Fear makes come true that which one is afraid of... Viktor E. Frankl

Anxiety Disorders, Phobias, Obsessional and Phobias

TA understanding and interventions

There is as far as I know nothing written in the TA literature specifically about treating or understanding anxiety, phobic, or OCD disorders and beyond the rather simplistic articles on personally adaptations there is also very little if anything on dealing with Obsessional and Compulsive disorders. Yet these are very commonly presented problems by clients seeking help in the therapy room and are often themes in supervision, training, and coaching settings.

Despite being a terrible joke, it is always enjoyed in therapy and training groups: – Everyone knows it really should be “CDO” and not “OCD”.

TA understanding – All the core concepts of TA can be used to understand and analyse clients with these disorders, which can be understood as “healthy” defensive responses which have become exaggerated and dysfunctional.

TA and the CTA exam – in writing the CTA psychotherapy examination the candidate must provide a diagnosis of the client using a commonly used system outside of TA, and the clearest tool for that is the DSM 5. The DSM5 gives a very clear description of different manifestations of the various ways in which excessive anxiety is displayed.

So first a look at the DSM 5 –

DSM5 - Anxiety Disorders: “Excessive fear, anxiety and related behavioural disturbances.”

Fear is the emotional response to a real or perceived imminent threat whereas anxiety is anticipation of future threat.

These two states overlap, but they also differ, with fear more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviours, and anxiety more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviours.

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The level of fear or anxiety is reduced by pervasive avoidance behaviours:

- Panic attacks feature prominently within the anxiety disorders as a particular type of fear response.
- The anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behaviour, and the associated cognitive ideation.
- Anxiety disorders differ from developmentally normative fear or anxiety by being excessive or persisting beyond developmentally appropriate periods.
- They differ from transient fear or anxiety, often stress-induced, by being persistent, typically lasting 6 months or more.
- Since individuals with anxiety disorders typically overestimate the danger in situations they fear or avoid, the primary determination of whether the fear or anxiety is excessive or out of proportion is made by the clinician, taking cultural contextual factors into account.
- Many of the anxiety disorders develop in childhood and tend to persist if not treated.
- Most occur more frequently in females than in males (approximately 2:1 ratio).
- Anxiety disorders differ from developmentally normative fear or anxiety by being excessive or persisting beyond developmentally appropriate periods.
- Each anxiety disorder is diagnosed only when the symptoms are not attributable to the physiological effects of a substance/medication or to another medical condition or are not better explained by another mental disorder.

Specific disorders as described in the DSM 5

Separation anxiety disorder - fearful or anxious about separation from attachment figures to a degree that is developmentally inappropriate. There is persistent fear or anxiety about harm coming to attachment figures and events that could lead to loss of or separation from attachment figures and reluctance to go away from attachment figures, as well as nightmares and physical symptoms of distress. Although the symptoms often develop in childhood, they can be expressed throughout adulthood as well.

Selective mutism is characterized by a consistent failure to speak in social situations in which there is an expectation to speak (e.g., school) even though the individual speaks in other situations. The failure to speak has significant consequences on achievement in academic or occupational settings or otherwise interferes with normal social communication.

Individuals with specific phobia are fearful or anxious about or avoidant of circumscribed objects or situations. A specific cognitive ideation is not featured in this disorder, as it is in other anxiety disorders. The fear, anxiety, or avoidance is almost always immediately induced by the phobic situation, to a degree that is persistent and out of proportion to the actual risk

posed. There are various types of specific phobias: animal; natural environment; blood-injection-injury; situational; and other situations.

In social anxiety disorder (social phobia), the individual is fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinized. These include social interactions such as meeting unfamiliar people, situations in which the individual may be observed eating or drinking, and situations in which the individual performs in front of others. The cognitive ideation is of being negatively evaluated by others, by being embarrassed, humiliated, or rejected, or offending others.

In panic disorder the individual experiences recurrent unexpected panic attacks and is persistently concerned or worried about having more panic attacks or changes his or her behaviour in maladaptive ways because of the panic attacks (e.g., avoidance of exercise or of unfamiliar locations). Panic attacks are abrupt surges of intense fear or intense discomfort that reach a peak within minutes, accompanied by physical and/or cognitive symptoms. Panic attack may be used as a descriptive specifier for any anxiety disorder as well as other mental disorders.

People often describe having panic attacks when describing intense fear – however in order to be diagnosed as a panic attack amongst the episode must comply with:

- *Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur; Note: The abrupt surge can occur from a calm state or an anxious state.*

  1. Palpitations, pounding heart, or accelerated heart rate.

  2. Sweating.

  3. Trembling or shaking.

  4. Sensations of shortness of breath or smothering.

  5. Feelings of choking.

  6. Chest pain or discomfort.

  7. Nausea or abdominal distress.

  8. Feeling dizzy, unsteady, light-headed, or faint.

  9. Chills or heat sensations.

  10. Paraesthesia (numbness or tingling sensations).

11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).

12. Fear of losing control or "going crazy."

13. Fear of dying

Individuals with agoraphobia are fearful and anxious about two or more of the following situations: using public transportation; being in open spaces; being in enclosed places; standing in line or being in a crowd; or being outside of the home alone in other situations. The individual fears these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms. These situations almost always induce fear or anxiety and are often avoided and require the presence of a companion.

The key features of generalized anxiety disorder are persistent and excessive anxiety and worry about various domains, including work and school performance, that the individual finds difficult to control. In addition, the individual experiences physical symptoms, including restlessness or feeling keyed up or on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; and sleep disturbance.

Substance/medication-induced anxiety disorder involves anxiety due to substance intoxication or withdrawal or to a medication treatment.

In anxiety disorder due to another medical condition, anxiety symptoms are the physiological consequence of another medical condition.

Medical Intervention: The NICE guidelines = followed by medical practitioners in the UK follow the medical model, prescribing medication (anti-depressives) and also 12 sessions of CBT, as a psycho-education.

TA Model understanding and psychotherapeutic approaches to anxiety disorders: As stated earlier, all the core concepts of TA can be used to understand and analyse these disorders, which are understood as "healthy" defensive responses which have become exaggerated and so become dysfunctional.

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TA's core beliefs are central to the TA approach to understanding and treating the anxiety disorders.

- "Everyone is OK"
- "Everyone is responsible for their feelings, behaviours, and actions"
- "Everyone can change"

These core beliefs lead to working contractually using open communication, and therefore many of the models of TA can be used by the client to make meaning of their experiences leading to "decontamination" of the Adult and in longer term work to deconfusion of the Child and Parent ego states.

The emotions – Enable Meaning to be made and provide energy for life as described in the Disney Film Inside Out:

- **Anger –** providing energy to change situations.
- **Fear –** there is danger, energy to flee or fight.
- **Joy –** energy to celebrate life and relationships.
- **Disgust –** revulsion and energy to avoid the risk
- **Sadness –** expressing loss.

Emotions rather than being feared or got rid of are to be welcomed along with their message which needs to be interpreted, understood, and acted upon.

One explanation of anxiety states are that the client is falsely interpreting their "normal and healthy" emotional response to their experience and is making meanings regarding their experiences which while familiar are actually based on script and protocol decisions, supported by discounting, and consequently leading to overwhelming misunderstood emotions and repetitive dysfunctional actions and thinking.

Many clients who present in this way can be described as having panic / phobias / intense obsessive-compulsive disorders. They often need "emergency first aid strategies" in order to function in their daily lives and therefore prior to engaging in the therapeutic exploration, however while these strategies may appear to be seductively simple the therapist needs to keep in mind that if the solutions were simple then it is likely the client would already be using them prior to coming for therapy.

One question to ask in the initial assessment is:

- If you were not experiencing the panic / phobia / OCD / anxiety what might you be feeling. thinking and doing?

This question can open many areas for consideration and itself may prove to be extremely helpful to the client, however it is also important to make a "risk assessment". Is the client's presentation covering over suicidal / violent ideations or the fear of going "crazy"? If so, then it is imperative to ensure the client's safety. In TA terms this is often described as the client closing her / his escape hatches: Making an Adult decision to stay alive and safe, without resorting to violence or acting in a crazy way.

Working Contractually: The contract is mutually agreed between the client and the therapist. Initially the client may not have a clear idea of their desired outcome from therapy. Clients often express the desire to be "less anxious", "more in control", "feel happier". Therefore, the initial contract is to explore the client's experience of themselves and their relationships in the world and to make meanings of their experience. Once the client understands their experience they can then decide how and what changes they wish to make. TA Models to understand Anxiety, phobia, OCD are those used to understand any client's presentation:

1) **Script System Analysis** – specifically regarding the client's presentation of anxiety / phobic responses / OCD:

    a. What script / counter script messages, including modelling from significant caretakers were experienced by the client during childhood.
    b. What script / counterscript decisions did they make. decisions did they make?
    c. **Protocol**: What script decisions were made preverbally?
    d. What is the client's stroking patterns and **attachment style** and how is their presentation an expression of their attachment style?
    e. During infancy / childhood what meanings became associated with feelings and how ere they managed**?**
    f. Where in the body does the client experience emotion?
    g. **Trauma:** What specific traumatic childhood events occurred which may be one off or a repetitive experience – such as neglect, or violence in the family and how did the child make meaning and experience themselves and others during these traumatic experiences.
    h. Traumatic events, especially when experienced as life threatening after childhood can also be incredibly significant and may change the client's experience of themselves or others and their place in the world. (the world may change from being safe to being dangerous)

i. Life and death and insanity, what decisions did the infant / child / teenager / adult make about life, death and insanity and how are they manages in the client's script?
j. How is the client's presentation an expression of the script?
k. What is the primary "personality adaptation" – and how is this reflected in their presentation?
l. What redecisions need to be made and is there a congruence between what the client "needs" and wants to change?

m. Racket Analysis:
   i. When the client is experiencing XYZ what are they believing about themselves, others, and life?
   ii. When they are running those belief's what are their feelings / fantasies and behaviours?
   iii. What feelings and thoughts are being excluded / suppressed?
   iv. What in life has reinforced the client's expression of beliefs and ways of behaving and experiencing life.
   v. What emotions, thoughts, behaviours were allowed, encouraged and stroked during infancy and childhood?
   vi. How is the client maintain their supply of these familiar strokes in their lives now?

n. Transgenerational scripting – What was the familial history in relation to the client presentation.

2) Ego States analysis and impasse analysis:

a. What is the content of the Parent and Child ego states in regard to the client's presentation? For example – is the excessive fear based in the Parent or Child?
b. What is the second order ego state analysis of the client's process?
c. How are the client's inner conflicts expressed as: first, second, and third-degree impasses?
d. How are the client's intrapsychic conflicts acted out in their daily lives and relationships?

3) Discounting:

a. How is the client maximising and minimising aspects of themselves, life and others?
b. Is the client seeing their options and the possibility of solving their problems in healthy ways?

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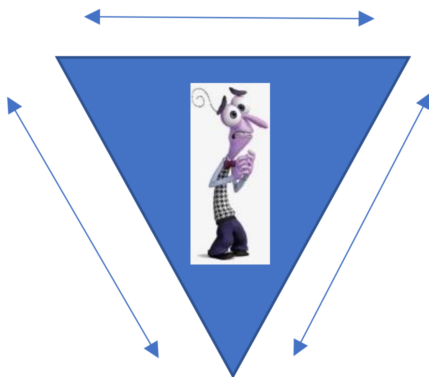

The drama triangle – games:

(Roles = Persecutor, Rescuer, Victim.)

- What games is the client playing and what is their role in the game?
- What are the advantages and disadvantages of the games?
- What happens if the client steps out of the game?
- How do the games maintain the client's presenting problems?

Treatment Strategies:

The therapeutic endeavour:

The initial goal of therapeutic intervention is for the client to find strategies enabling the client to return or to continue with their personal and professional lives.

- Theoretically I think of this first stage of therapy as exploring and resolving 1st degree impasse(s), which is described as "decontamination work" - strengthening the Adult ego state boundaries to make decisions appropriate to the here and now.
- To differentiate between here and now issues and archaic interference with living in the present moment.
- Berne described this phase as gaining social control and symptom relief.

The second phase of the therapeutic work is to deal with the underlying issues and the focus moves from specific daily events with the goal of making lasting changes.

- Theoretically this is understood as exploring and resolving embodied 2nd and 3rd degree impasses.
- Berne described this as psychoanalytic / script cure.
- This phase of psychotherapy is focussed on deconfusion of the Child ego state and constructing a healthy Parent ego state.

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Specific Questions / techniques related to working with Anxiety disorders:

1) If you were not obsessing / panicking / being phobic / being anxious:
    - **a.** what would you be: feeling / doing / thinking about?
    - **b.** What would others be doing differently?
    - **c.** What would change in your life / other people lives?
2) If your panic / obsession / phobia etc had a voice –
    - **a.** What would it say to you?
    - **b.** What would it say to others – including me as the therapist?
3) If your panic / obsessions / phobia was in charge of your life:
    - **a.** What outcome would it be wanting for you in your life?
    - **b.** What outcome would it want for others?
4) What colour / shape / weight / soft / hard qualities has your panic etc.
    - **a.** What happens if you paint it / change its shape etc?

The above interventions can be made in several ways:

1) Simply by asking the client.
2) By using the imagination to put the panic etc onto a cushion and running a “Parent interview with it”
3) By using an object / toy / animal / drawing etc to represent the panic.
4) In groups have another member of the group act out the role of the panic etc.

Dealing with panic and anxiety directly:

Breathing exercise – Diaphragm breathing: This technique specifically teaches clients to breathe with their diaphragm. When breathing with in this way it is impossible to panic at the same time.

A. Place your finger on your belly button and breathe in deeply
B. As you breathe in your belly needs to push your finger up.
C. Once you are breathing with your diaphragm then: breathe in and hold your breath for a count of 2, and then breathe out holding and then hold your breath for a count of 2.

Relaxation – using a Naturalistic Trance Induction. Used for an easy introduction to trance / relaxation, can be used for any trance work, including visualisations, general relaxation and to preparing to sleep. Note that technically a trance is any “altered state of awareness”, including running fantasies and using imaginative exercises.

Clients are taught this technique, initially with the therapist talking them through the experience and once understood / learned the client uses it for themselves.

All the surroundings are utilised in creating the relaxation, sights, sounds, and feelings, Sensations, smells, tastes. Use the client's own breathing to pace with them, inviting the client to be relaxing as they breathe out.

Make each individual statement as the client breathes out, gradually slowing, deepening, and softening your own voice with each statement. Use an altered pattern of speech, not your normal voice as your voice will become an anchor for future relaxation / trance induction. Additionally, (copying Milton Erikson) I often move forward slightly with each statement or move my hand or even just my fingers gently and slightly down with each statement and as the client breathes out.

l. Invite the client to sit in a relaxed posture and then:

2) Make 5 non-threatening and obvious statements regarding the client’s experience:

- You are sitting, hearing the sounds around us,
- You are listening to my voice,
- You can feel the chair,
- you are breathing.

3. Then on their next breath out suggest they are relaxing, in a surprising / enjoyable way.

4. Repeat this process using 4 observations, then 3, 2, l, and at that point the client will be in a deep relaxed / altered state.

You can alter this process, inviting the client to count down with their fingers as you talk. This can then be used to create a self-induced relaxed state; this is particularly useful for clients wanting to fall asleep. They can give themselves the suggestion that they will fall into a deep and relaxing sleep, waking only at the appropriate times after the final observation and suggestion to relax.

Dissociative techniques – Dissociative techniques used to distance the clients from overwhelming feelings or for specific traumatic experiences they can be used to work through the feelings and panic / phobic responses associated to known past events. Some of these techniques are based on magic and use the “child” imagination we all have – and some are NLP techniques, which integrate well with TA.

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Bob and Mary Goulding encouraged their client's who were scaring themselves with scary fantasies to replace the scary fantasy with a sexual fantasy: In my experience when clients first hear this suggestion they always laugh – but can then enjoy their new freedom to have enjoyable fantasies. You cannot run a sexual fantasy and panic at the same time!

The Helicopter… In the specific traumatising story

1) Tell the story of the trauma as recalled, with as many details as possible. Include sounds sights, smells, and feelings. 2) Start the story in a safe place, (e.g. asleep in bed) and end the story well after the traumatic event, again when in a safe secure place.

Finding the helicopter:

1) Tell the story again; associated into the story… be in the story, e.g. "I am driving along when I see a dog run in front of me…"

2) At the moment when the scare starts notice yourself entering a helicopter, (magic carpet / space rocket / riding on an angel's back… etc)

3) Leave the scene and fly up high… "so high that you are no longer afraid, the event is unfolding below you… you can see you driving along etc." Ensure safe feelings and security…

4) Fly along in time so all the events unfold in the distance below…

5) Keep going until you are once again in your safe place, at which point you can see that you are safe.

6) Let the helicopter fly down again and re-enter the safe scene in the safe place feel the good feelings associated with the safe place.

Repeat his process at least 3 or 4 times: On each telling of the story speed up the flying part of the process so that it is finally running very quickly, like a video on fast forward.

To get back to the start of the story run the tape backwards again at high speed.

Once the client has worked through this process ensure they are associated in the here and now in the room and then ask how they are currently feeling… noticing and stroking changes and the good feelings them are experiencing. e the good safe feelings….

Finally recall the event and ask for their reflections now – the goal is for them to be dissociated from the trauma and be experiencing the reality that they are now safe.

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Additional things you can do is to invite changes in "sub-modalities" … as if a director of a movie… add / change sounds / music / colours.. make it a black and white movie… you can even put others into the scene if you wish… see at the movies below…

At the Movies - Also See wounded kid therapy TAJ July 1988

1. See yourself in black and white on a movie screen, involved in a neutral behaviour.

2. Now float out away from the screen as far as you wish, maybe even going back into the projectionist's room, or watching a movie of yourself watching the movie.

3. When ready watch yourself going through the event, which you have decided to deal with, go through the event until the event is over, and all on the movie all is well again.

4. Now everything is OK again stop the movie, freeze frame it, step back into the movie, turn it into a colour one with sound and very quickly run it backwards.

5. Now test by recalling the event, have the feelings been dissociated from the event. The memory will remain… however the person will now be dissociated rather than associated into their experiences.

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