CHAPTER 4

The reformulation of panic attacks and a successful cognitive behavioral treatment of social evaluative anxiety

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In recent years there has been increasing interest among psychologists and other social scientists in social constructionism, an epistemological approach that emphasizes the observer's/scientist's active role in defining reality. Consistent with a lively interest in cognitive science, the core constructionist assumption finds its roots in the observations of ancient philosophers as well as in the writings of poets and playwrights. Shakespeare put the idea this way: "There is nothing either good or bad, but thinking makes it so" (Hamlet, Act 2). And constructionism has been explicated of course by many current social philosophers (e.g., Gergen, 1994). While the extreme position can lead to an undesirable solipsism—there is no external reality worth worrying about—the message seems to us relevant and important for clinical psychologists. We have put the issue as follows in a discussion of constructive assessment in therapy with homosexuals:

... clients seldom come to mental health professionals with problems as clearly delineated and independently verifiable as what a patient brings to a physician... a client usually goes to a psychologist or psychiatrist in the way described by Halleck (1971). That is, the client is unhappy; his life is going badly; nothing seems to be meaningful; she's depressed more than her life circumstances would seem to warrant; his mind wanders when he
tries to concentrate; unwanted images intrude on her consciousness or in her dreams. The clinician transforms these often vague and complex complaints into a diagnosis or assessment, a set of ideas about what is wrong and, usually, what might be done to alleviate what is wrong. I would argue, then, that psychological problems are for the most part constructions of the clinician: our clients come to us in pain, and they leave with more clearly defined problems that we assign to them (Davison, 1991, pp.142-143).

A constructionist approach was taken in the case described in the present chapter. As will be shown, the nature of the referral was transformed very early in the therapy. A treatment program was then devised that was consistent with the reformulated clinical problem. The orderly and favorable course of therapy is consistent with the proposition that the reformulation of the patient's problem was useful. It is of course impossible to prove that the kind of positive outcome reported here would not have arisen with other assessment and therapeutic strategies, but the following case report is, we believe, of heuristic and demonstrational value.

NATURE OF THE REFERRAL

The first author was teaching a graduate clinical course in psychological intervention several years ago and had decided to have as the practicum component of an otherwise theory- and research-based seminar his treatment of an ongoing patient in the program's teaching clinic. The clinic director arranged for the therapist to see a female patient whose problem was described by a social worker she had been seeing as panic attacks. This therapist believed her patient would profit from a behaviorally oriented treatment, possibly systematic desensitization. The social worker described her approach as psychodynamic and family systems-oriented, so she did not feel qualified to embark upon the kind of behavioral treatment that she considered appropriate for her patient. (It is worth noting that the referring therapist's view of desensitization as the best intervention for panic attacks was not consistent with the research literature, which supports a treatment aimed at exposure to interoceptive stimuli like accelerated heart rate intentionally created by the patient in session and then reduced by various coping techniques such as relaxation, e.g. Barlow, 1988.)

The patient, whom we shall call Marie, agreed in writing to have all sessions with GCD videotaped and made available for use in professional training contexts. This she did because she hoped that this complete archiving of her treatment might help in educating future clinicians and thereby assisting other patients.

ASSESSMENT AND REFORMULATION

The first session of this therapy was perhaps the most critical. The referring clinician and the patient came together to our training clinic for the initial consultation, and with the patient's permission, there was a brief preliminary session with the social worker alone so that she might provide some context for the referral.

The social worker had been seeing the patient for ten months and described her as a 39-year old thrice-married full-time high school drama instructor and part-time actress who, as a recovering alcoholic, had been abstinent for 18 months. She had been complaining of what both the social worker and the patient referred to as "panic attacks," and these were marked by elevated heart rate, perspiration, and what the patient called "mind-fucking" cognitions. The social worker described the patient also as suffering from low self-esteem and a high need for approval.

A question in the therapist's mind before even seeing the patient was whether these "panic attacks" were uncued. Before the initial consultation, the therapist was prepared to embark on a therapy program drawn from the work of Barlow and his associates on panic disorder (Barlow, 1988), but consistent with his behaviorist assumption that unrealistic anxiety is usually triggered by identifiable environmental antecedents, he embarked in the preliminary interview with the social worker on a line of questioning that, he believed, might lead to a reformulation of the problem.

We learned from the referring therapist that Marie had a long history of sensitivity to criticism, dating back to childhood experiences with a "hypercritical" mother. This prompted GCD to ask whether criticism could be an important cue for Marie's "panic attacks": "Does she react with this extreme anxiety when she perceives she might not do well? Are there other situations in which she experiences the anxiety?" Answers by the social worker and, later in the session, by the patient herself, yielded support for our evolving hypothesis that criticism, or social evaluation, might be a powerful cue for sometimes extreme bouts of anxiety which the patient and the social worker were labeling panic attacks.

After speaking with the referring therapist for about half an hour, GCD spoke with Marie without her therapist present. Marie readily engaged the therapeutic situation with energy and intelligence. She presented as an attractive, intelligent, articulate person who was strongly motivated to make maximum use of the weekly sessions that GCD was able to offer her during the coming semester as part of his graduate course. She showed considerable emotional lability in this session, tearful one moment,
reflective and composed the next. Despite the inevitable intrusiveness of the session being videotaped, including the presence of a third person in the room to monitor the videotaping, Marie and the therapist managed readily to concentrate on the therapy process itself.

As a follow-up on the briefing with Marie's clinician, our first line of questioning with the patient focused on determining if specific situations could be linked to her feelings of intense anxiety. Some excerpts will illustrate:

**THERAPIST:** Are there things that trigger greater or lesser degrees of anxiety? For instance, I understand that you feel anxious during auditions.

**PATIENT:** Auditions or any other kind of situation when people might criticize me.

**T:** Would you describe yourself as sensitive to criticism? Can a negative remark stay with you for hours, even a day or two?

**P:** Definitely. I have always been that way since I was a child. My mother was very critical. . . . I can hear her nagging...

**T:** Can you recall a recent situation that was very troubling? One in which you were very anxious about criticism?

**P:** Yeah, a few months ago I auditioned for an industrial shoot. When I got there I heard that everything had gone wrong that day. There were technical problems and [problems also with] the house they chose for the location. I got very anxious and worried about doing a good job so everyone would feel better. I could feel my heart pounding and my hands were sweating.

From this exchange, GCD began to construct a theme of extreme interpersonal performance anxiety/sensitivity to criticism. "Panic attacks", especially in the sense of uncued bouts of extremely high anxiety, did not seem as useful a way to construe the patient's predicament as anxiety reactions to a range of specific and specifiable situations. The patient found the therapist's use of the descriptor "thin-skinned" very apt to refer to her sensitivity to criticism. Marie reported a long learning history of her anxiety reactions to a range of specific and specifiable situations.

In response to direct questions, Marie also expressed certainty that the "panics" she experienced never occurred out of the blue. And as the first session continued, she began referring to them as anxiety feelings rather than an panicky feelings. Furthermore, as she began to see some orderly relationships between her anxieties and specifiable events in her environment, she derived reassurance that she was not, as she had been fearing, losing her mind (a not infrequent associated symptom of panic disorder). The lack of evidence for panic disorder marked by recurrent uncued panic attacks, coupled with an emerging picture of a woman who had for years been extremely concerned about pleasing others and very fearful of being criticized by them, gave further support to the reformulation of the patient's difficulties as centering around high levels of social evaluative anxiety.

The therapist observed to the patient that high levels of nervous tension punctuated by extreme anxiety ("panic attacks") in response to social evaluation were understandable, given that she was an actress often going to auditions. As the therapist learned in succeeding sessions, auditions and acting in general provide a very thin schedule of positive reinforcement and a very concentrated schedule of punishment. At the same time, he agreed with her judgment that her anxiety reactions were much greater than the situations warranted and that they were probably interfering with her ability to perform as well as she was capable of.

**DESIGNING AN INTERVENTION BASED ON THE REFORMULATION**

Because the therapist considered systematic desensitization as a strong possibility for treatment, he inquired into past experiences that the patient might have had with relaxation training. She reported that she had done Hatha Yoga and considered herself fairly proficient at achieving a state of relaxation when she put her mind to it in a controlled environment. This boded well for her learning progressive relaxation that would be applied in desensitization. Her background as an actor suggested to the therapist that she would have no trouble in the imaginal role-playing that is intrinsic to desensitization (whereby an imagined event has to be the functional equivalent of an actual one).

During the second session, additional questioning provided further evidence in support of that hypothesis, pursuing an allusion by the patient about the fear of the unknown:

**T:** Does the fear of the unknown have anything to do with not knowing what to do, a fear of harm that might befall you?

**P:** I'm aware of something physiologically that happens to me, the excessive sweating, the adrenaline flowing, and I don't know why that happens. I think it comes down to "they won't like who or what I am... I don't know what any other actors' insides are like but I can't imagine spending the rest of my life feeling what I have over the past year. I always compare myself..."
to other people. I look around and see that they all seem fine and I’m about to pass out. I am dying inside from the anticipation. One way I judge the appropriateness of how I feel is to see how others are feeling.

"People-pleasing" and sensitivity to criticism go hand in hand with assertiveness problems, and Marie was no exception. She readily agreed that she had great difficulty expressing her needs and disagreeing with others. Whether time would permit a focused approach to nonassertiveness was doubtful, but the therapist harbored the belief that reducing her concern about the opinions of others would likely have a beneficial effect on her nonassertiveness.¹

At the end of the second session, the therapist asked Marie to gather data for their collaborative project as an important first step in efforts to reduce her interpersonal anxiety. She was asked to write down situations or events where she found herself getting more anxious "than you believe the event warrants". Feelings of anxiety, therefore, were construed for her as useful tools for treatment, cues that would help in the formulation of a therapy that would target her excessive anxiety in reaction to a range of specific and specifiable situations.

By this point the therapist was considering a cognitive intervention based on Ellis (1962, 1993). Because rational—emotive behavior therapy focuses on internal monologues and (sometimes unverbalized) assumptions that reflect an overly demanding, perfectionistic attitude towards the self and/or the environment, the therapist began to ask the patient to consider what goes through her mind when she becomes anxious. Therefore, in addition to the self-monitoring of external events that seemed to trigger unwarranted anxiety, Marie was asked to try to take notice of what she was thinking about while she was feeling inappropriate anxiety. The therapist was thus laying the groundwork also for a cognitive therapeutic approach to complement desensitization. The following exchange illustrates how this self-monitoring assessment was presented to the patient:

T: What someone says or does is the external situation so write that down [in the coming week as soon as possible after it happens]. But an important part is also what you bring to the situation. It’s very important and useful to know what the thoughts are when you feel anxious. Start from your feelings as a signal to gather data. Include your "self-statements" or things you say to yourself.

C: Subtext. In acting we call it subtext.²

GCD emphasized the distinction between useful and maladaptive anxiety so that Marie would not be concerned that she would "lose her edge" in behaving under the pressure of acting auditions. In other words, the goal of the therapy would not be to render her unconcerned about the quality of her performance, unable to "get up for" an acting challenge, rather it would be to teach her ways to avoid the debilitatingly high degrees of anxiety that had been preventing her from performing at her best and that had been making her role as an aspiring actress little better than a living Hell. This theme was discussed again towards the end of treatment, when Marie was beginning to feel a good deal less anxious generally and in social evaluative situations in particular. To drive the point home, the therapist described the inverted-U function in experimental psychology, whereby optimal performance is at a point of moderate arousal; too little arousal can contribute to a lackadaisical performance while too much can interfere with the expression of talents and skills that the person possesses. This metaphor seemed to make a great deal of sense to Marie and helped her adopt not only a realistic view of therapy but an adaptive one as well.

In collaboration with the patient, the therapist generated the hypothesis that a reduction in sometimes high levels of performance anxiety and sensitivity to criticism would be of material benefit. In the interests of making maximum use of the limited time available, the therapist presented to the patient a two-pronged approach: systematic rational restructuring, an imagery-based strategy for implementing Ellis’s rational-emotive behavior therapy (see Goldfried & Davison, 1976, 1994, chapter 8); and taped systematic desensitization, Wolpe’s imagery-based method for reducing anxiety (Wolpe, 1958) and adapted for audiotaped presentation (Goldfried & Davison, 1976, 1994, chapter 6). They would be combined on audiotape in order to accommodate the time restriction (an academic semester). The cognitive component would be directed at altering cognitions in a manner that would lessen the patient’s catastrophizing and absolutist attitudes towards acting and other situations in which she could be unfavorably evaluated/criticized. The desensitization component would aim to break the links between specifiable anxiety-provoking situations and what might be non-cognitive mediated autonomic reactions that had been classically conditioned to inherently innocuous situations or situations of less than monumental import. While there are empirical data attesting to the efficacy as well as clinical effectiveness of both strategies, the combination of the cognitive and desensitization components was new in the therapist’s practice and, to his knowledge, not previously (or since) reported on.³

Using the information gathered between sessions by the patient, the therapist worked with her over several sessions to create a 19-item anxiety hierarchy that represented her anxiety disorder (in DSM-IV terms, she would probably have been given a diagnosis of social phobia). A
sampling of these items will illustrate this central aspect of the therapy. The numbers in parentheses represent the patient's rating of the aversiveness of the item on a 100 point subjective rating scale, where a rating of "1" indicates that the situation would evoke or has evoked no anxiety at all in real life, and "100" indicates that the situation is or would be as anxiety-provoking as she could imagine anything being. The fact that some of the ratings appear very precise (e.g. 59 instead of 60) is a result of items sometimes clustering within a general range and of the need to rank-order them. Note: while the construction of an anxiety hierarchy is usually seen as an aspect of treatment, it is in fact as much a part of the clinical assessment for it involves the fine-grain specification of the patient's anxiety-related clinical problems.

At school, you are having a production meeting for the musical. You've done your work, and other people are reporting being on schedule, too. (15, easiest item)

After a Twelve-Step meeting, you're inviting Mary and Ingrid to have lunch at your house. (25)

Arriving for the shooting of the industrial [a training film], you are parking your car on the street near the house where the shoot is going to be. (30)

As you enter the house for the shooting of the industrial, the casting director asks you who you are. You tell her who you are. (40)

At home, you are putting on your make-up as you get ready to leave for the production company audition. (48)

You've just arrived at the production company audition and you're scopeing out the competition. (59)

You're walking down a long hall in heels on your way to the production company audition room. (62)

At the reading for the play, you're a few beats late with your first entrance. (65)

At the industrial shoot, the director is yelling at you to get together with the continuity director and clean up the dialogue. (68)

You're sitting around your dining room table with Kathy, Marion, and your daughter. You, Marion, and your daughter are smoking. Your husband comes in then quickly turns on his heel, goes into the kitchen, and bangs around some to show his displeasure. (80)

At the reading for the play, you're making an entrance and realize that you didn't turn the page and you now have to find your place in the script. (92)

At the industrial shoot, you're working with the continuity director to clean up the dialogue, and she is having you repeat each sentence often until you get it correct. (95, most difficult item)

It should be noted that the nature of the hierarchy itself is constructive in nature. That is, we have never viewed a specific anxiety hierarchy as the only or best one for a given patient at a given time. Knowing that a person is, as here, exceedingly sensitive to criticism does not in itself dictate those situations to which she will be desensitized or otherwise taught to cope with. An anxiety hierarchy or any other group of situations in a patient's life are, in our view, best seen as a sampling from an infinite number of situations that could be represented. We put the matter thusly many years ago in a discussion of desensitization:

[We view themes pursued in therapy) as a conceptualization of the therapist. We have long ago stopped asking ourselves whether we have "truly" isolated a basic anxiety dimension of our clients. Rather, we ask ourselves how best to construe a person's difficulty so as to maximize his gains. In other words, rather than looking for the "real hierarchy," we look for the most useful hierarchy. This has important implications, not the least of which is the freedom to attempt to reconceptualize various client problems in terms amenable to desensitization. The clinician must ask himself what the implications are likely to be should a particular desensitization actually succeed. For instance, will a person depressed about her lack of meaningful social contacts be happier if her inhibitions about talking to people are reduced by desensitization [in contrast to suggesting she find different people to associate with, for example; and/or trying to change her relationship with her husband, etc.]? Looked at in this way, the clinician would seem to have both greater freedom and greater challenge in isolating anxiety dimensions. (Goldfried & Davison, 1976, 1994, p.115)

Recall that the therapist was planning also a cognitive intervention based on Ellis. As noted earlier rational-emotive behavior therapy deals with internal monologues and assumptions that reflect art overly demanding, perfectionistic perspective on life. The therapist therefore began to ask the patient to consider what goes through her mind when she becomes anxious. This kind of discussion took place at various times during the first few sessions.

The anxiety hierarchy constructed with Marie was used in an imagery-based procedure that combined systematic desensitization and the cognitive approach of Albert Ellis. The desensitization component entailed instructing the patient to relax away even the slightest degree of tension elicited by a given aversive image. Relaxation was thereby seen as a coping response to anxiety per the self-control desensitization strategy originally proposed by Goldfried (1971). 4 The cognitive component involved first providing the patient with and then later encouraging her to develop on her own self-statements that reflected a less demanding, less absolutistic view of her interactions with others. For example, to deal with the item, "You're phoning your friend Jane to borrow an outfit for the production company audition," the therapist asked her to cope with the tension by saying silently to herself, "While it would be nice for the outfit
to be great and for the audition to go well, it's not a catastrophe if things don't go perfectly." The patient imagined each item twice, the first time using relaxation to lessen her anxiety, the second time using a coping self-statement to control her tensions.

An aspect worth noting is the degree of *choice* that we indicated this combined treatment was designed to give her. That is, we proposed to her that one of the most frightening and daunting consequences of being exquisitely sensitive to negative evaluation—especially when one's life is full of such challenges, as hers was because of her acting—was that one felt tugged and pulled and dominated by external events. Learning ways to cope with such anxiety should lessen the feeling that one is helpless. Also, inherent in cognitive therapy, as with humanistic and existential therapies, is the guiding and core assumption that people do not react so much to what the world serves up to them, rather they can learn to choose to *construe* the world in a particular way (within practical and sensible limits, of course). The therapy, then, was aimed at increasing the range of choices she might have. Significantly, this discussion in the fourth session led to the patient crying, a reaction she said arose from feeling the relevance of the choice issue and allowing herself to have some hope that she could achieve more freedom in her emotional life than had been the case for many years.

The combined desensitization–REBT therapy in imagination was carried out across five sessions, with the therapist presenting items serially to the patient in groups of between two and four in session and making a tape of these presentations. This exercise occupied no more than half of a given session, with the patient instructed to practice with the tape between sessions. There was always discussion of the patient's experiences with each tape at the beginning of the following session, and then time was available to talk about related issues.

THE PROGRESS OF THERAPY

A number of events took place during the therapy that indicated that our particular construction of the patient's problems and the intervention based on it was proving useful. The importance of attending to the patient's self-talk was underscored in the fourth session, when she came in with a report of an audition that week having gone well because she had tried not to "beat up on myself" as she usually did when things were not going as well as they "should." She found herself realizing that she would be unlikely to get the part because she looked too young for it. With this pressure removed, she was able to relax and ended up auditioning very well. This experience, unplanned by the therapist, gave her insight into the role of self-talk and of not taking a "musturbatory" attitude towards a challenge and confirmed the therapist's developing belief that a cognitive approach would be useful as part of the therapeutic intervention.

Practicing relaxation with audiotapes was also facilitated by the patient's developing ability to refrain from demanding perfection of herself. She reported in the seventh session that she was able not to worry about how well she was doing with the practice and as a consequence was able to see it as less of a challenge to be perfect and more as something to enjoy, focusing on the process and not the desired outcome. 

In the ninth session she reported a good audition and attributed it to two factors: she knew beforehand that she had the part, and she saw that it was someone else's role that was to be decided on during the audition, not hers.

During the thirteenth session, she recounted being able to deal with some stressors in a less agitated way than usual and made the following comment:

The good side of all this [dealing with stressful situations] is that I feel so good about situations that come up that before would have made me very nervous and very anxious that haven't. I've had very quick clarity on the ability to put it into perspective and judge what my role is ... I'm not getting emotional and I know I couldn't have done that last year . . . I was at a party where everyone was singing. One of the songs was an audition song of mine and everyone stopped singing because I was singing so well. When they stopped, I could feel my anxiety just go right up but I was able to continue singing and bring it down again.

In the fifteenth session, Marie commented that the hierarchy items she had worked with the preceding week seemed "silly" to get upset by. These were items that she had ranked as moderately anxiety-provoking.

In the second-last session, Marie said she was on her way to an audition and was, to her pleasure, looking forward to it as an occasion to apply her newly learned relaxation and cognitive restructuring skills.

While the therapeutic contract called for a time-limited therapy aimed directly at her "panic attacks," other themes were developed and discussed to some degree during the 17 sessions of treatment. Each of these themes could well have occupied our time, and each of them could have been construed as relevant to the "panic attacks". One such theme was problems the patient and her husband were having with one of the patient's daughters, a 17-year old suffering from an eating disorder. This
naturally added to the stress that the patient had sought help for. Also a source of concern were conflicts with her husband, which seemed to be centered around his overbearing attitudes towards family finances. Coupled with this was a lack of assertiveness in the patient, something she herself traced to her traditional southern upbringing, constraints and limitations that she chafed under as a co-equal breadwinner in the marriage. And finally there was the continuing battle against a drinking problem that both she and her husband had been waging with help from AA. When she entered therapy with us, she had been abstinent for a year and a half.

These are issues which, as noted, were the subjects of discussion from time to time and would, under ordinary circumstances, have demanded greater attention in our therapy. The unease that the therapist experienced in paying little concentrated attention to these problems was alleviated by the knowledge that the patient was maintaining therapeutic contact with the referring social worker, who, it should be mentioned, watched the videotapes of the treatment and conferred periodically with us.

The last session, the seventeenth, took place five months after the initial consultation and included the referring therapist in a review of the course of the treatment. The social worker, who had seen Marie several times during the course of our therapy with her, confirmed our positive judgment of her general anxiety level and her ability to deal with stressful situations without the panic that had been the basis of the original referral to GCD. The audition that Marie had gone to immediately following the preceding session, along with a second one that week, had both gone very well. As she put it: "I just nailed both those auditions. I feel the anxiety creeping up and I use it for the auditions. It's just not unmanageable ..."

At this wrap-up, the therapist encouraged Marie to practice with the relaxation tapes about once a week and also with the last couple of desensitization-REBT tapes (which dealt with the most difficult hierarchy items) in order to keep these newly acquired cognitive skills fresh and available to apply to the stressors in any person's life. "It's like staying in good physical condition... It takes repetition and drill," GCD observed. Marie would begin seeing her social worker therapist once again to work in particular on her marital stress, and the plan was for her to phone GCD for a two-month follow-up session.

This session in fact took place. Marie was continuing to have good auditions and was even getting some paid acting jobs. She commented jokingly that on one voice-over she was doing, she was feeling so relaxed that the director told her to "put more of an edge on it." She had no trouble doing so. Her home situation continued to pose major challenges—her daughter's bulimia and ongoing conflicts with her husband—but she expressed confidence that, with the continuing help of her social worker therapist, she would be able to cope adequately. In general, she saw herself as less of a pawn and more of an assertive person with legitimate rights and the means to achieve them.

A second follow-up session five months later was planned and took place, constituting a seven-month follow-up. At this meeting the gains already noted seemed to be holding. She was continuing to audition and to get jobs, and was planning to leave her teaching job in order to focus more on her acting career. She described her marriage in very positive terms and was having less frequent sessions with the social worker. She and her husband were continuing to attend AA meetings regularly. At the end of the session, GCD reminded her that slip-ups were inevitable and that she would be well advised to see them as temporary and a part of normal daily life.

A letter 18 months later and a phone call two years after that, or about three years after termination, confirmed that things continued to be going well. She had taken a management position at a large upscale department store in Los Angeles and asserted that her social evaluative anxiety was gone. This had given her, she said, a sense of self-empowerment that was having generalized positive effects in her life.

**SUMMARY**

This case study illustrates the manner in which a presenting complaint of panic attacks was reformulated into a theme of social evaluative anxiety. This construction of the patient's problem led to a two-pronged approach: systematic desensitization and rational-emotive behavior therapy, combined in a novel imaginal therapeutic procedure that was conducted largely via audiotapes made over several consulting sessions and used in daily at-home practice by the patient. In this procedure, relaxation and positive self-statements were applied by the patient as self-control ways to ease tension in a range of social evaluative situations, most especially auditions for this part-time actress. As with most people who commit to psychotherapy, this patient had other problems as well, among them a continuing battle against problem-drinking, a bulimic daughter, problems of nonassertiveness, and a marriage that showed some signs of strain. The time-limited nature of the therapy reported here precluded dealing with these issues, but the stress occasioned by them seemed to benefit from the anxiety-reduction procedure as did much as the interpersonal performance anxiety that was the target for intervention. A follow-
up of almost three years suggested that the treatment gains were being maintained and that the patient was succeeding in coping well with life’s inevitable stressors.

NOTES

1. Nonassertive patients always pose a process problem for the therapist, namely, a concern that the patient will agree with interpretations and other statements of the therapist when, in fact, she doesn’t. It is always good practice to make an extra effort with such patients by pointing out the importance of their expressing their needs and disagreements openly in session. This not only facilitates the treatment but also provides an opportunity for the patient to experiment with being more assertive. In this therapy we watched for opportunities for the patient to disagree with us and were gratified to find some. For example, during the relaxation training, Marie brought up problems she was occasionally having and reported at-home practice sessions that did not result in her feeling more relaxed after listening to a tape than she was beforehand. Also, there were many occasions when she expressed a difference of opinion about the therapist’s interpretation of an event. Another sign that the patient was prepared to tell the therapist things she believed he would rather not hear was a comment in the twelfth session when she reported that listening to the desensitization-REBT tape the previous week had been “boring” and that she had experienced resistance within herself about working with the tape on a daily basis, as had been prescribed. (The therapist construed her boredom as a positive sign, to wit, that the hierarchy items were becoming easier for her to cope with.)

2. Notice how the patient immediately grasped the importance of a person’s ongoing dialogue with herself. The therapist made clear on this and other occasions the connections and similarities between what was going on in their therapy together and what an actor is familiar with and uses to enhance her work.

3. The nature and role of clinical innovation have been reviewed previously by us (Davison & Lazarus, 1994, 1995; Lazarus & Davison, 1971).

4. There are many ways to conceptualize the mechanisms underlying the effectiveness of systematic desensitization. If the effects derive from counterconditioning (cf. Davison, 1968; Wolpe, 1958), then relaxation is viewed as a response that is substituted for anxiety. As implemented here, we focused on the coping aspects of relaxation as suggested by Goldfried (1971), but the strategy we followed would also satisfy the procedural requirements of counterconditioning.

5. Not always considered when teaching patients relaxation is the attitude that is best suited for acquiring this skill, and we believe that reports of “relaxation-induced anxiety” (Heide & Borkovec, 1984) may arise from overlooking this variable. We have made it a practice to spend time before a first induction explaining the mind-set that is helpful in deriving benefit from this training. Discussion centers around such themes as viewing relaxation as a skill that requires patience and practice, understanding new sensations like tingling in the fingers as good signs rather than something to be alarmed about, and emphasizing that the patient retains ultimate control over what is happening.

6. It is interesting that positive outcomes were being reported before intentional work on the anxiety hierarchy had been undertaken. While one never knows how to explain changes in a single case study, we attribute these glimmerings of improvement to several possible factors: (1) the ubiquitous placebo effect, considering especially the big build-up that the referring therapist had given the patient prior even to coming to our training clinic for the first session; (2) reassurance that her “panic attacks” were not just coming out of the blue, that they were ultimately controllable, and that they did not signify that she was losing her mind; (3) and the discussions that had begun in the second or third sessions about the philosophy of rational-emotive behavior therapy, in particular the desirability of making fewer absolutistic demands on oneself and one’s environment. With respect to the last point, it sometimes occurred to us that we were not so much telling Marie anything new as we were endorsing a way of approaching challenges that she already understood but had been reluctant to adopt.

REFERENCES


