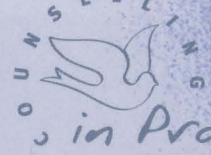
Second Edition

COUNSELLING IN PRACTICE

Counselling for Anxiety Problems

Diana Sanders
& Frank Wills



Series editor: Windy Dryden
Associate editor: E. Thomas Dowd

Counselling for Anxiety Problems

Counselling in Practice

Series editor: Windy Dryden
Associate editor: E. Thomas Dowd

Counselling in Practice is a series of books developed especially for counsellors and students of counselling, which provides practical, accessible guidelines for dealing with clients with specific, but very common, problems. Books in this series have become recognized as classic texts in their field, and include:

Counselling with Dreams and Nightmares
Delia Cushway and Robyn Sewell

Career Counselling
Robert Nathan and Linda Hill

Counselling Couples
Donald L. Bubenzer and John D. West

Counselling People with Communication Problems
Peggy Dalton

Counselling for Family Problems
Eddy Street

Counselling for Stress Problems
Stephen Palmer and Windy Dryden

Counselling People on Prescribed Drugs
Diane Hammersley

Counselling for Fertility Problems
Jane Read

Counselling for Psychosomatic Problems
Diana Sanders

Counselling for Grief and Bereavement
Geraldine M. Humphrey and David G. Zimpfer

Counselling for Eating Disorders, second edition
Sara Gilbert

Counselling Survivors of Childhood Sexual Abuse, second edition
Claire Burke Draucker

Counselling for Depression, second edition
Paul Gilbert

Counselling for Post-Traumatic Stress Disorder, second edition
Michael J. Scott and Stephen G. Stradling

Counselling for Alcohol Problems, second edition
Richard Velleman

Counselling for Anxiety Problems

Second Edition

Diana Sanders and Frank Wills

SAGE Publications
London • Thousand Oaks • New Delhi

First published 1992
This edition first published 2003

SAGE Publications Ltd
6 Bonhill Street
London EC2A 4PU

SAGE Publications Inc
2455 Teller Road
Thousand Oaks, California 91320

SAGE Publications India Pvt Ltd
32, M-Block Market
Greater Kailash – I
New Delhi 110 048

British Library Cataloguing in Publication data

A catalogue record for this book is available
from the British Library

ISBN 0 7619 6574 2
ISBN 0 7619 6575 0 (pbk)

Library of Congress Control Number: 2002108287

Typeset by Mayhew Typesetting, Rhayader, Powys
Printed in Great Britain by TJ International Ltd, Padstow, Cornwall

Contents

List of figures and tables

List of Figures

List of Tables

Preface

We were both very pleased to be invited to write a revised edition of Richard Hallam's original book, *Counselling for Anxiety Problems*, first published in 1992. We have worked together on a number of projects, including writing *Cognitive Therapy: Transforming the Image*, published by Sage in 1997, which aims to present counsellors with the developments in cognitive therapy which, we believe, make it more attractive for counsellors to use or to integrate with their practice. The opportunity to work on *Counselling for Anxiety Problems* follows on from our theme and interests: to promote the successful developments in cognitive therapy for anxiety problems in a way which is accessible and attractive to the counselling world. We are convinced by the strong evidence that cognitive therapy offers a realistic and effective therapy for our many clients burdened by anxiety problems, while at the same time being aware of the criticisms and dangers inherent in adopting one approach too rigidly. We hope to present the balance of our thinking in this book.

As Richard Hallam states in the preface to the first edition: 'All of us can empathize with what it might be like to suffer from an "anxiety problem".' Anxiety is second to depression as one of the most common psychological problems for which people seek help, from their GPs, counsellors, psychologists, psychotherapists and psychiatrists, and can be pervasive and disabling. Anxiety is an experience of many dimensions, affecting our physiology, feelings, behaviour and patterns of thinking, and is both triggered and maintained by environmental factors. There are many different manifestations of anxiety, the main ones being panic disorder, agoraphobia, specific or social phobias, obsessive compulsive disorder, post traumatic stress disorder, acute stress disorder, generalised anxiety disorder and anxiety problems related to medical conditions or substance abuse. Whatever our feelings and beliefs about the value of diagnosis and diagnostic categories, understanding the kinds of problems our clients are experiencing is vital to being able to offer appropriate solutions. The approach

in therapy and counselling for anxiety problems varies for different types of anxiety, and what works for one problem may well be counterproductive for another. This book therefore separates different types of anxiety problems, and describes specific counselling approaches for the different problems, rather than considering anxiety as a single problem.

Why Cognitive Therapy for Anxiety?

In this book, we aim to offer an overview of anxiety problems, to look at how cognitive therapy seeks to understand and conceptualise anxiety, and to offer practical guidelines for working with anxious clients generally, and with different forms of anxiety. The reader may stop at this point and ask whether they wish to subscribe to a cognitive approach to anxiety problems. We would urge that the approach is fully understood and evaluated, for both its strengths and weaknesses, before the reader makes up his or her mind. Why cognitive therapy for anxiety? Firstly, cognitive therapy for anxiety problems has improved in leaps and bounds over the past decade, enabling psychological therapists* to have greater understanding of the problems and offer more targeted therapeutic interventions. This is particularly true for some of the most difficult and complex types of anxiety, such as obsessive compulsive disorder and severe agoraphobia. The essence of cognitive therapy is to understand the meanings that thoughts, events, ideas, physical symptoms or behaviours hold for clients. A careful and detailed understanding of meanings, and specific work targeting meanings that are unhelpful, outdated or out of proportion, is central to cognitive therapy, and we have many ideas and tools at our disposal to help us, and our clients, to do this work. Secondly, good research shows that cognitive therapy is effective in helping people recover from anxiety disorders (Clark, 1999a) and cognitive approaches emerge as the treatment of choice for anxiety (Roth and Fonagy, 1996; DeRubeis and Crits-Christoph, 1998; Department of Health, 2001). Thirdly, it is a parsimonious form of therapy, and clients can feel much better, as well as addressing underlying problems, in relatively few sessions. Fourthly, cognitive therapy is not simply a short-term fix for symptoms (Wills and Sanders, 1997), but can offer clients a real understanding of why they are anxious, what is important to

* We use the term 'psychological therapist' as a generic term to encompass counsellors, psychotherapists, psychologists and others offering psychological therapies.

them, and what keeps the anxiety going, in terms of both present and past experience.

Having extolled the virtues of cognitive therapy for anxiety, we are by no means underestimating the potential for other therapies to significantly help anxious clients. Therapists from different disciplines, be they humanistic, psychodynamic, interpersonal, integrative or cognitive analytic, have their various understandings of anxiety disorders, and can help clients to understand and work with anxiety in different ways. All therapies, we believe, aim to encourage understanding of meanings, but within different conceptual models. In non-cognitive therapies, there is less 'benchmark' research evidence to demonstrate effectiveness. We suspect that this is mainly because the outcome variables, often of symptom reduction, running through randomised controlled trials of anxiety treatments, are different to the outcome variables of non-cognitive therapy. The recent publication in the *British Medical Journal* of studies looking at the effectiveness of counselling for depression is a welcome addition to the research on counselling (Bower et al., 2000; Ward et al., 2000). We hope to offer, in this book, both a 'purist' cognitive understanding of anxiety disorders, based on both clinical and empirical evidence, and ideas and focus from other disciplines. However, we also believe that if cognitive therapy is practised well, it automatically includes many of the active ingredients of other forms of psychotherapy, particularly the qualities of the therapeutic relationship necessary for any therapy to succeed. Cognitive therapy has been called 'the integrative psychotherapy', integrating ideas and approaches from many other therapies, within a cognitive framework or conceptualisation (Alford and Beck, 1997).

Counselling and Cognitive Therapy

How do cognitive methods fit within the counselling world? Demands are growing for counselling to be more accountable and to 'prove itself', particularly in one of the main settings in which British counselling takes place, the National Health Service, where evidence-based practice and accountability are required. As cognitive therapy was formed within the research-minded orbit of Beck and his colleagues (Wills and Sanders, 1997), it has benefited by being able to claim much evidence for effectiveness (Department of Health, 2001). In some cases, the strong evidence for cognitive therapy has been used as evidence against other therapies, and we have watched with increasing alarm as otherwise rational people have spoken of counselling and cognitive

behavioural therapy (CBT) in oppositional terms. The writing partnership between the two authors (and hence the approach of this book) is based on the concept that counselling and CBT are complementary skills which empower each other. Diana is a counselling psychologist who finds that cognitive therapy is a powerful aid to her practice. Frank is a counsellor who has found that the psychological dimension of cognitive therapy has sharpened and amplified his counselling practice. Both authors have considerable experience in training and have found that good counselling skills greatly enhance the quality of cognitive therapy practice (Wills and Sanders, 1997).

In operating in the middle ground between counselling and cognitive therapy, there is always the danger of succeeding only in offending both parties. Our basic position is that if counselling is to become truly 'post-tribal' then the focus should be on what different models can learn from each other (Inskipp and Proctor, 1999). While this position will be exemplified throughout the book, a few tasters here might persuade the doubtful reader to read on. Counselling can learn from cognitive therapy the use of structure, the concentration on generalising the gains of therapy outside the sessions and building ongoing evaluation into sessions. Cognitive therapy can learn from counselling that psychological theory can only take you so far, that clients are essentially individuals who often do not react in textbook fashion, and that self-awareness and good skills add immensely to the interpersonal reality of sessions.

Overview of Counselling for Anxiety Problems

This second edition of *Counselling for Anxiety Problems* has a number of key themes, which are different from the first edition, based on thinking and research in the field over the past decade. We focus on developments in describing and conceptualising individual anxiety problems, enabling counselling to be more targeted on the specifics of the problems. We describe counselling protocols for different anxiety disorders, and look at the pros and cons of protocol-based counselling. We bring new thinking in cognitive therapy, including the specifics of thinking in anxiety, the anxiety equation, concepts of safety behaviours where people's attempts to cope with anxiety become part of the problem, and developments in using 'behavioural experiments' as ways of helping people test out their fears and develop new ways of seeing that are less laden with anxiety.

The book is divided into two parts. Part I describes general issues and themes relevant to counselling clients with anxiety. We start with an overview of anxiety problems, what causes them, how they keep going, and how to distinguish the different forms. We outline the cognitive approach to anxiety disorders, and describe how different problems can be conceptualised. The book goes on to look at the therapeutic relationship when working with anxious clients, highlighting particular issues in developing a working alliance. The following chapters describe in detail how to assess anxiety problems, and the tools and techniques that can be used with anxious clients.

Part II is devoted to the nuts and bolts of counselling with different types of anxiety, with separate chapters describing different anxiety disorders and how to adapt counselling accordingly. We cover problems of panic, agoraphobia, worry and general anxiety, specific phobias, social anxiety, health anxiety and obsessive compulsive disorder.* The book aims to provide an overview of working with clients with these problems, giving information about relevant research and further reading. The book concludes with an appendix of resources, self-help organisations, publications and web sites, with information for both counsellors and clients.

The client studies throughout this book are ficticious characters, but are based on examples from our clinical experience, chosen to illustrate specific problems, issues and ways of working.

* The problems of post traumatic stress disorder and general stress are well covered in Palmer and Dryden (1995) and Scott and Stradling (2000).

Acknowledgements

We have learned much of what we know about anxiety through our work with colleagues in Oxford and Newport, Wales, and through our clients, and we are very grateful to all concerned. We thank the kind souls who spent time reading and tactfully commenting on drafts: Jacqueline Tonin, Ann Perry, Brian Hunter, Kathy Baines, June Parkinson, Barbara Sanders and Norma Morrison, and thanks to Helen Jenkins for her help with references. We are, as always, supremely appreciative and grateful to our respective spouses – Diana to her husband, Mo Chandler, and Frank to Annie Wills – who have put up with us changing into preoccupied beasts during intensive writing phases, and helped us in all sorts of ways. We are of course appreciative of each other for negotiating and working collaboratively in this joint project. Alison Poyner and Louse Wise at Sage have been supportive and helpful throughout.

Every effort has been made to trace all the copyright holders, but if any have been inadvertently overlooked the publishers will be pleased to make the necessary arrangement at the first opportunity.

Figure 1.1 C.A. Padesky and K.A. Mooney (1990), 'Clinical tip. Presenting the cognitive model to clients', *International Cognitive Therapy Newsletter*, 6: 13–14. Huntington Beach, CA: Center for Cognitive Therapy. © 1986 Center for Cognitive Therapy. Reproduced with permission.

Table 2.1 S. Palmer and W. Dryden (1995), *Counselling for Stress Problems*. London Sage.
A.T. Beck, G. Emery with R.L. Greenberg (1985), *Anxiety Disorders and Phobias. A Cognitive Perspective*. New York: Basic Books.

Figure 2.3 © 1995 Center for Cognitive Therapy.

Figure 2.4 C.A. Padesky and K.A. Mooney (1998), 'Between two minds: the transformational power of underlying

assumptions', workshop given at 28th Congress of the European Association for Behavioural and Cognitive Therapies. © 1995 Center for Cognitive Therapy. Reproduced with permission.

Figure 2.5 M. Fennell (1989), 'Depression', in K. Hawton et al. (eds), *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide*, p. 171. Oxford: Oxford University Press. Reprinted by permission of Oxford University Press.

Figure 6.3 A. Wells and A. Hackman (1993), 'Imagery and core beliefs in health anxiety: content and origins', *Behavioural and Cognitive Psychotherapy*, 21 (3): 265–74. Cambridge: Cambridge University Press.

Figure 6.5 A.T. Beck, A.J. Rush, B.F. Shaw and G. Emery (1979), *Cognitive Therapy of Depression*. New York: Guildford Press.
A.T. Beck, G. Emery with R.L. Greenberg (1985) *Anxiety Disorders and Phobias. A Cognitive Perspective*. New York: Basic Books.
D. Burns (1999), *The Feeling Good Handbook*, rev. edn. London: Penguin.

Table 7.1 APA (2000), *Diagnostic and Statistical Manual of Mental Disorders: 4th edition text revision*. Washington, DC: American Psychiatric Association.

Figure 7.1 D.M. Clark (1986), 'A cognitive approach to panic', *Behaviour Research and Therapy*, 24: 461–70. Oxford: Elsevier Science. Reprinted with permission from Elsevier Science.
A. Wells (1997), *Cognitive Therapy of Anxiety Disorders. A Practice Manual and Conceptual Guide*. Chichester: John Wiley & Sons Limited.

Table 7.3 APA (2000), *Diagnostic and Statistical Manual of Mental Disorders: 4th edition text revision*. Washington, DC: American Psychiatric Association.

Table 7.4 A. Wells (1997), *Cognitive Therapy of Anxiety Disorders. A Practice Manual and Conceptual Guide*, pp. 113–18. Chichester: John Wiley & Sons Limited.

Table 8.1 APA (2000), *Diagnostic and Statistical Manual of Mental Disorders: 4th edition text revision*. Washington, DC: American Psychiatric Association.

Figure 8.1 T. Ricketts and G. Donohoe (2000), adapted from A. Wells (1997), *Cognitive Therapy of Anxiety Disorders*, p. 204. Chichester: John Wiley & Sons Limited.

Figure 9.1 APA (2000), *Diagnostic and Statistical Manual of Mental Disorders: 4th edition text revision*. Washington, DC: American Psychiatric Association.

Table 10.1 APA (2000), *Diagnostic and Statistical Manual of Mental Disorders: 4th edition text revision*. Washington, DC: American Psychiatric Association.

Figure 10.1 D.M.Clark and A. Wells (1995), 'A cognitive model of social phobia', in R.G. Heimberg et al. (eds), *Social Phobia: Diagnosis, Assessment and Treatment*, pp. 69–93. New York: Guildford Publications.

Table 11.1 APA (2000), *Diagnostic and Statistical Manual of Mental Disorders: 4th edition text revision*. Washington, DC: American Psychiatric Association.

Figure 11.1 D. Sanders (1996), *Counselling for Psychosomatic Problems*. London: Sage.
P. Salkovskis and C. Bass (1997), 'Hypochondriasis', in D.M. Clark and C. Fairburn (eds), *Science and Practice of Cognitive Behaviour Therapy*. Oxford: Oxford University Press.

Table 12.1 APA (2000), *Diagnostic and Statistical Manual of Mental Disorders: 4th edition text revision*. Washington, DC: American Psychiatric Association.

Table 12.2 Obsessive Compulsive Cognitions Working Group (1997), 'Cognitive assessment of obsessive-compulsive disorder', *Behaviour Research and Therapy*, 35: 667–81. Oxford: Elsevier Science.

Figure 12.2 P. Salkovskis, E. Forrester, H.C. Richards and N. Morrison (1998), 'The devil is in the detail: conceptualizing and treating obessional problems', in N. Tarrier, A. Wells and G. Haddock (eds), *Treating Complex Cases*, p. 56. Chichester: John Wiley & Sons Limited.

PART I

THEORY AND PRACTICE OF COUNSELLING FOR ANXIETY

1

Introduction

Imagine a world without fear or anxiety. A new-born baby, entering such a world, would not survive long. Without innate fears, such as fear of strangers, the unknown, the unexpected, the dark, creeping insects, or heights, the curious child would soon be unprotected from danger, not knowing that the fear response leads them to safety. The fear response enables us to survive: being rightly fearful of actual dangers leads us all to take care, to seek help, to fight the dangers or run away. Bowlby (1969) described how animals of all species are genetically biased to respond with anxiety to any stimuli that are cues to potential danger to that species. Such threats include not only obvious threats to life, but also anything that endangers our relationships with other people. We are social beings: our need to relate and be close to other humans plays such an important role in the survival of humans as a species that it is not surprising that anxiety can be aroused by anything perceived as potentially disrupting or damaging to our interpersonal relationships, often a central theme in counselling.

The fear response can be overcome in extreme situations, such as bungee jumping, tightrope walking across two hot air balloons, getting friendly with tigers. The authors cannot speak with personal experience about overcoming such extreme dangers, but many of us are familiar with the experience of fear and anxiety, and have been both saved from danger and limited by our individual fears.

Anxiety is the experience of fear which has overtaken the sense of 'objective' danger. The line between, on the one hand, normal, sensible levels of fear, and anxiety on the other is a fine one. Most

of us are familiar with the experience of anxiety: anxiety about failing exams, about being thought well of by friends, about travelling to new places and so on. We may feel anxious meeting a new client, giving a talk, writing a book. All these might seem entirely normal and understandable. For an infant to be nervous of strangers and start crying, is normal; for an adult to be so scared of other people's evaluation that the individual is unable to speak to others without being overwhelmed by fear, is classified as anxiety. To be vigilant when crossing the road helps us to avoid stepping in front of traffic; to be so scared of something awful happening that the individual cannot leave the house, is anxiety. In these cases the fear response has spiralled out of control, bringing into play a host of other ways of being: we start behaving differently, avoiding things that make us anxious, trying to cope with the anxiety, or worrying excessively. We are beginning to enter the realm of anxiety disorders.

In this chapter we describe the experience of anxiety, and look at how it can be understood in terms of a network of different interacting elements: cognition, emotion, biology, behaviour and environment. We describe how these elements are dominant to different degrees in different problems: for example, the cognitive activity of worry predominates in generalised anxiety problems; panic attacks may be primarily a physical experience; agoraphobia is characterised by the behaviour of avoidance, such as not leaving the house. We describe the different forms of anxiety our clients may experience and present with, and suggest how diagnostic categories can be useful in helping both to understand our clients' difficulties and to plan our counselling. We look at the evolutionary origins of anxiety, enabling us and our clients to gain a more sympathetic understanding of problems which result from over-effective evolutionary adaptation. We end by looking at how clients with anxiety problems present to counsellors.

Understanding Anxiety

Early psychotherapeutic formulations of anxiety centred on the psychodynamic concept of repression developed by Freud. This was founded on the idea that many anxieties took on the function of helping to repress much deeper worries, often associated with the sexual content of the unconscious. Although these ideas are no longer so influential, they contain several features which have proved of enduring value. Most modern concepts of anxiety, for example, give 'avoidance' a central place in the maintenance of

anxiety problems and this involves a type of repression, yet not that of the strictly Freudian mode. Additionally, more recent approaches to anxiety have returned to the concept of trait anxiety, the view that certain people have enduring personality traits which make them more predisposed to developing anxiety disorders. Thus, as Freud proposed, there might be much deeper, personality-based aspects to anxiety than has sometimes been suggested by others who have focused on 'state' anxiety. The behaviourists have been particularly keen to challenge the psychodynamic view of anxiety. Watson and Rayner (1920) in their famous 'Little Albert' experiment, conditioned a little boy to be fearful of white rats, and wrote rather gloatingly that some psychoanalysts would later attribute the boy's fears to a deep-seated anxiety in the unconscious. As will be seen later, while learning does undoubtedly play a role in the development of anxiety disorders, it is far from a complete explanation of the phenomenon.

In more recent models, anxiety is understood to arise when the individual has certain beliefs about the dangerousness of situations which hold important individual meaning for that person. Once situations, events, sensations and mental events are seen as dangerous, a complex web of emotions, actions, physiological reactions and thoughts is formed. This leads to the cycles of anxiety which cognitive therapy has aimed to describe, understand and change (Clark, 1999a). The central theme of anxiety problems, in contrast to other difficulties, is that anxiety is based on anticipating problems in the *future*: 'I will die'; 'I will lose my job'; 'My partner will leave me'; 'I will make a fool of myself.' In this respect, it differs from depression, which tends to be more associated with the *past* – 'I failed'; 'I've been abandoned' – and with hopeless rather than threatening predictions about the future: 'There's no point, nothing will change.' While loss is the key cognitive theme of depression, for anxiety it is the theme of impending threat and danger (Beck et al., 1985).

Elements of Anxiety

Anxiety is a complex, multifaceted experience, a feeling which comes flooding into our whole selves, affecting many different aspects of our being. It was eloquently described by one of our clients as 'a sudden visitor who has a habit of calling unexpectedly and penetrating into every nook and cranny of my house all at once – and who won't take any hints to leave'. Anxiety is a

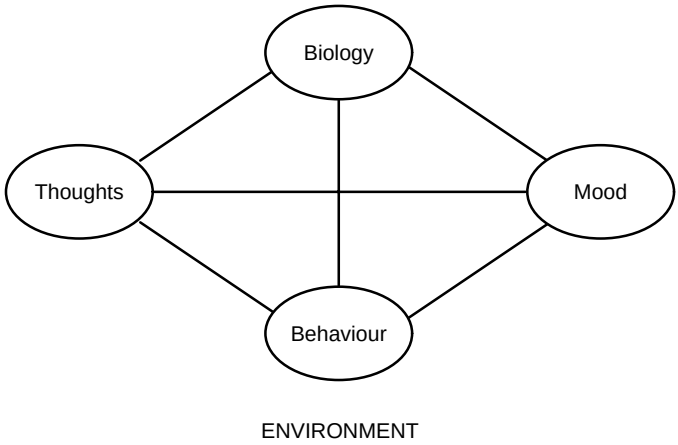


Figure 1.1 *Generic cognitive models for understanding anxiety*

Source: Padesky and Mooney (1990) (reproduced with permission)

combination of different elements – cognition, emotion, biology, behaviour and environment – which are linked and trigger one another off. A generic model for understanding anxiety is shown in Figure 1.1, and illustrated by the following short examples:

Anxiety affects us **physically**, with a large number of somatic symptoms:

> An explosive tight feeling in my chest.
> I worried to the point where I began to feel dizzy and sick.
> My heart was racing and seemed to be missing beats.

Anxiety affects the way we **think** and use our mental powers:

> I think to myself 'I'm going trippy again . . . I'm going mad . . . You must think I'm a loony.'
> I thought to myself 'I can't go to work like this, I'd screw up for sure.'
> I thought that if I just keep trying to work this out, I'll work out the answer but my attention kept wandering, I never did work it out.

Anxiety is itself an **emotion** and is strongly related to other emotions. Anxiety can result from other emotions, such as low mood or depression, and can produce many other emotions:

> I felt really happy that Sue wanted to see me but then I began to really worry – perhaps she is just going to hurt me again.

> I used to be really worried and work myself into huge anxiety states about my job but just lately I seem to have given up and I've been feeling so down.

Anxiety affects what we do and how we lead our lives: our **behaviour**:

> I used to worry so much about my business presentations that I started turning up early so I could plan every single aspect of it. One time I got there before the office even opened and the cleaner called security, I was terrified that it would be reported and I'd be seen as an emotional wreck.
>
> I felt so awful I knew I had to leave the restaurant– I mumbled something and rushed out to the loo, I was in there for ages and then asked my husband to get me home as soon as possible.

There are also enormous **social and environmental** factors in anxiety that both trigger and maintain problems, as Chris's situation demonstrates. Chris was originally in a public sector job which had very little to do with selling services. During the 1990s, when introducing the business ethic to public services was seen as a way of making them more efficient, his job changed so that he had to sell the services of his agency.

> You have to go out and sell the research services we have. I have never had to do things like that. I have had no training for it and, looking back, it wasn't me at all. The other thing is that you kind of came to feel that being a public service person was a bad thing to be, like you were inefficient by definition almost – so this isn't the best frame of mind to go out and sell yourself and the agency. . . . Now it is hinted that your job depends on generating income. There are constant reorganisations and threats of redundancy. There haven't been any yet but several people have gone on early retirement or through ill health.

Anxiety is a complex network of all these elements, all of which are linked by cause and effect to each other. Thoughts, feelings, physiology, behaviour and environment interact with each other in many different ways, each playing varying roles in the different anxiety problems. The elements of anxiety and their interactions are described in more detail in Chapter 2.

Anxiety can be very disruptive, weaving its way into the individual's personal relationships, social life and work. It may begin subtly – beginning to prepare slightly more than usual for giving lectures – but then roller-coasting towards spending hours preparing, lying awake at night worrying about whether the teaching is good enough, and eventually having to give up teaching, because of anxiety.

Types of Anxiety Problems

The thorny issue of diagnosis

> Diagnosis is a medical task which creates a simple dichotomy between the sick and the well. (Pilgrim, 2000: 304)

One of the many fascinating aspects of anxiety is its wide and varied expression and the range of problems categorised as 'anxiety disorders'. The panic-prone individual and the worrier may be easier to stereotype than the apparently accomplished socialite who engages in a multitude of hidden 'safety' behaviours to prevent other people's negative evaluation, or the individual with obsessive compulsive disorder who internally tries to control his or her thoughts.

In this book, we divide anxiety problems into the different disorders as described by the diagnostic systems of *DSM–IV* and *ICD 10* (*International Classification of Diseases*, 10th edn.). Since 1952, the American Psychiatric Association has published a *Diagnostic and Statistical Manual* (*DSM*) on a periodic basis, the latest being the revised edition in 2000 (*DSM–IV-TR*). The value and use of *DSM* criteria to understand, categorise or offer therapy to our clients is a rich source of reference and also a minefield, full of debate and lack of resolution, and is a controversial topic in the therapeutic world. We summarise some of the debate and present our rationale for using diagnostic categories in a parsimonious and thoughtful way to guide our counselling practice for anxiety.

Diagnostic categories are much used in psychotherapy research, particularly in cognitive therapy, where researchers attempt to define a uniform population in order to generalise results to other uniform populations. They are also used in psychiatry, where matching the right pharmacological therapy to the problem is vital. However, in the world of counselling and psychotherapy we are aware of the pitfalls. Strawbridge and James (2001) and Sequeira and van Scoyoc (2001) summarise a debate on the issue held by the British Psychological Society Division of Counselling Psychology, listing concerns such as the questionable nature of categories, the power of labelling clients, pathologising distress, the risk of using psychiatric and research categories outside these contexts, and competence of practitioners to diagnose, given limited training in using diagnostic tools.

For a number of reasons, we believe that using some system to classify and categorise the different forms of anxiety our clients are experiencing is important. We would take a pragmatic

approach, and look for what may be helpful in using 'labels' and try not to get sucked into being absolute or obsessional. A pragmatic view of diagnostic categories is to see them as useful guidelines for practitioners to help us to understand and help our clients, but also as guidelines to be reviewed critically. We need to avoid reifying diagnostic categories, that is, treating them as more discrete and 'real' phenomena than they actually are. In particular, being clear about clients' problems can help us to gear up our therapy to be more effective. Much of the work on cognitive therapy for anxiety has shown how specific approaches work well for specific anxiety problems, as described in later chapters. Methods of formulation and specific techniques to use have been shown to work differently with different problems: for example, some of the methods to identify and challenge thoughts that are useful for managing panic attacks may become counterproductive and unhelpful for problems such as general anxiety and worry. The importance of clarifying what the problem is in order to find solutions is illustrated in the case of Stan:

> Stan was a young man who came for employee counselling for help with excessive anxiety and panic. Initial counselling focused on helping him to deal with his panic attacks. As counselling proceeded, it became clear that feelings of panic mainly happened when he had to meet a new client at work and in other unknown social situations. Stan imagined that other people, especially potential clients, were negatively judging him from the word go. It became clear that his problems lay mainly in the arena of social anxiety, which needed addressing directly in counselling. After realising this, it made more sense to help Stan learn to check the evidence more closely on whether people were judging him, rather than try to help him to stay calm in the face of supposed judgement.

Categories of anxiety problems

DSM–IV (APA, 2000) describes seven main 'anxiety disorders': panic, agoraphobia, specific phobia, social phobia or anxiety, obsessive compulsive disorder (OCD), post traumatic stress (PTSD) and generalised anxiety disorder (GAD). An eighth type of anxiety is health anxiety, classified as hypochondriasis in the somatoform disorders, despite sharing many of the salient characteristics of anxiety problems. Many have characteristics in common, but differ according to whether there are specific triggers for the anxiety, or whether the anxiety appears to accompany the person all the time. All the problems are disabling, distressing and

have a significant impact on the person's life; often such problems are misunderstood by others, who cannot understand the level of fear experienced. We describe the different disorders in more detail in the chapters on individual problems, but briefly outline the differences below.

Panic disorder is characterised by episodes of intense physical symptoms of anxiety, arising out of the blue, and that feel frightening and uncontrollable. Often people experience panic and fear in situations in which they have experienced previous attacks. Panic attacks are a 'fear of fear': the individual interprets a range of sensations from the body, including those arising from anxiety itself, as evidence that something catastrophic is about to happen, such as fainting, sudden death, loss of control, or negative social evaluation. The person may develop a range of ways of coping with real or possible attacks, such as keeping control, being extra vigilant for bodily signs and avoiding trigger situations.

Agoraphobia can be understood as a variant of panic disorder: the individual may well suffer from panic attacks, and learns to cope by avoiding situations completely, or by engaging in a wide range of more subtle ways of avoiding facing their fears, such as only going out with someone else, or restricting the range of places visited. People with agoraphobia can appear free of anxiety, but would be stricken with fear if they had to go to feared places.

The main feature of **specific phobias** is strong and persistent fear that is 'excessive or unreasonable', triggered by specific objects or situations: animals, aspects of nature, vomit or blood, for example. The fear leads the person to take lengthy and complex steps to avoid coming into contact with their fears, which interferes with their normal activities. People with specific phobias can be misunderstood, mocked or teased for their fears, but this is to belittle the impact phobias can have on the individual and his or her life.

In **social phobia**, the person fears negative evaluation or judgement from others, and lacks confidence in their own abilities as social beings. This may well ring true for many of us, particularly when put before a critical audience, but for the socially fearful individual any kind of social interaction, including standing next to a stranger at a bus stop or taking shopping through the checkout at the supermarket, can be a huge ordeal. Socially phobic

people engage in many subtle techniques that result in confirming themselves as socially incompetent, by focusing on the self rather than the social situation. They use their bad feelings as evidence that they are coming across badly, and believe they are being judged because they are judging themselves. Many socially phobic clients are skilled at avoidance.

Generalised anxiety disorder is characterised by worry: the individual worries about many everyday events and possibilities, the worry feeling out of control, persistent and severe. Generalised anxiety is also characterised by many of the physical and emotional symptoms of anxiety – the individual may feel anxious, on edge and tense most of the time. The themes of their worries may be of inability to cope, and of personal vulnerability.

The central theme of **health anxiety** concerns interpreting bodily signs, past and present, as indicators of serious illness, leading the individual to check for illness and seek reassurance. Both panic and health anxiety may be seen as a fear of the consequences of physical changes, but in panic disorder the threat is seen as imminent, whereas in health anxiety the danger may be no less, but round the corner. The individual with health anxiety worries excessively about their own health, the possibility of disease and any bodily symptom, and tries to allay such anxiety by repeatedly checking, going to doctors, reading up on their problems, and discussing them with others.

Obsessive compulsive disorder can be complex and difficult to understand. It is marked by a range of obsessions and/or compulsions, which take up a large proportion of the individual's time and energy, and cause distress to themselves and others. Most people with OCD can recognise that their obsessions and compulsions are unnecessary or out of proportion, but feel unable to stop. Some people 'ritualise', engaging in repeated ritual behaviours; others 'ruminate', worrying about their thoughts and engaging in mental ways of controlling their thoughts or behaviours, to stop the thinking. The central themes involve a sense of over-responsibility for self or others. The individual fears that their actions or thoughts themselves can have untoward consequences, and this leads to a variety of ways to stop, control or neutralise them. For example, they feel responsible for others' health, which may result in excessive rituals of washing and cleaning to avoid harm; or they feel responsible for controlling the bad thoughts that they have about others.

Anxiety and Evolution: a Necessary Part of the Human Experience

It is a mistake to see the anxiety response to threat as necessarily a pathological process. Anxiety has a strong evolutionary survival value and is therefore likely to be 'hard-wired'. All the different components of anxiety – somatic, cognitive, emotional and behavioural – are, in essence, primitive reactions to danger, which serve to keep us safe and thereby promote our survival (Beck et al., 1985; Beck, 1991).

> When we consider the common fears of childhood – falling, being injured, drowning, suffocating, the dark, deep water, and so on – we can see that some of these at least may serve to deter the child from venturing into unfamiliar or dangerous places before he has the requisite abilities and skills . . . the interpersonal fears, such as fear of strangers or of separation from a caretaker, may be conceived of in similar terms . . . the fear of negative evaluation seems to serve as a deterrent to behaviour that will alienate other people. (Beck et al., 1985: 13)

We may all be born with innate fears, such as fears of the dark, of strangers, creeping insects, strange noises, or of blood or vomit, which later on in life can be evaluated more rationally in order to overcome the innate fear response. Specific phobias may represent such innate fears which the individual has not grown out of.

Beck et al. (1985) describe many of the protective mechanisms to deal with specific dangers, all of which prompt the individual to engage in behaviours that will lead to safety. These include:

- autonomic responses designed to repel an attack, such as a pronounced drop in blood pressure and fainting for those with a fear response to needles or blood injury – a mechanism designed to prevent further blood loss after injury;
- responses designed to stop the individual going further into a 'danger zone', such as automatically grabbing at a stationary object if the person feels he or she is falling (such as the individual with panic attacks who clings on the supermarket trolley to prevent 'passing out' in public);
- gastrointestinal responses to the fear of having eaten something noxious;
- reflexes which stop us falling, such as the so-called 'visual cliff' reflex, discovered by research conducted in the 1960s (Walk and Gibson, 1961) that showed that babies and young children, as well as a host of other infants including turtles and kittens, immobilise when they come to the edge of a