Simply effective

Group Cognitive Behaviour Therapy

A Guide for Practitioners

SAMPLE CHAPTER

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Appendix A

Cognitive Behaviour Therapy Pocketbook – Revised

The CBT Pocketbook is used after first screening clients for possible disorders using the 7 Minute Health Screen Audit – Revised (Appendix B) or the First Step Questionnaire – Revised (Appendix C). The disorders in the Pocketbook are listed in alphabetical order. For each disorder there are questions which directly access each symptom in the DSM-IV-TR criteria. For a symptom to be regarded as present it must produce clinically significant distress or impairment. When there is a need to reassess the client, the same questions can be asked again to check progress.

A conceptualisation of each disorder is presented for sharing with the client. A 'Sat Nav' for that disorder follows, to be used as an aide-memoire during therapy (it is not intended to replace the session-by-session guidelines). The 'Sat Nav' identifies and summarises treatment targets and treatment strategies. Finally usage of the Pocketbook is governed by the mnemonic FACT. The F and A stand for first assess. The third letter of FACT, 'C', stands for conceptualisation. The last letter of FACT, 'T', stands for treatment and under this heading the core cognitive behavioural interventions are summarised in the Sat Nav.

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Depression

During the last 2 weeks have you been:

1. Sad, down or depressed most of the day nearly every day?
2. Have you lost interest or do you get less pleasure from the things you used to enjoy?
3. Have you been eating much less or much more?
4. Have you been having problems falling asleep, staying asleep or waking up too early of a morning?
5. Have you been fidgety, restless, unable to sit still or talking or moving more slowly than is normal for you?
6. Have you been tired all the time nearly every day?
7. Have you been bothered by feelings of worthlessness or guilt?
8. Have you had problems taking in what you are reading, watching/listening to or in making decisions about everyday things?
9. Have you been hurting or making plans for hurting yourself?

If the client answered yes to five or more of the above (at least one of which has to be question 1 or 2) then it is likely that the client is suffering from depression.

Conceptualisations – present a story that makes sense to the client and is consistent with the CBT model. Examples:

(a) 'on strike for better pay and conditions'
(b) 'stopped investing so there can't be a return'
(c) 'you equated your worth with doing . . . how do you know there can't be other routes to a sense of achievement and pleasure?'
(d) 'why would the dice be forever loaded against you?'

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Depression Sat Nav

Therapeutic targets	*Treatment strategies*
1. Depression about depression	Focus on responsibility for working on solutions and not on responsibility for problem
2. Inactivity	Developing a broad investment portfolio, wide-ranging modest investments
3. Negative views of self, personal world and future	Challenging the validity, utility and authority by which these views are held. Use of MOOD chart
4. Information processing biases	Highlighting personal biases and stepping around them using MOOD chart
5. Overvalued roles	Valuing multiple roles, renegotiation of roles in social context
6. Relapse prevention	Personally constructed self-help 'manual', utilising key points from therapy and drawing on self-help books and computer-assisted material

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Generalised anxiety disorder

Ask the client if they would regard themselves as a 'worrier', in the sense that they always find something to worry about and if they are not worrying they worry that they are not worrying? If the worry has been excessive or uncontrollable (more days than not) for at least six months and they have three or more of the following symptoms (more days than not):

1. tiring very easily
2. restlessness, keyed up or on edge
3. difficulty concentrating or mind going blank
4. irritability
5. muscle tension
6. difficulty falling or staying asleep

then it is probable that they are suffering from generalised anxiety disorder. (However, a diagnosis of GAD is not given if they are suffering from depression; the latter is regarded as more significant in the diagnostic 'bible' DSM-IV-TR, American Psychiatric Association 2000).)

Conceptualisation – the essence of GAD can be conveyed to clients as follows: 'worry about everything and nothing, worry even if there is nothing to worry about', 'imagination runs riot, what if this, what if that, what if the other'.

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Generalised anxiety disorder Sat Nav

Therapeutic targets	*Treatment strategies*
1. Beliefs about the uncontrollability of worry	Worry postponement, worry time. Planned ignoring of worries
2. Beliefs about the danger of worry	
3. Avoidance, reassurance seeking	Openness to all triggers of worry episodes, trusting in own judgement
4. Thought control strategies	Demonstration of rebound effect of thought suppression
5. Positive beliefs about worry	Examination of the evidence and counter evidence
6. Maladaptive metacognitive beliefs about problem solving and intolerance of uncertainty	Problem orientation and effective problem solving
7. Task interfering cognitions (TIC), horror video	Switching to task oriented cognitions (TOC) TIC/TOC Switching to reality video
8. Perception that demands exceed resources	Working sequentially rather than simultaneously, weaning off excessive responsibility – responsibility pie
9. Managing mood	Use of MOOD chart
10. Tension	Applied relaxation
11. Relapse prevention	Recap of all treatment strategies and distillation of relapse prevention protocol

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Obsessive compulsive disorder

Obsessions

1. Are you bothered by thoughts, images or impulses that keep going over in your mind?
2. Do you try to block these thoughts, images or impulses by thinking or doing something?

Provided the client's concerns are not simply excessive worries about everyday problems and provided the client sees these thoughts/images as a product of their own mind, then yes responses to questions 1 and 2 above indicate a likely obsession.

Compulsions

1. Do you feel driven to repeat some behaviour, e.g. checking, washing, counting, or to repeat something in your mind over and over again to try to feel less uncomfortable?
2. If you do not do your special thing do you get very anxious?

Yes responses to these last two questions indicate a probable compulsion.

Note: the client has to be aware that their obsession and compulsion are excessive or irrational and they must also significantly interfere with functioning or cause significant distress.

Conceptualisation – normalise the client's thoughts/ideas/fantasies by likening the mind to a 'railway station', nobody can control what 'train of thought/image comes in'. Point out that (a) trying to neutralise them by overt behaviours, e.g. repeated handwashing, or covert rituals, e.g. counting to a certain number, 'feeds' the intrusions, (b) pursuing a feeling of certainty is like searching for the 'Holy Grail'; and (c) they take an excessive share of the 'responsibility pie'.

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Obsessive compulsive disorder Sat Nav

Therapeutic targets	*Treatment strategies*
1. Model of mental life, serious misinterpretation of intrusions – thought action fusion (TAF), thought object fusion (TOF) and thought event fusion (TEF)	Develop more appropriate model, detached mindfulness about intrusions
2. Inappropriate goal state, e.g. absolute certainty, perfect cleanliness	Distilling achievable goals
3. Appraisal of intrusions	Encourage perception of reasonable degree of control by postponement strategies. Use of bOCD chart and completion of Personal Significance Scale
4. Neutralising images, thoughts, behaviours	Behavioural experiments – Dare Don't Avoid a Realistic Experiment
5. Overestimation of danger/ intolerance of uncertainty	Distillation of realistic probabilities. The necessity of tolerating uncertainty
6. Cognitive and behavioural avoidance	Demonstration of the harmlessness of thoughts. Discussion of 'why don't you warn others of these dangers?'
7. Excessive responsibility, low mood	Responsibility pie, therapist contracts to remove responsibility, MOOD chart, memory aids
8. Unassertive communication	Communication guidelines
9. Unrealistic appraisals	Leader playing devil's advocate of personal significance of intrusions, co-leader challenging the leader's 'appraisals', assisted by group members
10. Relapse prevention	Personalising the OCD Survival Manual

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Panic disorder and agoraphobia

1. Do you have times when you feel a sudden rush of intense fear, that comes on, from out of the blue, for no reason at all?
2. Does it take less than ten minutes for the panic attack to reach its worst?
3. During your last bad panic attack did you have four or more of the following:
   i. Heart racing
   ii. Sweating
   iii. Trembling or shaking
   iv. Shortness of breath or smothering
   v. Feeling of choking
   vi. Chest pain
   vii. Nausea
   viii. Dizzy, light-headed, unsteady or faint
   ix. Things around seemed unreal
   x. Fear of losing control
   xi. Afraid you might die
   xii. Numbness or tingling sensations
   xiii. Chills or hot flushes

If the client answered yes to each of the three questions above it is likely that they are suffering from panic disorder.

Some people with panic disorder avoid certain situations for fear of having a panic attack, e.g. going places alone, crowded shops. If this is the case it is then necessary to establish whether this avoidance interferes with their daily routine, job or social activities. If the answer to this is also yes then they are probably suffering from panic disorder with agoraphobic avoidance. The agoraphobic avoidance would be regarded as severe if they are totally unable to go out by themselves, mild if they just can't go great distances by themselves and moderate if how far they can go by themselves is in between.

Conceptualisation

(a) Advise that panic attacks are fuelled by catastrophic interpretation of unusual but not abnormal bodily sensations. View panic attacks as a 'Big Dipper Ride', ascending the symptoms get worse, tempting to get off near the top, but if the client does not do anything then the symptom comes down the other side within ten minutes.

(b) Suggest that using 'safety behaviours' prevents learning that nothing terrible would happen if they did nothing at all in the panic situation.

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Panic disorder Sat Nav

Therapeutic targets	*Treatment strategies*
1. Fear of fear, anxiety sensitivity, catastrophic labelling of bodily symptoms, hypervigilance for bodily symptoms, monitoring of panic attacks	Psychoeducation
2. Avoidance of activities and situations, anxiety sensitivity	Construction of exposure hierarchy, in-vivo and interoceptive exposure
3. 'Safety' procedures, avoidance	Daring to gradually wean off 'safety' procedures, troubleshooting cognitive saboteurs to continued interoceptive and in vivo exposure
4. Intolerance of discomfort, feared consequences, key cognitive saboteurs	Interoceptive and in-vivo exposure, challenging 'catastrophic' cognitions, dares as behavioural experiments, downward arrow technique
5. Relapse prevention	Identifying likely precipitants for panic, distillation and rehearsal of a protocol. Exercise as a possible preventative measure. Regular review of protocol

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Post-traumatic stress disorder

A.

1. Have you ever been involved in a very serious accident, incident or assault that still plays on your mind?

If more that one trauma is reported: which one of these affected you most?

2. How did you react when it happened?

If unclear: Were you afraid or did you feel terrified or helpless?

In order to meet criterion A the person must have both objectively experienced an extreme event A(1) and felt intense fear, helplessness or horror at the time A(2).

B.

i. Do you have distressing memories or pictures of the incident popping into your mind?
ii. Do you have distressing nightmares of the incident?
iii. Do you ever feel that you are not just remembering the incident but that you feel like it is happening again and lose some awareness of where you are, what you are doing?
iv. Do you come across any reminders of the incident that cause you to get very upset?
v. Do you get any physical symptoms such as breathing heavily, heart racing, sweating when you come across reminders?

In order to meet criterion B at least one of the symptoms in this category must be endorsed.

C.

i. Do you try to block thoughts/images and avoid conversations about the incident?
ii. Do you avoid activities, places or people that bring back memories of the incident?
iii. Is there any big gap in your memory of the incident that you don't remember even though it was at a time that you were conscious?
iv. Have you lost interest in or stopped bothering with things you used to do that you enjoyed?
v. Have you felt that you are not connecting with others, more than just a bit out of sync?

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vi. Do you feel flat, unable to feel warm to people?
vii. Do you have a sense that you are going to die young, by a particular age?

In order to meet criterion C at least three of the symptoms in this category must be endorsed.

D.

i. Are you having difficulty falling or staying asleep?
ii. Have you been having outbursts of anger or snapping?
iii. Do you have trouble concentrating sufficiently to read or watch TV?
iv. Are you on guard a lot of the time, keep checking on things?
v. Are you easily startled, taking more than seconds to calm down?

In order to meet criterion D at least two of the symptoms in this category must be endorsed and these sympyoms must represent a change in functioning from before the trauma.

For a diagnosis of PTSD not only must the client have at least one intrusion, three avoidance and two disordered arousal symptoms but the symptoms must have lasted at least a month and significantly interfered with their working or domestic life.

Conceptualisation – suggest client has developed a 'dodgy alarm' (amygdala) that goes off (a) at any reminder, (b) anything not exactly the way you want it to be and (c) unexpected noises or sudden movements. Client reacts as if in a 'war zone', making communication with others very strained.

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Post-traumatic stress disorder Sat Nav

Therapeutic targets	*Treatment strategies*
1. Beliefs about PTSD	Normalisation of symptoms – utilisation of *Moving On After Trauma*
2. Cognitive and behavioural avoidance	Advantages and disadvantages short and long term of avoidance
3. 'No one can understand what I've been through'	Realistic portrayal of discomfort to be expected. Underlining similarities of trauma and responses
4. Managing reminders	The menu of options for handling reminders
5. Behavioural avoidance Fear of anxiety	Beginning the journey of a return to normality by gradual 'dares'
6. Processing of traumatic memory	Written or verbal account of trauma and its effects – elaboration of the memory
7. Motivation Group issues	Motivational interviewing
8. Rumination Cognitive avoidance Disturbed sleep/nightmares	Addressing the traumatic memory at a specific time and place
9. Discrimination of triggers	Using similarities and differences
10. Irritability, emotional avoidance – 'control freak'	Traffic light routine. Managing 'seething' over the trauma and its effects, coping strategies
11. Persistent and exaggerated negative expectations of oneself, others or the world and persistent distorted blame of self about the cause or consequence of the traumatic event – core maladaptive schemas in PTSD	Use of MOOD chart to modify observed thinking and underlying assumptions Use of magnifying glass analogy to illustrate exaggeratedly negative view of self, others and world
12. Cognitive avoidance Behavioural avoidance Hypervigilance for danger	Attention control and detached mindfulness Continuing to 'dare'

continues

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Therapeutic targets	*Treatment strategies*
13. Impaired relationships	Beginning to invest in people
14. Low mood, pain/disability View of self, world and future	Mood management strategies Cognitive restructuring, the importance of a broad investment portfolio
15. Relapse prevention	Budgeting for unpleasant reminders and distilling a protocol Constructing a PTSD Survival Manual

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Social phobia

1. When you are or might be in the spotlight, say in a group of people or eating/writing in front of others, do you immediately get anxious or nervous?
2. Do you think you are much more anxious than other people when the focus is on you?
3. Do you think that you are more afraid of social situations than you should be?
4. Do you avoid social situations out of a fear of embarrassing or humiliating yourself?
5. Do these social anxieties bother you?

If the client answered yes to each of the above five questions it is likely that they are suffering from social phobia..

Conceptualisation – present a formulation that makes sense to the client and is consistent with the CBT model. Examples:

(a) 'It is as if people with social phobia think that they are at the centre of a circle, others are on the edge of the circle looking at them marking them out of 10. If it was really like that no one would do anything, I'd be like a frightened rabbit frozen in car headlights on a country road'.
(b) 'Can you be sure that the story you carry around of how others think about you is correct? Maybe different people have different stories?'
(c) 'Who says you have to be perfect socially, to be acceptable, politicians are never short of words but who trusts them?' When you think of people you like are they really the most socially skilled people?'

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Social phobia Sat Nav

Therapeutic targets	*Treatment strategies*
1. 'I'm an oddity'. Beliefs that maintain social anxiety	Distillation of working model of each member's disorder Questioning of typical thoughts (on 'second thoughts'). Survey to determine what makes people 'acceptable'
2. 'Inside' view of self. Expectation of high standards	Contrasting 'Inside' view of self with 'Outside' view of others using video feedback. Exposure to feared situations. Survey to determine standards of others
3. Safety behaviours. Information processing biases	Contrasting anxiety experienced using safety behaviours with those when not using. Vigilance for all or nothing thinking, personalisation, mind-reading and mental filter
4. Non-disclosure of personal information	Modelling and role play of self-disclosure
5. Anticipatory anxiety and post-event rumination. Past humiliations	Cognitive restructuring and re-scripting
6. Anticipatory anxiety and post-event rumination. Relapse prevention	Moderating worry and disengagement from it. Role play of anticipated difficult situation, ensuring adherence to Survival Manual to prevent full-blown relapse

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Appendix B

The 7 Minute Health Screen/Audit – Revised

This screen is an interview format for The First Step Questionnaire – Revised (Appendix C) and provides guidance on interpreting the latter. It covers the common mental disorders and positive findings can be investigated further by turning, where indicated, to the relevant page in the Cognitive Behaviour Therapy Pocketbook (Appendix A). If the focus is on auditing the effects of an intervention, the time frame for questions can be altered, e.g. past 2 weeks.

1. Depression	Yes	No	Don't know
During the past month have you often been bothered by feeling depressed or hopeless?			
During the past month have you often been bothered by little interest or pleasure in doing things?			
Is this something with which you would like help?			

A positive response to at least one symptom question and the help question suggests that detailed enquiry be made, page 182.

2. Panic disorder and agoraphobia	Yes	No	Don't know
Do you have unexpected panic attacks, a sudden rush of intense fear or anxiety?			
Do you avoid situations in which the panic attacks might occur?			
Is this something with which you would like help?			

A positive response to at least one symptom question and the help question suggests that detailed enquiry be made, page 188.

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3. Post-traumatic stress disorder	Yes	No	Don't know
In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:			
i. Have had nightmares about it or thought about it when you did not want to?			
ii. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?			
iii. Were constantly on guard, watchful, or easily startled?			
iv. Felt numb or detached from others, activities, or your surroundings?			
Is this something with which you would like help?			

A positive response to at least three symptom questions and the help question suggests that detailed enquiry be made, page 190.

4. Generalised anxiety disorder	Yes	No	Don't know
Are you a worrier?			
Do you worry about everything?			
Has the worrying been excessive (more days than not) or uncontrollable in the last 6 months (a time frame of the last 2 weeks can be used if the intent is to audit an intervention rather than screen)?			
Is this something with which you would like help?			

A positive response to at least two symptom questions and the help question suggests that detailed enquiry be made, page 184.

5. Social phobia	Yes	No	Don't know
When you are or might be in the spotlight, say in a group of people or eating/writing in front of others, do you immediately get anxious or nervous?			
Do you avoid social situations out of a fear of embarrassing or humiliating yourself?			
Is this something with which you would like help?			

A positive response to at least one symptom question and the help question suggests that detailed enquiry be made, page 194.

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6. Obsessive compulsive disorder	Yes	No	Don't know
Do you wash or clean a lot?			
Do you check things a lot?			
Is there any thought that keeps bothering you that you would like to get rid of but can't?			
Do your daily activities take a long time to finish?			
Are you concerned about orderliness or symmetry?			
Is this something with which you would like help?			

A positive response to one or more symptom questions and the help question suggests that detailed enquiry be made, page 186.

7. Bulimia	Yes	No	Don't know
Do you go on binges where you eat very large amounts of food in a short period?			
Do you do anything special, such as vomiting, go on a strict diet to prevent gaining weight from the binge?			
Is this something with which you would like help?			

A positive response to the symptom questions and the help question suggests that detailed enquiry be made.

8. Substance abuse/dependence	Yes	No	Don't know
Have you felt you should cut down on your alcohol/drug?			
Have people got annoyed with you about your drinking/ drug taking?			
Have you felt guilty about your drinking/drug use?			
Do you drink/use drugs before midday?			
Is this something with which you would like help?			

A positive response to at least two of the symptom questions and the help question suggests that detailed enquiry be made.

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9. Psychosis	Yes	No	Don't know
Do you ever hear things other people don't hear, or see things they don't see?			
Do you ever feel like someone is spying on you or plotting to hurt you?			
Do you have any ideas that you don't like to talk about because you are afraid other people will think you are crazy?			
Is this something with which you would like help?			

A positive response to at least one of the symptom questions and the help question suggests that detailed enquiry be made.

10. Mania/hypomania	Yes	No	Don't know
Have there been times, lasting at least a few days, when you were unusually high, talking a lot, sleeping little?			
Did others notice that there was something different about you? If you answered 'yes', what did they say?			
Is this something with which you would like help?			

A positive response to at least one of the symptom questions and the help question suggests that detailed enquiry be made.

IMPORTANT NOTE: If, when you inspect the 7 Minute Mental Health Screen/Audit – Revised or the First Step Questionnaire – Revised, the person screened positive for either items 1 (depression), 8 (substance abuse/dependence), 9 (psychosis) or 10 (mania) ask:

Have you been hurting or making plans for hurting yourself?

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Appendix C

The First Step Questionnaire – Revised

This questionnaire is a first step in identifying what you might be suffering from and pointing you in the right direction. In answering each question just make your best guess, don't think about your response too much, there are no right or wrong answers.

1.	Yes	No	Don't know
During the past month have you often been bothered by feeling depressed or hopeless?			
During the past month have you often been bothered by little interest or pleasure in doing things?			
Is this something with which you would like help?			

2.	Yes	No	Don't know
Do you have unexpected panic attacks, a sudden rush of intense fear or anxiety?			
Do you avoid situations in which the panic attacks might occur?			
Is this something with which you would like help?			

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3.	Yes	No	Don't know
In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:			
i. Have had nightmares about it or thought about it when you did not want to?			
ii. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?			
iii. Were constantly on guard, watchful, or easily startled?			
iv. Felt numb or detached from others, activities, or your surroundings?			
Is this something with which you would like help?			

4.	Yes	No	Don't know
Are you a worrier?			
Do you worry about everything?			
Has the worrying been excessive (more days than not) or uncontrollable in the last 6 months?			
Is this something with which you would like help?			

5.	Yes	No	Don't know
When you are or might be in the spotlight, say in a group of people or eating/writing in front of others, do you immediately get anxious or nervous?			
Do you avoid social situations out of a fear of embarrassing or humiliating yourself?			
Is this something with which you would like help?			

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6.	Yes	No	Don't know
Do you wash or clean a lot?			
Do you check things a lot?			
Is there any thought that keeps bothering you that you would like to get rid of but can't?			
Do your daily activities take a long time to finish?			
Are you concerned about orderliness or symmetry?			
Is this something with which you would like help?			

7.	Yes	No	Don't know
Do you go on binges where you eat very large amounts of food in a short period?			
Do you do anything special, such as vomiting, go on a strict diet to prevent gaining weight from the binge?			
Is this something with which you would like help?			

8.	Yes	No	Don't know
Have you felt you should cut down on your alcohol/drug?			
Have people got annoyed with you about your drinking/ drug taking?			
Have you felt guilty about your drinking/drug use?			
Do you drink/use drugs before midday?			
Is this something with which you would like help?			

9.	Yes	No	Don't know
Do you ever hear things other people don't hear, or see things they don't see?			
Do you ever feel like someone is spying on you or plotting to hurt you?			
Do you have any ideas that you don't like to talk about because you are afraid other people will think you are crazy?			
Is this something with which you would like help?			

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10.	Yes	No	Don't know
Have there been times, lasting at least a few days, when you were unusually high, talking a lot, sleeping little?			
Did others notice that there was something different about you? If you answered 'yes', what did they say?			
Is this something with which you would like help?			

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Appendix D

General Group Therapeutic Skills Rating Scale

1. REVIEW OF HOMEWORK/AGENDA

0	Therapist did not set an agenda/did not review homework
2	Therapist set an agenda that was vague or did not involve group members/vague reference to previous session's homework
4	Therapist worked with group members to set a mutually satisfactory agenda/ difficulties with previous session's homework were locked onto
6	Therapist set an agenda that was suitable for the available time. Established priorities and tracked the agenda/difficulties with previous session's homework were effectively problem solved

2. RELEVANCE

0	Therapist did not ensure content was relevant to every group member at some point in the session
2	Therapist ensured content was relevant to most members most of the time
4	Therapist ensured content was relevant to all group members most of the time
6	Therapist ensured content was relevant to all group members throughout session

3. ADAPTATION

0	Therapist did not check out group members' understanding of what was being taught
2	Therapist did some checking out of group members' understanding but failed to successfully adapt material for those who had some difficulty
4	Therapist checked out understanding of all group members and was able to suitably adapt material for most of those with difficulties
6	Therapist tailored explanations to the level of understanding of each group member

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4. INCLUSION

0	Therapist allowed the most vociferous group members to dominate the group
2	Therapist made attempts to include less vocal members but was not able to give them sufficient space to express themselves verbally and emotionally
4	Therapist ensured all group members had reasonable air time but had some difficulties with some of the less vocal group members
6	Therapist ensured that all group members had sufficient air time to express both their thoughts and feelings, including commentary on the group session as a whole

5. ADDITIONAL DISORDERS

0	Therapist either did not acknowledge a group member's expression of difficulties with a disorder that was not the prime focus of the group or spent such time on these concerns that other members were losing focus, e.g. chatting amongst themselves
2	Therapist acknowledged a group member's additional difficulty but without signposting a direction from which appropriate help might come, e.g. an individual session, or tried unsuccessfully to address the additional difficulty but showed a lack of competence in this area
4	Therapist managed group members' expressions of additional concerns and was mostly able to offer succinct advice and reassure that these difficulties could be addressed
6	Therapist managed to address all group members' expressions of additional problems and suggest appropriate options for their resolution without losing focus on the main teaching for the session

6. MAGNIFYING SUPPORT AND MINIMISING CRITICISM

0	Therapist did not acknowledge the power of other group members to influence each other for both good and ill
2	Therapist paid minimal attention to expressions of emotional and tangible support from group members to each other
4	Therapist encouraged group members to come up with solutions to members' problems based on what had been taught in the sessions, underlying support proffered and ensuring that criticism was reframed in terms of different behaviours rather than an attack on the person
6	Therapist magnified group support for a member and short-circuited personal attacks, utilising the period during which the group was assembling and departing to enhance alliances between members and pick up on members' concerns

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7. UTILISING GROUP MEMBERS AS ROLE MODELS

0	Therapist focused entirely on himself/herself as the source of persuasion
2	Therapist made fleeting reference to the positive behaviour of a group member but without making it explicit to what other member that behaviour might be particularly relevant
4	Therapist, to large extent, tuned into the cultural/religious background, friendships in the group to build alliances that would reinforce the learning and application of material taught
6	Therapist adeptly tuned into the assumptive world of each group member and was able to draw on it to reinforce alliances between members and ensure application of material taught outside the session

8. THERAPIST PRESENTATION SKILLS

0	Therapist/s gave a didactic presentation with no written summary of material covered. If more than one therapist, there was no synchrony between therapists, they were not reinforcing what each said or coming to each other's aid at difficult moments
2	Therapist/s did provide written summary of material covered but it consisted largely of printed words and at a reading age above some of the group. When diagrams were provided they were overly complex. Role plays were not used or if used did not follow a format of therapist modelling, group member practice and therapist feedback. If more than one therapist, whilst they shared the burden of presentation, there was little humour or support between them and some defensiveness
4	Therapist/s provided written summaries, diagrams of materials covered at a level accessible to all group members. Role plays were used and appeared to have enhanced group members' understanding. If more than one therapist, the therapists synchronised with humour and encouragement, helping create an appropriate climate
6	Therapist/s provided written summaries, diagrams at a level accessible to all but also highlighted other resources, books, computer-assisted therapy that some members might derive additional benefit from. Role plays were used and followed a format of therapist modelling, group member practice and therapist feedback that accentuated the positives and problem solved the negatives. If more than one therapist, the therapists seemed to 'dance' very well, presenting material effortlessly with humour and without defensiveness

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9. ADDRESSING GROUP ISSUES

0	Therapist did not address any group issues that arose, such as timing of the group, number of sessions, difficulties in scheduling individual sessions, conflicts between group members, confidentiality, ambivalence about attendance, dropouts, ending of group and relapse
2	Therapist did address some group issues but was unnecessarily defensive
4	Therapist addressed most difficulties expressed by group members in a spirit of openness
6	Therapist addressed all group issues in a collaborative way with group members, engaging them in a problem solving process

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Appendix E

Intake questionnaire

Questionnaire – *please answer each question as best you can*

Name: Date:

Address:

d.o.b.

Telephone no:

Are you working?

What kind of work do you do?

What kind of work (if any) did you do in the past?

How do you spend your day?

How were things at school?

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Did you have any particular problems at school? If you did what were they?

Do you have any qualifications? If so what are they?

What (if any) are the major problems you are having at the moment?

1.

2.

3.

Please indicate when the problems listed above began and also if there was a time when they got much worse.

1.

2.

3.

Have any very scary things happened to you or did you see such things happening to others? If so write them down below and put when they happened (include any abuse in childhood).

1.

2.

3.

Have you had any professional (doctor or counsellor) help for any of your difficulties? If you did please indicate when, for how long and from whom.

1.

2.

3.

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Have your parents or brothers or sisters suffered with their nerves? If yes please indicate who and if you can what they suffered or are suffering from.

What has your mood been like?

How much have you been drinking alcohol in the past month?

Have you been taking any drugs? Please indicate any prescribed drugs as well as any other drugs that you may be taking.

1.

2.

Was there a time in the past when you took drugs that were not prescribed by your doctor? YES/NO

If yes to the above please indicate what drug/s you took, when and for how long.

1.

2.

Have you been in trouble with the law? YES/NO

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Appendix F

Monitoring progress of group members

Disorder												
Group member's name												
Session 1												
Session 2												
Session 3												
Session 4												
Session 5												
Session 6												
Session 7												
Session 8												
Session 9												
Session 10												
Session 11												

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Appendix G

Standardised Assessment of Personality – Abbreviated Scale

Only circle Y (yes) or N (no), in the case of question 3, if the client thinks that the description applies *most of the time* and *in most situations*.

1. In general, do you have difficulty making and keeping friends? . . . Y/N
   (yes = 1, no = 0)
2. Would you normally describe yourself as a loner? . . . . . Y/N
   (yes = 1, no = 0)
3. In general, do you trust other people? . . . . . Y/N
   (yes = 1, no = 0)
4. Do you normally lose your temper easily? . . . . . Y/N
   (yes = 1, no = 0)
5. Are you normally an impulsive sort of person? . . . . . Y/N
   (yes = 1, no = 0)
6. Are you normally a worrier? . . . . . Y/N
   (yes = 1, no = 0)
7. In general, do you depend on others a lot? . . . . . Y/N
   (yes = 1, no = 0)
8. In general, are you a perfectionist? . . . . . Y/N
   (yes = 1, no = 0)

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Appendix H

Depression Survival Manual

1. How depression develops and keeps going

Depression usually involves loss of a valued role, for example in a relationship or job. But by itself that is not sufficient; the person also has to become inactive, giving up on what they used to do and making sure they take a picture of most things from the worst angle (negative spin).

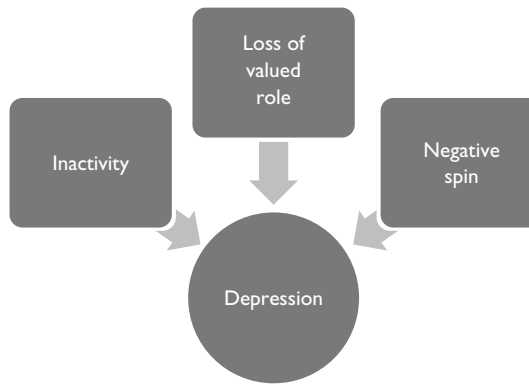

Figure 1 Lighting the fire of depression and keeping it going.

What have you stopped doing that you used to enjoy?

What is it that puts you off doing some of what you used to enjoy?

Is there something in particular making you go on strike for better pay and conditions?

Depression is kept going by a negative view of self, personal world, the future and depression about depression (Figure 2).

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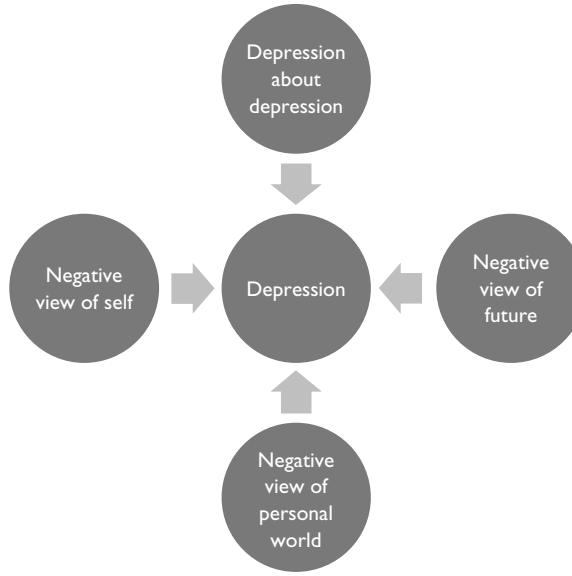

Figure 2 Fuel for the fire.

How do you feel about yourself?
How do you feel about others?
How do you feel about the future?
How do others feel about you?
Does the way you feel about yourself square with how others see you?
Are you sure that you are wholly responsible for your depression?
Are you responsible for working on a solution to your depression?
What sort of things could you timetable yourself to do?
Would you be more able to do them if you did them in small doses, e.g. phone call to friend rather than spend an evening with them?

2. No investments, no return

In depression it is as if the person stops investing in what might give them a sense of achievement or pleasure. The dice feel loaded against you, like a boxer knocked to the canvas thinking 'what is the point in getting up, I will only get knocked down!' If not investing is combined with putting a negative spin on your previous investments, e.g. 'that just showed how stupid I am!', then the result may well be depression, (Figure 3); the negative spin often involves seeing hassles as catastrophes.

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Figure 3 Putting your money under the carpet and seeing hassles as catastrophes.

But if you don't invest there can be no return. It is rather like having some money, putting it under your carpet and then complaining because it has lost value with inflation. You might well think these days that the banks are not to be trusted! But you would probably advise a friend with some money to make lots of small, low risk investments in very different places or maybe just deposit accounts in different banks. Many people with depression have had all their investments in just one place, a relationship or a job. They may have been encouraged to keep investing in the one place because the returns were good. But it is just a question of time before any one investment runs out of steam, for example the person might lose a job or their partner dies. You can choose not to invest but it is a choice.

What investments are you making at the moment?

Is there a balance between things that might give you a sense of achievement and those that might give you a sense of pleasure (Figure 4)?

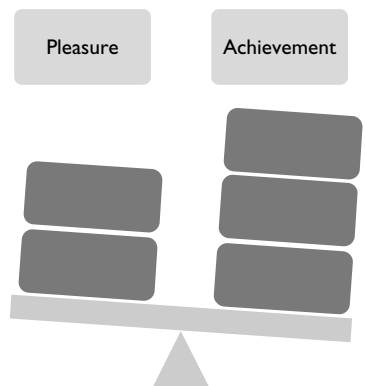

Figure 4 Investing in achievement and pleasure.

Sometimes the investments that you think will be good don't come off and sometimes ones that you don't expect to deliver do. Could you see yourself making a wider range of investments?

Is there a pattern to your mood, is it worse at certain times in the week?

Is there anything you could plan to do at the particular times you tend to feel low that might lift your mood a little?

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If your major investment didn't work what do you take that to mean about you?

Use the ruler below:

0	1	2	3	4	5	6	7	8	9	10

No distress

Extreme distress

to indicate how distressed you have been each day, morning, afternoon and evening and what, if anything, you were doing at the time.

Table 1 Activity and mood

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning 0–10 Activity							
Afternoon 0–10 Activity							
Evening 0–10 Activity							

Looking at your activities and mood in Table 1, is there a pattern, e.g. worse in the morning, or when you are not doing things?

Could you come up with a better way of arranging your activities, e.g. get up with the alarm and go for the morning paper before you have a cup of tea rather than lie in bed?

Keep a record of any positive experiences in great detail, e.g. not just that 'it was great to bump into an old school friend' but 'it was great for John to remind me that when we were making a noise and the librarian said ''this table out'', we picked it up and began walking with it'.

3. On second thoughts

The first thoughts of those who are depressed are usually more negative than they need to be. Cognitive behaviour therapy is not only about becoming gradually more active but also about standing back and pausing

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at your first automatic thought and checking to see if there is a better second thought.

When you got up this morning what were your first thoughts about coming to the group?

Were these first thoughts more negative than they needed to be?

Did you or could you come up with better second thoughts?

Do you often think 'I think too much'?

Is it thinking that you do, or agonising?

Once you have reasonable second thoughts don't pick at them, decide what to do and do it. Become an Actor not a Ruminator. The more objective second thoughts might feel uncomfortable and take a lot of acting upon before they become second nature; don't get distracted by agonising, refuse to play the Ruminator.

To help you manage your moods pass them through the MOOD chart shown in Table 2. The first letter of MOOD, 'M', stands for monitor your mood, the second letter, 'O', stands for observe your thinking, what it sounds as if you have said to yourself, the third letter, 'O', is for objective thinking, more realistic second thoughts, and the final letter, 'D', is for deciding what to do and do it.

Table 2 MOOD chart

Monitor mood	Observe thinking	Objective thinking	Decide what to do and do it
1. Mood dipped standing drinking coffee looking out of the window.	Life is passing me by like the cars.	It is passing everyone by, it depends on what I do with it.	I could do some painting and decorating or maybe visit my sister. I'll do the painting/ decorating today and visit sister tomorrow.
2. Mood dipped when I received a letter that I am not getting any unemployment benefit.	It's going to be awful.	It is going to be difficult, I will not be able to pay child maintenance but I do have a really good relationship with my daughter, ex will not be happy though. I will not be able to afford car insurance but Mum will not mind loaning it to me.	I will appeal against the decision with the help of my solicitor and ring Mum and ex.

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In the first example of the use of the MOOD chart, the person is daydreaming, gazing out of the window when they notice that their mood has dipped. Daydreams can be like a poisonous gas without a smell in that because nothing has actually happened, such as an argument, it can be difficult to pinpoint exactly what the person has said to themselves to feel the way they do.

To identify the 'toxic' negative thought the individual has to do a slow motion action replay of the situation they were in when the upset occurred to get something of a clue to their reflex/automatic thought. Their observed thinking (column 2) may be nothing more than an informed guess as to 'what it sounds as if they have said to themselves to feel the way they do'. It should be noted that in the first example, in column 3 the objective thinking, the person acknowledges that there is, as is often the case, a grain of truth in the observed thinking, i.e. it has some validity. But in column 3 the person is challenging the utility of thinking 'life is passing me by'. Finally in column 4 the person comes up with some investments: painting/decorating and visiting his sister.

In the second example the person encounters a hassle, the stopping of his benefit, but typically in depression any hassle is immediately viewed as a catastrophe, 'it is going to be awful'. A catastrophe can be shrunk back to a hassle by the client asking themselves 'what specifically is so bad about what has just happened?' and the person identified two issues, an inability to pay child maintainance or for car insurance. Because these concerns were made very specific they were then open to reappraisal and the person was able to reflect that at least his relationship with his daughter would not be harmed and there was possible financial help from his mother.

You can cross-examine your automatic negative thought in three different ways, you can ask:

How true is this?
How useful is this way of thinking?
Who says I should look at this in this way?

4. Just make a start

If you are depressed, waiting until you feel like doing something is like waiting for a big Lottery win! Depression is like dragging a ball and chain, to do anything is a major achievement (Figure 5).

You have to give yourself permission to break any task, e.g. cleaning the house, into small chunks: vacuum the living room, then have a break, e.g. cup of tea, and then do the next small task, e.g. empty and fill the dishwasher.

When you are doing the tasks, either those intended to give you a sense of achievement, e.g. cleaning the house, or pleasure, e.g. going for a walk,

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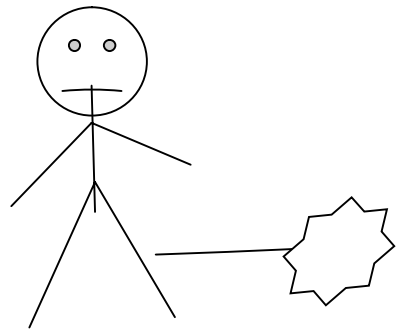

Figure 5 Depression and the ball and chain.

you will probably feel you are going through the motions. But if you continue to invest, the taste of life is likely to come back but you can't say exactly when. It's a bit like beginning to exercise in the gym, all you get to begin with is aches and pains with little to show and it takes some weeks to notice a difference.

What thoughts have put you off doing things?

Have you been expecting yourself just to do things as you did before you became depressed and then because this all seems too much not doing anything?

If you put the thoughts that have sabotaged your activity through the filter of the MOOD chart, what more objective second thoughts (column 3) could you come up with?

5. Expectation versus experience and recalling the positive

In advance of an activity, the depressed person usually predicts that they are not going to enjoy the activity but they usually feel a bit better from doing the activity than if they don't (Figure 6).

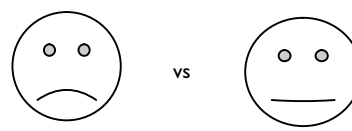

Figure 6 Expectation versus experience.

On a scale 0–10, where 10 is the best you have ever felt and 0 is the worst, how did you feel getting ready to come to the group today?

On a scale 0–10, how do you feel right now?

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If you felt, say, 3/10 before coming out today and, say, 6/10 now, you could use the numbers 3 and 6 as a reminder, that there is a gap between 'expectation' and 'experience' and that you can trick yourself into inactivity by relying on your 'expectation' rather than your 'experience'.

But there is another problem in depression, to do with how you remember your experience. Tonight if your partner or a friend asked you how you got on in the group today what would you likely say?

Probably most would say one word, 'OK', a bit like asking your children what they did in school today, the reply is invariably 'nothing', but you know they must have done something! 'Nothing' is shorthand for 'I can't be bothered plugging in my brain, switching on and coming up with an answer', but if then a friend rings they go into graphic detail about something good that happened. If you are suffering from depression you tend to recall the good things in a vague way, e.g. 'OK, my team drew', you do not go into detail, e.g. 'it was superb when Liverpool equalised in the last minute of extra time'. So tonight if you talk of the group session don't just say 'OK or even some expletive!', try and recall in detail some good moment, e.g. a chat with a group member over coffee as the group was assembling. Then follow this up with keeping a detailed record of the positives in your week.

6. Negative spin or how to make yourself depressed without really trying

Imagine that you wanted to make someone depressed by what you say, so that for example if a child tells you enthusiastically that they got a 'B' in their maths exam, what could you say to make them depressed?

Possibilities are 'you should have got an A', i.e. you home in on the negative and discount the positive, getting a 'B'; this is called using a 'mental filter'. Other possibilities are 'you didn't try hard enough'; this is called 'jumping to conclusions' as without being inside the child's head you can't know how hard they tried. To make the child depressed you just focus your camera in such a way that the lens, setting and filter give a negative spin. You might feel like smashing the camera of an adult who makes a child depressed in this way! But if you are depressed you are probably using a camera with these odd settings to make yourself depressed! The first step in taking an objective picture is to become aware of the ten settings of the camera that cause problems, then to step around them (Table 3).

There are no water-tight distinctions between the information processing biases, and many people who are depressed customarily use a number of them.

Do any of these ring bells for you?

Which ones do you think you need to make a note of, to make yourself aware of what you might be doing when you are getting upset?

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Table 3 Information processing biases

1. Dichotomous (black and white) thinking, e.g. 'I'm either a total success or a failure'.
2. Mental filter, focusing on the negative to the exclusion of the positive, e.g. 'how can you say it was a lovely meal, how long did we have to wait for the dessert to be served?'
3. Personalisation, assuming just because something has gone wrong it must be your fault, e.g. 'John did not let on to me coming into work this morning, must have been something I said'.
4. Emotional reasoning, assuming guilt simply because of the presence of guilt feelings, e.g. 'I can't provide for the kids the way I did, I've let them down, what sort of parent am I?'
5. Jumping to conclusions, e.g. assuming that being asked to have a word with your line manager means that you are in trouble.
6. Overgeneralisation, making negative predictions on the basis of one bad experience, e.g. 'I've had it with men after Charlie, you cannot trust any of them'.
7. Magnification and minimisation, magnifying faults or difficulties, minimising strengths or positives, e.g. 'I am terrible at report writing and I am lucky to have got good appraisals for the last couple of years'.
8. Disqualifying the positives, e.g. brushing aside compliments and dwelling on criticism.
9. 'Should' statements, overuse of moral imperatives, e.g. 'I must do . . . I should . . . I have to . . .'.
10. Labelling and mislabelling, e.g. 'if I make a mistake I am a failure as a person'.

You might want to get hold of David Burns' book Feeling Good: The New Mood Therapy *from the library or buy it online to read more about these 10 biases in Chapter Three. It has also got lots of other useful information on depression.*

7. An attitude problem?

A person's attitude to life can be fine for many circumstances but run into problems if certain types of events (key events) occur; there are some examples in Table 4.

Do you see yourself as being as being addicted to approval (sociotrope)?

Do you see yourself as addicted to success (autonomous)?

Most things that people are addicted to are fine in themselves, but are a problem when they dominate their life. If you are a true sociotrope or autonomous you might want to consider weaning yourself off, there will be withdrawal symptoms and you may always find them tempting. There might be the odd slip but you can prevent it becoming a full-blown relapse by using the MOOD chart and spotting whether the upset is really to do with an attitude from the past. Today's upsets and past attitudes overlap to some extent (Figure 7).

What has upset you today might be a key event in that it opens the door to a particular attitude (e.g. a key event for a sociotrope might be not being praised by her boss for a piece of work today) and upset. Using the MOOD

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Table 4 Attitudes and problems

Attitudes	*Problems (key events)*
'I must be liked all the time and in all circumstances' (a sociotrope – addicted to approval)	A relationship breaks up
'If I am not the top I am a flop' (the highly autonomous person may be addicted to achievement)	Fails to get promotion or an exam or is made redundant
'Everything has to be done just so' – the perfectionist	No longer given the time to get everything perfectly right
'To be happy you have got to have . . .' excessively rigid	When you cannot achieve what you judged necessary for happiness

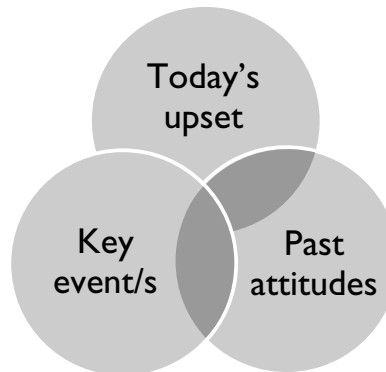

Figure 7 Today's upset, past attitudes and key events.

chart the sociotrope might come up with a more useful attitude (objective thinking), e.g. 'approval is nice but no one can rely on it, it is not like oxygen', and then stop depressive rumination using the 'D' of the MOOD chart and get on and do something, invest.

Your attitudes might be about perfectionism or extreme rigidity about how things should be and there is nothing wrong with these attitudes in the right place but if certain key events occur it can be your undoing.

Use the MOOD chart for monitoring your mood, but try and be alert for any key event that has called onstream an 'attitude problem' and come up with/use your antidote to this 'gremlin', in the objective thinking column; don't stew on your upset once you have sorted it, get on to the 'D' of MOOD and 'Do'.

If you are weighed down by a low opinion of yourself (Figure 8), you might play the sociotrope, autonomous or perfectionist to lift it for you, but long term it's too heavy. Alternatively you might numb the pain of low self-esteem by being very rigid, e.g. 'if I can continue this job or this relationship

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then just maybe I can think of myself as OK', but the anaesthetic (an overvalued role) eventually wears off, exposing the 'nerve'.

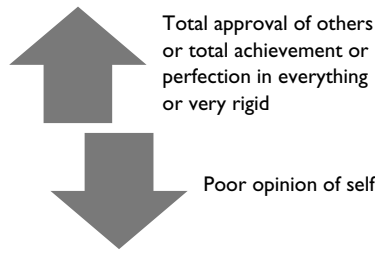

Figure 8 Strategies unequal to the task of lifting low self-esteem.

By realising where your low self-esteem comes from you can begin to tackle it.

8. My attitude to self, others and the future

Your attitude to yourself, others and the future can play a major role in maintaining depression. The depressed person usually has a negative view of themselves. For some people low self-esteem is very long-standing but became much worse after the loss of a valued role, e.g. children leaving the nest or the loss of a job. For others the negative view of self is of more recent origin (Figure 9).

How has your view of yourself changed?

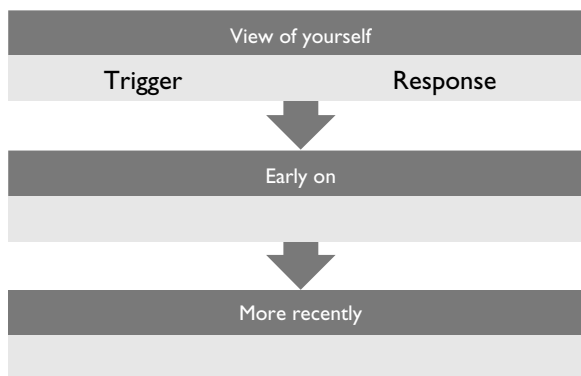

Figure 9 What makes me think about myself the way I do?

If your low self-esteem goes way back, what do you wish had been said to you that might have made a difference?

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Do you think you would have been as bothered by recent upsets if your self-esteem was already intact?

Do you equate your worth as a person with an achievement or perhaps with the approval of someone important to you?

Is it possible to be worthwhile without this achievement or approval?

Do you think a jury would return a 'not guilty', 'guilty' or the Scottish 'not proven' verdict on you?

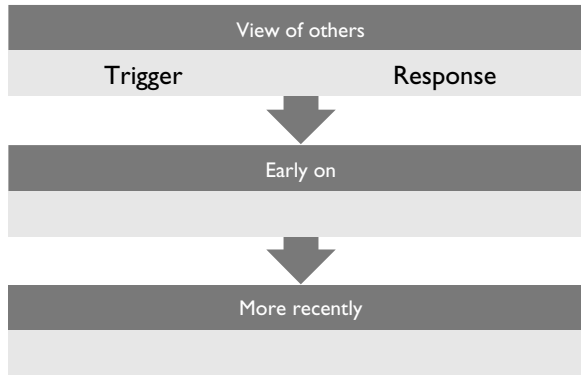

Figure 10 What makes me think of others the way I do?

What is the story you carry round with you of how other people are (Figure 10)?

Do you need to update the story, say in the light of your experiences in the group?

Do you use dichotomous thinking about yourself and others, e.g. they are either 'saints or sinners'?

Do you dwell on the mistakes of yourself or others, leaving the positives out of the reckoning, employing a mental filter?

With a negative view of yourself, you may be reluctant to let others get to know you. You might also think others are going to be critical of you, so better stay in your shell. The negative view of yourself and others conspires to produce a negative view of the future (Figure 11).

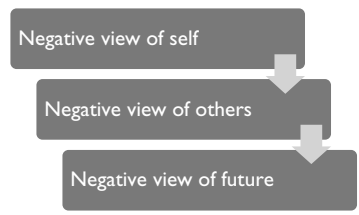

Figure 11 Negative view of the future.

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The negative view of the future leads to inactivity, a failure to invest and thereby depression.

Can you be certain that the future is going to be negative?

Have there been good times in the past?

Can you be certain good times cannot come again?

Can you commit to constructing a future, despite life being a bit of a bomb-site at the moment?

9. Be critical of your reflex first thoughts, not how you feel

In depression the person tends to criticise themselves for what they have been feeling and yet have an uncritical acceptance of their automatic negative thoughts. To overcome depression the person has to climb a number of stepping stones, accepting without criticism what they are feeling, identifying negative automatic thoughts, distilling objective thoughts, then investing in life (Figure 12).

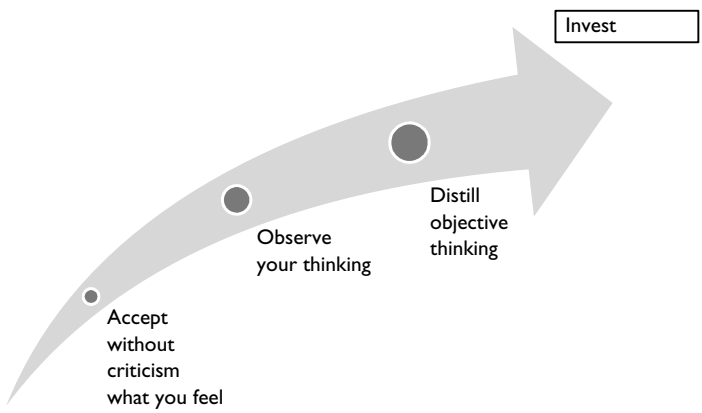

Figure 12 Stepping stones out of depression.

Do you often think 'I shouldn't be feeling . . .'?

How useful has it been to blame yourself for what you have been feeling?

Who, other than yourself, says you should be blaming yourself for what you feel?

Sometimes people are so afraid of what they feel, that they try to distract themselves by feverish activity that ends in exhaustion, at which point the feelings return. This emotional avoidance is self-defeating and needs to be replaced by an acceptance of experienced emotion. However, within cognitive behaviour therapy the emotion experienced does not necessarily have the last word. To climb out of depression a first step is to acknowledge

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what you feel without apology, avoiding depression about depression. Depression is challenge enough without double depression.

10. Preventing relapse

The more episodes of depression you have had, the more likely you are to have another one. However, with the skills learnt in this programme you may well be able to stop a slip becoming a full-blown relapse. When you are feeling better, you may want to forget about the skills you learnt in the group because they remind you of the bad times in your life. But depression tends to create a fault line, and you could again crack along the fault line if you came across a similar set of circumstances. But if you have your own Survival Manual and take active steps to use your skills at the first signs of depression, you can nip it in the bud. So that you are prepared, it is useful to have 'fire drills' even when there is no 'fire' – reading your Survival Manual at good times.

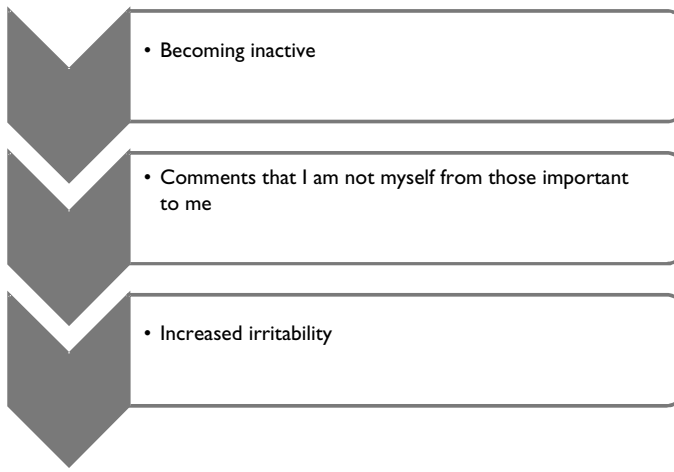

Figure 13 Early warning signs.

Some common early warning signs are shown in Figure 13.

Are there any other signals you get when you are beginning to slide?

The temptation is to deny that you are beginning to slip (this is called cognitive avoidance) because the memory of last time is so painful. But if you acknowledge you are beginning to slip and use the tools from the programme, you can stop the depression gathering momentum. Depression is like a rock running downhill, stopping it near the top as it begins its descent is relatively easy.

What situations do you think might be most dangerous for you?

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What would your gameplan be in the event of such triggers?

What changes to your week would you need to make?

What activities/contacts would you need to make?

What thoughts would be the best antidotes to the negative automatic thoughts that would come onstream?

How would you remind yourself to be patient with yourself while you give the tools a chance to make a difference?

How would you avoid blaming yourself, that you are experiencing signs of depression?

Which resources would you call upon: this Survival Manual, supportive friend, self-help book, therapist?

What thoughts might get in the way of accessing the help you need?

How would you answer the thoughts that might sabotage your seeking help?

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Appendix I

Panic Disorder and Agoraphobia Survival Manual

If you are not a little anxious crossing a busy road there could be serious consequences. A little anxiety helps us perform properly. So that anxiety itself is not a problem, it makes you prepared for action, without it you would be a danger to yourself. However, some people have anxiety sensitivity, they fear the symptoms of fear or anxiety. They have come to believe that experiencing certain symptoms is harmful. A person may develop a 'fear of fear' by hearing others express fear of certain sensations, e.g. feeling faint in public, or hearing wrong information about the harmfulness of certain sensations, e.g. breathlessness/palpitations means there is something wrong with your heart, or witnessing a catastrophic event such as the fatal heart attack of a loved one.

If you experience negative events such as the death of a family member or someone close to you, poor close relationships, loss of a role or conflicts about your role, they may lead to bodily sensations that are not in themselves harmful but may result in the development and maintenance of panic attacks if you already have high anxiety sensitivity.

A panic attack is a sudden wave of anxiety that reaches a peak within a few minutes, and may include palpitations, light-headedness, breathlessness and fear of losing control. If at least some of the panic attacks occur for no reason, e.g. when you are asleep or somewhere with no danger, and occur repeatedly, this is classified as panic disorder. Many people with panic disorder worry about the next panic attack and avoid situations they think might trigger them, e.g. a busy shop; this avoidance is called agoraphobia. Those suffering from panic disorder and agoraphobia not only fear their bodily sensations but also have fears of the situations that they are avoiding, e.g. 'if I go there I will be stranded if I have a panic attack'. Sometimes it is not just places that are avoided because of a fear of a panic attack but certain activities, e.g. physical exertion, sexual relations, taking a hot shower or bath, drinking coffee, watching an exciting or scary film.

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1. Putting a 'danger' label on bodily sensations and using 'safety' procedures guarantees panic

Imagine that you are at a railway station with a friend happily awaiting your train. The friend points out an unattended bag and says 'I wonder whose that is?' and you might look around for the owner. But when your friend says 'could be a terrorist bomb?' your heart might miss a beat and you probably look around more earnestly. It is as if the 'label' you put on the 'bag' makes a big difference to your body's reaction. In a similar way if you put a catastrophic label on everyday bodily sensations, e.g. your heart racing, and tell yourself 'my heart racing means I'm having a heart attack', this makes your bodily sensations, e.g. heart racing, even stronger. In panic disorder the sufferer is constantly scanning their body for unusual bodily sensations and once detected they are catastrophised, i.e. a danger label is attached, resulting in more bodily symptoms; the person becomes even more alarmed and a vicious circle (Figure 1) is set up.

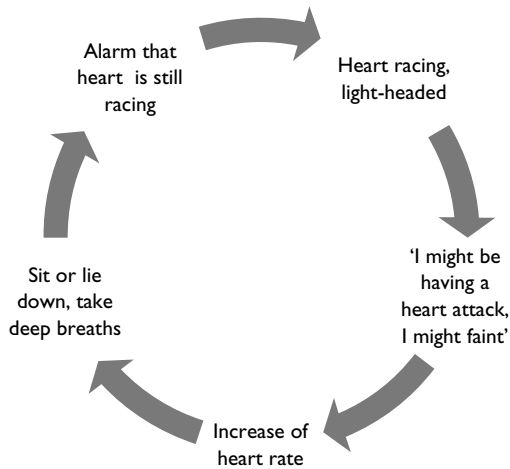

Figure 1 The vicious circle of panic.

Starting in the one o'clock position in Figure 1, you might wake up noticing that your heart is racing and feel light-headed. Going clockwise around Figure 1, you might think that you are having a heart attack and are going to faint; this catastrophic interpretation causes an increase in heart rate, the six o'clock position in Figure 1. You might then take some 'safety precautions', the eight o'clock position, perhaps breathing deeply, opening a window or sitting down. But then you find that these 'safety' procedures are not making much if any difference, you become 'alarmed', the eleven o'clock position, which continues to fuel the palpitations and

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light-headedness, coming full circle to the one o'clock position. Because the sufferer from panic disorder keeps literally going round in circles with their symptoms, they often end up at the local A&E Department to be told usually that there is nothing wrong with their heart. Overcoming panic disorder involves breaking the circle in Figure 1 by challenging the reflex automatic catastrophic thoughts about unusual bodily sensations, four and eleven o'clock positions, and avoiding the 'safety' procedures, the eight o'clock position.

2. If you can think yourself into panic can it be that dangerous?

Just read over the following pairs of words:

Breathless	Suffocate
Dizzy	Faint
Chest tight	Heart attack
Unreality	Seizure or going insane
Numbness	Stroke
Palpitations	Dying
Lightheadedness	Losing control
Nausea	Vomiting uncontrollably

As you read through the above words, you may have noticed the beginning of symptoms of panic. If you can bring on such symptoms can they really be that serious? Can you bring on a stroke in the next few minutes just by thinking about it?

3. Being on 'sentry duty' for bodily sensations triggers an alarm

Generally we only notice what we are looking for, e.g. when looking for a parking space we might not take in a partner's questions about what present to buy for whom but might take in the patrolling traffic warden. Focus just now on whether there are any pins and needles, numbness, warmth in your right big toe, now switch your attention to your left big toe and notice what sensations you have: warmth, numbness, pins and needles. When focusing on your left big toe you probably didn't notice what was happening to your right big toe. Leaving your camera on bodily sensations sets the scene for becoming alarmed about them. If a friend is holding a glass of wine you might say to them 'are you OK, only I noticed your hand shaking slightly there?', they might react somewhat abruptly with a denial that there is any shaking but then focus attention on their hand, hold the glass more tightly so as not to 'shake' and end up putting the glass down

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because it is uncomfortable. (You might need to explain that you were just winding them up!) In order to manage panic attacks it is necessary to learn to focus externally rather than internally.

4. If you can bring on a panic attack can it be that serious?

Try breathing quickly and deeply (hyperventilate) for just a minute. Did you notice any physical sensations when you stopped? If you experienced some sensations, were they anything like those of a panic attack. If hyperventilation did not produce any sensations try holding your breath for 30 seconds. What did you notice? Anything like your panic symptoms? If holding your breath did not produce any sensations, try running on the spot for a minute. What did you notice? Anything like your panic symptoms? Most sufferers from panic disorder can find some exercise that if they do for long enough produces symptoms that are like their panic attacks. Can such symptoms really be that serious if you can bring them on? No matter how long you tried to bring a stroke or a heart attack on you could not do it but you can bring on a panic attack.

5. Slow motion action replay of your most recent bad panic attack and monitoring your attacks

Some panic attacks are much worse than others. When was your last bad panic attack? Jot down in the panic diary shown in Table 1 when it was and where you were (the first column in the diary).

Table 1 Panic diary

Time and place of panic attack – situation	On a scale 0–10, where 10 is the worst possible, how bad was this attack?	During this attack what thoughts went through your mind?	Did you do anything special to manage this attack?	What would have been a better way of thinking and behaving in this situation?

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In the second column put a number, 1–10, that indicates how severe the attack was, say 8. Now take yourself back to this attack and try and remember what went through your mind and put this in the third column, e.g. 'thought I was going to faint and make a show of myself'. Then in the fourth column write what you did, e.g. 'rushed home'. Then in the final column write down how you might have played it differently, e.g. 'stayed where I was, stayed standing, told myself you can't faint in a panic attack if your heart is racing because if your heart is racing your blood pressure is going up, you can only faint when blood pressure goes down'. If you keep the diary and practise playing the attacks differently, gradually you will see that the panic attacks happen less often and that they are not as severe when they do happen, eventually petering out.

6. Monitoring your avoidance

Many people with panic disorder avoid certain situations. On a scale 0–8, where 8 is always avoid it and 0 is would not avoid it, indicate below with a number how much you avoid the following situations:

Travelling alone or by bus	
Walking alone in busy streets	
Going into crowded shops	
Going alone far from home	
Large open spaces	

As you gradually dare yourself to tackle these avoided situations, to begin with you may get more panic attacks. But if you keep practising, these attacks gradually become less severe and less frequent, your scores come down and you reclaim your life. Have a think about what dares you could attempt this week. It is important that you do not try too much, overcoming the agoraphobia is like, as a child, gradually daring yourself in a swimming pool to try things in order to swim, if you try too much too soon it is like throwing yourself in at the deep end, it will just put you off. It doesn't matter how small your steps are, you will get to where you want if you keep training.

7. Beginning to dare

To reclaim your life you have to begin with 'baby steps' to approach what you avoid. Think of it as climbing a ladder back to what you did before your first panic attacks (Figure 2). Week by week try and climb a rung of

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	Example	
Week 10	Travel to city centre alone and shop as I used to before the panic attacks	
Week 9	Travel by bus alone to city centre and shop briefly at a quiet time, do old routine in the gym	
Week 8	Travel by bus alone to city centre and meet friend, shop together	
Week 7	Three times in the week get the bus to supermarket by self and shop briefly at a time when it is not busy, go to the gym at a time when it is not busy and do some light exercise	
Week 6	Daily travel by bus unaccompanied three stops but met by relative, continue going to local shops, go accompanied to supermarket but stand in queue by self	
Week 5	Daily go to local shop when it is busy, go to supermarket when accompanied but shop by myself for a few minutes meeting up with relative in café, travel by bus accompanied	
Week 4	Daily walk to local shop by myself when it is not busy, go to supermarket accompanied, stay at home alone all day	
Week 3	Daily walk around the block by myself, stay at home alone for a half day	
Week 2	Drink just a couple of cups of coffee a day, daily walk to the end of the road and back by myself, stay at home alone for 60 minutes	
Week 1	Take a hot shower daily, walk to the end of the road by myself and meet relative there, stay at home alone for 30 minutes	

Figure 2 Ladder to life.

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the ladder. An example training schedule is shown in the second column of Figure 2. In the third column put in what might be the rungs of the ladder for you. It is always a bit of a guess as to what the next rung of the ladder should be and if you try a rung and can't manage it, you just have to make a smaller step. For example, in Figure 2, if the person struggled with their week 6 assignment and felt overwhelmed by trying to travel three bus stops alone, they might try just one bus stop and get used to this before trying three bus stops again. In this way if at any step you feel overwhelmed you can always introduce an intermediate step. The idea is to make the steps difficult but manageable, not overwhelming.

As you climb the ladder you learn to tolerate panic symptoms, losing your 'fear of fear'. Overcoming 'fear of fear' is the passport to life.

8. Saboteurs of the 'dares'

Sometimes clients get stuck at a particular rung of the ladder; for example, they may have become able to shop accompanied but cannot do so by themselves and the reason may not be very apparent. Using the downward arrow technique (Figure 3) can unearth the bottom line, which can be targeted.

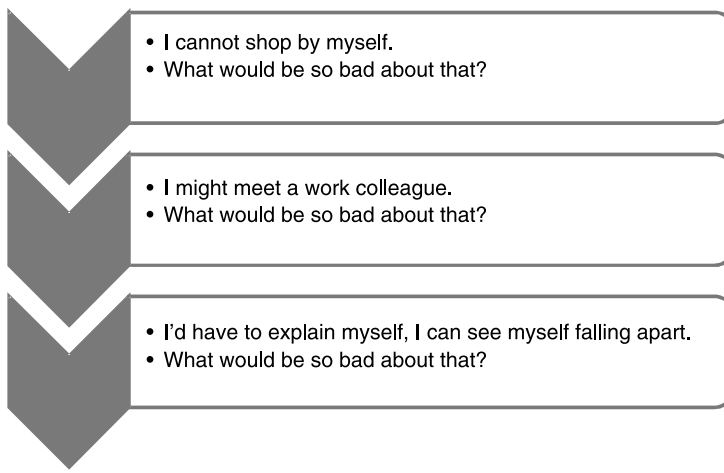

Figure 3 Downward arrow technique – example.

In the example in Figure 3 the bottom line is that the person has an image of themselves 'falling apart' and this could then be targeted by asking whether all images are necessarily true; I might have an image of being the most handsome/pretty person in this universe but would doubt this makes it true!

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There are two ways of tackling feared consequences. The first is to ask how likely the worst outcome would be. If I were a betting person would I bet on this worst outcome? If I would not place a bet, do I really believe that the worst outcome is likely? So the person above with the fear of shopping alone might ask themselves 'would I bet my partner £50 that if I met a former colleague whilst shopping alone, I would fall apart? Money has a way of concentrating your mind so that you become realistic! The image of 'falling apart' can then be reconstructed with a more realistic scenario of, say, imagining asking the former colleague whether they had any planned holidays and then excusing yourself because you are in a hurry. The second strategy is to ask how awful the feared consequence might be. So that in the above example the person might respond 'if I fell apart in front of a former work colleague, they would likely think I was physically unwell, because that is likely to be more their experience'.

9. Seeing 'dares' as experiments – 'don't avoid realistic experiments'

A dare is a two-sided coin. On one side a dare is about gradually doing what you have been avoiding; on the other side, it is about performing a realistic experiment. For example, you might fear having a panic attack in a lift, fearing that you will have to get out quickly to get some air. You could test out whether you really have to make a dash for air, by deliberately holding your breath in the lift, seemingly making less air available and discover that there is in fact always enough air available. Or you might experience palpitations when you are alone in a busy city centre, you could test out whether your heart racing really is dangerous by walking very quickly for a few minutes, making your heart race even more and discovering that an increased heart rate signifies nothing at all. If your fear is of going crazy in front of others, you could test whether this is really possible by planning to go deliberately crazy in front of others at a particular time and discovering what actually happens at the appointed time.

10. Relapse prevention

Panic attacks do tend to recur at times of stress or loss, the secret is to not take them seriously. The temptation will be to withdraw from the situations in which the panic attack occurred, so the task is not to be bullied into changing your behaviour. If you have begun to engage in avoidance behaviour, construct a ladder to reclaim your life. In Table 2, there are examples of common catastrophic thoughts and their antidotes. Try adding your own common catastrophic thoughts and their antidotes.

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Table 2 Catastrophic thoughts and their antidotes

I'll be trapped on the aeroplane, I'll make a show of myself.	I can go to the toilet or just close my eyes until the panic passes.
These pins and needles mean there is something wrong with my circulation, probably a blood clot on the way.	I can get pins and needles from everyday things such as leaning on my arm for a time, if I imagine a blood clot I will also imagine it dissolving.
It's ridiculous to feel unreal as if everything is far away when I'm in a queue. Others will see that I'm weird.	Feeling as if you are distant from your surroundings is a very common stress reaction. How can others measure how distant I feel?
I can't get close to anyone because of this sweating, they will notice, maybe even smell, that something is up.	Nobody has ever commented on my sweating, maybe I'm just 'on sentry duty' for this symptom, so I notice the slightest perspiration.
The light-headedness probably means a brain tumour, my dad had one.	Brain tumours aren't hereditary, you can feel light-headed for thousands of trivial reasons such as getting up quickly from a chair.

Review Table 2 on a regular basis so that in the event of a panic attack the antidotes can be easily recalled.

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Appendix J

Post-traumatic Stress Disorder Survival Manual

Serious road traffic accidents, assaults, explosions are the type of events that can give rise to post-traumatic stress disorder. Such events can act like a 'pebble in water' (Figure 1) spreading out in their effects.

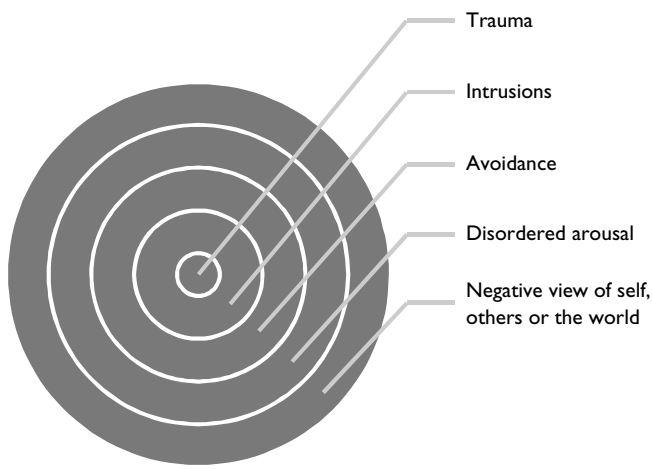

Figure 1 'Pebble in the water' effect of trauma.

After an extreme trauma you might experience pictures of the incident coming into your mind, sometimes for no reason. At other times the memories are brought on by reminders. The memories are like unwelcome guests (intrusions in Figure 1) and may be joined by other intruders – nightmares of what did or could have happened. The intrusions are horrible and you most likely try to make sure that they are not triggered, by for example avoiding conversations about the incident or by staying away from the scene of the incident. Thus avoidance (see Figure 1) is the second major ripple effect of the trauma. If you are preoccupied by memories of the incident and are avoiding anything connected with it, this is likely to mean a major disruption of your life, resulting in disordered arousal (Table 1).

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Table 1 Disordered arousal

- Disturbed sleep
- Increased irritability
- Poor concentration
- Hypervigilance (on 'sentry duty')
- Easily startled

The collective name for the symptoms in Table 1 is disordered arousal, which is the third ripple in Figure 1. As the wave of PTSD spreads out through intrusions, avoidance and disordered arousal it extends as far as a fourth and final ripple (Figure 1), a negative view of yourself, others or the world (e.g. 'I am bad', 'no one can be trusted', 'my whole nervous system is permanently ruined', the 'world is completely dangerous'). There is a common sense connection between an extreme trauma and flashbacks/nightmares and avoidance but few victims anticipate how negative they have become about almost everything.

You are not alone with these reactions. You might find reading this brief Survival Manual a stepping stone to reading the self-help book Moving On After Trauma *(available online or from your bookshop) in which you can read about the steps taken by someone just like yourself to recover from PTSD. The book is also a guide for relatives and friends, who often feel that they are 'walking on egg shells' with the trauma victim – if they leave the victim alone the latter is inactive and accuses those close of abandoning them; alternatively if they encourage the victim to be more active they are accused of nagging. Many trauma victims try to cope with their sleep problems and fearfulness by increasing alcohol consumption or taking drugs; the latter can become problems in their own right, distracting attention from tackling the underlying PTSD.*

1.Normal reaction to an abnormal situation

Intrusions, avoidance, disordered arousal and disturbed relationships are a normal reaction to an abnormal situation. The good news is that the majority of people recover from PTSD and, for those who do not, 7 out of 10 recover by the end of cognitive behaviour therapy.

The trouble is that your reactions may not feel at all normal, you can feel a sense of danger/threat even though you know there is no danger. You can say all the sensible things to yourself but as soon as you are in a situation remotely like what happened to you the logic seems to go out of the window. Well, you are not going crazy, it just feels like it! The key problem is a 'dodgy alarm' (Figure 2). The brain has its own alarm called the amygdala; it is as if ordinarily the alarm is over to the left in the ten o'clock position, should something 'alarming' happen, e.g. a person approaches

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you with a weapon, the alarm rings and you pump oxygen to your muscles ready to take flight or maybe even fight. However, for some people when the alarm rings it becomes stuck in a 'war zone' position, the two o'clock position to the right.

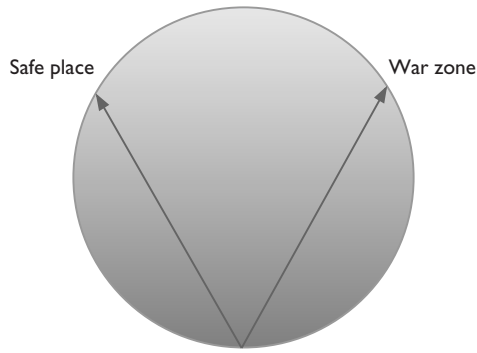

Figure 2 Dodgy alarm – amygdala.

In this position there is a sense of threat even though objectively there is little or no danger. The amygdala is also the seat of emotional memory, and it works on matching rather than logic, so that whenever you come across anything even vaguely like the incident it goes off. When it goes off you may feel a surge that appears to go from the top of your stomach into your chest.

It is as if you are in a war zone but others are in a safe place. This leads to a sense that you are in your own world (Figure 3) disconnected from those around you.

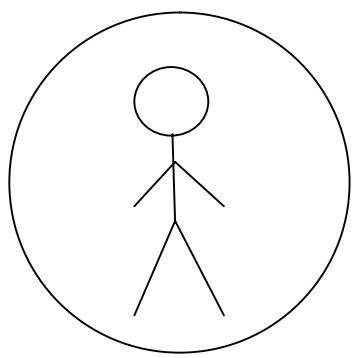

Figure 3 The PTSD bubble.

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This sense of isolation, can lead to feelings of numbness/emptiness, feeling flat (Figure 4), as if somebody has left a fizzy drink standing around for a long time.

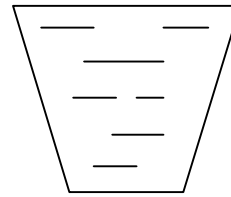

Figure 4 Emotional flatness.

Such emotional flatness can lead to guilt feelings such as not feeling warm towards your partner and a deterioration of relationships, e.g. no enthusiasm for returning a phone call to a friend.

Recovery involves:

- resetting the alarm (Figure 2), moving it gradually anticlockwise from the war zone position, to the vertical, twelve o'clock position (an area of less conflict) and finally back to the ten o'clock position, a safe place;
- stretching the bubble (Figure 3), gradually reconnecting with people;
- getting the 'fizz' back (Figure 4), by beginning to invest again in life;
- learning not to take the alarm's ringing seriously, by putting its activation into context.

2. Resetting the alarm

Overreacting in every possible way is one of the hallmarks of PTSD. Knowing that you overreact will lead you to avoid situations that might trigger these extreme responses. Without fully realising it, you have spotted that you have developed an oversensitive alarm and you have dedicated your life to not tripping it. Unfortunately just as exercise is usually necessary for back trouble despite an increase in discomfort, so too it is necessary to trip the alarm in order to reset it. Although you may know with your head, in your better moments, that certain situations are not really dangerous, your 'guts' do not. The 'gut' reactions change most powerfully when a person dares themselves to do what they have been avoiding and discover that nothing bad happens. The alarm can be coaxed back to a safe place by gradual dares.

The situation is rather like teaching a toddler to swim: the first dare might be to have them jump in and you catch them, then when they are comfortable doing that they might jump in next to you without your

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catching them, etc. Thus, for example, a person with PTSD following a road traffic accident might week by week take the steps in Figure 5.

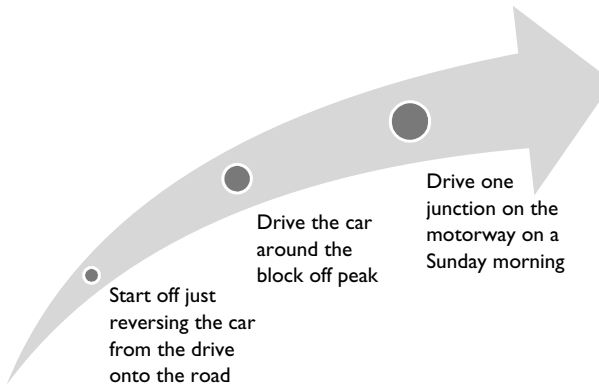

Figure 5 Resetting the alarm by daring small steps.

Each dare or step trips the alarm. It will feel awful at the time but afterwards the alarm moves anticlockwise a notch. What dares could you have a go at? Just jot them down below:

1. .....

2. .....

3. .....

Start off with the easiest of the dares, in this way gradually building your confidence. The idea is not to become a 'dare devil' but to gradually, simply dare to do what you would have done before the trauma. The more you can get back to doing what you did before, the better you are likely to feel.

Unfortunately learning anything is never smooth. It is often the case that after making significant progress the person comes across an all too vivid reminder of their trauma. It is very tempting at this point to abandon the training programme. But whilst the alarm may have moved slightly clockwise, continued dares soon repair the situation and the alarm is reset in a safe place. It is necessary to budget that training will be a matter of two step forwards and one back and not become demoralised.

Dares can show that what you feared is not as dangerous as you thought. In fact dares can be thought of as experiments to test out whether your gut reactions have much to do with everyday reality now. The letters of the word dare also stand for:

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- **D**on't
- **A**void a
- **R**ealistic
- **E**xperiment

You might, for example, have a fear of a busy shopping centre, so a realistic experiment might be to dare yourself to go into such a centre for just one item and test out whether anything unbearable does actually happen. If you repeat the experiment a number of times you will have collected a great deal of evidence of no danger and you will become less fearful. A dare is a two-sided coin, on one side it is about changing your thinking by doing a realistic experiment and on the other side it is about changing your behaviour by daring to do something you have been avoiding. Dares are a gesture of defiance proclaiming that no horror has the last word.

3. Better ways of handling the traumatic memory

You have probably tried to blank the memory, distracting yourself by doing something or talking to someone. Trouble is that that works only briefly. Here is why: supposing if I said:

'Do not think about the orangutan'

As you continue to read you are still thinking of orangutans (perhaps you think he looks like somebody you know!). The more you try to deliberately not think of something the more you think about it.

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Sufferers from PTSD fear that if they don't try to block the memory it will dominate and spoil their life. But if you try to block the memory you are guaranteed that it is constantly on your mental TV. Realistically, though, you cannot help but think about the incident sometimes as it has had such a big impact on your life. The secret of handling the traumatic memory is attention control, at times letting the memory just float in and out of your mind without getting involved/rising to the bait, whilst having a special time when you address your concerns about the incident and its effects. It is rather like children pestering you to do something whilst you are busy doing a task; if you just say 'go away, I'm busy' two minutes later they are back but if you say 'I'm busy right now but I'll fix your bike at about 11.0 a.m.', provided you do turn up at 11.0 a.m. they may leave you alone. There are a number of ways of dealing with the memory at the special time (Table 2).

Table 2 Better ways of handling the memory

- Write a page a day about the incident and its effects
- Dictate the story of the trauma and ask someone to write it down
- Dictate the incident into a recording device, e.g. mobile phone

Your first reaction to the alternative ways of handling the memory may well be 'no way', perhaps a feeling that you will be 'overwhelmed by the memory or that it will become uncontrollable'. But if you approach dares, a little step at a time, though it is uncomfortable it is manageable. Perhaps when you first begin to write/dictate you might leave out the most painful part or you can only write a few lines. That's fine, day by day you just gradually dare yourself to do a bit more. Usually after about two or three weeks of this you just become bored with what you are writing/dictating. When you are bored by something you no longer have nightmares about it, nor are you distressed in the day by the memory of it. The goal is to become as 'bored' as the orangutan looks; this usually takes about 20 minutes a day of writing/re-reading, dictating/reading/listening for about two to three weeks.

4. Safety first?

Since your trauma you probably do many things for safety that you didn't do before; just take a moment and jot a few down:

1. .....
2. .....
3. .....

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Your safety behaviours might include repeatedly checking the front door is locked, or checking that the children are still breathing when they are asleep or perhaps insisting that you are in the front passenger seat not the rear or only driving to places you know.

To what extent do you try to persuade others close to you, to do what you now do?

. . . . . .

If not doing what you do now is really dangerous, what stops you making more efforts to persuade others to behave just like you?

. . . . . .

If there is a clear and present danger to those close to you, from their not behaving just like you, would you not insist and check on them even when they are out of sight and might laugh at you if you rang or left a text message?

. . . . . .

Is it that you do these 'safety behaviours' as a way of trying to avoid discomfort, rather than believing that not doing them is dangerous?

. . . . . .

Is it just embarrassment that stops you trying to persuade people in your local area via say local radio, to behave exactly as you do? Surely with your care of people you would do more?

. . . . . .

Am I truly putting safety first or are these new behaviours simply a way of trying to calm the stormy seas that I feel I'm sailing through?

. . . . . .

One possibility is that the new 'safety behaviours' are more about wanting to feel in control because you may have felt so out of control in the incident. Young children often engage in magical thinking, e.g. not stepping on the cracks on the pavement as they go to school so that teacher does not shout at them; can you be sure that your new 'safety behaviours' are not magical thinking? Consider dropping the new 'safety behaviours' by engaging in gradual dares.

5. Photographing the trauma and its consequences from different angles

The mind is rather like a camera and how you take a photograph of the trauma makes a big difference. For example, you might be leaving your

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camera on what could have happened and regularly watch a horror video of family members at your funeral. Not surprisingly, using the camera in this way is upsetting. You could instead focus on the reality, for example a nasty accident with some injuries; although unpleasant the reality video is much less upsetting than the horror video. Are you addicted to watching horror videos of what happened? If you are, what about practising switching your attention from the horror video to the reality video?

Reminders of your trauma can mean that you do not simply remember what happened but you re-experience it again, almost as if you are back again at the scene of the accident. When this happens the difference between 'then' and 'now' becomes blurred. Common reminders are smells, sounds or seeing your trauma on TV. These reminders have become 'transporters' taking you back in time. Unfortunately reminders are always about, but you can learn how not to board the 'transporter' by letting yourself experience what that particular smell, sound or sight means today. For example, if the smell of petrol takes you back to re-experiencing your accident you might deliberately let yourself smell petrol, reminding yourself that you are safe, just smelling it in the garage. Possibly it is the sight of a particular car, a knife or a loud bang. Just looking and listening to these now either in real life or on the internet can teach you that they do not always have awful consequences. In this way you recognise some similarity between the reminder and your trauma but at the same time spell out very important differences. When you come across any reminder play 'spot the differences'; like the childhood game, the more differences that you come up with the better you have done.

Guilt is often associated with PTSD; for example, you might be a bus driver who knocks down and kills an elderly person, when the latter without warning steps from the pavement into your path. In such circumstances it is easy to feel very guilty perhaps haunted by the expression of the person as the bus went towards them. But you can take a different angle using a responsibility pie (Figure 6).

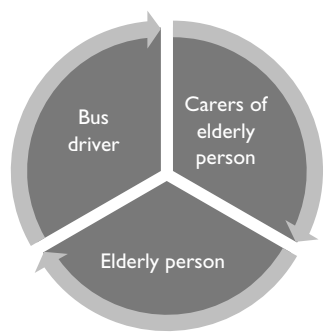

Figure 6 Responsibility pie.

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Going clockwise around the pie you might decide the carers of the elderly person bear some responsibilty for letting them out unsupervised and it may that the elderly person deserves a slice of the pie because of their stubbornness, leaving only a small slice for the driver. Indeed the driver's slice may be even smaller if the bus was poorly maintained. Using the pie people often conclude that they are much less blameworthy than they first thought.

6. PTSD and negativity

Guilt may relate to the incident or to the consequences of the incident. For example you might think 'I should have warned the driver when I saw the oncoming car' or 'I should be over this by now' or 'I should be working/providing'. Alternatively the negativity can be focused on blaming others e.g. 'the emergency service vehicle should have been better maintained and shouldn't have been speeding'. Such negative automatic first thoughts can have the sting taken out of them by coming up with more realistic second thoughts. One way of doing this is to use the MOOD chart (Table 3). The first letter of MOOD, 'M', stands for monitor your mood, the second letter, 'O', stands for observe your thinking, what it sounds as if you have said to yourself, the third letter, 'O', is for objective thinking, more realistic second thoughts, and the final letter, 'D', is for deciding what to do and doing it.

Table 3 MOOD chart

Monitor Mood	Observe thinking	Objective thinking	Decide what to do and do it
1. Mood dipped standing drinking coffee looking out of the window.	I should be over this by now	Who said I should, it is not my fault if I have not had the right tools to get over PTSD	I could dare myself to go swimming
2. Mood dipped when I saw my neighbour going to work	I am weak I can't face going back to where it happened	I can't be that weak I have started some dares, I'll get back to work gradually, I just have to pace it	I will ring some colleagues and meet up with them socially first

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Whenever your mood dips you will have greater access to the memory of the incident, it will seem more vivid and real. It is therefore important to take the sting out of your reflex negative thought as quickly as possible; the longer you pick at or ruminate about the automatic thought, the more difficult it is to take a photograph from a different angle. In theory you can come up with better second thoughts without writing things down using the MOOD chart, but it is a bit like learning maths for the first time and trying to do the sums in your head.

It is as if the negative view of self, others and the world, the fourth ripple in Figure 1, gets washed up on the 'shore line', solidifies and becomes a magnifying glass through which anything negative is 'read', e.g. the unexpected visit of a relative is viewed, not as a slight hassle, but as a catastrophe. Operating with the 'magnifying glass' becomes so familiar to PTSD sufferers that they often do not realise they are using it. But the habitual use of the magnifying glass results in feelings of detachment and estrangement from others. The first step in weaning yourself off use of the magnifying glass is becoming aware of the differences in your 'reading' with and without this apparent 'aid'.

Spend a few minutes completing Table 4 and the questions that follow.

Table 4 My views before and now

	Myself	Others	The world	The future
View now				
View before				

What do you think others close to you think of you now?. . . . . .

. . . . . .

. . . . . .

Do they agree with you about the amount of danger you are in? . . . . . .

. . . . . .

. . . . . .

If they don't agree about the level of danger, why might that be?. . . . . .

. . . . . .

. . . . . .

Do they agree with how you look at what happened in the incident?. . . .

. . . . . .

. . . . . .

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Looking back at your answers above they are probably very different depending on when you took the photograph (before or now) and whether it is your view or others'. The social support provided by others or indeed the lack of it can also influence your observed thinking. If your observed thinking is exaggeratedly negative this will influence your behaviour, which is likely to be avoidant.

7. Restoring relationships

PTSD puts a great strain on relationships. Often the sufferer is irritable over the most minor of events, no longer shows affection and cuts themselves off from relatives and friends. Many sufferers feel guilty that they no longer have feelings of warmth to their partner. The apparent demands of others exceed their resources and they feel 'on a short fuse' (Figure 7).

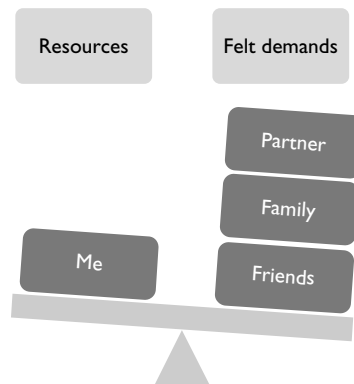

Figure 7 Disturbed relationships.

High levels of stress are experienced when the felt demands exceed the resources and the see-saw tips up. The imbalance is expressed via irritability, straining relationships. Yet those who view themselves as supported are more likely to recover.

One way of helping to restore relationships is to question what you take to be the demands of others. For example, how true is it that your partner and children insist you provide financially in the way you did before the incident? How true is it that friends see you as a lesser person for not being able to do what you did before? Who is setting unrealistic standards, yourself or those around you?

Sufferers from PTSD tend to go into their own world, the 'bubble' in Figure 3, and stop investing in relations and friends. But because there is no

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investment there can be no return. Recovery from PTSD depends on gradually beginning to invest in those close to you again. You might start off with going for a walk with your partner, asking your partner about their day, giving a hug or perhaps telephoning a friend for a few minutes. To begin with you may well feel that you are going through the motions but eventually some enthusiasm will come back.

In order to moderate your outbursts you might imagine a set of traffic lights on red as soon as you notice the first signs of irritability. Then when the lights go to amber ask yourself is what has just happened really the end of the world? Did they really do it deliberately to wind me up? Then when the lights go to green go into another room to calm down. To begin with, many people go through the lights on red and it may take a few weeks' practice to learn to obey them. It may be that if you trust your partner or family member enough you can ask them to remind you to use the traffic lights when you are getting irate.

Many PTSD sufferers stop communicating with family members after their trauma and the latter are left bewildered as to how to cope. Initially rather than try to explain yourself ask those around you to read this Manual; this may act as a stepping stone to their understanding the trauma self-help book *Moving On After Trauma*.

8. Writing the gameplan for the next chapter of your autobiography

Because the trauma has had such a big influence on your life, it can become the only lens through which you look at life. Though you might recall pleasures and achievements from before the incident you will probably only do so briefly and just long enough to dwell on what you have lost as a consequence of the trauma.

The first step forward is to recognise that you are using a trauma lens, then to stand back and instead see the bigger picture. To do this, spend some time collecting photographs, memorabilia and writing in graphic detail about your pleasures and achievements before the trauma. You could regard this as a first chapter of your autobiography. The second chapter you have already written or dictated is about the trauma. The following chapters are all about the life you are going to construct and your gameplan for dealing with likely difficulties. In writing the third and later chapters you could summarise in your own words those strategies you have found most useful in stopping domination by the trauma. In this way these chapters become your own personalised Survival Manual that you can make ready reference to at the first sign of difficulties.

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Appendix K

Social Phobia Survival Manual

Talking about your social phobia is likely to be the most difficult thing in the world because it means the spotlight will be on you. This is why comparatively few people with social phobia attend for treatment. But without treatment few get better. One study of people with social phobia showed 63% of them still suffering social phobia 12 years after it began.

Social anxiety (which includes social phobia and shyness) has two main ingredients, fear and avoidance. If you greatly fear small groups you might be put off going to group therapy and if you avoid social gatherings like Christmas works parties, you don't learn that they are not that dangerous and you are really anxious when forced to attend a social gathering, e.g. a meal after a wedding. Both fear and avoidance are necessary to the running of the engine of social anxiety (Figure 1).

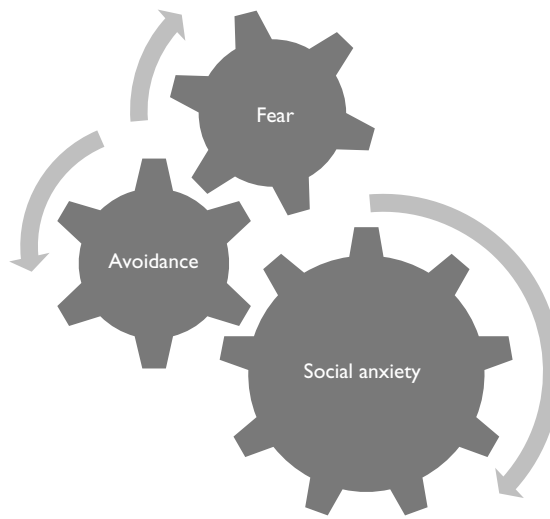

Figure 1 The engine of social anxiety.

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Which social situations would you like to conquer? Common concerns of people with social phobia include: being introduced, meeting people in authority, using the telephone, having visitors come to the house, being watched doing something, being teased, eating at home with an acquaintance, eating with the family, talking to someone you are physically attracted to, writing in front of others and public speaking. Underline those that are an issue for you and put a number 0–10 next to the items you have underlined to indicate how much you fear this situation. Perhaps also write down below if there is any other social situation that is an issue for you and how much you fear it:

. . . . . .

. . . . . .

Starting with the less fearful situations (the lower scores) gradually dare yourself to enter those situations. The more often you enter the feared situation the more your fear reduces, if you avoid the situation that turns the wheel of fear in Figure 1.

As you are driving the 'social phobic's car' you assume others are out to get you. But instead of checking out whether they really are dangerous (are some worse than others?), you turn inwards on yourself, focusing on your bodily sensations, e.g. turning stomach, feeling shaky, and explain this discomfort as a response to the high expectations of others.

It is if other people are hypercritical teachers surrounding you (Figure 2).

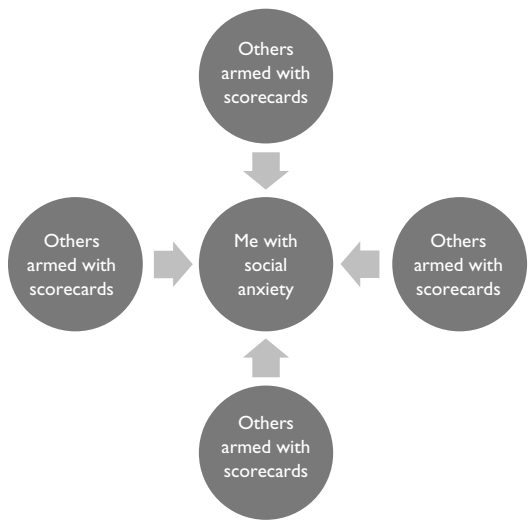

Figure 2 The social anxiety story.

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In social phobia the individual regards themselves as such an 'oddity' that they believe others must be looking at them and negatively evaluating them.

But the story that non-social phobics carry around is shown in Figure 3.

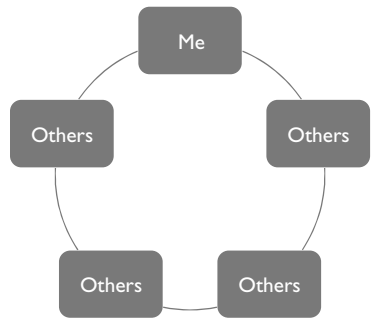

Figure 3 The normal story.

In Figure 3 others might notice you in passing but no more so than others. Further, they are unlikely to bother making a judgement of you unless you do something either very kind or harmful.

1. Beliefs that maintain social anxiety

If you have started daring yourself to encounter some of the situations that you fear, as recommended above, this will likely trigger some socially anxious thoughts/beliefs. Make a note below of any such thoughts coming onstream as you let yourself be the focus of attention:

. . . . . .

. . . . . .

The following seven beliefs are usually held firmly by people suffering from social phobia and are the reflex thoughts often experienced in social situations. But how true are they for you? Are these ideas useful? How did you come by these ideas?

1. 'Others zoom in on my negatives'

People suffering with social phobia believe others focus on their peculiarities, e.g. sweating, whereas non-sufferers believe that others react to them as a whole person. To test out whether others really do focus on 'oddities' try an experiment: in conversation with people you know do something unusual a couple of times, e.g. pull your ear lobe or rub your

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nose, then see if there is any sign of them having noticed. The person with social phobia has a story about themselves based around their perceived deficit, e.g. blushing, whereas the story others (the viewers) are using sees them as a whole person – warmth, smiles, interest – and the perceived deficits are at worst only a minor part of the whole picture.

2. *'They have put me under the microscope and found me wanting'*

Why would others bother putting you under the microscope? What would they be seeking to discover? How do you know that they feel negatively about you? What is the evidence that they all feel negatively about you? Do some feel more negative about you than others? Can you be sure what others think of you, if they are a bit shy?

3. *'Others have high expectations of how you should be socially'*

It is as if the person with social phobia believes that there are Commandments about how they should be socially, e.g. 'I must have something interesting to say', as opposed to a guideline, e.g. 'it might be an idea to ask them how their moving house went, just show some interest'. Social life flows more easily with the equivalent of a Highway Code rather than Commandments; sometimes you need to drive on the right, e.g. when overtaking a parked vehicle; if there was a Commandment 'Thou shalt always drive on the left' traffic would soon come to a standstill.

4. *'I should worry when I'm going to have to meet people'*

What is the advantage of worrying before you meet people?

What is the disadvantage of worrying before you meet people?

Would you conduct the following experiment: resolve not to worry before your next meeting with someone and see whether it goes any better or worse than your last meeting?

5. *'After talking to people, I should put my performance under the microscope and agonise about it'*

What is the advantage of this?

Has it helped you improve the quality of your contact with people?

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6. *'Don't tell anything about yourself, certainly not how you feel'*

Can you be sure that this idea is not contributing to your difficulties? In Figure 4 follow the arrows round clockwise from the one o'clock position.

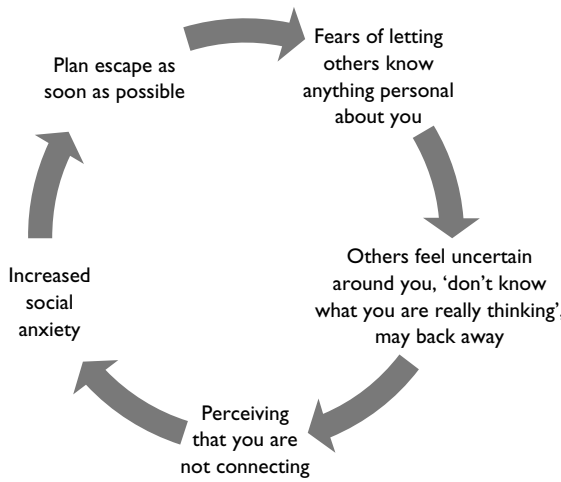

Figure 4 The price of not letting others get to know you.

7. *'I should remember previous humiliations in detail, they should guide how I operate with people'*

When really bad things happen to people such as being in a very serious car crash it can then become very vivid in their mind – the sights, sounds and smells. Because it remains so vivid it might put the person off driving or being a passenger in a car. Most get around this by reminding themselves that in all their years of travel by car they had never experienced anything like it and it was really a one-off and they gradually dare themselves to get back into the car. In a similar way for people with social phobia there can be vivid recall of some humiliation, e.g. being teased over a long period at school or being heavily criticised by parents when you expressed any disagreement with their views. These memories can be so strong that you don't just remember them but you feel again all the bodily symptoms that you felt at the time of your humiliation. Whilst you cannot just forget such memories, you can begin to make sure that they do not have the last word, by stepping around them and acknowledging that the 'humiliators' are probably not like most adults. You can give adults a chance and see what the results are. You could keep a daily count of the number of non-humiliators.

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2. Second thoughts

The person with social phobia feels that they are an 'oddity', they don't fit in, but they make the mistake of thinking it is abnormal if you think of yourself in such a way. Do a survey, ask people if they 'feel odd, don't fit in'; you could be surprised by the results! Most people think 'I am like them but they are not like me!', being inconsistent is actually normal, 'join the human race'.

Your thoughts about your thoughts (or feelings) are called metacognitions and it is these that are as much of a problem in social phobia as the thoughts/images/feelings that arise first. There is a special way of cross-examining your socially anxious thoughts and coming up with better second thoughts and behaviours (Table 1).

Table 1 On second thoughts

Social situation that made me anxious	*Bumped into a neighbour on the train.*
What I thought	*I'm trapped, what will I say? He will notice me sweating.*
What I did	*Mopped my face with a tissue, made an excuse that it was very hot on the train.*
What I did afterwards	*Agonised that he must think I am an idiot.*
What would be a better way of thinking and behaving that I could try out next time, in a similar situation?	*Just take an interest in the other person as if they were guests on a chat show and let them know something of me, let go of my 'safety behaviour' mopping my face. Don't 'pick' at the memory.*

In the example in Table 1 'What I did' refers to safety behaviour. These are behaviours the socially anxious person engages in to stop themselves 'falling apart'; in the example given the person repeatedly mopped their face. But there are a great range of safety behaviours, some observable such as avoiding eye contact, some more subtle such as washing the dishes/preparing the food rather than have conversations, and others are more covert plans such as not revealing any personal details. What safety behaviours do you use?

3. What do others really notice?

The socially anxious person feels that they are being scrutinised by others, particularly strangers. Try doing something that you normally do, in the way you usually do, e.g. go into a shop and buy a newspaper and make a careful note of the assistant's reactions and behaviour. Then the next day do the same again, but this time brush the bottom of your nose with your hand and make a note of the assistant's reaction. Perhaps the following

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day, as you are being given change pull your ear lobe and again note the reactions. On the following day try scratching under one of your armpits as you are given change and notice the reactions. Then ask yourself what do the results of these experiments mean?

4. Daring to drop safety behaviours

Your safety behaviours are designed to avoid catastrophe. But many safety behaviours exhaust people and probably make a disaster more likely to happen. For example, the car driver who drives very slowly leaving lots of space in front might encourage others to overtake and cut in front, perhaps creating the very circumstances they wish to avoid. In a similar way you might find that your safety behaviours are more trouble than they are worth. If you are at a social gathering use your usual safety behaviours with one person, then with the next person you meet try and put all your attention on them, 'forgetting' to use your safety behaviours, then compare which was the easiest. It is daring to drop your safety behaviours even for a brief period but the more that you do this the more your confidence increases.

5. Checking out whether other people do 'see' what you think they 'see'

There is often a gap between how a person sees themselves and how others see them. How we see ourselves often has more to do with our history. In the case of a person who is socially anxious their view of themselves may be more to do with a combination of factors: having been bullied or teased, parents who modelled social anxiety or passed on exacting standards about what was acceptable. This combination of factors may make a person feel both vulnerable and inadequate. Further, for the socially anxious person this felt inadequacy may be made 'obvious' to others in many different ways, e.g. blushing, stammering, boring conversation, trembling hands, quavering voice. But others may not notice such signs and if they do may not see them as catastrophic. The socially anxious person may see themselves as insignificant, others may beg to differ. The difficulty for the person with social anxiety is that they may refuse to believe any positive feedback from others, discounting it on some grounds or other, 'e.g. 'they are just a really nice person'.

One way of getting a reality check on what others see is to write down what you think others would see if you were in a brief conversation with others. Then have a brief conversation with a friend or family member and have it recorded on a digital camcorder or mobile phone then look at it when it is played back. In reviewing the playback ask yourself, is it as bad as you thought it was going to be? Did your face go as red as you expected? Did you stammer as much as you thought you would? Was the person you

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were talking to interested in you? Then play it back again and try to be objective about what you see, imagine you are someone who is reasonably well disposed to you, what do you make of what you see now? Did you notice that as you become the more objective other person you become less critical of what you are seeing?

Just as it is possible to distort a football match by having people watch only recorded highlights of the fouls, it is possible to distort what you think other people see without lying by using a mental filter. For example, you might focus on the fact that you stammer or blush but neglect that you smiled and the other person seemed interested – an example of applying a mental filter. The socially anxious person is over-alert for signs of danger, so they might pick up that the other person has a blank expression and interpret this negatively on the basis that 'if a person is not obviously for me then they are against me'; this is an example of all or nothing thinking and it leaves out of the equation that the person might be neutral. It is often as if the socially anxious person holds themselves wholly responsible for anything other than a wholly positive response from others and in addition they view absence of the latter as a catastrophe. Rather than escape from (or avoid) the social situation you might pause as if at traffic lights when you believe you encounter 'rejection', and *then* ask 'What alternative explanations are there for the other person's behaviour? What is the story with them? Are they perhaps shy? Is it that they are not interested in the particular subject matter of the conversation? Are they preoccupied with some personal concern?' Then when the lights go to green decide what to do, perhaps change the subject matter of the conversation and focus intensely on what you or they say, rather than your internal feelings. In summary when assessing your social performance check out whether you have used:

- personalisation
- mind-reading
- all or nothing thinking
- a mental filter.

If you have used one or more of the above, do a re-take.

6. Revisiting feared situations and what makes a person likeable

Make a list of feared social situations from least to worst, e.g. paying at the checkout in a supermarket, eating in a cafe by yourself, eating in a restaurant in company, asking your boss for information, chatting in a group at lunch time. Then write down your prediction of what will happen if you approach the feared situation, tackle each in turn but concentrate on

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the other person not yourself. In this way assess whether the anticipation is worse than the experience. Develop second thoughts about the situations you fear using Table 1.

Write down a list of people that you really like and put them in order from most liked to least liked. Then using the same list of people, put them in order of who would be most at ease meeting a group of strangers. Comparing the two lists are the most socially skilful the most likeable? If your liking of others seems not to do with their low social anxiety how do you know that others do not like you in spite of your social anxiety? In a group of social anxiety sufferers you will probably like some members more than others despite their social anxiety.

If you went for an interview, or to see your local councillor or MP and they knocked their cup of coffee over at the start would you feel less warm, more warm or neutral about them? Strangely you can get others to relax more with 'mistakes'. Perhaps one of the reasons for mistrust of senior managers and politicians is that they appear to perform socially so effortlessly. It may be that what you think of as a 'mistake' is to a degree at least an asset.

7. Haunted by the memory of humiliation – if I knew then what I know now

Sometimes the person with social phobia is haunted by the memory and feelings associated with a humiliation, e.g. being asked to take a turn reading in school, being unable to do so, then being teased by other children. Further, these same feelings may be resurrected again as an adult whenever you are put in the spotlight. Make a note of any such memories – where you were, what happened, how you felt. Then imagine you are revisiting the scene of the humiliation and you see the younger you upset. With the knowledge you have as an adult how would you comfort the younger you? Would you give the younger you a hug? Would you tell you as an adolescent/child that not everybody is the same as the 'teasers' or perhaps that the 'teasers' have their own problems and can only feel good by 'rubbishing' others? If you experience very strong negative emotion it may be that it is really this younger version of yourself that is getting upset and needs soothing before you can move on and make an adult response.

8. Worry before, during and after a social encounter

Worry is normal and is only a problem when it interferes with your daily activities. Some worry is necessary in order to plan how to handle a situation. So that trying to eliminate worry before a social encounter is striving for an unrealistic goal. For example, if you know a particular relative/friend is going to visit you, by way of preparation you might run

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through what they might like to eat. Are they vegetarian? What interests/hobbies do they have? It is reasonable to try and sort out what the 'story' of the other person is so that you have some 'doors' through which you might enter their world. However, in social phobia the focus is much less on the other person but rather on the internal sensations that might be experienced at the time of the encounter and the 'inside' view of what the other person might see. If the 'story' of the other person is considered at all, the person with social phobia will assume that they are going to be very critical. Consequently the level of anticipatory worry is such that for the social phobic it may well take away enjoyment in the lead-up time to the encounter. Thus the goal prior to a social encounter is to engage in worry to the extent that it is preparatory, then to disengage from worry and switch attention to other matters, continuing to focus on the latter despite some feelings of anxiety.

For the social phobic, worry about the social encounter may take the form of a horror video about what is going to happen. The constant replay of this horror video before meeting someone serves to heighten anxiety. However, the horror video can be swapped for a reality video that acknowledges probable discomfort but graphically predicts good enough impression management. In analysing their performance afterwards, the person is likely to use some of the information processing biases detailed in Section 5 to put a negative slant on how they connected with the other person. Dwelling on this 'negative slant' makes the person with social phobia at best very fearful of the next social encounter and at worst such situations are avoided (see the introduction to this Manual).

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Appendix L

Obsessive Compulsive Disorder Survival Manual

OCD can show itself in behaviours such as checking/cleaning, lining objects up and hoarding but sometimes the OCD is less visible and might consist simply of trying to block unwanted thoughts/images, pure obsessions; about 20–30% of OCD sufferers have pure obsessions. A journey through the minds of others can help the person suffering from OCD see that they are not quite as weird as they think, rather it is their response to their mental life that is the problem.

1. 'And I thought I was weird'

The OCD sufferer watches the same programmes on their mental TV (Figure 1) as the normal, non-OCD person, but the OCD sufferer is distressed by what they see. If you doubt that 'normal' people watch the same 'programmes', ask a group of friends 'would you all dare to be totally truthful about the thoughts and images that have gone through your mind in the last 30 minutes?' There is likely to be an embarrassed silence, followed by some laughter, but nobody prepared to declare all! Try doing a survey of friends/family: ask each of them individually whether they would be prepared to disclose all thoughts/images that have come to mind in the last 30 minutes.

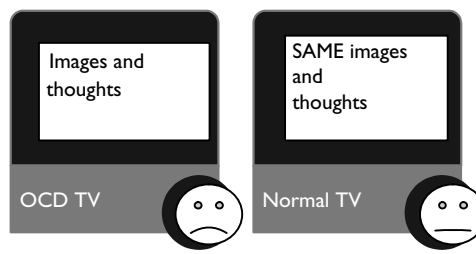

Figure 1 OCD sufferers give programmes a poor reception.

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The mind is rather like your local railway station, you can't control what 'trains' of thought come in, it may not be the train you want, your train may be delayed and you may be frustrated seeing all these other trains coming and going and people happily boarding them. But eventually a train you want arrives. In OCD it is as if the sufferer tries to stop the train/s they don't want by jumping onto the track. The noise from the train may be irritating, preventing conversation, but trying to stop the unwanted trains is not a good idea. The unwanted trains often have destinations that are in the opposite direction to what the OCD sufferer wants (Figure 2). A nurse might feel that being caring is very important to her (the arrow to the right in Figure 2), but the images/thoughts that go over in her mind are in the opposite direction, for example stabbing patients. Or a devoutly religious person may have images/thoughts of screaming obscenities in church.

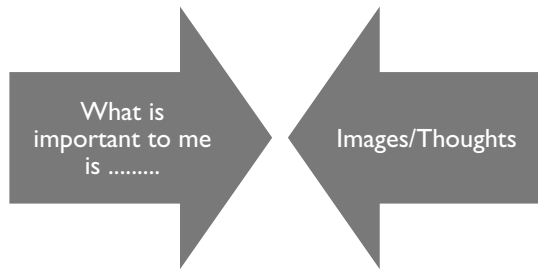

Figure 2 Obsessions – going against the grain.

2. OCD – a serious misinterpretation of mental life

Thoughts/images can be triggered by something, e.g. seeing someone very attractive, or can occur for no reason, e.g. bored, daydreaming and we have a thought/image of someone very attractive. There is no control of what pops into one's mind; at times it can be very inconvenient and other images/thoughts would be more conducive to the task at hand, but fighting them is rather like my protesting today about bad weather on a Bank Holiday Monday, when I would quite like to go for a walk. The mind is always untidy, but played skilfully you can still get a sense of fulfilment, achievement and pleasure, but in OCD the sufferer gets hooked by trying to get their mind 'tidy' *before* engaging with life. It is rather like a student studying for an exam constantly making lists of what they are going to revise but never getting round to actually revising. It is not that making a list in the first place is not a good idea but it becomes an end in itself rather than a means to an end. Figure 3 shows how OCD feeds on itself.

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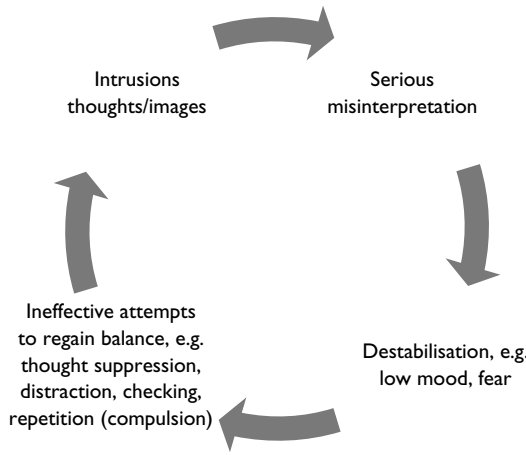

Figure 3 The maintenance of OCD.

The OCD cycle, in Figure 3, starts in the eleven o'clock position with a thought/image that may have been triggered by some event or combination of events, e.g. longer than expected period of illness and stress about work, or have no obvious trigger. For the sake of illustration the thought/image might be about shooting all family members; the likelihood is that such intrusions occur in an individual who is particularly caring/committed to their family. The problems set in when the person seriously misinterprets (the one o'clock position in Figure 3) these intrusions as meaning they are likely to shoot family members. The person has fused together the intrusion and the likelihood of a catastrophic event – thought action fusion (TAF). Not surprisingly this makes them feel off balance (the five o'clock position in Figure 3), fearful, low mood. The person may then seek to regain their balance by repeating the same behaviour (a compulsion), e.g. washing or cleaning and/or trying to block the thoughts or images. But the intrusions are in effect on an elastic band; the harder they are pushed away the more they spring back. (Try not to think of pink elephants for 30 seconds, start right now, time it . . . how many times did you actually think of pink elephants in the 30 seconds?). Performing a compulsion brings the sufferer relief from their anxiety but they feel driven to repeat the behaviour because of such relief. Just as a person who is an alcoholic might get temporary relief from their anxiety by having a drink so too the person with OCD might engage in a compulsive behaviour that brings relief, but for both of them their behaviour makes matters worse in the long run. When the coping strategies don't work (the seven o'clock position in Figure 3) this further fuels the intrusions and the OCD cycle continues. Cognitive behavioural treatment breaks the cycle by challenging the serious misinterpretation, ineffective coping strategies and low mood.

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3. OCD – playing by different rules

OCD sufferers differ from non-OCD sufferers in attaching a different significance to their intrusive thoughts/images. It is as if the intrusive/thoughts images are an unattended piece of luggage at a railway station – most people would hardly notice it, but the OCD sufferer notices, as they are very on guard for danger. Not only do they have a thought it could be a bomb but the image/thought and its consequences are so vivid that the thought/image event become one (thought event fusion; TEF). Actions are then taken to remove the 'threat'. However the actions of the OCD sufferer create more problems than they solve. The ways in which the rules and actions of the OCD sufferer are counterproductive can be illustrated by considering their actions with regard to the completion of a jigsaw. Imagine the following examples:

1. The person has to make sure they have the four corner pieces to start with. Not bad you think, probably many people do this. But then they want to count the number of pieces to check there are the same number as indicated on the box. Bit weird you may think. But then they are not quite sure they have correctly counted the number of pieces, so they count again. Whilst counting they get distracted and so have to start all over again. Getting weirder you may think. Then they count just one time more to be certain. What's going wrong here?

In this example the individual is pursuing feeling certain, they cannot tolerate being uncertain. But this side of the grave there is no certainty; can you be absolutely certain that a close relative has not just died as you are reading this? Faced with this uncertainty an OCD sufferer might abandon reading and go and ring the relative. They might feel relieved when the person answers the phone. But this only encourages them to ring when there is any uncertainty. One of the treatment targets in OCD is intolerance of uncertainty.

2. The person won't do the jigsaw because it shows a picture of harm coming to someone they love. What's going wrong here? What if they would do it but a bit reluctantly if someone was with them? What would this mean?

In this example the person is fusing together an image of harm and an action, harming them. It is a thought action fusion (TAF), but a special type, a moral TAF, in that thinking a thought is almost the same as doing it. If they would do the jigsaw if accompanied, this suggests that responsibility is a big issue; if others are involved responsibility is divided but that responsibility is too much (inflated responsibility) if they are solely involved

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in actions/consequences. Inflated responsibility is one of the treatment targets in OCD.

3. What if they wouldn't do the jigsaw if it showed some thoughts/images that go over and over in their mind that they are embarrassed or ashamed or disgusted about?

This is a further example of TAF. Just as in a restaurant a person has to consider all the options on the menu in order to choose what is 'good', so too it is impossible to choose a moral good without also considering the moral bad. Further, it is not what is being considered (the scrutinising of the menu) that itself leads to actions, but the planning that leads to action, e.g. after scrutinising the menu asking for a vegetarian menu. That is, morality is about planning and actions rather than intrusive thoughts/images.

4. What if they wouldn't do the jigsaw because its very old, a bit dirty? Or because someone horrible had done this jigsaw? What if they would do it but with gloves?

In this example there is a fear of contamination, but it is a form of magical thinking, imagining that just because someone horrible had done the jigsaw, the person could be contaminated by them – the thought and object have become fused (thought object fusion; TOF) and they need to take steps to prevent the harm by using gloves.

5. What if they have got to order all the pieces in a perfect straight line or a proper circle before starting? What if this order is broken?

The above example suggests a perfectionism at work, everything has to be 'just so' in order to proceed. This perfectionism is a very inefficient way of working; most things can be done to a 'good enough' standard, reserving 'perfectionism' for that which really requires it.

6. What if they keep hoarding such jigsaws in case they want to do them?

Just about anything could come in handy at some time. It seems likely that an intolerance of uncertainty underlies hoarding, wanting to be certain that everything is available. The contradiction is that in amassing so much material, that which is likely to be wanted is 'unavailable'. Hoarders usually have both a negative belief about their hoarding, e.g. everything is just a mess' and a positive belief, 'at least I won't be without', together with an implicit assumption that to be without is catastrophic.

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7. What if they put pieces together that don't belong?

In OCD sufferers are putting together pieces that do not belong together (Figure 4), vertically from the centre, thought action fusion (TAF), left downward diagonal, thought object fusion (TOF), right downward diagonal, thought event fusion (TEF). If these fusions are used habitually OCD may develop.

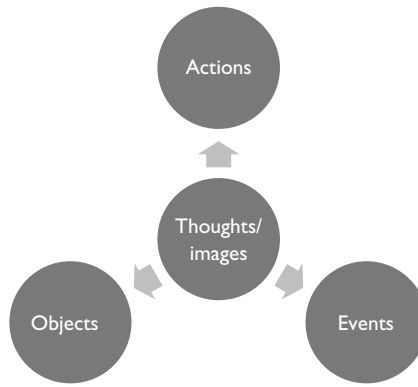

Figure 4 Problem fusions.

8. What stops you completing the jigsaw? Can you identify any fusion?
9. How would you persuade others to complete the jigsaw?
10. If your way is right, why wouldn't you persuade others to do it your way?

4. Developing a different story about your mental life

If you tell yourself a horror story about your intrusions (thoughts/images), e.g. 'they mean I am mad/bad/wicked', you will feel distressed, just as a young child would be distressed and have trouble sleeping if read a horror story before bed. With a child one puts their fears, e.g. about wolves, into a context, how many wolves did they count today?, how many wolves did their older brother/sister count today? etc., so too the fears of the OCD sufferer have to be placed in context. One way of doing this is to use the beat (b) OCD form (Table 1).

In the example given in Table 1, the OCD sufferer has identified her magical thinking about the need to do things three times and, by a consideration of how others act in the same situation, has identified her exaggerated sense of responsibility. Instead of obsessive rumination (column four of Table 1) about these concerns she has decided to test out (a behavioural experiment) the need for the magical behaviour and

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Table 1 **bOCD**

bOCD *is a mnemonic for remembering how to shrink disturbing thoughts about images/thoughts to size. In the first column, detail the thought/images that may have* ***b****esieged you today and indicate, if you can, what may have triggered them. The* ***O*** *of OCD here stands for* ***o****bserve your thoughts about your thoughts/images and record these in the second column. The* ***C*** *of OCD here stands for* ***c****onsider alternative thoughts to your thoughts about your images/thoughts and, if you can, record these in the third column. The* ***D*** *of OCD here stands for daring to begin to act as if the thoughts in the third column are true.*

I am **besieged** by these images/thoughts	**Observe** your thinking about these, images/thoughts:	**Consider** alternative thoughts, ones that others may have about these *same* images/thoughts. Also **Consider** why you would not try to persuade others of the truth of your thoughts about the besieging army of images/thoughts:	**Dare** to act, however briefly, as if the thoughts in column 3 (C) are true, and see what happens. Record the 'dare' and the consequences.
I don't remember switching the cooker off, the house could burn down, the kiddies next door could die in the fire.	This means there is danger, I should go home and check.	I'll probably be OK, even if I can't remember having switched the cooker off, it is unlikely to end in catastrophe. Just because I have thoughts about it doesn't mean it's going to happen – thought event fusion. There would be no point in trying to persuade my boss that I needed to go home from work just because I couldn't remember having switched the cooker off, he would look at me as if I was daft. I wouldn't try to persuade my mum to stop whatever she is doing and go home if she couldn't remember having switched the fire off, why is it OK for her and not me?	This time I will dare myself not to go home but I will ring my mum to go around and check, at least it is a start. Rang my mum who said 'do you think I've got nothing better to do', but she went round and later rang me to say everything was OK. I felt down that I had obviously inconvenienced her.

continues

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Table 1 (continued)

Harm is going to come to my Gran, she is getting on, she had a fall at home last week, tripped on a footstool.	I must ring her throughout the day, if I just do things three times, switch the kettle on and off three times before making a drink, trace my eye around a picture exactly three times – if I'm interrupted I will have to start again.	I might make her trip even more because she keeps having to rush to the phone when I ring. I wouldn't try to persuade my mother to ring through the day because she would tell me she visits once a day and that's enough, she told Gran off for leaving the footstool around as she doesn't use it. Grandad used it before he died. I exaggerate my responsibility for what happens to Gran, she has to do her bit, Mum and sister do their bit and I'll do my bit.	Just ring Gran morning and evening. Dare to have a day off from doing things three times and see does anything terrible happen to Gran the next day.

adjust her behaviour to be more in line with an objective view of how much responsibility she does bear. 'Dares' are an experiment, testing out whether there really will be any harm from not engaging in the compulsive behaviour and whether the mind does really operate in the way the person with OCD believes, e.g. whether thinking harm is going to come to Gran makes harm happen to her. The letters of Dare can be thought of as standing for Don't Avoid a Realistic Experiment. If your thoughts about your thoughts/images really bother you, test out that they would really stand up in 'Court' before you accept them.

The bOCD is for use whenever you feel plagued by the OCD. A common trigger for an intense wave of OCD is a deterioration in mood. For example, an OCD sufferer away on holiday might be little troubled that clothes were not washed instantly, but when they return home there is again

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a felt urgency to immediately wash clothes. It is therefore useful for OCD sufferers to tackle not only the army of besieging thought/images using bOCD but also more generally any dips in mood.

5. Managing your MOOD

To help you manage your moods pass them through the MOOD chart (Table 2). The first letter of MOOD, 'M', stands for monitor your mood, the second letter, 'O', stands for observe your thinking, what it sounds as if you have said to yourself, the third letter, 'O', is for objective thinking, more realistic second thoughts, and the final letter, 'D', is for deciding what to do and doing it.

Table 2 MOOD chart

Monitor mood	Observe thinking	Objective thinking	Decide what to do and do It
1. Mood dipped arriving back home from holiday.	I'll have to get the washing done, here I go again getting obsessed about the washing.	Everyone has to do washing when they come home from holiday, I used to do it even before my OCD.	Get on and do the washing, if I start to get plagued by it I will use the bOCD form.
2. Mood dipped hearing that I have got to reapply for my own job.	I am going to be unsuccessful with the time I have had off for the OCD.	The time off won't help, but they do know I am very conscientious, maybe too much of a perfectionist for my own good. Colleagues are in the same boat.	I will arrange some practice role plays with my boss.

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6. Daring to postpone 'safety' behaviour

With OCD, sufferers feel out of control. But postponing a safety behaviour, like checking you have really locked the car on the drive, for just a minute, can give a sense of control. Gradually the time for which you postpone things can be gradually increased. The period for which you postpone the safety behaviour constitutes a mini-experiment in which you test out the belief that something terrible will happen if the behaviour is not performed. It is a useful short-term goal to become able to postpone the 'safety' behaviour for 15 minutes; this is a reasonable testing period for the observed thinking, rather like a test-drive with a possible new car. Long-term the goal would be to give up the 'safety' behaviour and return to your way of operating before the OCD. Keep a daily record of the duration of your postponements.

Sometimes it is not so much that the OCD sufferer engages in an observable behaviour, such as checking the car is locked, but they agonise about some image or thought, e.g. do they really love their partner? In such instances it is important not to suppress the thought, to do so has a rebound effect, but to cultivate a detached mindfulness about the thought. The first step in detached mindfulness is that thoughts/images/questions are just that, in and of themselves; they do not have a significance but a significance can be accorded to them, if and when a person decides to do so. They are best treated as the type of background noise one hears whilst in conversation with a person in a room full of people chattering. An odd background phrase or word might briefly capture your attention but you focus on the person you are talking to, whilst making a mental note to address the overheard snippet at another time, perhaps when you meet the other person. The 'special time' is the period when you address the concern using bOCD. Often the concern has evaporated by the time you have the opportunity to use bOCD; if it hasn't it is addressed systematically using the form.

7. Managing relationships

If an OCD sufferer is stressed by a relationship or conflict they are more likely to engage in OCD behaviour, so that effective management of relationships can reduce OCD symptoms. One way of doing this is by checking that you are observing the communication guidelines in Table 3.

If you are very stressed out by some situation either at home or work you are more likely to engage in obsessive behaviours and/or thoughts. In order to de-stress you might have to communicate effectively with those around you. One way of ensuring this is to keep to the guidelines ('Highway Code') in Table 3. For example, you might be stressed out in work and you could just go and complain to the boss. But even though you may be correct in

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Table 3 Communication guidelines

1.	In stating a problem, always begin with something positive
2.	Be specific
3.	Express your feelings
4.	Admit to your role in the problem
5.	Be brief when defining problems
6.	Discuss only one problem at a time
7.	Summarise what the other person has said and check with them that you have correctly understood them before making your reply
8.	Don't jump to conclusions, avoid mind-reading, talk only about what you can see
9.	Be neutral rather than negative
10.	Focus on solutions
11.	Behavioural change should include give and take and compromise. Any changes agreed should be very specific

your complaint your boss might not listen because it is 'just a complaint'. However, if you say something positive first (first rule of the 'Highway Code'), such as 'I appreciate you're really busy at the moment but if we could make a time to discuss . . .' then the complaint is more likely to be taken seriously. If the complaint is expressed in a vague way, e.g. 'I just can't stand this job' or 'I don't like your attitude', it makes it difficult for the recipient of the complaint to deal with. However, if it is specific (second rule in Table 3), e.g. 'I don't like it that for the last week of every month I have to do two jobs instead of one', the other person has a chance of doing something about it. The complaint has to be expressed with feeling (rule 3 in Table 3) otherwise the other person will think it doesn't matter to you, but if expressed with too much emotion the other person may not look at the detail of your complaint, withdraw and dismiss you as having a personality problem. If you can admit to your role in the problem, e.g. 'I know I do stress myself out a bit by being a perfectionist but two jobs instead of one for a week every month is a bit much', it encourages the other person to listen, particularly if you have been very brief in stating what bothers you (rule 5 in Table 3). But people are often not brief, they break rule 6 by bringing up another problem, e.g. 'oh by the way I've got to have the school holidays off this year', and the conversation may then go off in a different direction with the original problem unresolved. Sometimes people don't check out what the other person is trying to say before going on the offensive; in this example an employer might respond with 'hmm it is going to be difficult to get extra help on a Friday because lots of people like to make a long weekend of it', to which the response might be 'so you don't care if I am in pieces at the end of the month'. Here the employee is breaking rule 8, jumping to conclusions/mindreading instead of seeking to clarify what her boss is saying 'are you saying that the last week in the month, there could be help Monday–Thursday but Friday would be difficult?' and the tone of the latter is neutral rather than negative (rule 9,

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Table 3). Finally the communications should usually involve a compromise so that both parties feel they won (rule 11, Table 3). If one person obviously loses they are subsequently likely to take revenge in some way. The discussions should be solution focused (rule 10, Table 3) rather than blaming and involve give and take, e.g. 'I will do extra work the last week in the month, so that the accounts can be completed for the end of the month, if I get some help Monday to Thursday'.

The same communication guidelines can be used by OCD sufferers with family members/friends as they gradually try to engage in a more normal life. For example, an OCD sufferer with a fear of contamination might for the first time in a long time agree to go out for a meal with relatives but only if they agree in advance that they will not 'fuss' if the OCD sufferer just has bottled water.

8. The thought police – revision

It is as if the OCD sufferer employs a thought/image policeman with the following job description:

1. You will be responsible for law and order in the mind. Thought/image policemen are expected to operate with a belief that any misdemeanour must be severely punished, otherwise law and order will break down.
2. You must be alert for any signs of danger, investigate any signs, only stop when you are certain there is no danger.
3. If something bad happens the person employing you should be regarded as the biggest suspect no matter what they are capable of.
4. You must make it known to your employer that any misdemeanours, i.e. thoughts/images that come to mind that are the opposite of what they value or believe in, are 'hanging' offences.
5. You should keep your employer informed that if something could go wrong it most likely will go wrong and that therefore actions necessary to prevent catastrophe are to be given pride of place
6. A responsible thought/image policeman makes his employer aware that thoughts/images are indicative of what will happen in the real world so his task is to advise on the zapping of certain thoughts/images.
7. The thought/image policeman is responsible for summoning backup, the decontamination unit, when thoughts/images are disgusting or are about someone/something that is digusting.

How is your thought/image policeman operating? Which of 1–7, above is he particularly good at? How costly is it for you when you regard this thought/image policeman as credible? If you give this thought/image policeman a 15-minute coffee break does anything terrible happen? If you are unsure try it and see. What were the results? What about reducing costs

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by making him work part-time, perhaps a day on duty, then a day off, and see if you are any worse off on the days he is not on duty? What about seeing him as having no credibility and making him redundant? What about telling him to take a hike?

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Appendix M

Generalised Anxiety Disorder Survival Manual

'If I am not worrying about one thing, I am worrying about another.'
'I even worry about not worrying.'
'I also worry about worrying.'
'I imagine the worst.'

If the above sounds familiar you may have always been a worrier, but it has possibly become worse, 'uncontrollable', after some disappointments. Persisting uncontrollable worry lies at the heart of generalised anxiety disorder (GAD). More than three out of five of those undergoing cognitive behaviour therapy for GAD fully recover by the end of treatment.

Uncontrollable worry is like a fire, there are lots of different materials you can put on it to keep it going, and different people with GAD tend to put on different combinations of materials. In Figure 1, the fire of uncontrollable worry is started by a belief that worry is uncontrollable and usually also by a belief that worry is dangerous:

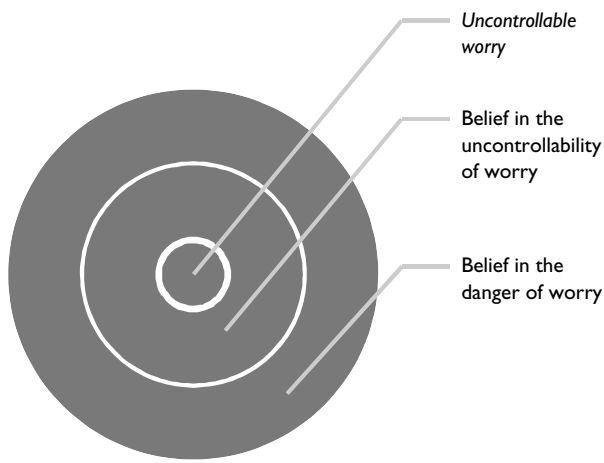

Figure 1 Starting the fire of uncontrollable worry.

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Two questions for you:

1. How much do you believe that your worrying is uncontrollable? A 0 would be not believing it at all, a 100% would be totally believing it and 50% 'so so' . . . . . .
2. How much do you believe that your worrying is dangerous? A 0 would be not believing it at all, a 100% would be totally believing it and 50% . . . . . .

Once the fire is started you can keep it going by adding 'coals' (Figure 2).

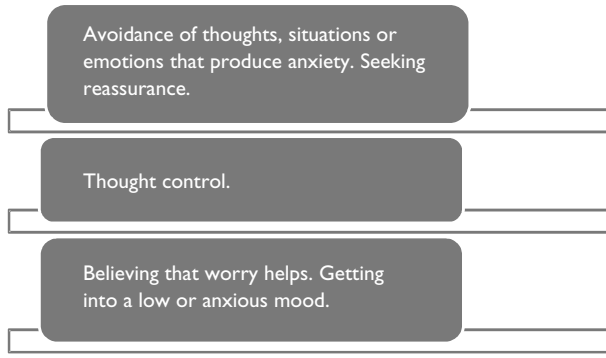

Figure 2 Keeping the fire of anxiety burning.

How do you think that you keep your anxiety going?

1. Worry is controllable

It may often feel like worry is uncontrollable but think what happens to your worrying when the phone goes; at least for the duration of the call you have let go of the worry. In the same way if you are vigorously exercising you find that you are not worrying.

Worries are a bit like a child pestering you, if you say 'go away' within minutes they are back. But if you say that you will attend to the child/worry at a particular time, there is a chance that they will leave you alone until the special time. It is a matter of putting worries in boxes to be sorted out at particular times, leaving you freer to get on with life. However, just like children, worries can have 'temper tantrums' when you tell them there is a time and a place for their concern to be addressed. The best way of handling child tantrums is a technique called planned ignoring where you refuse to make eye contact or get involved in any discussion with the child until they have calmed down. As a parent begins to implement this strategy

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the child's tantrums often get worse before they get more manageable, because the child feels they are losing control of the adult. So too as you practise planned ignoring of worries, initially they can feel even more pressing but calmly telling yourself that you will sort the content out properly at a special worry time, a 15–30 minute period at a particular time, you can gradually develop a sense that worry is controllable. Often what you were worrying about earlier has evaporated by the time your worry time comes around. For example, you may have woken in the night worrying about a particular concern and planned to note it and ignore it until your scheduled worry time at say 6.30 p.m. but by the time it comes around the issue has evaporated, it is no longer a source of concern. In this way you can learn that many worries just take care of themselves. The worry time strategy is a way of changing your beliefs about worry (what are called metacognitions) and these include the belief that worry is uncontrollable and that all worries deserve immediate attention. If a worry is still an issue at the worry time, writing about it for a couple of minutes or dictating it into a recorder, can help you come up with another way of looking at the particular concern. Using a worry time means that a continuing issue has been thought through about as far as you can take it. Outside the worry time you are not 'thinking' about the issue but 'agonising' about it, rather like 'picking at a sore'. The idea is not to 'pick at sores' but to sort them out as best you can at the worry time. For many GAD sufferers the 'inflammation' that comes from the 'picking' at the 'sore' is worse than the 'sore' itself.

2. Worry is not dangerous

Most sufferers from GAD believe that their worrying is dangerous. You might fear that your worry might mean that you will lose control or go insane. Perhaps you fear that your worrying will cause a heart attack or stroke. You can test out these beliefs in lots of different ways. One way is to take your pulse, then take your pulse again when you dare yourself to deliberately try and worry about something. You will find that you cannot even increase your pulse rate when you worry. If you fear that your worry might drive you insane, have a half hour when you dare yourself to worry as much as possible and then the next half hour just go about your business in your normal way. At the end of the hour ask yourself did you or others see any more signs of insanity in the first half hour as in the second half hour? Testing out your metacognitions (beliefs about worry) in this way is a matter of doing dares. The word 'dare', also stands for Don't Avoid a Realistic Experiment, so if you feared your worry could bring on a heart attack or a stroke, a realistic experiment might be to compare what symptoms of a heart attack/stroke you showed on a typical day with those you showed on a day when you worried as much as possible.

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3. Giving up reassurance seeking and blocking of thoughts

Worry is the 'Beast' in the adult pantomime of 'Beauty and the Beast', you may worry that you are at the mercy of the 'Beast' and it is dangerous. Others can tell you that the 'Beast' is not dangerous or you can seek reassurance that there is no danger but in the end you have to tell yourself there is no danger by changing your metacognitive belief about 'worry' to, for example, 'it's just an actor wearing a frightening mask'. The temptation is to run away from the 'Beast' but it is part of the pantomime of life and you just exhaust yourself, it's like trying to run away from your shadow.

If you try to block a thought it becomes more powerful. Try just now not to think of a 'black polar bear'; what happened . . .? You find you can't stop thinking of black polar bears!

4. Worry doesn't work

GAD sufferers often worry because they believe that this will stop bad things happening or they will be more prepared. If you believe there are advantages in worrying, the worry is likely to continue even though you know there are also disadvantages to worry such as interfering with your sleep or making you irritable. But does worrying really stop bad things happening? This week worry about not winning the National Lottery on Saturday, then on Saturday night when the winning numbers are announced, see if all your worry stopped you missing out on the jackpot.

There is a comfort in worrying in that you feel you can prevent bad things happening but it is 'magical thinking', like a child not stepping on the cracks on the pavement on the way to school so that the teacher does not tell them off. The 'magical thinking' makes the child feel in control. It may be that on one particular day the teacher does not tell the child off, perhaps because they are distracted with naughtier children, and the child might conclude not stepping on the cracks works. In a similar way, if a catastrophe does not occur the GAD sufferer might think that their worrying works.

5. Stop yourself 'making mountains out of molehills

In deciding to postpone almost all your worries to the worry time, you are working on a new metacognitive belief that 'almost all worries turn out to be molehills'. Further, even if the worry is a mountain, e.g. having a very serious illness, you are operating on another new metacognitive belief: 'why should I spend time agonising about it, better live each day as best I can and make plans in the worry time'.

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In your worry time you can put worries into perspective by assessing whether they are a molehill or a mountain. A 'molehill' is something trivial, such as it may be raining on your day's holiday, and a 'mountain' something like the death of a person you were very close to. In Figure 3 there is a 'road' from 'mountain to molehill'.

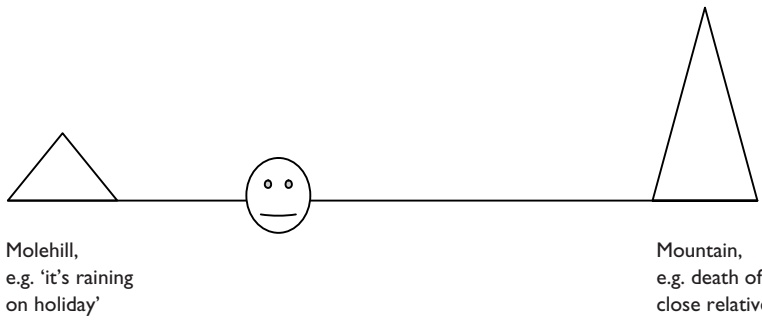

Figure 3 The road from mountain to molehill.

If, for example, you were concerned that you might not find the right present for someone, looking at Figure 3 you might think it is not a catastrophe like a death, but a bit more serious than finding it raining on holiday, and locate it nearer the molehill, with an expression of slight concern.

6. Have realistic expectations, learn from mistakes

Both the 'worry time' and the 'mountain to molehill road' are part of a new gameplan for dealing with the cut and thrust of everyday life. They sound very easy, but usually they take a lot of practice, as old habits die hard. Some days you will be much better at applying them than others but gradually you can increase how often you apply them. Nevertheless it does tend to be two steps forward and one back. It is necessary to be very patient with yourself whilst you learn these new skills; beating yourself up at each slip makes it worse. If there is a slip in the application of these strategies, do a 'slow motion action replay' of how this came about so you can learn from it. For example, it may be that one morning you had a lie-in and you started thinking of all you had to do so that by the time you got up you were in the wrong frame of mind to apply either of the above strategies. In reviewing this 'off day' you might decide to look at the 'road from mountain to molehill' each time you sit down or have a drink and have an alarm clock go off at the worry time.

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7. Accept hassles as inevitable, problem solve them as best you can

The frame of mind that you bring to bear on life's hassles has a big effect on how you handle them. If you think that because there are hassles in your life either you or others must be to blame then this distracts you from getting on and sorting out the hassle. Technically it means that you are not problem orientated or more exactly are problem disorientated, like a spinning top in a sea of problems! However you organise life there will be hassles. To sort out a hassle go through the steps show in Figure 4.

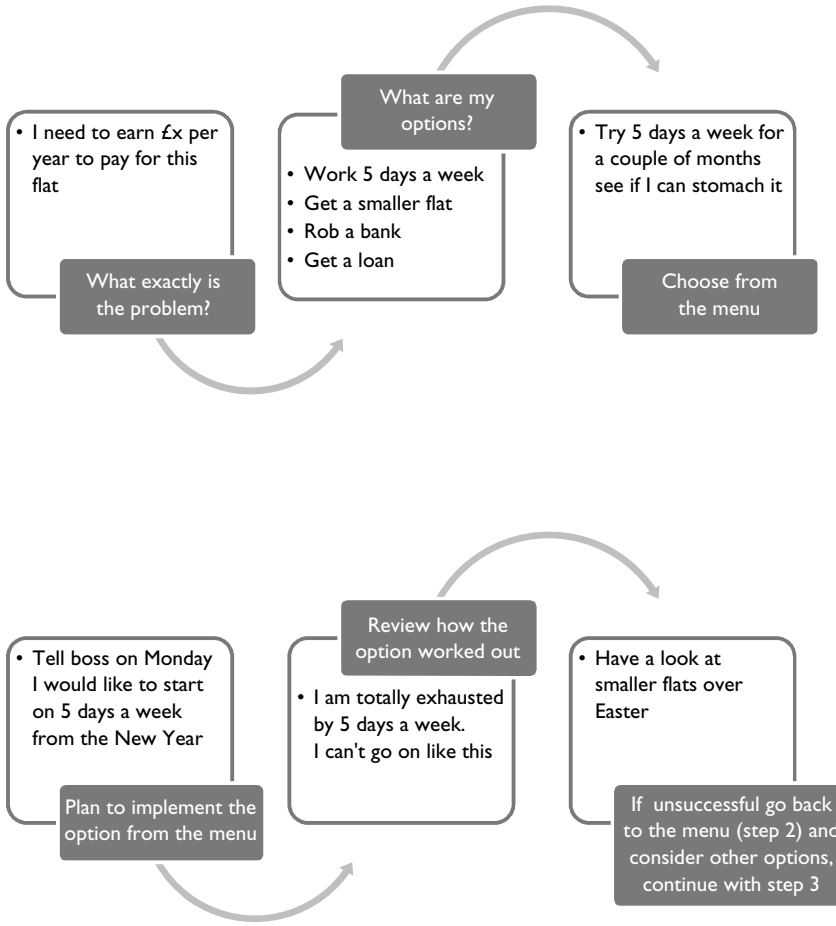

Figure 4 The steps of problem solving.

For clients with GAD the most difficult part of problem solving is not actually the steps shown in Figure 4, but the step before in which they

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suffer from problem disorientation, in which, continuing the example above, the person might spin around thinking 'I'm stupid I should know what I want to do by this stage in my life, I've moved house so many times it's ridiculous, if I hadn't given money to "y" I wouldn't be in this position but I know they needed it'. The first task is to stop spinning, then to focus on something very specific. Problem solving is like taking a photograph, the subject has to be in sharp focus for a decent picture. At the top left of Figure 4 problem solving involves very precisely defining what the problem is. Many problems are not solved because they are 'too fuzzy'; for example, 'I don't know how I am going to stay here' as opposed to 'I need to earn £x to stay in this flat'. Once the problem is tightly defined, solutions begin almost to suggest themselves.

There can be no certainty that a chosen solution will work out because you haven't got a crystal ball, but many people with GAD insist on waiting until they feel certain before taking action. As a consequence they go round in circles revisiting the same arguments and become frustrated with themselves. Tolerating some uncertainty in choosing from the menu of options is critical to moving on with the problem solving process. It is necessarily unknown whether the chosen option will work out and so it is important not to blame yourself if it does not work out. If the chosen solution does not work out return to the menu, choose and try something else until successful.

Problem solving may be sabotaged by 'a problem disorientator', called TIC, which stands for task interfering cognitions (cognitions are thoughts or images), e.g. 'You know you are not up to this, who are you trying to kid, you know you will cock it up again'. The TICs run in parallel alongside TOCs, task orientated cognitions, which are the problem solving thoughts such as: What exactly is the problem here? What are my options here? (Figure 4). The secret is to calmly keep switching from TIC to TOC, i.e. TIC/TOC. If you continue to refuse to take the TICs seriously rather like a toddler having tantrums the TICS lose their power.

8. Use a turnstile rather than have an open door

From time to time everyone feels overwhelmed, you have answered the phone, there's a knock at the front door and you are already running late. Dealing with everything at the same time is stressful. But sufferers from GAD have an almost constant sense of being overwhelmed, feeling that the demands on them exceed their resources. The stress can be reduced by making a list of all that needs to be done, then putting the items on the list in order of importance. The tasks are then placed outside a turnstile and the most important item is let through first. Do just a 'good enough' job on this task then have a break, say a cup of tea, to celebrate its completion. Then let the next task through, complete this task, have a break, then the next and

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continue in this way. Do not have an open door for tasks, doing a number at the same time. If you have an open door when you are doing one task you will be thinking you should be doing another (task interfering cognition), and at the end of the day you may feel that you have accomplished nothing with a lot of tasks half done. It may be that a real emergency (something for which there would be serious consequences if you didn't attend to it immediately) crops up and you have to put what you are doing back outside the turnstile to focus on the emergency, but this should be the exception and you would still be maintaining doing one thing at a time.

Perfectionism, an excessive sense of responsibility and automatically assuming that because you feel guilty you are guilty can all sabotage completing tasks. For most tasks others simply expect a 'good enough' not a perfect performance. It is important to distinguish between the usually very few tasks that need to be done perfectly and the many where 'good enough' will suffice. It can suit others very well to make you take on total responsibility for tasks, when in fact they and probably others are partly responsible. Sometimes the responsibility of others is indirect in that they do not give you the tools to do the job, e.g. one person left to do the work of three colleagues. As a consequence it is likely that some of the recipients of your work will be unhappy, e.g. keeping one of them waiting, and this might lead to guilt feelings on your part. But if you take all guilt feelings as evidence of personal failure then you will be very stressed. It is important therefore not to take on board responsibility for the queue of tasks but just for working your way through it systematically.

9. Make realistic predictions, don't get hooked by the worst case scenario

Sufferers from GAD expect the worst and therefore take excessive precautions, e.g. not letting their young children climb. If a situation is ambiguous, e.g. being told that their boss wants to see them, they will assume the worst, e.g. that they are going to be reprimanded. Even when it becomes apparent that what was most feared is not going to happen, it brings only momentary relief as they switch their attention to another worry. It is as if the GAD sufferer is hooked by worst case scenarios. Sometimes it is not just thinking that something bad will happen but there is an accompanying graphic image of what they fear, e.g. attending casualty with their young child.

Worst case scenarios are probably best regarded as being like fire drills at your place of work, worth doing very occasionally so that you have a gameplan for that eventuality. But such drills/scenarios are disruptive if done on a regular basis. It is therefore generally more useful to swap the horror video for a reality video, the statistically most likely sequence of events – that which you would bet money on happening.

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10. Practise tolerating uncertainty and anxiety

Earlier it was mentioned that problem solving always means trying out some solutions that you cannot be certain will work and as such there is a need to tolerate some uncertainty whilst you see how the chosen solution works out. Tolerating uncertainty is often particularly difficult for GAD sufferers because of a dislike of any anxiety symptoms (anxiety sensitivity), which are seen as a threat and perhaps also as an abnormality. The goal of GAD sufferers is often to create a mill pond and they carefully monitor whether this is being achieved; if this goal state is not reached they become alarmed. A more reasonable goal state is a river, with constant waves, and exceptionally these waves are either very high or the river is like a mill pond. Thus though it is possible to become very relaxed after exercise or a relaxation exercise (these involve tensing and relaxing each muscle group in turn), to expect such a state routinely in the day is unrealistic. Nevertheless exercise, relaxation exercise and meditation are very good ways of changing gear, and that which seemed something of a mountain (see Figure 3) beforehand is often shifted in the molehill direction. Tolerating the symptoms of anxiety can be likened to tolerating the feelings of discomfort that arise during exercise. Further, the anxiety discomfort is no more significant than the physical discomfort in exercise.

11. Don't avoid thoughts, greet each thought!

GAD sufferers often find some thoughts alarming and try to distract themselves from them, but the more you try to distract yourself from a thought the more prominent it becomes. Right now don't think of a green polar bear . . . you are probably finding that you can't help but think of them. This is called the rebound effect: the more you push away a thought or image, the more it springs back. Stay with alarming thoughts long enough to sort them out, don't just see them as very negative and run. What do you fear might happen if you stayed a little longer with your disturbing thoughts, greeting such thoughts? Just jot down what you fear:

. . . . . .

. . . . . .

. . . . . .

Common answers are 'the pain would be unbearable', 'I would just get so low/angry'. Don't avoid experiencing the intense emotion. If you let yourself experience and name the emotion there are special ways of moving on using the MOOD chart, (Table 1), but if you block the emotion it goes underground and has a way of gnawing away at you.

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To help you manage shifts in mood pass them through the MOOD chart. The first letter of MOOD, 'M', stands for monitor your mood; the second letter, 'O', stands for observe your thinking, what it sounds as if you have said to yourself; the third letter, 'O', is for objective thinking, more realistic second thoughts; and the final letter, 'D', is for deciding what to do and doing it.

Table 1 MOOD chart

Monitor mood	Observe thinking	Objective thinking	Decide what to do and do it
1. Mood dipped noticing the two children playing.	Anthea's head seems slightly smaller than her sister's. If I hadn't had a complicated delivery she wouldn't have mild learning difficulties.	I'd have given my left arm not to have had a complicated delivery, I can't blame myself. Anthea is perfectly happy.	Join in the game with my daughters.
2. Mood dipped thinking of Anthea's future.	How is she going to manage when she is older and I am not around?	I've probably got another fifty years and with the family there is always going to be someone there for her.	Must give a ring about her attending the Monday night club/disco.

In the second example on the MOOD chart Anthea's mum's first thoughts (first 'O') were of a horror video of her daughter's future, the

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second thoughts (second 'O') are a more objective reality video. It is important that the horror video is not replaced by a fantasy, e.g. 'I am sure everything will be all right', there is no advantage in positive thinking simply in describing matters as they are really likely to be. This does not mean that Anthea's mum might not have moments when she is upset by an image of her daughter much older and alone, but they are fleeting moments from which she can move on.

To help change 'observed thinking'(first thoughts) into 'objective thinking'(second thoughts) you can use the questions in Figure 5.

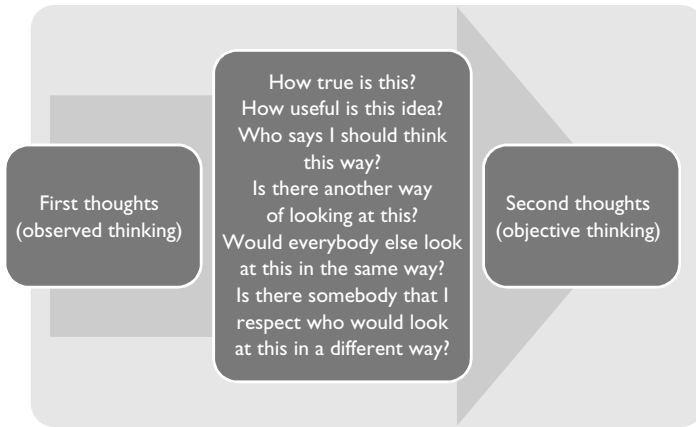

Figure 5 From first thoughts to second thoughts.

In practice you may often not have the opportunity to use the MOOD chart until your worry time.

12. Dare to live

Many GAD sufferers are committed to avoiding any risk but they are in a quandary because they are also committed to other goals such as encouraging their children to be independent. Living is impossible without taking calculated risks. Thus a parent might allow their 14-year-old and a friend to go to the local town centre but most would probably not allow a 10-year-old to do so. Just as a child's confidence is built up by the doing of gradual dares, so too adults are likely to get a sense of achievement and pleasure from calculated risk taking, Total avoidance of risk is likely to result in a sense of imprisonment. There is a need to dare to live.

Most GAD sufferers expect the worst but the actual experience is usually not as bad. If you think of a possible forthcoming challenge, e.g. meeting up with old school friends, make a note of how bad you think it will be on a

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scale 0–10, where a 10 is absolutely awful and 0 is wonderful. Then if you dare to meet up with them, score what the actual experience was like on the same scale 0–10. In anticipation you are probably quite anxious, your score might well be a 7/10 but usually the actual experience is better, say 4/10. If you keep scoring expectations and experiences you will probably find there is a gap, the situations are much worse in imagination than in the real world. Once you know that you have an expectation experience gap, you can stand back from yourself and almost laugh at yourself when you are getting very anxious.

Picking at worries has become a habit for GAD sufferers, with often a long chain of 'what ifs . . .?', e.g. 'what if I can't find the right present . . . what if he/she doesn't think I could be bothered . . . what if I am late getting to the shops . . . what if I can't find anywhere to park . . . what if what I want is too expensive?' The GAD sufferer may not stop long enough to answer one 'what if?' before rushing on to the next and experiences a sense of their mind racing away. The chain can be cut short by answering each 'what if?' as it arises; if there is no obvious answer then it can be postponed to be addressed systematically in the worry half hour. Don't 'pick' at your worries.

13. Better managing sleep and irritability

Sleep difficulties and irritability are two of the symptoms of GAD. Lack of sleep can cause increased irritability in almost anyone. Getting off to sleep can be a particular difficulty for GAD sufferers, who often complain that at this time their mind races from one worry to another. The sleep difficulties are increased further if you become irritated that you are not yet asleep; perhaps you begin thinking 'if I don't get to sleep soon I'll be exhausted tomorrow'. The more irritated you become, the more difficulty you have in catching sleep. Often sufferers try and cope by going to bed steadily later, some to such an extent that they end up sleeping more in the day than at night.

Sleep difficulties can be tackled by having a fixed routine involving going to bed at the same time whether tired or not. If worries intrude they can be dealt with using the worry time strategy (Section 1), but if you are not asleep within 20–30 minutes calmly get up, focusing attention elsewhere, for example by reading or having a warm milky drink, and only go back to bed when you are really tired. Again if not asleep within 30 minutes calmly get up and switch attention. In this way the bed stops becoming associated with a battle zone in which you fight to get to sleep. Sleep tends to happen when you are not trying.

Many GAD sufferers find that they are 'snappy' and this can lead to strained relationships. Close relationships can be eased by asking others to read this self-help manual to 'put them in the picture' and by practising a

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traffic light routine for anger. Imagine a set of traffic lights on red as soon as you notice the first signs of irritability. Then when the lights go to amber ask yourself is what has just happened really the end of the world? Did they really do it deliberately to wind me up? Then when the lights go to green go into another room to calm down. To begin with, many people go through the lights on red and it may take a few weeks of practice to learn to obey them. It may be that if you trust your partner or family member enough you can ask them to remind you to use the traffic lights when you are getting irate.

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Appendix N

The Personal Significance Scale (PSS)

Name: Date:

Please read the following statements carefully and circle the number that best corresponds to the extent to which you agree with each statement regarding your intrusive thoughts and images.

Specific thoughts, images: _____

_____

_____

Please use the following scale:

0 Not at all	1	2	3	4 Somewhat	5	6	7	8 Totally/ Definitely

1. Are these thoughts really personally significant for you?	0 1 2 3 4 5 6 7 8
2. Do these thoughts reveal something important about you?	0 1 2 3 4 5 6 7 8
3. Are these thoughts a sign that you are original?	0 1 2 3 4 5 6 7 8
4. Do these thoughts mean that you might lose control and do something awful?	0 1 2 3 4 5 6 7 8
5. Do these thoughts mean that you are an imaginative person?	0 1 2 3 4 5 6 7 8
6. Do these thoughts mean that you might go crazy someday?	0 1 2 3 4 5 6 7 8

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7. Is it important for you to keep these thoughts secret from most or all the people you know?	0 1 2 3 4 5 6 7 8
8. Do these thoughts mean that you are a sensitive person?	0 1 2 3 4 5 6 7 8
9. Do these thoughts mean that you are a dangerous person?	0 1 2 3 4 5 6 7 8
10. Do these thoughts mean that you are untrustworthy?	0 1 2 3 4 5 6 7 8
11. Would other people condemn you if they knew about your thoughts?	0 1 2 3 4 5 6 7 8
12. Do these thoughts mean that you are really a hypocrite?	0 1 2 3 4 5 6 7 8
13. Do these thoughts mean that you have an artistic talent?	0 1 2 3 4 5 6 7 8
14. Would other people think you are crazy or mentally unstable if they knew about your thoughts?	0 1 2 3 4 5 6 7 8
15. Do these thoughts mean that one day you may actually carry out some actions related to the thoughts?	0 1 2 3 4 5 6 7 8
16. Do these thoughts mean that you enjoy the company of other people?	0 1 2 3 4 5 6 7 8
17. Do these thoughts mean that you are a bad, wicked person?	0 1 2 3 4 5 6 7 8
18. Do you feel responsible for these thoughts?	0 1 2 3 4 5 6 7 8
19. Is it important for you cancel out or block the thoughts?	0 1 2 3 4 5 6 7 8
20. Would other people think you are a bad, wicked person if they knew your thoughts?	0 1 2 3 4 5 6 7 8
21. Do you think that you should avoid certain people or places because of these thoughts?	0 1 2 3 4 5 6 7 8

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22. Do these thoughts mean that you are weird?	0 1 2 3 4 5 6 7 8
23. Should you fight against and resist these thoughts?	0 1 2 3 4 5 6 7 8

24. Do these thoughts have any other significance for you? Details:

25. What caused your thoughts to occur when they started?

26. Why do these thoughts keep coming back?

Scoring of PSS

Items 3, 5, 8, 13 and 16 are buffer items and are not included in the scoring of the PSS. Thus for scoring purposes there are 18 items on the instrument and scores can therefore range from 0 to 144. However, Whittal *et al.* (2010) also excluded the first item 'Are these thoughts really personally significant for you?' from their study so that the scale they used comprised 17 items, with scores ranging from 0 to 136. Whittal *et al.* have explained (personal communication) that the focus of their study was clients with pure obsessions and as such clients would necessarily endorse this symptom, consequently it was excluded. In the Whittal *et al.* (2010) study, the mean pre-treatment PSS score was 86.0 (standard deviation 24.0) and the post-treatment mean 46.0.

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