

Mental Health and Society Introduction to Anxiety Week 15

You've probably been introduced to the area already. Freud said anxiety can be adaptive if it motivates people to learn new ways of approaching life's challenges. Becomes a problem if we experience it in the absence of a visible cause or in response to stimuli which others do not find anxiety provoking.

Most theories of anxiety begin with the autonomic nervous system, which connects the central nervous system to the other organs of the body and helps to regulate their functions, like breathing, heartbeat, perspiration, blood pressure. The ANS is divided into two parts, the sympathetic system and the parasympathetic system. When we appraise a situation as fear-producing the sympathetic nervous system raises heartbeat and respiration rate - the fight or flight response. The parasympathetic nervous system on the other hand is involved in returning our heartbeat and other functions to resting level.

People differ in how they respond when anxious - some may sweat, others may suffer a pounding heart and so forth, the exact profile of anxiety reactions will differ for different people.

People may also differ in terms of their readiness to become anxious. Anxiety may be a personality *trait* (Spielberger, 1966; 1972; 1985) which might originate in constitutional differences or be developed through early experiences. Anxiety may also be a temporary *state*. Again, people differ in their tendency to see situations as threatening. Walking through a forest may be threatening for one but enjoyable for another. Changes through life course may occur too. E.g. children are afraid of the dark but this wears off in adulthood.

Appraisal: In order for these responses to be activated we undertake some sort of appraisal of the situation - a primary appraisal - if we appraise it as threatening we may then go on to a secondary appraisal where we assess whether we have the resources to deal with it (Lazarus and Folkman, 1984)

In the US anxiety disorders are relatively widespread, affecting 15-17% of the adult population in any given year (Kessler et al, 1994; Regier et al, 1993; Eaton et al, 1991; Blazer et al, 1991; Davidson et al, 1991). Somers et al (2006) in a review of prevalence studies conducted to date (North America, Puerto Rico, Mexico, Europe, Australia, New Zealand, Taiwan, Hong Kong, Korea, and Iran) found that pooled one-year and lifetime prevalence rates for any anxiety disorder were 10.6% and 16.6% respectively. Different studies yielded different rates among all kinds of anxiety disorder. Women had higher prevalence of anxiety disorders than men. The one-year prevalence of any anxiety disorder: 16.4% for women v 8.9% for men; lifetime prevalence of any anxiety disorder: 18.5% for women v 10.4% for men). A study in the UK by Martin-Merino et al (2010) revealed rather lower rates (a two year prevalence rate of 7.2%) and anxiety was associated with heavy alcohol use, smoking and addiction problems as well as stress, sleep and depression disorders. Anxiety patients used health care services more frequently than controls. Among patients diagnosed with anxiety, 63% were treated pharmacologically. Antidepressants accounted for almost 80% of prescriptions.

Anxiety involves feelings of uncertainty, helplessness and physiological arousal. Sometimes referred to as part of the group 'neuroses' - characterised by anxiety, personal dissatisfaction and inappropriate but not psychotic behaviour. DSM IV groups them as 'anxiety disorders'.

Explanations for anxiety disorders

1) Cultural, social and environmental approaches

People in threatening situations are more likely to suffer mental health problems, chief among them anxiety with exaggerated startle reactions, sleep disturbance and specific fears and avoidance behaviour (Baum and Fleming, 1993; Melick et al, 1993). In the aftermath of the Three Mile Island nuclear accident in 1979 researchers studied the psychological impact on people living nearby and discovered that mothers of pre-school children in the neighbourhood displayed five times the rate of anxiety and depression disorders compared to mothers of comparable age in comparable families outside the area. Although some of the symptoms subsided the Three Mile Island mothers were still showing elevated rates of anxiety and depression a year later. Anxiety has been linked to experiences of displacement, marginalisation and fears of cultural extinction in refugees (Nickerson et al, 2009). Different cultures may formulate (and perhaps even experience) anxiety differently, for example the idea of 'ataque de nervios' in Latin cultures (Varela & Hensley-Maloney, 2009).

Anxiety might be related to social change. The US population seems to be showing increased rates of anxiety problems, e.g. Weissman et al (1978) discovered rates of 1.4% for phobias and 2.5% for generalised anxiety. By the 1990s these had increased to 11% and 3.8% respectively (Regier et al, 1993; Blazer et al, 1991; Eaton et al, 1991). There are higher rates of anxiety disorder in urbanised countries (Compton et al, 1991; Hwu et al, 1989). With technological changes come some new kinds of fears e.g. in a survey reported by Swingle, 1993) 55% of Americans said they were afraid of using video recorders, answering machines or personal stereos and 32% said they were intimidated by computers and were afraid of damaging the machine.

Poverty is linked with anxiety disorders. Blazer et al (1993) discovered that for those with incomes below \$10,000 a year the rate of anxiety disorders is twice what it is for those with higher incomes. Mauksch et al (2001) discovered that low income uninsured people in the US had rates of anxiety disorder of 36% compared to 16% in the general population. Civil war and social upheaval are associated with a variety of anxiety like symptoms. Abramowitz's (2005) participants in Guinea talked about 'people who cry in their minds' after civil war experiences.

In the US this has also been tied to race. E.g. according to Belle (1990) and Bennett (1987) African Americans have the highest rate for generalised anxiety disorder (6% compared to 3.5% for whites). African American women have much higher phobia rates (20%, as opposed to 9% for whites) in any given year.

Horowitz (2010) notes some shifts in the diagnosis and treatment of anxiety and depression. From being 'rare' in the immediate post WWII period, depression has become relatively common. Whilst anxiety and related issues like stress were a major focus of study and intervention in the 1950s and 1960s, in recent years a number of the symptoms have been redefined as depression, so that anxiety has become a shrinking category.

2) Psychodynamic explanations

According to Freud (e.g. 1917; 1933) we experience realistic anxiety when we are confronted with a genuine external danger, whereas we experience neurotic anxiety if we are prevented from expressing our id impulses. Moral anxiety arises from our being threatened or punished for expressing our id impulses, as a result of which these impulses themselves come to be perceived as threatening. Specific fears result from overuse of the defence mechanisms of *repression*, where people push the feared object deeper and deeper into unconsciousness, and displacement, where they attach the fear to otherwise neutral objects. Generalised fear results from a breakdown of defence mechanisms, perhaps where they have not been sufficiently developed in childhood. More recently, object relations theory suggests that children with strict or punitive parents come to fear being attacked by 'bad objects' or losing 'good objects' (Cirese, 1993; Zerbe, 1990). Alternatively, if parents do not treat children in a confident relaxed and supportive manner the self will not develop appropriately and the child may develop *disintegration anxiety* where the self is perceived as lacking support and develop defensive processes to safeguard their damaged self (Zerbe, 1990). These individuals may be overwhelmed by the stress of adulthood and suffer from *self fragmentation* (Diamond, 1987).

In support of these psychodynamic positions, experimenters have manipulated people's anxiety. For example Rosenzweig (1933; 1943) arranged for subjects to fail half the problems on a test they believed was important. They remembered less about the questions on which they failed. Luborsky (1973) looked at transcripts of therapy sessions and showed that people reacted to topics that they were anxious about by changing the subject, forgetting what they were talking about and denying negative feelings. In cultures where children are punished more, adults seem to have more fears and anxieties (Whiting et al, 1966). Where parents are overprotective, children seem to be more anxious (Jenkins, 1968; Eisenberg, 1958). Some other studies have been less supportive, for example Raskin et al (1982) looked at people presenting with anxiety disorders and did not find a history of harsh discipline or disturbed childhood behaviour.

4) Humanistic and existential explanations

These propose that people become anxious when they have difficulty in accepting themselves honestly and when their defensive postures stop them looking at themselves with acceptance. When children fail to receive unconditional positive regard from others they may become overly critical of themselves and set themselves overly high self standards. These conditions of worth mean that anxiety provoking self judgements break through. Therapists then try to surround the person in unconditional positive regard and create the conditions whereby people can come to believe in themselves and stop evaluating themselves unfavourably. This idea has received some support (Chodorkoff, 1954), but there has been little independent verification of humanistic theories. By nature, humanistic therapists are sceptical of scientific evaluations of their work.

According to existentialists, people are governed by an existential anxiety, a fear of the limits and responsibilities of human existence (Tillich, 1952). Existential analysts have suggested that people, in modern technological competitive societies deny their fears and freedom of choice and lead inauthentic lives, where they are overly concerned with conforming to the standards of society (May, 1965; Bugenthal, 1965). Again, little systematic research has been conducted on this perspective

because of the belief of many such therapists that their subject matter is not adequately captured by scientific research. However, for Scott and Weems (2013), existential concerns were a significant component of anxieties suffered by the survivors of Hurricane Katrina in the US. Egerod et al (2011) report a study of intensive care patients completing diaries to resolve their existential concerns and related anxieties following critical illness and intensive care treatment.

5) Behavioural explanations - learning to fear.

In 1922 Bagby described a case where a child acquired a phobia (of running water) as a result of an aversive experience. This appeared to reflect the recently discovered principles of conditioning. This was part of a search to find other ways in which fear could be learned. Watson and Rayner (1920) and Little Albert acquiring a fear of rats and Jones (1924) and Little Peter being conditioned out of his fear of rabbits. With the development of social learning theory in the 1960s Bandura and Rosenthal (1966) argued that fear may be learned from watching others being fearful. Once we have acquired the fear we will tend to avoid the fear-producing object and thus will experience a reduction in anxiety. Hence, we learn to avoid the feared object.

Some authors have detected specific instances where fears seem to arise from unpleasant events (Ost, 1991; Merckelbach et al, 1991). Others have not found this relationship (Marks, 1987; Keuthen, 1980). This theory has been extended to include the idea of preparedness - that evolution prepares us to be more afraid of certain objects, like animals, darkness, heights etc. (e.g. Marks, 1977; Seligman, 1971).

6) Cognitive explanations

Assume that anxiety is caused by maladaptive assumptions. E.g. Ellis (1977; 1984) suggests that people are inclined to seek approval from everyone, to despair if things are not the way they want them, and keep dwelling on the possibility of fearsome events occurring. Hence people are inclined to overreact and experience fear when confronted with new life events. In a related theory, Beck describes how some people constantly make assumptions that imply they are in immanent danger (Beck & Greenberg, 1988). Experimental evidence has supported some of the features of these models of anxiety. When people are told to repeat to themselves anxiety provoking statements they show more respiratory changes and emotional arousal (Rimm & Littvak, 1969). Beck et al (1974) found that people suffering from free floating anxiety reported negative assumptions and automatic thoughts about physical injury, illness or death; mental illness; psychological impairment or loss of control, failure or inability to cope; and rejection, depreciation and domination. Cognitive theorists believe that people whose lives have been punctuated by unpredictable negative events are more likely to be vigilant in trying to predict what may go wrong in the world around them and be inclined to interpret ambiguous stimuli as threats (Pekrun, 1982). People in laboratory studies respond more fearfully to unpredictable or un-warned negative events compared to predictable ones or those which they are warned about (Weinberg and Levine, 1980). Cognitive therapy 'improves emotional processing as indicated by reductions in negative thinking, alteration of the information processing bias, and a shift from negative schema activation to endorsement of more positive attitudes and beliefs' (Clarke and Beck, 2010: 420).

7) Biological explanations

These have concentrated on the kinds of neurotransmitters and subsystems of the brain involved in anxiety states. Like many other 'mental disorders', important clues emerged through observation of the action of drugs. Benzodiazepines (Valium, Xanax and Librium) were observed to reduce anxiety in the 1950s and the development of brain scanning techniques in the 1970s helped researchers to pinpoint that these drugs seemed to be most active in the hypothalamus and limbic system, in binding to receptor sites (remember what we did about neurotransmitters and their receptors a few weeks ago?) (e.g. Gray, 1987; Costa, 1985; Hollister, 1982).

The benzodiazepines bind to receptors which are designed to receive the neurotransmitter GABA (gamma amino butyric acid). GABA is an inhibitory neurotransmitter - it makes the neurone receiving it less likely to 'fire'. The elevated rate of neural firing in fear reactions is believed to be brought back to resting level by the GABA producing neurones which inhibit the cells which receive them from firing. Perhaps people with anxiety disorders do not have a working GABA feedback system, e.g. by not secreting enough GABA, by secreting other chemicals which interfere with the action of GABA or having GABA receptors which do not readily bind to the neurotransmitter. Benzodiazepines act on GABA receptors and increase their ability to bind GABA (Leonard, 1992; Costa and Guidotti, 1979)

This explanation is not complete, as it is known that a number of chemicals, not just GABA, can bind to GABA receptors (Bunney and Garland, 1981). GABA is used very widely in the brain - about 40% of neurones can secrete GABA, so which ones are responsible? Through the 1990s increasing evidence was mounting of some "paradoxical reactions" to taking antianxiety medication, including disinhibition, increased anxiety, anger and rage, hostility and hyperactivity (Paton, 2002). The action of drugs is not necessarily specific. Vulink et al (2011) report that antipsychotic drugs have been used for anxiety conditions by a number of practitioners and researchers in recent years, and over the available studies anywhere between 27 and 71% of patients showed 'promising' responses.

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Second part of anxiety disorders Mental Health and Society week 15

Some of the more noteworthy syndromes are:

1) Generalised or free floating anxiety. Diffuse vague unpleasant feeling of fear and apprehension. Worries about unknown dangers or risks inherent in everyday events. Symptoms may include rapid heart rate, loss of breath, loss of appetite, sweating, fainting, diarrhoea, nausea, frequent urination, tremors. With f-f anxiety, there's no obvious cause of the worry, nor is it easily attributed to recent life experience. The symptoms are i) Motor tension muscle tension, shakiness, inability to relax, strained facial expression, easily startled ii) Autonomic reactivity sympathetic and parasympathetic activity contributing to the physical symptoms, heart, stomach respiration, sweating. iii) Apprehensive feelings about the future. iv) Hypervigilance - scan the environment for dangers. Related to the hyperaroused state.

Generalised anxiety is defined as a disorder that does not involve a lack of contact with reality.

2) Panic disorder Like anxiety but intense and sudden. Periods of intense anxiety interspersed with normal functioning. Symptoms similar to anxiety but may also include chest pains and palpitations. Some psycho sensory symptoms - distortion of light intensity, sound intensity, strange feeling in stomach, sensations of floating, turning, moving, feelings of unreality or loss of self identity. Attacks may be several seconds, a few hours or even days long. People with panic attacks may develop anxiety that they're about to suffer an attack, particularly in embarrassing situations, in public.

3) Phobias - Phobos Greek god of fear. Specific fear or anxiety, about a particular object or situation. Fears may not be linked to likelihood of the event happening: e.g. more traffic accident fatalities than violent crime victims but more people worry about crime than car accidents (Sarason and Sarason, 1989). Fear may occur even if the phobic person imagines the object or situation. Phobias may develop gradually without there being a specific event or situation which sets it off. Some e.g. fear of cats, cars, staircases are part of everyday life to most of us; others e.g. fear of snakes, heights, pain are felt to some degree by most people. Torgensen (1979) typology of phobias from study of phobic patients:

- i) Separation fears - crowds, travelling alone, being alone at night.
- ii) Animal fears - mice, rats, insects, spiders
- iii) Mutilation fears - open wounds, operations, blood or bleeding.
- iv) Social fears - speaking in public, being watched.
- v) Nature fears - heights, mountains, cliffs, the sea.

Sometimes people develop cumbersome ways of dealing with phobias, subway woman etc. avoiding phobia object. Most common phobias are about things that could really be dangerous (McNally, 1987). Maybe evolutionary e.g. fear of snakes more common than fear of electricity. Tend to be grouped into three categories, namely

- i) Simple phobias - fear of a specific object like spiders or claustrophobia. Therapy might involve promoting associations between fear arousing stimuli and non anxiety responses.

ii) Social phobias fear and embarrassment in dealing with others. People may fear that the signs of their embarrassment may show to others, trembling, stuttering, blushing. May involve fear of asserting oneself, fear of making a mistake and fear of public speaking. May involve people feeling inadequate and having social and interpersonal inadequacies. Marks (1987) some techniques for dealing with social phobia. i) Respond to anxiety symptoms by approach rather than withdrawal. ii) Greet people properly with eye contact. iii) Listen carefully to people and make a mental list of possible topics of conversation. iv) Show that you want to speak, initiate conversation asking questions etc. v) Speak up without mumbling. vi) Tolerate some silences vii) Wait for cues from others in deciding where to sit, when to pick up a drink and what to talk about viii) Learn to tolerate criticism by introducing controversy deliberately at an appropriate point.

4) Agoraphobia. Literally fear of the market place. More generally fear of entering unfamiliar situations. May involve fear of leaving home or secure setting. May deteriorate or improve and object of fear may change. Agoraphobics can be divided into those who suffer panic attacks and those who don't. Agoraphobia can develop from panic attacks, because patients associate the panic with the situation in which it occurs. Agoraphobia is sometimes associated with clinging dependent personality (Gittelman and Klein, 1984) and separation anxiety in childhood.

5) Obsessive compulsive disorders Obsessive people are unable to get an idea out of their minds. Compulsive people feel compelled to perform a particular act over and over. E.g. Lady Mac Beth and hand washing. Obsessions may involve doubt, hesitation fear of contamination or fear of one's own aggression. Compulsive behaviour may involve counting, ordering, washing etc. Sometimes purely cognitive, e.g. to prevent bad things happening recite series of words to self. Some people have obsessive thoughts but do not act on them, others have obsessive thoughts which lead to compulsive behaviour and a very few have compulsive behaviour without related obsessive thoughts. Obsessive compulsive people can be very cautious. O-C problems usually characterised by i) The obsession or compulsion intrudes insistently and persistently into the individual's awareness ii) A feeling of anxious dread intrudes if the thought or act is prevented for some reason. iii) The obsession or compulsion is experienced as foreign to oneself as a psychological being. iv) The individual recognises the obsession as absurd or irrational but can't do anything about it. v) Individual feels a need to resist it. O-C people may be very indecisive. O-C rituals may involve i) checking e.g. taps, locks ii) Cleaning or cleanliness iii) Slowness iv) Doubting own competence and conscientiousness. These tendencies increase during periods of stress. Obsessional thoughts can occur in psychotic behaviour, but in the latter cases people are more detached from reality. O-C problems are like phobias in that both involve anxiety. Sometimes associated with interpersonal problems.

6) Hysteria. Originally treated by Charcot in C19th. Organic complaints for which no organic cause had been found. Complaints of e.g. loss of sensation in the skin, pains, blindness, paralysis, tics, muscular contractions and seizures. Often accompanied by what Charcot called 'la belle indifference' - Patients did not seem to be concerned about their condition. Also, hysterical patients had their own theories about bodily functioning and the symptoms were compatible with these theories. Charcot used hypnosis and suggested to patients while they were in the trance that

their symptoms would disappear - considerable success. Influenced Freud and Pinel. Pinel extended Charcot's work and believed that the onset of the hysterical symptoms was related to an upsetting event and that if patients expressed these feelings the symptoms could be relieved. In US now called somatoform disorder. Somatoform disorder includes i) Psychogenic pain disorder - pain without or in excess of what would be expected from organic symptoms. May be to do with trying to get attention from others or associated with actual or threatened interpersonal loss. ii) Hypochondriasis - where people show unrealistic fear of disease despite reassurance that his or her social or occupational functioning is not impaired. May include obsessive preoccupation with bodily organs and worry about health. Tend to misunderstand the nature of physiological activity and exaggerate symptoms when they occur (Kellner, 1987). iii) Somatisation disorder involves multiple somatic complaints, often chronic, sometimes called Briquet's syndrome. Headaches, fainting, nausea, vomiting, abdominal pains, bowel trouble, menstrual and sexual problems, allergies. May induce doctors to perform operations. Woodruff et al (1974) compared 50 somatising patients and 50 normal controls and found that three times as much body tissue had been removed from somatising patients. S-D's usually accompanied by difficulties in social relationships, exaggerated displays of emotion and self-centred attitude. iv) Conversion disorders involve complaints by patients that they have lost all or part of some bodily function. Does not seem to be under voluntary control. Symptoms often follow stressful event. Psychoanalysis suggests that the symptom represents an underlying conflict. Sometimes symptoms conflict with medical knowledge, e.g. glove anaesthesia, where patients claim to have lost sensation in their hands, very unlikely neurologically. (But might occur with carpal tunnel syndrome) Episodes may follow upsetting or challenging events. Symptoms may allow person to escape the aversive stimuli or get sympathy. Group hysteria also possible where people who live and work together may suffer similar symptoms.

Therapies

Anxiety disorders are often addressed with behavioural and cognitive behavioural therapies. Here, I'll describe an approach called **Stress Inoculation training (SIT)**. This incorporates a great many insights from CBT approaches and attempts to make the process of change explicit. Developed by Donald Meichenbaum (1976; 1996) and based on the work of Ellis (1973; Rational Emotive Therapy) it is based on the notion that people have problems because they feel it is necessary always to be totally competent, that they have no control over their feelings, that they must rely on others who are stronger, or that they cannot overcome their past misfortunes. As a result suffer self hatred, hostility, sense of worthlessness and inadequacy. RET tries to replace these beliefs with more positive methods of self evaluation. SIT involves getting the client/patient to talk to him/herself differently about the problem. There are several phases: i) educational phase in which patient is encouraged to analyse problem rather than just panic. They are told that fear involves a) physiological arousal and b) anxiety engendering thoughts, images and self statements. Get client to re-label the physical sensations as e.g. eagerness to demonstrate competence. Result is a change to a sense of learned resourcefulness instead of learned helplessness. The shift in cognitions may in itself lead to a shift in autonomic functions. Client is instructed in the application of specific phrases and skills. Practice and rehearsal. Instruction in muscle relaxation too.

From Meichenbaum (2006)

Educational Components of Stress inoculation Training

SIT helps clients:

1. Appreciate that the stress they experience is not abnormal and not a sign that they are “going crazy”, nor “losing their minds”. Rather, their distressing reactions may be a “normal” reaction to a difficult and challenging stressful situation.
2. Appreciate that many of their reactions may be the “wisdom of the body”, or “Nature’s way” of coping with overwhelming stressors. For example, intrusive ideation may be a way to try and make sense of what has happened; denial may be a way to “dose oneself” in order to deal with so much stress at a given time. (In fact, each of the symptoms of PTSD could be reframed as a coping efforts – See Meichenbaum, 1996).
3. View their current coping efforts as a reflection of a “stuckness” problem, namely using (or overusing) a coping pattern such as dissociation that at one time was adaptive (e.g., when being repeatedly raped in an incestuous situation) or being hypervigilant (i.e., continually being on “sentry duty” even when it is no longer required). The problem is that clients are “stuck” (not “crazy”, nor “inadequate”, “weak”) using coping efforts that at one time were adaptive, but are now being overemployed.
4. Recognizing how they may inadvertently, unwittingly, and perhaps even unknowingly employ intra-personal coping efforts (avoidance, suppression, rumination and brooding, contrafactual thinking, and safety behaviors) that make the stressful situation worse. Educate clients about the transactional nature of stress.
5. Appreciate that their stress reactions are made up of different components (biopsychological perspective, physiological arousal, plus cognitive appraisals) and that these reactions go through different phases (namely, the phase of preparing for a stressor, the phase of confronting the stressor, the phase of being truly tested or overwhelmed, and the phase of reflecting on how they handled or did not handle the stressor). In this way, their stress reactions are differentiated into several phases that are made up of different components. Patients are educated about how each phase can trigger appropriate coping efforts.
6. Notice the “cycle” by which internal and external triggering events (12 o’clock on an imaginary clock) elicit primary and secondary emotions (3 o’clock) and accompanying thoughts (automatic thoughts, thinking processes and schemas or beliefs) (6 o’clock) which, in turn, lead to specific behaviors and resultant consequences (9 o’clock). Clients can be asked to self-monitor, if indeed, they engage in such “vicious” (stress-engendering) cycles. Moreover, clients can be asked if they do so, “What is the impact, what is the toll, what is the price of engaging in such a cyclical pattern?” Moreover, what can be done to break the cycle?” The various coping efforts follow naturally from such probes.
7. Appreciate the distinction between the “changeable” and “unchangeable” aspects of stressful situations and to fit either problem-focused or emotional-focused coping efforts to the perceived demands of the stress-engendering situation.
8. Break down or disaggregate global stressors into specific short-term, intermediate and long-term coping goals. Such goal-directed thinking nurtures a sense of hopefulness.
9. Debunk any client or significant others myths concerning their presenting problems (e.g., myths concerning rape, sexual abuse) and challenge so-called Stage-models of reactions to stress. Also address any myths concerning stress and

coping such as: (1) People need to go through uniform emotional stages of reactions in response to stress; (2) There is a “right” way to cope’ (3) Distressed people cannot experience positive emotions in the aftermath of traumatic stress; and (4) People should not expect to experience stressful reactions well after stressful life events occur.

Stages in Stress Inoculation Training

Phase I: Conceptualization

- In a collaborative fashion, identify the determinants of the presenting problem of the individual's stress concerns by means of (1) interview with the client and significant others; (2) the client's use of imagery-based reconstruction and assessment of a prototypic stressful incident; (3) psychological and environmental assessments; and (4) behavioral observations. (As Folkman et al., 1991, suggest, have the client address “who, what, where, and when” questions: “Who is involved?”, “What kind of situations cause stress?”, “When is this kind of situation likely to occur?”, “When did it occur last?” (Meichenbaum 1996, 2001).
- Permit the client to tell his or her “story” (solicit narrative accounts of stress and coping, and collaboratively identify the client's coping strengths and resources). Help the client to transform his or her description from global terms into behaviorally specific terms.
- Have the client disaggregate global stressors into specific stressful situations. Then help the client break stressful situations and reactions into specific behaviorally prescriptive problems. Have the client consider his or her present coping efforts and evaluate which are maladaptive and which are adaptive.
- Have the client appreciate the differences between changeable and unchangeable aspect of stress situations.
- Have the client establish short-term, intermediate, and long-term behaviorally specifiable goals.
- Have the client engage in self-monitoring of the commonalities of stressful situations and the role of stress-engendering appraisals, internal dialogue, feelings, and behaviors. Help the client appreciate the transactional nature of his or her stress. (Use the clock metaphor of a “vicious cycle”, as above). Train the client to analyze problems (e.g., to conduct both situational and developmental analyses and to seek disconfirmatory data – “Check things out”).
- Ascertain the degree to which coping difficulties arise from coping skills deficits or are the result of “performance failures” (namely, maladaptive beliefs, feelings of low self-efficacy, negative ideation, secondary gains).
- Collaboratively formulate with the client and significant others a reconceptualization of the client's distress. Socratically educate the client and significant others about the nature and impact of stress, and the resilience and courage individuals manifest in the face of stressful life events. Using the client's own “data”, offer a reconceptualization that stress is composed of different components (physiological, cognitive, affective, and behavioral) and that stress reactions go through different “phases”, as described above. The specific reconceptualization offered will vary with the target population; the plausibility of the reconceptualization is more important than its scientific validity. In the course of this process, facilitate the discovery of a sense of meaning, nurture the client's hope, and highlight the client's strengths and feelings of resourcefulness.
- Debunk any client myths, as above.

Phase 2: Skills Acquisition and Consolidation

A. Skills training (tailor to the needs of the specific population and to the length of training)

- Ascertain the client's preferred mode of coping. Explore with the client how these coping efforts can be employed in the present situation. Examine what intrapersonal or interpersonal factors are blocking such coping efforts.
- Train problem-focused instrumental coping skills that are directed at the modification, avoidance, and minimization of the impact of stressors (e.g., anxiety management, cognitive restructuring, self-instructional training, communication, assertion, problem solving, anger control, applied cue-controlled relaxation training, parenting, study skills, using social supports). Select each skill package according to the needs of the specific client or group of clients. Help the client to break complex stressful problems into more manageable sub problems that can be solved one at a time.
- Help the client engage in problem-solving by identifying possibilities for change, considering and ranking alternative solutions and practicing coping behavioral activities in the clinic and *in vivo*.
- Train emotionally-focused palliative coping skills, especially when the client has to deal with unchangeable and uncontrollable stressors (e.g., perspective taking, selective attention diversion procedures, as in the case of chronic pain patients; adaptive modes of affective expression such as humor, relaxation, reframing the situation, acceptance skills and spiritual rituals).
- Train clients how to use social supports effectively (i.e., how to choose, obtain, and maintain support). As Folkman et al. (1991) observe, help clients appreciate what kind of support is needed (informational, emotional, tangible), from whom to seek such support, and how to maintain support resources.
- Aim to help the clients develop an extensive repertoire of coping responses in order to facilitate flexible responding. Nurture gradual mastery.

B. Skills rehearsal and consolidation

- Promote the smooth integration and execution of coping responses by means of behavioral and imagery rehearsal.
- Use coping modeling (either lives or videotape models). Engage in collaborative discussion, rehearsal, and feedback of coping skills.
- Use self-instructional training to help the client develop internal mediators to self regulate coping responses.
- Solicit the client's verbal commitment to employ specific efforts.
- Discuss possible barriers and obstacles to using coping behaviors and ways to anticipate and address such barriers.
- Build in the technology of generalization.

Phase 3: Application and Follow-through

A. Encouraging application of coping skills in the form of stress inoculation trails

- Prepare the client for application by using coping imagery, together with techniques in which early stress cues act as signals to cope.
- Expose the client in the session to graded stressors via imagery, behavioral exposure to stressful and arousing scenes.
- Use graded exposure and other response induction aids to foster *in vivo* responding.

- Employ relapse prevention procedures: Identify high-risk situations, anticipate possible stressful reactions, and rehearse coping responses.
- Use counter attitudinal procedures to increase the likelihood of treatment adherence (i.e., ask and challenge the client to indicate where, how, and why he or she will use coping efforts).
- Bolster self-efficacy by reviewing both the client's successful and unsuccessful coping efforts. Ensure that the client makes self-attributions ("takes credit") for success or mastery experiences (provide attribution retraining).

B. Maintenance and generalization.

- Gradually phase out treatment and include booster and follow-up sessions.
- Involve significant others in training (e.g., parents, spouse, coaches, hospital staff, police, administrators) as well as peer and self-help groups.
- Have the client coach someone with a similar problem (i.e., put client in a "helper"/consultative role).
- Help the client to restructure environmental stressors and develop appropriate escape routes. Ensure that the client does not view escape or avoidance, if so desired, as a sign of failure, but rather as a sign of taking personal control.
- Help the client to develop coping strategies for recovering from failure and setbacks, so that lapses do not become relapses.
- Work with clients to avoid revictimization.

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