Purpose

Introduction

Important

Important

IV. Study Unit: Basic Techniques of the Psychotherapeutic Treatment of Anxiety

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The purpose of this chapter is to acquaint the user with the basic techniques of the psychotherapeutic treatment of anxiety.
After studying the chapter, the student will be able to assess the basic symptoms of anxiety, to make a cognitive conceptualisation of the symptoms of anxiety, and to employ the basic treatment techniques of the symptoms of anxiety.

Introduction

This chapter acquaints the reader with those more simple psychotherapeutic techniques, with the help of which one may be of assistance in alleviating the various symptoms of anxiety disorders more effectively.

Target group: General practitioners and medical students

Suggested study methods

Read the texts and watch the video sections belonging to each text.
Following this, answer the comprehension questions.
If you were not able to answer all the questions, survey the problematic parts in the texts again.
After that, do the exercises belonging to the video sections, and finally do the self-check tests.
We suggest that each course of lectures should be surveyed in one go.

Total **amount of study-time necessary:** 3 hours

Recommended Reading

Gabbard, G.O., Beck, J.S., Holmes, J. Oxford Textbook of Psychotherapy. Oxford University Press, 2007. In each chapter this will be the recommended reading.

Key words: anxiety, panic, aetiology, cognitive techniques, autogenic training, treatment of avoidance behaviour

Summary	**Content of Chapter:** **IV. Basic Techniques of the Psychotherapeutic Treatment of Anxiety** **IV.1 Anxiety and Fear** IV.1.1 Symptoms of Anxiety IV.1.1.1 Physical Symptoms of Anxiety IV.1.1.2 Emotional and Cognitive Symptoms of Anxiety IV.1.1.3 Logical Fallacies and Negative Beliefs Typical of Anxiety Disorders IV.1.1.4 Behavioural Change Concomitant with Anxiety **IV.2 The Aetiology of Anxiety** IV.2.1 Organic causes affecting the symptoms of anxiety IV.2.2 Behavioural therapeutic theory of the causes of anxiety disorders IV.2.3 The aetiology of anxiety in a cognitive approach IV.2.4 The psychoanalytical theory of the causes of anxiety **IV.3 Anxiety disorders** **IV.4 Psychotherapeutic Treatment of the Symptoms of Anxiety** IV.4.1 Discussing the symptoms of anxiety; cognitive conceptualisation of the symptoms; questioning anxiety-arousing cognitions IV.4.1.1 The educative stage of cognitive restructuring IV.4.1.2 Revealing panic-inducing cognitive processes and mechanisms IV.4.1.3 Cognitive conceptualisation of the symptoms of generalised anxiety IV.4.1.4 Revealing the alleviating and aggravating circumstances of the symptoms IV.4.1.5 Revealing logical fallacies; catastrophisation IV.4.1.6 Normalisation of symptoms with the help of psychoeducation IV.4.1.7 Identifying panic-attack inducing emotions IV.4.1.8 Revealing logical fallacies; emotional reasoning; distraction of attention IV.4.1.9 Attachment problems at the bottom of anxiety conditions IV.4.1.10 Case conceptualisation IV.4.1.11 Correction of dysfunctional assumptions and negative thoughts; cognitive diary; giving home assignments IV.4.1.12 Discussing home assignments and identifying cognitive schemata

	IV.4.2 Regaining control over the physical symptoms of anxiety IV.4.2.1 The autogenic training IV.4.2.1.1 Establishing therapeutic alliance with psycho-education IV.4.2.1.1.1 Assessing the effects of anxiety on the muscular system; its psycho-education IV.4.2.1.1.2 Assessing the effects of anxiety on the blood vessels of the skin and on perspiring; its psycho-education IV.4.2.1.1.3 Assessing the effects of anxiety on respiration; its psycho-education IV.4.2.1.1.4 Assessing the effects of anxiety on blood circulation; its psycho-education IV.4.2.1.1.5 Assessing the gastrointestinal symptoms of anxiety; its psycho-education IV.4.2.1.2 Presentation of autogenic training IV.4.2.1.2.1 Relaxation of the muscular system IV.4.2.1.2.1.1 Relaxation of the muscular system. Progressive relaxation IV.4.2.1.2.2 Feeling of warmth; exercise of relaxation of the vascular system IV.4.2.1.2.3 Exercises of respiration, blood circulation and the abdominal organs IV.4.2.1.2.3.1 The technique of breath control IV.4.2.1.2.4 Safe place imagination **IV.4.3 The treatment of avoidance behaviour concomitant with anxiety** IV.4.3.1 Assessing avoidance behaviour; selecting the target of the treatment IV.4.3.2 Exposition methods

Chapter IV.1: Anxiety and Fear

Fear and anxiety are phenomena with similar bodily experiences. Anxiety is an internal feeling of fear, where the person is not aware of the cause of the fear. In this chapter the symptoms of anxiety are presented. The physiological symptoms of anxiety are the expressions of the activation of the autonomic nervous system. Anxiety can be a normal reaction to a danger threatening direct physical damage or to such situations which present a danger to the self-esteem or the psychological well-being of the person. Normally, anxiety is the expression of the adaptive reaction of the organism. The autonomic nervous system prepares the organism for an increased motor activity that is to say, for fight or flight. A complete abolition of anxiety cannot be the goal of therapy. An anxiety with minor intensity can be motivating and may increase performance; a more intense anxiety, however, may result in function disorders (Yerkes and Dodson, 1908).

Symptoms similar to, or identical with, those of anxiety may be brought about by organic causes too, the diagnosis and termination of which may decrease or abolish pathological levels of anxiety.

Important

We speak of pathological anxiety when there is no immediate physical or psychological danger, or when the degree of the emotional reaction is not in proportion to the danger. Anxiety can be the symptom of almost all mental illnesses. Anxiety disorders are such mental illnesses where the leading symptom is anxiety.

IV.1.1 Symptoms of Anxiety

Anxiety has physical, cognitive and behavioural symptoms. The symptoms of anxiety, concerning their course, may be of durable standing, as, for example, in generalised anxiety, or may develop paroxysmally as in a panic attack. The onset of panic attacks may be effected by some external cause as, for example, in phobias, by some internal cause as in compulsive disorders, and there are instances when the cause itself cannot be easily grasped by the patient as in panic disorders.

Task
List the physical symptoms of anxiety

IV.1.1.1 Physical Symptoms of Anxiety

Important

The physical symptoms of anxiety affect almost all organ systems. In the table below we list the physical symptoms of anxiety for each and every organ system.

Legend: *Table 1: The physical symptoms of anxiety.*

Cardiovascular System:
- Palpitations
- Tachycardia
- Substernal pressure, precordial pain not related to exertion
- Facial flushing
- Feelings of having a heart attack

Pulmonary System:
- Shortness of breath
- Sense of inability to get enough air, sense of suffocation
- Repeated yawning or sighing
- Feeling of a tight band around the chest or throat
- Excessive dryness of the mouth

Gastrointestinal System:
- Epigastric discomfort, pain, fullness
- Belching, heartburn
- Feeling of being unable to swallow
- Nausea
- Diarrhea or constipation
- Anorexia or overeating to calm anxieties

Nervous System:
- Difficulty in concentrating, poor memory
- Dizziness, lightheadedness, syncope, typically no loss of consciousness
- Insomnia
- Nightmares
- Headaches
- Blurred vision
- Numbness or tingling of the extremities and/or periorally
- Tremors, muscle pain or stiffness
- Weakness of extremities
- Inability to sit still or to relax, feeling of being tense

Genitourinary System:
- Increased frequentcy of urination
- Alterations in menses
- Decreased libido
- Impotence, anorgasmia, dyspareunia

IV.1.1.2 Emotional and Cognitive Symptoms of Anxiety

Task

List the emotional and cognitive symptoms of anxiety

As a result of anxiety powerful emotions arise. In compulsive disorders fear is a determinant emotion. In social phobias shame, along with anxiety and fear, is the most determinant emotion. In generalised anxiety disorders and other long-standing anxiety disorders symptoms typical of depression often develop and a depressive disorder may also develop.

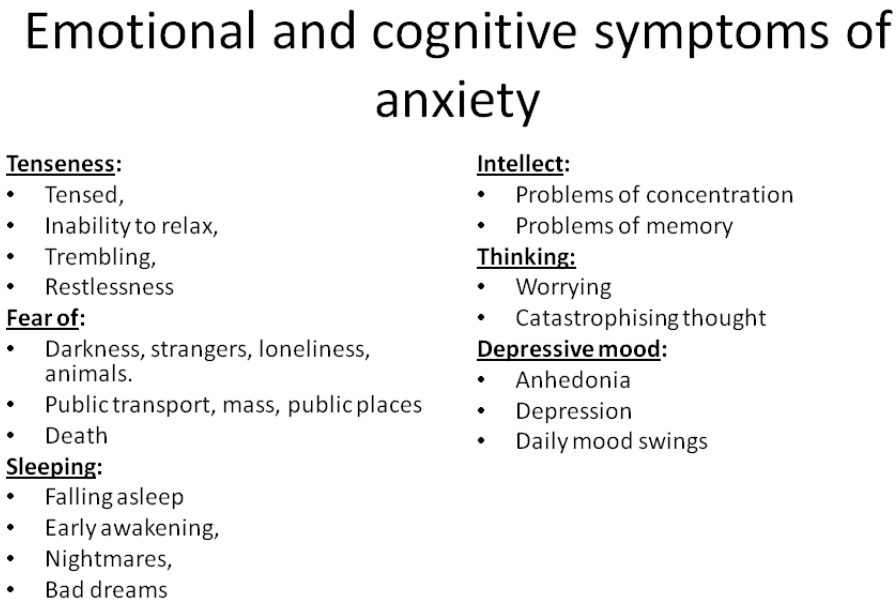
Anxiety affects the cognitive performance as well. An anxiety with minor intensity, on account of its vitalizing and motivating effect, may increase cognitive performance. A more intense anxiety may impair cognitive performance, and may cause attention and concentration disorders.

Task – Read the logical fallacies and find other examples of them

Table 2 presents the emotional and cognitive symptoms of anxiety.

Important

Table 2: The emotional and cognitive symptoms of anxiety.



IV.1.1.3 Logical Fallacies and Negative Beliefs Typical of Anxiety Disorders

Anxiety may be brought about by anxiety provoking thoughts, and just the other way round, an increase of anxiety activates anxiety provoking thoughts which may further increase anxiety. Logical fallacies are typical of the way of thinking of clients suffering from anxiety disorders. The most common logical fallacy in anxiety disorders is catastrophisation.

Legend: *Supplement 2: Logical Fallacies*

COGNITIVE DISTORTIONS AND LOGICAL FALLACIES.

Question

Which are the behavioural symptoms of anxiety? What are their functions?

1. **All-or-nothing thinking** (splitting), also called dichotomous thinking.– Thinking of things in absolute terms, like "always", "every", "never", and "there is no alternative". Few aspects of human behavior are so absolute. All-or-nothing-thinking can contribute to depression, anxiety and other psychopathology.

2. **Overgeneralization** – Taking isolated cases and using them to make wide generalizations.

3. **Mental filter** – Focusing almost exclusively on certain, usually negative or upsetting, aspects of an event while ignoring other positive aspects. For example, focusing on a tiny imperfection in a piece of otherwise useful clothing.

4. **Disqualifying the positive** – Continually deemphasizing or "shooting down" positive experiences for arbitrary, ad hoc reasons.

5. **Jumping to conclusions** – Drawing conclusions (usually negative) from little (if any) evidence.

6. **Mind reading** – Assuming special knowledge of the intentions or thoughts of others.

7. **Fortune telling** – Exaggerating how things will turn out before they happen.

8. **Magnification and minimization** – Distorting aspects of a memory or situation through magnifying or minimizing them such that they no longer correspond to objective reality. In depressed clients, often the positive characteristics of other people are exaggerated and negative characteristics are understated.

9. **Catastrophizing** – Focusing on the worst possible outcome, however unlikely, or thinking that a situation is unbearable or impossible when it is really just uncomfortable.

10. **Emotional reasoning** – Assuming reality to reflect emotions, e.g. "I feel it, therefore it must be true."

11. **Should statements** – Patterns of thought which imply the way things "should" or "ought" to be rather than the actual situation the patient is faced with, or having rigid rules which the patient believes will "always apply" no matter what the circumstances are.

12. **Labeling and mislabeling** – Explaining behaviors or events, merely by naming them; related to overgeneralization. Rather than describing the specific behavior, a patient assigns a label to someone or himself that implies absolute and unalterable terms. Mislabeling involves describing an event with language that is highly colored and emotionally loaded.

13. **Personalization** – Attribution of personal responsibility (or causal role) for

events over which the patient has no control. This pattern is also applied to others in the attribution of blame.

IV.1.1.4 Behavioural Change Concomitant with Anxiety

Behavioural changes concomitant with anxiety can be divided into two groups: the behavioural symptoms belonging to anxiety and the symptoms of fighting with the symptoms of anxiety.

1.) Components of the *behaviour belonging to anxiety*:

a) (they are manifested) partly in the motor appearance of tension,

b) partly in expressive behaviour,

c) and partly in the components of motor coping:

i) fight

ii) flight

iii) freeze

2.) *Safety behaviours* aimed at preventing anxiety:

The function of part of the behavioural changes concomitant with anxiety is to terminate the inconveniences caused by anxiety. The problem with these forms of behaviour is that they may further increase the symptoms of anxiety or may play a considerable role in preserving them. The hyperventilation arising to alleviate the symptoms concomitant with the anxiety and affecting the respiratory system may further increase the severity of the panic attack. The avoidance behaviour joining the phobias may preserve the phobic symptoms and may further increase the anxiety joining the phobias. Under compulsion, to reduce the anxiety caused by the compulsive thought, safety seeking behaviour is an active avoidance behaviour (compulsive actions). In the given situation these actions decrease anxiety; nevertheless they play a role in preserving them in the long run, since the cessation of anxiety reinforces this behaviour.

Legend: *Table 3: The symptoms of anxiety behaviour.*

Behavioral symptoms of anxiety

1. Anxiety related motor symptoms:

- hand tremor,
- restlessness,
- frequent breathing (over 20 breath/min)
- trembling

2. Anxiety related emotional expressions:

- tensed facial expression,
- exophtalmus,
- dilatations of pupills
-

3. Anxiety related adaptive motor programs:

- flight
- fight
- freezing
-

4. Anxiety related safety behaviour:

- avoiding behaviour: avoiding anxiety provoking situations
- hyperventillation: to reduce feelings of dyspnoe
- compulsive behaviors: to reduce obsessive thought induced anxiety

Important

Task

Summarize the behavioural therapeutic theory of the causes of anxiety disorders

Question: What is the cognitive model of anxiety?

Chapter IV.2: The Aetiology of Anxiety

IV.2.1 Organic causes affecting the symptoms of anxiety

The various diseases of internal organs, stimulants, and narcotics may cause symptoms of anxiety or those of something resembling anxiety. Prior to commencing psychotherapeutic treatment, these causes have to be precluded. In the case of organic causes, these have to be treated first.

Legend: *Table 4: Organic causes of anxiety.*

Organic causes of anxiety

- **Neurological disorders:** Cerebral neoplasms, cerebral syphilis, cerebral trauma, cerebrovascular disease, encephalitis, epilepsy,Huntington's disease, migraine, multiple sclerosis, postconcussional syndrome, subarachnoid hemorrhage, and Wilson's disease
- **Hypoxia:** Anemia, cardiac arrhythmias, cardiovascular disease, and pulmonary insuffi ciency
- **Endocrine disorders:** Adrenal dysfunction, disorders of female virilization, parathyroid dysfunction, pheochromocytoma, pituitary dysfunction, and thyroid dysfunction
- **Infl ammatory diseases:** Polyarteritis nodosa, rheumatoid arthritis, systemic lupus erythematosus, and temporal arteritis
- **Other systemic disorders:** Carcinoid syndrome, chronic infections, febrile illnesses, hypoglycemia, infectious mononucleosis, porphyria, posthepatitis syndrome, uremia, and systemic malignancies
- **Toxic agents:** Alcohol, amphetamines, arsenic, benzene, cannabis, caffeine, carbon disulfi de, mercury, organophosphates,
- penicillin, phosphorus, sulfonamides, sympathomimetic agents, and vasopressors
- **Vitamin deficiencies:** Pellagra and vitamin B12 defi ciency

IV.2.2 Behavioural therapeutic theory of the causes of anxiety disorders

According to behavioural therapy, anxiety may occur as a conditioned response to fear. During the process of conditioning the conditional stimulus (underground station) occurs together with an unconditioned, fear-triggering stimulus (escalator went wrong, I cannot escape), and the fear reaction is associated with the conditional stimulus (underground station). An anxiety disorder develops when a fear-reaction is conditioned to the stimulus that does not unconditionally elicit fear (agoraphobia: underground station elicit fear reaction). If, for example, a girl has grown up with an abusive father, the anxiety appears at the sight of the father. The process of generalisation may lead to the triggering of anxiety at the sight of all grown-up males. According to the social learning model anxiety disorder may develop in a child who is growing up amongst anxious parents. If a parent reacts

to all physical symptoms of the child with alarm, the child will learn that normal bodily functions are alarming.

IV.2.3 The aetiology of anxiety in a cognitive approach

A common feature of the various cognitive models is that they emphasise the role of those internal evaluating processes in the development of anxiety, which give an estimation of the possible dangers in a given situation. Another common element is the anticipatory phase, the pre-situational danger assessment, which is characterized by the negative overvaluation of the possible (physical or social) outcome. Behind all these there exist numerous irrational and permanent thinking distortions. In preserving anxiety the concurring increased vegetative arousal and the behavioural changes play an important role. If the safety behaviour aimed at preventing anxiety is the passive avoidance, this leads to panic and phobia. Under compulsion, to reduce the anxiety caused by the compulsive thought, safety seeking behaviour is an active avoidance behaviour (compulsive actions). In the given situation these actions decrease anxiety; nevertheless, they play a role in preserving them in the long run, since the ceasing of anxiety reinforces this behaviour.

IV.2.4. The psychoanalytical theory of the causes of anxiety

Freud made a distinction between fear, which is objective anxiety, and neurotic anxiety.

Fear or objective anxiety consists of three components: 1/ real external danger, 2/ proper assessment of danger as a potentially harmful phenomenon, 3/ emotional experience of anxiety, the intensity of which is in proportion to the degree of danger.

Question
According to psychoanalytical theory, which are the major mechanisms that elicit anxiety?

Neurotic anxiety was described by Freud as a psychobiological process; here, however, the danger is within: an illicit drive, which had been punished in childhood, was suppressed, and then went out of control of the individual, is now made conscious anew, and fills the individual with anxiety. For instance, in his childhood his self-asserting anger was followed by the love-withdrawal of the attachment figure, thus as soon as the realization of his desires and goals are illegitimately restricted, he gets angry, but his anger is associated in his

Important	unconscious with the love-withdrawal of the attachment figure, and this precipitates an acute separation anxiety in him. So, instead of anger he feels anxiety. There are different forms that are distinguished as the causes of anxiety. The most powerful of these is the *disintegration anxiety*, inspired by the feeling of the disintegration of the personality – this is typical mainly in severe personality and psychotic disorders. In the case of *persecution anxiety* an external persecuting person threatens the individual with annihilation. In *separation anxiety* fearing of losing the important attachment figure is determinant. In the case of fearing *the loss of love*, it is not losing the attachment figure which affects anxiety in the individual, but that he loses the love of that person. *Castration anxiety* occurs during the sexual development of the individual, and is expressed in fears of the damage of the sex organs, or in every such situation, where the person is required to exercise adult sexuality. Typical of mature personalities is the *superego anxiety*, which occurs subsequent to the development of internalized moral values, when the person deems his own deeds improper, and this brings about anxiety in him. **IV.3 Anxiety disorders** Anxiety disorders are classified on the basis of the course of the anxiety symptoms, and of the exacerbating factors, and of the safety behaviours. Legend: *Table 5: Anxiety disorders DSM-IV.*

ANXIETY DISORDERS

(DSM-IV-TR, 2000)

- Panic Disorder with Agoraphobia or without Agoraphobia
- Agoraphobia without Panic Disorder
- Specific Phobias
- Social Phobia
- Obsessive–Compulsive Disorder (OCD)
- Posttraumatic Stress Disorder (PTSD)
- Acute Stress Disorder
- Generalized Anxiety Disorder
- Anxiety disorder Not Otherwise Specified

IV.4 Psychotherapeutic Treatment of the Symptoms of Anxiety

Important

The basis for the treatment of the person suffering from anxiety symptoms is provided by the establishment of a therapeutic relationship that grants safety and has an atmosphere of acceptance. During medical practice we often meet persons suffering from anxiety disorders. In the course of the medical treatment, there are numerous situations which provoke anxiety. We are also presenting a few basic techniques for the treatment of persons suffering from anxiety disorder.

In the following videos we present the psychotherapeutic treatment of a patient suffering from anxiety disorder.

IV.4.1 Discussing the symptoms of anxiety; cognitive conceptualisation of the symptoms; questioning anxiety-arousing cognitions

IV.4.1.1 The educative stage of cognitive restructuring

Important

In the first phase of the treatment of the anxiety and panic attacks we try to make the patient recognize the anxiety inducing erroneous assessment of the bodily sensations, and we explain to him that the panic indisposition is in fact the result of reactions, which can be considered natural.

In the case of anxiety disorders with concomitant panic symptoms it is of great help for the patient if he can understand that his complaints are not the indications of a grave and mortal physical illness, but are the symptoms of a panic attack, which constitutes no threat to his life and can be treated with psychotherapy and/or with medicine.

The assessment of the initial symptoms of John reveals that on account of his panic attacks, the patient had recurrently been taken to doctors, hospitals and heart specialists, and he was never informed of the nature of his affliction in a satisfactory manner. The fact that he has no physical disease could not set his mind at rest, since for him the heavy pain that entails a panic attack meant that he suffers from a serious illness, only the doctors have yet not been able to identify it.

IV.4.1.2 Revealing panic-inducing cognitive processes and mechanisms

We are illustrating with examples how determinant the interpretations can be with regard to the emotional reactions given to the eliciting situation. Panic indispositions are often attached to external circumstances by patients, and the automatic negative interpretations are connected to these situations. Often these are not even made conscious; it is only the feeling of anxiety that remains. An important element of the therapy is improving the patient's skill of recognizing and identifying these thoughts. We may, for instance, help him by asking: "What thought crossed your mind in that instant?"

An important part of the treatment of panic attacks is informing the patient of the nature of his indisposition. The gravity of the attacks lessens even by the patient's realizing that he has no mortal disease, "only" a panic attack.

IV.4.1.3 Cognitive conceptualisation of the symptoms of generalised anxiety

Besides the panic attack, the patient also reports on worrisome thoughts concomitant with fearful anticipation typical of generalised anxiety. Cognitive therapy maintains that at the bottom of generalised anxiety one can find the distorted processing of information coming from the surrounding environment, which is the result of the selective attention focussed on the negative characteristics of events.

Important

The therapist helps to break down the condition overwhelming the patient to its components, to name these components, and, by means of the case conceptualisation sheet, to prepare later interventions.

The anxiety experience is broken up into the following components:

- events eliciting symptoms (he thinks of his friend)
- automatic thoughts evaluating events (he must have been hit by a car)
- emotional reactions (worrying, palpitations)
- safety behaviour (he phones the friend)
- the cognitive schema in the background of the complaints is also revealed, along with the life-spanning character of the symptom
- and the memory of that recurrent childhood fear that the emergence of the important attachment figures (the parents) was totally unpredictable. A frequent theme of both panic disorders and generalised anxiety is the fear of separation involving the safety-providing attachment figure (parent, partner) is not accessible.

A_P_1_Figure_IV_4_1_

Legend: *Figure 1: The 3-Column Table – Anxiety over friend's accident.*

Event	**Negative automatic thought**	**Reaction: feeling, physiology, behavior**
Pain in the chest	I will die	Fear of death Tachicardia Call the ambulance

Important

IV.4.1.4 Revealing the alleviating and aggravating circumstances of the symptoms

An early step of the treatment is to help the patient to collect the means by which he was able to alleviate the gravity of anxiety or avoid its occurrence all by himself. Psychotherapy is feasible only if the patient has his own resources for overcoming his illness.

Of the symptom-reducing methods employed by the patient himself, four could so far be identified:

- distracting attention from the physical symptoms
- establishing connections
- cognitive reassessment of symptoms
- collecting information about the illness

IV.4.1.5 Revealing logical fallacies; catastrophisation

Logical fallacies are cognitive mechanisms which in the course of thinking, remembering, perceiving and planning highlight the negative and threatening aspects of things, and by doing so, distort experiences into a negative direction.

Legend: *Supplement №2: Logical Fallacies*

COGNITIVE DISTORTIONS AND LOGICAL FALLACIES.

Important

1. **All-or-nothing thinking (splitting), a**lso called dichotomous thinking– Thinking of things in absolute terms, like "always", "every", "never", and "there is no alternative". Few aspects of human behavior are so absolute. All-or-nothing-thinking can contribute to depression, anxiety and other psychopathology.

2. **Overgeneralization** – Taking isolated cases and using them to make wide generalizations.

3. **Mental filter** – Focusing almost exclusively on certain, usually negative or upsetting, aspects of an event while ignoring other positive aspects. For example, focusing on a tiny imperfection in a piece of otherwise useful clothing.

4. **Disqualifying the positive** – Continually deemphasizing or "shooting down" positive experiences for arbitrary, ad hoc reasons.

5. **Jumping to conclusions** – Drawing conclusions (usually negative) from little (if any) evidence.

6. **Mind reading** – Assuming special knowledge of the intentions or thoughts

	of others. 7. **Fortune telling** – Exaggerating how things will turn out before they happen. 8. **Magnification** and **minimization** – Distorting aspects of a memory or situation through magnifying or minimizing them such that they no longer correspond to objective reality. In depressed clients, often the positive characteristics of *other people* are exaggerated and negative characteristics are understated. 9. **Catastrophizing** – Focusing on the worst possible outcome, however unlikely, or thinking that a situation is unbearable or impossible when it is really just uncomfortable. 10. **Emotional reasoning** – Assuming reality to reflect emotions, e.g. "I feel it, therefore it must be true." 11. **Should statements** – Patterns of thought which imply the way things "should" or "ought" to be rather than the actual situation the patient is faced with, or having **rigid rules** which the patient believes will "always apply" no matter what the circumstances are. 12. **Labeling and mislabeling** – Explaining behaviors or events, merely by naming them; related to overgeneralization. Rather than describing the specific behavior, a patient assigns a label to someone or himself that implies absolute and unalterable terms. Mislabeling involves describing an event with language that is highly colored and emotionally loaded. 13. **Personalization** – Attribution of personal responsibility (or causal role) for events over which the patient has no control. This pattern is also applied to others in the attribution of blame.
Important **Question** **What is emotional reasoning?** **Important**	In the development of a panic attack, the phenomenon of catastrophisation plays an important role. We call catastrophisation the phenomenon, when one deems an occurrence a harbinger of some terrible catastrophe. When the patient, in the case of a panic attack, perceives that something works differently in his body (his heart is throbbing violently; he breaths heavily; there is a twinge in his chest; he has a headache, he feels numb, etc.), he deems it a harbinger of some mortal illness. This induces a fear of death in him, which leads to further anxiety and the perception of further bodily symptoms. If the catastrophising assessment of the bodily changes can be transformed successfully, then no panic attack will develop from the anxiety later on. One of the techniques of the cognitive treatment of panic is the questioning of the catastrophising thoughts. In the course of the assessment we demonstrate the technique to be employed, and examine how the patient reacts to it. Legend: *Figure №2: The 7-Column Table. Panic Symptoms – Catastrophisation.*

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Event	Negative automatic thought	Reaction: feeling, physiology, behavior	Reasons pro negative tought	Reasons against negative tought	Logical fallacy used	Re-evaluation of event	Changes of reaction
Pain in the chest	I will die	Fear of death Tachicardia	Bodily sensations are stronger and stronger	Doctors said that my heart is healthy.	Catastrophisation	These are the symptoms of anxiety	Fear of death disappears and anxiety is reduced

IV.4.1.6 Normalisation of symptoms with the help of psycho-education

An important element of the treatment of panic disorder is psycho-education, which in this case means that the patient is informed that the realized bodily activity, experienced as a harbinger of catastrophe, is in fact part of the normal functioning of the organism. In the enclosed video recording we demonstrate this technique, which we call *normalisation of somatic sensations.*

In the development of a panic attack an important role is attributed to the fact that the patient pays increased attention to his bodily or somatic activities and ascribes catastrophising meaning even to normal functioning. Most processes of the functioning of the organism (muscular activity, respiration, cardiac action, digestion, etc.) happen automatically and there is no need for them to be made conscious. Under physical stress or in emotional states the functioning of the organs may become conscious. Conscious somatic activities are normally not ascribed with a catastrophising meaning, thus they do not cause anxiety.

IV.4.1.7 Identifying panic-attack inducing emotions

In the course of the cognitive conceptualisation of the anxiety problem, the therapist and patient discuss many situations that may induce a panic disorder. In

	the case of John, we are trying to reveal the broader context of the inducement of the panic attack. If the patient is alone, his attachment system becomes activated and alarms him that he is in danger. In his case separation anxiety acquires concrete meaning by recalling the savage murders broadcasted in television news reports. Meanwhile the therapist, by assessing traumas, excludes the post-traumatic origin of the symptoms. Those fantasies, in which he becomes the victim of a murder, induce powerful fear in him which is accompanied by somatic symptoms, the catastrophising interpretation of which launches the panic attack. It is of great help for the patient if he understands that the panic attack does not come out of nothing, but is preceded by a feeling, which is accompanied by somatic symptoms. **IV.4.1.8 Revealing logical fallacies; emotional reasoning; distraction of attention** ***Emotional reasoning:*** On the basis of his "strong" feelings the person considers something to be true (he currently believes it), and underrates or ignores the facts supporting the contrary. Recognizing and questioning emotional reasoning helps alleviating the symptoms of anxiety. **IV.4.1.9 Attachment problems at the bottom of anxiety conditions** One of our basic instincts is the attachment instinct. The survival of a baby depends on whether the attachment figure (its mother or another nursing person) is near to it or not. At the departure of the attachment figure an alarm reaction occurs in the baby, leading to acute anxiety and the feeling of fear. The return of the attachment figure brings about the alleviation of the fear-reaction, then total relief. Even in adulthood, when we are in trouble, the presence of those near to us, comforts us. It is typical of persons suffering from anxiety disorder that in the presence of the attachment figure their anxiety symptoms lessen, and panic attacks do not eoccur. **IV.4.1.10 Case conceptualisation**
Important	

An important part of the treatment is to make it clear for the patient, what connections there are between the external and internal events, the negative thoughts assessing the events, the emotional end somatic reactions, as well as the safety and coping behavioural responses. The summary and representation of these phenomena in a process model we call *case conceptualisation*. Case conceptualisation is an appropriate means for strengthening the therapeutic alliance. In the course of a case conceptualisation it can be discovered if the therapist had misunderstood something, and the therapist and patient can work together in elaborating the processes happening within the patient. Case conceptualisation helps the patient to understand the development of the symptoms overwhelming him and the processes happening in the background. The significance of the individual psychotherapeutic interventions can easily be made understandable through case conceptualisation.

IV.4.1.11 Correction of dysfunctional assumptions and negative thoughts; cognitive diary; giving home assignments

One of the possible cognitive therapeutic methods is writing a diary, in which the patient analyzes his indispositions. It is important for him to realize that the negative interpretation developed in him on the impact of external or internal experiences, is only one of the possible hypotheses. We have to suggest to him that there are numerous other interpretations as well. These should be written down by him in columns. This is the "multi-column" technique, was developed by Aaron Beck in 1976.

IV.4.1.12 Discussing home assignments and identifying cognitive schemata

In the anxiety diary, assembled with the multi-column method, negative automatic thoughts are generally organised around various themes. According to the assumption of the cognitive model, in the background of these themes cognitive schemata can be found. It is characteristic of cognitive schemata that when activated in various life situations, they heavily distort the interpretation of certain phenomena.

An important part of the therapy is the identification and naming of the cognitive schemata. Subsequent to the naming the next task is that the patient should be able to identify the moment when a schema is being activated, and at the activation of

the schema he should be able to question his negative automatic thoughts.

Another aim is to strengthen more alternative adaptive cognitive schemata, thereby facilitating the more realistic judging of situations.

IV.4.2 Regaining control over the physical symptoms of anxiety

We are presenting here the four techniques (presented in Table I.) of regaining control over somatic symptoms of anxiety.

1. ***Psycho-education*** refers to the information given about somatic symptoms. This aims to normalize the physiological changes accompanying anxiety. The fact that the doctor knows about these symptoms, is in itself a reassuring feeling for the patient. If he finds out that these are common human phenomena and there are many other people experiencing them, it reduces his feeling that he is alone in the world with a weird illness. It brings him great relief if we tell him that the physiological changes caused by anxiety are part of the normal functioning of the body, and are no premonitory symptoms of some grave illness.

2. ***Autogenic training, progressive relaxation*** aims to alleviate the physiological changes accompanying anxiety, and create a relaxed and calm physiological condition.

3. ***Breath control*** is a common technique, which serves to control the hyperventilation that plays an important role in the development of panic attacks.

4. ***Safe place imagination*** refers to technique of developing a cognitive skill, by the help of which patients learn to bring about the feeling of safety.

Important

IV.4.2.1 Autogenic training

A method developed by J. H. Schultz, first published in 1932. As its name suggests, it’s a regular training done by ourselves, in the course of which we acquire a totally relaxed mental and somatic state by concentrative self-relaxation and a passive attention directed to ourselves. The result of regular training is an

	"organismic switch" to rest tone, which means that in possession of this skill we are able to control our organic and mental activities in accordance with our actual intentions and purposes. **The basic level of autogenic training consists of six exercises:** 1. Relaxing the muscles. 2. Feeling of warmth in the skin. Relaxing the vascular system. 3. The exercise of the heart. 4. The exercise of breathing. 5. Warming up the abdomen, balancing the gastro-intestinal system. 6. Exercise of the coolness of the forehead. Autogenic training is a very useful method in treating anxiety disorders, since with the help of the first 5 exercises the person can reach an effect contrary to the characteristic somatic concomitants of anxiety, thus alleviating or even terminating the vegetative component of anxiety. Before we start teaching the patient the practice of autogenic training, it is worth explaining him the essence of the method and how it relates to the problem of anxiety. **IV.4.2.1.1 Establishing a therapeutic alliance with psycho-education** Establishing an appropriate therapeutic alliance increases the efficiency of the therapeutic intervention and cooperation of the patient. A therapeutic alliance is principally determined by three factors: an agreement (1) concerning the goals of therapy, (2) concerning the duties of therapist and patient, and (3) a warm and accepting relationship. At the introduction of each new technique it should be made clear for the patient how that particular technique (autogenic training, relaxation) connects to the mutually set goal (in this case to the controlling of the panic attack), and how what they are about to do together will lead to the alleviating of the problem. In the case of autogenic training, the connection between certain tasks of the training and the symptoms of anxiety should be clarified for the patient, so that he would understand how the tasks will lead to the alleviation of the somatic symptoms of anxiety. **IV.4.2.1.1.1 Assessing the effects of anxiety on the muscular system; psycho-**

education

One of the most characteristic concomitants of anxiety is the increase of muscular tension. Anxiety occurs as the result of the mentally experienced danger, and one part of this anxiety is muscular tension. Relaxation of the muscles reacts upon the mental state and reduces the gravity of the anxiety experience.

IV.4.2.1.1.2 Assessing the effects of anxiety on the blood vessels of the skin and on perspiring; psycho-education

The coolness and dampness of the skin are frequent symptoms of anxiety. When discussing the symptoms, it is important to take good care, in the course of identifying the symptoms, not to induce renewed anxiety in the worrying and anxious patient.

IV.4.2.1.1.3 Assessing the effects of anxiety on respiration; psycho-education

Assessing hyperventilation employed as a compensating strategy for terminating heavy breathing, a lump-in-the-throat feeling and a feeling of suffocation at the occurrence of anxiety may help in the normalisation of phenomena.

IV.4.2.1.1.4 Assessing the effects of anxiety on blood circulation; psycho-education

Placing tachycardia, palpitations and other cardiac and thoracic troubles into proper context, and the continuation of cognitive techniques, since we give normalizing meaning to these symptoms instead of the catastrophising interpretation employed by the patient.

IV.4.2.1.1.5 Assessing the gastrointestinal symptoms of anxiety; psycho-education

Identifying gastrointestinal complaints helps the patient in normalising the abdominal symptoms.

IV.4.2.1.2 Presentation of autogenic training

After assessing those somatic symptoms of anxiety, which the autogenic training aims to alleviate, we demonstrate the exercise.

IV.4.2.1.2.1 Relaxation of the muscular system

The muscular system is under our volitional control, therefore patients can master this method relatively easily. Some patients, however, have initial problems with mastering passive relaxation. In such cases we recommend contrasting relaxation with tensing the muscles. This method helps patients understand on experience level what passive relaxation is like.

IV.4.2.1.2.1.1 The relaxation of the muscular system: progressive relaxation

Although the method of progressive relaxation contains the muscle-relaxing technique employed by autogenic training, nevertheless it is an active relaxation technique. It is mainly recommended in the case of patients who have problems with passive relaxation. It is based on the notion that if stress or tension is accompanied by muscle tension, then relaxing the muscles will bring about the decrease of mental tension. Its aim is that by retuning the motor end of the psychomotor chain, that is the muscle system, a mentally relaxed state shall be reached.

IV.4.2.1.2.2 Feelings of warmth: relaxation exercise for the vascular system

Contracting and relaxing the muscles of blood vessels cannot be influenced by us. Our skin blood vessels give quick responses to emotional impacts: e.g. blushing to shame or cooling down of the limbs to fear. In a pleasant, calm and relaxed state our skin normally feels warm, for the walls of the blood vessels of the skin are relaxed, and blood circulation is increased. The aim of the exercise is to create a state contrary to anxiety in the blood vessels of the skin as well. The mechanism for mastery is based on the following phenomenon: by imagining the warming-up of the skin and by the uttered sentences we can attain the dilatation of the blood vessels. With the relaxation of the muscles vein tonicity subsides in the small arteries and in the skin capillaries; and with the dilatation of the blood vessels of the skin the sensation of warmth increases.

IV.4.2.1.2.3 Exercises for respiration, blood circulation and the abdominal

organs

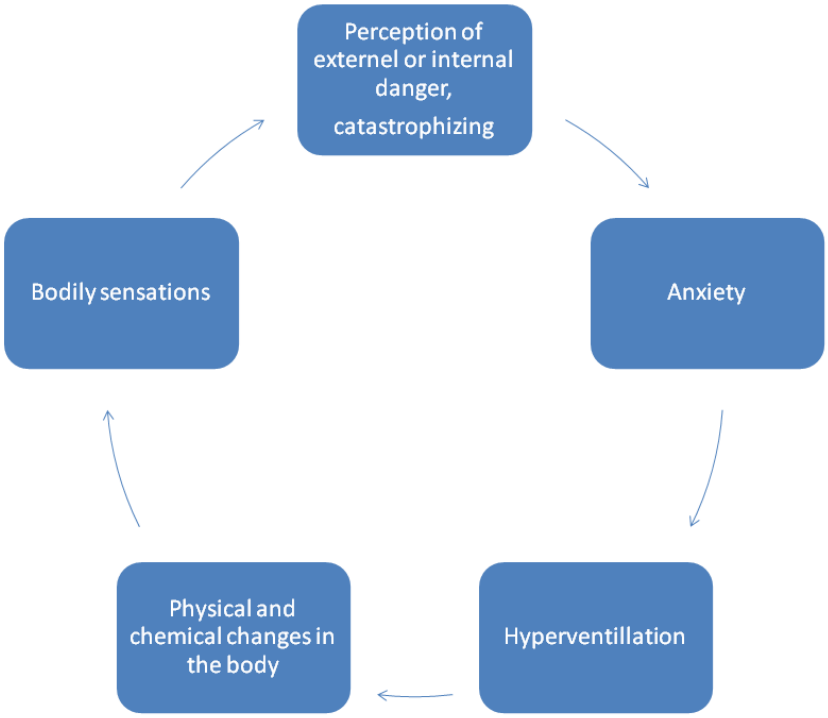
The observation and regulation of respiration is an important part of controlling the anxiety state. In the course of the autogenic training, after the relaxation of the muscles and the warming-up of the skin, breathing generally becomes relaxed.

Observation and perception of the pulsation of the heart further develops body consciousness. In patients with panic disorder the feeling of palpitations may provoke the launching of a panic attack. Thus directing the attention to the pulsation of the heart may be a symptom-provoking technique.

The warming-up of the abdomen aims the relaxation or normotony of the visceral muscles and the blood vessels. The warming-up of the abdomen exercise significantly alleviates the symptoms of anxiety localised to the height of the abdomen and the cardia.

IV.4.2.1.2.3.1 The technique of breath control

The efficiency of the technique of breath control is important, because the hyperventilation accompanying the attack leads to hypocapnia, which worsens the symptoms of the panic indisposition. We make the patient practise even, normal paced breathing, and by this we train him to learn to control hyperventilation during panic attacks.
Legend: *Figure 4: Hyperventilation; panic.*



Important

IV.4.2.1.2.4 Safe place imagination

The essence of the imagination method is to help the patient in bringing about an emotional state. By mastering the imaginational exercise, he becomes able to wilfully induce within him a sentiment that is incompatible with anxiety. If he experiences that by controlling his own mind, he can establish within himself a feeling of safety; we may come to the point of disclosing to him that the feeling of danger is also induced by his own mind. In this way, an opportunity of changing from a feeling of danger to one of safety opens up before him.

In the course of the imagination we ask the patient to evoke a safe place. One of the most important basic principles is to give the fewest possible instructions for the creation of the imagination. We would like the imagined scenes to be completely the patient's own. The therapist should not suggest, and, if possible, should not give, guidance.

Our goal is to accurately grasp the patient's experiences without the therapist's own notions and assumptions influencing them. Generally, we use the following instruction: "Now close your eyes and think of a safe place. Just let whatever comes into your mind come naturally. Please tell me what you can see. We ask the patient to describe the scene aloud, in the present tense, and in first person singular, as if it was happening at that instant. We encourage him when using his

	imagination to use images instead of words and thoughts: “Evoking the imagination is not like thinking or free association, where a thought would attract further thoughts. Evoking the imagination is more like as if you were watching a movie. It, however, means more than that. I would like you to live it as well – become a character of the movie, and be part of the evolving events.” We help by elaborating the imagined scene, and thus images come to life, and the patient gets involved in the imaginary event.
Important	The therapist helps with questions: “Can you tell me what you see?”; “Can you tell me what sounds you hear?”; “Can you see yourself in the scene? What kind of expression do you see in your own face?” When the image takes form, with the help of the therapist they reveal the thoughts and emotions of all the characters in the scene. Does the patient appear in the imagination? What thoughts and emotions does the patient have? In which parts of his body do these emotions arise? What impulses to act does he have? Are there other persons present in his imagination? What do these persons think, what do they feel, and what do they want to do? The therapist asks the patient to speak loudly and understandably. As well as asking him about the feelings and emotions of the characters appearing in his imagination. What emotions do the characters feel towards each other? What do they want to get from each other? Are they able to say it out loud?
Question **Which are the steps of systematic desensitization?**	After the imagination work has ended, the therapist instructs the patient to open his eyes. Then they discuss the experiences of the patient with the help of the following questions: “What was this experience like for you?”; “What did these scenes mean to you?”; The therapist strives to have the patients undergo the experience of safety intense safety, as well as he trying himself to experience the imagined scenes and to understand them at the emotional level. Experiencing the patient’s imagination empathically helps a lot in understanding the patient.
	IV.4.3 The treatment of avoidance behaviour concomitant with anxiety
	Avoiding situations causing anxiety preserves pathological anxiety, or may result in an intense narrowing-down of functioning through avoidance behaviour. Patients, who had previously experienced panic attacks, soon learn how to avoid situations and things inducing violent anxiety. This avoidance behaviour often also extends to those situations in which they had previously experienced panic attack, and to those things as well, of which the patient only assumes that they might

induce panic.

Through the avoidance of panic inducing situations attacks may indeed be prevented – at least for a while. It may be observed, however, that in the long run patients need to avoid more and more kinds of situations, and because of this their living space and manner of living becomes more and more restricted. For the sake of successfully avoiding things that might induce anxiety, they need to radically transform their lives. Their family members and friends often need to take a hand in this, and the burdens of this might impair the quality of their lives too.

The majority of people are able to learn how to endure anxiety inducing situations, they can "even" endure it until anxiety culminates and then starts to diminish. Our success, of course, is much more guaranteed, if we enter into the treatment of avoidance behaviour subsequent to successfully acquiring the techniques of relaxation, disciplined breathing and conquering frightening thoughts.

IV.4.3.1 Assessing avoidance behaviour: selecting the target of the treatment

Avoiding many of the things that cause anxiety is not difficult in normal life. The person, for example, who is afraid of great heights, hardly ever gets into trouble (save the case, when he, as a tourist, needs to look around from the top of the Eiffel-tower, or some such high constructions). It causes great difficulty, however, if this same individual is a construction worker, working on construction sites.

Let us give the avoidance behaviour work-sheet to the patient, and ask him to collect the situations he permanently avoids. He is asked to evaluate these situations on a 0-10 points scale (0 = not important at all; 10 = extremely important), so that we can assess which situations and thoughts are the ones that fundamentally determine his life.

After we have we identified the avoided situations, which causes him the most difficulty in his life, we develop together a hierarchy of the avoided situations (from the most anxiety producing to the least anxiety producing ones) and make a decision about the series of intervention protocol. Some patients prefer to start the treatment with the problems, which cause less severe anxiety and gradually undertake solving more and more complicated situations. Others immediately seek to solve those problems that fundamentally impede their life – particularly in those

cases, when these problems cause them unbearable anxiety.

Let us check through our list again, then write down on a separate sheet those three anxiety inducing situations which we would like the patient to start becoming accustomed with.

IV.4.3.2 Exposition methods

The exposition methods of behaviour therapy have proven to be most efficient in treating avoidance behaviour and phobias. In the course of exposition methods, symptom inducing stimuli are evoked for the patient in a planned and controlled manner. The purpose of exposition is to make the patient gradually able to control the symptom inducing stimuli and symptomatic behaviour.

The most commonly employed exposition technique is *systematic desensitization*. In the course of the treatment the patient is exposed to situations inducing ever greater anxiety, from the mildest to the gravest. Subsequent to the mastering of autogenic training or progressive relaxation, imagining the anxiety inducing situations in a relaxed state helps in pairing up the anxiety inducing situation with the relaxed state. If the patient, while imagining the anxiety inducing situation, falls out of the relaxed state, we start the relaxation process anew, and repeat it until the patient is able to live through the previously avoided situation (e.g. shopping in TESCO in the course of the treatment of agoraphobia) in a relaxed state. This is the so-called *in senso* technique.

Desensitization may be carried out *in vivo* as well (e.g. the patient actually goes shopping with a friend or a family member, and later, when he has no more problem with this, he may go on practising it alone).

Another commonly used technique of behaviour therapy is *flooding*, in the course of which the patient must remain in the anxiety inducing situation until his anxiety starts to diminish.

These methods make it possible for the patient to try to endure those panic attacks or anxiety inducing situations which he avoided before. Our aim is to break the connection between the provoking situation and the anxiety reactions induced by it. To carry this out the patient must endure the situation until his anxiety subsides.

	When he has successfully done this, we may continue practising overcoming the next situation.