides the rationale for these questions, and examples of dialogues using them. Be sure to use

these questions in your dialogues designed to refute the mistaken beliefs of individual group member.]

Skills MM and NN: Countering Mistaken Beliefs With Affirmations and Ways To Work With Affirmation

Discuss the rules for writing affirmations presented under MM and NN of the Concepts and Skills section. Especially emphasize the importance of keeping affirmations in the present tense and avoiding negatives. If for any reason an affirmation causes an anxiety reaction, clients may need to use imagery desensitization before they can use the affirmation successfully.

Exercise

Now have clients break up into dyads. Rehearse the process of challenging mistaken beliefs and developing a positive affirmation in the same manner in which you worked with negative self-talk during the preceding week.

Finally, have group members share one or two affirmations that were particularly meaningful to them. Each clients should work with this affirmation during the following week, writing it down several times each day *or* meditating on it *or* writing it in big letters on a large piece of paper posted in a conspicuous place.

If this is the second-to-last session, encourage clients to share their feelings about the group coming to an end.

Homework

- Clients should continue their practice of exercise, relaxation, and imagery and *in vivo* exposure. They should also continue to use the Daily Record of Dysfunctional Thoughts to write out counterstatements to instances of negative self-talk.

- Instruct clients to write affirmations to counter any beliefs which they rated 3 or 4 on the Mistaken Beliefs Questionnaire. They should make a list of these affirmations and read through them slowly each day Alternatively, they can make a tape, either in their own voice or someone else's, with the affirmations presented slowly at ten-second intervals. They can listen to the tape each day, following their deep relaxation session or before going to bed at night.

Week 11 (Shorter Program) or Week 18 (Longer Program) Homework Review

Briefly discuss homework from the preceding week.

Procedures

This is the final group session for the shorter program. Plan to summarize everything that has been learned. Emphasize the importance of a

multilevel approach to recovery. Tell clients that they will optimize their chances of making excellent progress by following up with all of the strategies learned during the group.

Ask clients to make an estimate of how much they've improved during the course of the group. What changes have they seen? Are they satisfied with their progress?

Have clients complete the Self-Evaluation form they filled out at the beginning of the group to track more specifically the progress they've made (see the section on Measuring Change under Week 18). Have group members discuss their findings.

Encourage clients to try, if they feel ready, to deliberately reach Level 10 on The Anxiety Scale in confronting phobic situations. This serves at least two purposes: a) if they do reach Level 10, they'll find out that they can go through it and still survive; b) taking conscious control by "willing" severe anxiety to come often stops the anxiety (this is the concept of paradoxical intention developed by Victor Frankel, Jay Haley, and others).

Discuss with clients their plans for continuing to work on recovery goals after the group has disbanded. Let them know that they can continue to call in with questions, concerns, or to talk about their progress.

Optional Activities

Follow up the last group meeting with a "graduation dinner" extending into the evening. Reframing the last meeting of the group as a festive occasion will help clients to deal better with feelings of loss and abandonment that will come up at this time. Encourage clients to maintain contact with each other after the group has ended.

Week 11: Feelings

Procedures

Tell clients that they can expect to have more feelings come up as they begin to confront phobic situations they've been avoiding for a long time. Emphasize that this is an expected part of their recovery, and that it's a sign that they're getting better.

Discuss reasons why phobic people have a tendency to suppress their feelings (see Chapter 12 of *The Anxiety and Phobia Workbook).* Have group members share characteristics of their parents or early family situations that might have contributed to the habit of withholding feelings.

Go over the list of symptoms of suppressed feelings described in Chapter 12 of *The Anxiety and Phobia Workbook* and have a discussion about

how to recognize suppressed feelings.

Hand out the "Feeling List" from Chapter 12 of *The Anxiety and Phobia Workbook* and discuss its use in identifying feelings.

Discuss the guidelines for dealing with anger presented in Chapter 12 of *The Anxiety and Phobia Workbook.* Pay special attention to attitudes that prevent agoraphobics from acknowledging their anger, such as fear of losing control over themselves or fear of alienating their significant other.

Stress the importance of discharging angry energy by writing it out or physically releasing it onto inanimate objects. Group members need to do this *before* they communicate anger to the person they perceive as responsible for their feelings. It's also appropriate to express angry feelings to a neutral person first and then prepare to make an assertive request of the person with whom they feel angry. (This is a good point at which to introduce the distinction between aggressive and assertive communication. This will be elaborated on in the following week.)

Use the last 30 minutes to have group members write a letter communicating their feelings to a significant person in their life who, for whatever reason, is not available for a direct confrontation (see Exercise 5 at the end of Chapter 12 in *The Anxiety and Phobia Workbook).* Then have several clients share their letters. This process works very well to bring up

feelings in the group.

Homework

- Have clients start keeping a feeling journal and give themselves the opportunity during the following week to share their feelings with a person they can trust (Exercises 3 and 4 at the end of Chapter 12 of *The Anxiety and Phobia Workbook).*

- *Have clients read Chapter 13 of The Anxiety and Phobia Workbook.*

Week 12: Assertiveness

Homework Review

Review homework on feelings from the preceding week. Suggest that clients continue to keep a feeling journal and/or set aside at least an hour and a half per week to share their deeper feelings with their partner or a friend they can trust (the latter person needs to listen carefully without interruption or judgment).

Procedures

Define the concept of assertiveness by contrasting it with various

nonassertive styles of communication (for example, submissive, aggressive, passive-aggressive, manipulative). Have clients complete the What's Your Style questionnaire in Chapter 13 of *The Anxiety and Phobia Workbook* (allow about 10 minutes for this), to identify their characteristic styles).

Hand out a copy of the Personal Bill of Rights presented in Chapter 13 of *The Anxiety and Phobia Workbook.* Have clients talk about which rights are especially important to them.

Discuss the various facets of assertive communication:

- Developing nonverbal assertive behavior
- Recognizing your basic rights
- Being aware of your feelings and knowing what you want
- Making an assertive request

Give special emphasis to various elements of an assertive request, such as keeping it short and simple, being concrete and specific, using *I*-statements, objecting to behaviors rather than to personalities, not apologizing for your request, and not demanding or commanding.

Model assertive behavior in front of the group by having one of the group members role-play a situation that demands your assertive response.

For example, one group member could play a salesperson who doesn't give up, or a retail clerk who wants to give a store credit rather than a refund.

Another example might involve a partner who won't cooperate with a particular household chore, or a parent who is being manipulative. Have clients share their reactions to the role play, then have them divide into dyads to give everybody the chance to practice. Person A plays the role of a mechanic who did extra, unsolicited work on Person B's car and demands that B pay for everything. When the roles are reversed, Person B plays the role of trying to persuade A to buy a product or engage in an activity that A isn't interested in. After both role-plays have transpired, the group reconvenes and discusses what happened.

Time permitting, discuss and illustrate some of the tactics for avoiding manipulation discussed in Chapter 13 of *The Anxiety and Phobia Workbook:* broken record, fogging, content-to-process shift, and so on.

Homework

- Clients should post the Personal Bill of Rights in a conspicuous place at home and read through it carefully every day during the following week.
- Everyone should complete the Assertiveness Exercises in Chapter 13 of *The Anxiety and Phobia Workbook* and turn

them in the following week.

- Group members can practice being assertive with friends or close family members, using the skills learned in today's session. Warn them not to expect significant others to be entirely supportive of their assertive behavior if they aren't accustomed to it. The purpose of learning to be assertive is not to please others, but to gain increased confidence about expressing one's own feelings and needs.

- Clients should share with someone whom they haven't told before that they are agoraphobic, explaining their condition. This is a bold but essential step to recovery. They can use the Dear Person Letter at the end of Chapter 6 of *The Anxiety and Phobia Workbook* as a guide for doing this.

- Clients should begin reading Chapter 14 of *The Anxiety and Phobia Workbook* for the following week.

Week 13: Self-Esteem 1—Taking Care of Yourself

Homework Review

Review the homework on assertiveness from the preceding week. Recommend that clients take a class or workshop on assertiveness (through the adult education programs at local colleges) so that they can continue practicing skills.

Procedures

Define the concept of self-esteem. It's often useful to derive a definition from the group's ideas about the meaning of self-esteem.

Discuss causes of low self-esteem in terms of the variety of dysfunctional family situations that can lead to feelings of insecurity, inferiority, or shame (as described in Chapter 14 of *The Anxiety and Phobia Workbook).*

Have clients identify (from the Needs list in Chapter 14 of *The Anxiety and Phobia Workbook)* those particular needs to which they would like to give more attention. What can they do specifically to better meet these needs?

Introduce the important concept of the inner child, defining it both as a source of playfulness and creativity, and the part of the individual which carries the pain and emotional trauma from childhood. Time permitting, lead clients through the inner child visualization presented in Chapter 14 of *The Anxiety and Phobia Workbook* (allow about 30 to 40 minutes for the visualization and for a discussion of feelings it brings up).

Homework

- Clients should select two or three needs from the needs list and take specific actions during the coming week to meet

those needs. Everyone will report on this the following week.

- Have clients take specific actions to cultivate a relationship with their inner child, as suggested in Chapter 14 of *The Anxiety and Phobia Workbook* (for example, writing a letter to the child, carrying around a childhood photograph, or engaging in activities that give expression to the child).

- Clients should follow through with one item from the list of Self-Nurturing Activities in *The Anxiety and Phobia Workbook* (pp. 271-273) each day during the following week.

- Part III of Chapter 14 from *The Anxiety and Phobia Workbook* is assigned reading.

Week 14: Self-Esteem 2—Personal Goals and Accomplishments

Homework Review

Review homework from the preceding week.

Procedures

Continue discussion from the preceding week about how to take care of the inner child. What will clients do over the next month to take better care of their needs and to cultivate a more intimate relationship with their inner child?

Talk about the relationship of goals and accomplishments to self-esteem, as discussed in Part III of Chapter 14 of *The Anxiety and Phobia Workbook.* What goals have clients accomplished in the group so far in terms of overcoming specific fears and phobias? After a discussion of recovery goals, have clients do a goals-clarification exercise for their life in general. They can complete the worksheet (My Most Important Personal Goals) in Chapter 14 of *The Anxiety and Phobia Workbook.* Allow 20 minutes to complete the worksheet, and then have clients share their goals before the group as a whole.

Time permitting, clients should also complete the worksheet at the end of Chapter 14 of *The Anxiety and Phobia Workbook,* listing previous accomplishments, and then share what they've written with the group. In most cases, it's best to do either this or the long-term goals list described above, rather than both, to allow time at the end for discussion. The other exercise is left as homework.

Homework

- Clients should complete either the worksheet on their most important personal goals or the list of previous accomplishments, to be turned in the following week. Hand out the list of self-esteem affirmations from Chapter 14 of *The Anxiety and Phobia Workbook.* Clients should select those affirmations that are most relevant or personally

meaningful. Then they either: a) write these down on a list, which they'll read through each day, or b) put them on tape (allowing 10 seconds between each affirmation), which they'll listen to each day.

- Chapter 15 of *The Anxiety and Phobia Workbook* is assigned reading.

Week 15: Field Trip 2

The guidelines for Week 8 are applicable here. It's desirable at this point to go to a larger shopping mall than the one dealt with in Week 8, or else one that is farther away. Some clients may choose at this time to work on practicing driving—or perhaps on bridges or heights—with another person in the group accompanying them, rather than confronting phobias about stores or restaurants.

Week 16: Nutrition

Procedures

Have group members share about their use of caffeinated beverages and refined sugar. Then discuss the importance of avoiding both, as considered in Chapter 15 of *The Anxiety and Phobia Workbook.* It's useful to have clients complete the caffeine chart in Chapter 15 and then discuss the importance of

reducing caffeine consumption to less than 100 mg a day. Also give some time to presenting the concept of hypoglycemia and its influence on anxiety and depression. Ask clients about whether they've noticed any symptoms of hypoglycemia (such as weakness, irritability, or spaciness three hours after a meal) and present dietary guidelines for stabilizing blood-sugar levels.

Review and discuss the Low Stress/Anxiety Dietary Guidelines presented in Chapter 15 of *The Anxiety and Phobia Workbook.* What steps toward meeting these guidelines are clients willing to take in the next month?

Talk about the role of vitamin supplements in increasing resistance to stress, with particular emphasis on B-vitamins, vitamin C, calcium, and magnesium. Good books for upgrading your knowledge about nutrition and supplements are *Diet and Nutrition,* by Rudolph Ballentine; and *Healing Nutrients,* by Patrick Quillin. Patricia Slagle's book, *The Way Up From Down,* is a good resource for the use of amino acids to treat depression.

Homework

- Have clients keep a food diary for one week, using the worksheet in Chapter 15 of *The Anxiety and Phobia Workbook,* to be turned in during the following week.

- Clients should start taking vitamin supplements. At the bare minimum, they should take a high potency multivitamin

tablet once per day. Preferably they can begin taking B-complex, vitamin C, and calcium-magnesium at the doses suggested in *The Anxiety and Phobia Workbook.*

Week 17: Meaning, Purpose, and Spirituality

Homework Review

Review homework from the preceding week, going over clients' food diaries.

Procedures

Present and discuss the existential perspective on anxiety, pointing out the connection between a lack of personal meaning or life direction and a predisposition to anxiety. A good background book for this discussion is Rollo May's *The Meaning of Anxiety.*

Clients should complete the Life Purpose Questionnaire from Chapter 17 of *The Anxiety and Phobia Workbook* (allow 20 to 30 minutes) and then share their responses with the group. What are they willing to do in the next weeks and months to take steps toward realizing their identified life goals?

As an alternative to a discussion of the existential perspective, you may want to focus on the theme of spirituality. This, of course, requires very

delicate handling because of probable differences in religious motivation and orientation among group members. Since the program is focused on recovery from agoraphobia—and is not a course on spiritual growth—a discussion of spirituality is left to the discretion of the group leader.

Have clients discuss their feelings about the group ending next week.

Homework

Beyond practicing basic skills of relaxation, exercise, desensitization, and countering self-talk, there is no specific homework assigned for this week. If clients feel that they need to spend more time on the Life Purpose Questionnaire, and/or ponder more deeply about what might give their life a greater dimension of meaning, they should do so.

Week 18: Conclusion

See the previous discussion under Week 11 (Shorter Program).

Criteria for Measuring Change

At the outset of the group, clients are given the Self-Evaluation form found at the end of this chapter and asked to rate their degree of confidence on a percentage basis for each relevant phobia at three times: 1) the

beginning of the group, 2) the end of the group, and 3) six months after the group has ended.

Problems Specific to the Group

Noncompliance

Since recovery from agoraphobia depends on learning and integrating a variety of skills, the greatest obstacle to progress is the client's unwillingness to complete weekly homework assignments. Several things can be done to foster compliance. At the beginning of the group, the leaders must emphasize that clients are responsible for their own recovery, and that doing the homework is essential to their progress. While the group can provide support, guidance, and structure, it cannot do the work for them. Going over the homework at the beginning of each group session and asking clients how they did with the assignments will help emphasize the importance of daily homework. Clients are also told to set up reward systems, where they allow themselves pleasurable activities (such as calling friends or reading a favorite book), contingent on completion of homework. Part of the homework, in fact, is to develop a self-reward system and to report on it to the group. (It's especially useful to set up a reward system for practicing real-life desensitization.)

Since real-life desensitization (exposure therapy) is at the very heart of the treatment, clients are asked to share how their practice is going from time to time following the introduction to desensitization in Week 6. Resistance to practice is confronted through systematic inquiry instead of by pressuring, coercing, or otherwise embarrassing the client in front of the group. Relevant questions to ask might be: "What do you think is getting in the way of you practicing exposure?" "How do you feel about practicing?" "Is there anything that you feel might help make it easier for you to practice?"

Lack of Motivation

It's important to take notice of low motivation on the part of any client and to discuss it—preferably one-on-one, rather than in front of the group. Reasons for poor motivation are numerous, and can include clinical depression, secondary gains for remaining phobic (such as not having to go to work or remaining dependent on a spouse, unconscious collusion with partner/spouse to sabotage treatment, overt fear of real-life exposure, and diversion of a client's attention away from the program by situational stressors). Since unmotivated clients seldom say anything about their problems, it's incumbent upon the leader to deal with motivational issues as soon as they appear.

If the group as a whole appears to be unmotivated, the leader needs to

examine his or her own leadership style and approach. Since many agoraphobic clients have a tendency to be depressed, a purely didactic style of conducting the group is usually inadequate. The leader must be able to create (and sustain) an atmosphere of enthusiasm, consistently providing encouragement that recovery is possible. Copious praise of group members for their successes will help. Fostering a feeling of support and strong cohesiveness among group members will also help. Cohesiveness can be built by leading dyadic exercises during the first few weeks to enable group members to get acquainted. It can be sustained by ensuring that clients make assigned phone calls to each other each week. Finally, the leader may ask for feedback from clients after the first few weeks.

Relapse Prevention

During the final session of the group, you should emphasize what it will take to maintain the gains acquired from the group and to continue making progress toward long-term goals for recovery. The following four skills need to be practiced by clients on a daily (or nearly daily) basis to ensure optimal immunity from a resurgence of generalized anxiety or panic attacks.

1. A deep relaxation technique

2. Physical exercise (if possible, aerobic)

3. Good nutritional habits, minimizing the use of stimulants, sugar,

and processed foods

4. Stopping negative self-talk through the use of distraction, positive counterstatements, or affirmations

To overcome specific phobias, clients need to continue practicing imagery and real-life desensitization at least twice a week (and preferably more often). Clients must practice exposure until they are able to enter and comfortably deal with *all* of the situations they previously avoided. Harboring even one phobic situation that is never confronted can lead to avoiding other phobic situations and a general regression to old patterns of thought and behavior.

Resistance

Resistance to practicing real-life exposure to phobic situations is typically the greatest stumbling block for clients. Leaders should make group members aware of this problem during the sixth or seventh week by saying something like the following:

> Undertaking exposure to a situation you've been avoiding may bring up resistance. Notice any procrastination or delay in getting started with your exposure sessions: whether your attitude is "I'll do it later." The mere thought of actually going into a phobic situation may elicit strong anxiety, a fear of being trapped, or self-defeating statements to yourself such as: "I'll never be able to do it," or "This is hopeless." Instead of getting stuck in your resistance, you can see your situation as a major therapeutic opportunity to learn about yourself and work through longstanding

patterns which have held your life up.

Once you work through your initial resistance to real-life desensitization, the going gets easier. If you feel that you're having problems with resistance at any point, let me or the assistant know.

Clients also need to be told to expect some discomfort when they first confront situations they've long avoided. Some level of discomfort is actually a sign that exposure is working. You can tell clients:

Facing situations that you've been avoiding for a long time is not particularly comfortable or pleasant. It's inevitable that you'll experience some anxiety. In fact, it's common during exposure therapy to feel *worse initially* before you feel better. Realize that feeling worse is *not* an indication of regression, but rather that exposure is really *working.* Feeling worse means that you are laying the foundation to feel better. As you gain more skill in handling symptoms of anxiety when they come up during exposure, your practice sessions will become easier and you'll gain more confidence about following through to completion.

The concept of "secondary gain" should also be explained at some point during the first ten weeks, for example:

Any person, situation, or factor that consciously or unconsciously *rewards you for holding onto your phobias* will tend to undermine your motivation. For example, you may want to overcome your problem with being housebound. However, if consciously or unconsciously you don't want to deal with facing the outside world, getting a job, or earning an income, you'll tend to keep yourself confined. Consciously, you want to overcome agoraphobia, yet your motivation is not strong enough to overcome the unconscious "payoffs" for not recovering.

You should then ask clients to think about whether any secondary gains

are impeding their progress. If so, they should write down what they feel their own secondary gains might be and submit this to the group assistant as part of the homework for the following week. Either the assistant or the leader then arranges a one-on-one conversation with the client, usually by phone, to explore those sources of resistance.

References

Barlow, D.H. *Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic*. New York: Guilford Press, 1988.

----, and Craske, M. *Mastery of Your Anxiety and Panic*. Albany, New York: Graywind Publications, 1989.

---- ; O'Brien, G.T.; and Lust, C.G. "Couples treatment of agoraphobia." *Behavior Therapy*, 1984, 15, 41-58.

----, and Waddell, M.T. "Agoraphobia." In *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*. Edited by D.H. Barlow. New York: Guilford Press, 1985.

Beck, A.T. *Cognitive Therapy and Emotional Disorders*. New York: New American Library, 1979.

----, and Emery, G. *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York: Basic Books, 1985.

Benson, H. *The Relaxation Response*. New York: David Morrow & Co., 1975.

Bourne, E.J. *The Anxiety & Phobia Workbook*. Oakland, California: New Harbinger Publications, Inc. 1990.

Davis, M.; Eshelman, E.R.; and McKay, M. *The Relaxation and Stress Reduction Workbook*. Third Edition. Oakland, California: New Harbinger Publications, 1988.

Hardy, A.B. *TERRAP Program Manual*. Menlo Park, California: TSC Publications, 1986.

May, R. *The Meaning of Anxiety.* New York: W.W. Norton & Co., 1977.

Munby, J., and Johnston, D.W. "Agoraphobia: The long-term follow-up of behavioral treatment." *British Journal of Psychiatry,* 1980, 137, 418-427.

Shaffer, M. *Life After Stress.* New York: Plenum Press, 1982.

Slater, E., and Shields, J. "Genetical aspects of anxiety." *British Journal of Psychiatry,* 1969, 3, 62-71.

Torgersen, S. "Genetic factors in anxiety disorders." *Archives of General Psychiatry,* 1983, 40, 1085-1089.

Westphal, C. Die Agoraphobia: Eine Neuropathische Eischeinung. *Archives für Psychiatrie und Nerven Krankheiten,* 1971, 3, 384-412.

Wolpe, J. *Psychotherapy by Reciprocal Inhibition.* Stanford, California: Stanford University Press, 1958.

----. *The Practice of Behavior Therapy*. Second Edition. New York: Pergamon Press, 1973.

Popular Books Relevant to Agoraphobia

Greist, J.W.; Jefferson, J.W.; and Marks, I.M. *Anxiety and Its Treatment.* New York: Warner Books, 1986.

Handly, R., with Neff, P. *Anxiety and Panic Attacks: Their Cause and Cure.* New York: Rawson Associates, 1985.

Neuman, F. *Fighting Fear: The Eight-Week Program for Treating Your Phobias*. New York: Bantam Books, 1986.

Seagrave, A., and Covington, F. *Free From Fears.* New York: Pocket Books, 1987.

Sheehan, D. *The Anxiety Disease.* New York: Bantam Books, 1986.

Swede, S., and Jaffe, S. *The Panic Attack Recovery Book.* New York: New American Library, 1987.

Weekes, C. *Hope and Help for Your Nerves.* New York: Bantam Books, 1978.

----. *Peace From Nervous Suffering.* New York: Bantam Books, 1978.

Wilson, R. Reid. *Don't Panic: Taking Control of Anxiety Attacks.* New York: Harper and Row, 1986.

NOTES

1 This scale was adapted from a similar one developed by Dr. Arthur Hardy in the TERRAP Program Manual, page 5. Menlo Park, California: TSC Publications, 1986.

Self-Evaluation[2]

This evaluation is designed to measure your own estimate of your ability to function in the situations mentioned below, and is an indication of your confidence in certain common situations both before starting the program, after finishing the program, and six months after the program. Using the scale below (10 to 100), please rate your ability and confidence level in each of the following areas.

10 20 30	40 50 60	70 80	90 100
almost impossible to handle; low confidence	able to handle sometimes; uncertain	usually able to handle; moderately confident	always able to handle; very self-confident
	Before	*After*	*6 Months Later*
Leaving safety of home in company of support person			
Functioning alone within your home			
Functioning alone outside your home			
Driving a car around your neighborhood with someone			
Driving a car around your neighborhood alone			
Driving a car on a freeway with someone			

Driving a car on a freeway alone

Riding as a passenger in a car

Being with small groups of people *(i.e.,* parties, etc.)

Being in crowds *(i.e.,* football games, shopping malls)

Air travel

Crossing bridges

Riding in elevators

Heights (from inside)

Heights (from outside)

Eating in restaurants

Signing name in public

Shopping in supermarket

Assertiveness

Ability to relax when alone

Ability to relax when in a group

Ability to communicate your feelings

Ability to accomplish goals you have set for yourself

Ability to handle anxiety without drugs or alcohol

Ability to handle changes in routine and/or new situations

Ability to assess situations in terms of reality

Ability to make decisions	
Self-image, in general	
Ability to set long-term goals for yourself	
Ability to take charge of your own life	

Name _____ Starting Date _____

Program Location_____ Ending Date _____

Notes

2 Adapted from the TERRAP Program Manual (TSC Publications, Menlo Park, California) with the permission of Dr. Arthur B. Hardy.