# Contents

CHAPTER ONE

# What Makes Therapy Work?

Research has shown that therapy works. But specifically, how does therapy help people change? Some claim that change depends on the treatment model we use. Yet, differences in outcome between treatment models are modest (Benish, Imel, and Wampold 2008; Gerger, Munder, and Barth 2014; Tran and Gregor 2016). Unique methods do not create uniquely better results. Since outcomes are similar, what factors common to most models make therapy effective? Meta-analyses have shown that effective common factors across therapy models include the following:

- A good relationship
- Consensus between patient and therapist on a specific therapeutic task
- Agreement between patient and therapist on a positive goal the patient wants to achieve
- A persuasive reason to do the task to achieve that goal (Wampold and Imel 2015)

According to Norcross and Lambert (2018), the quality of the therapy relationship accounts for client improvement as much as, and probably more than, the specific ingredients of a particular treatment method. Thus, all therapists need relational skills that create an effective alliance to ensure a good outcome (Norcross and Lambert 2018, 8). Those skills include the following:

- Regulating the patient's anxiety so it is safe to declare a problem
- Helping the patient declare a problem
- Helping the patient declare his will to work on his problem
- Helping the patient declare a positive goal to work toward
- Getting consensus on the therapeutic task to achieve the patient's positive goal

All the while, the therapist must support the patient's wish for change while empathizing with his fear of it. Then they can work toward his goal.

Before we can begin therapy in any model, anxiety must be regulated so the patient feels safe. Then there must be a problem for which he wants help. Then we need to find out if he wants to work on that problem. These steps create the preconditions for a therapeutic alliance. Without a problem that he wants to work on to achieve a positive goal, there would be no reason to do therapy.

In a common factors theory (Bailey and Ogles 2019), certain principles of change are present in most effective therapies. These principles can be described and applied flexibly, and they are associated with good outcomes. Each of the skills in this manual follows these basic principles that apply to all effective models of therapy:

- If anxiety is not regulated, the patient cannot feel safe enough to work with you.
- If a patient cannot declare a problem, there is no reason to do therapy.
- If it is not the patient's will to do therapy, we have no right to ask him to do what he does not want to do.
- If there is no positive goal to work toward, therapy can achieve nothing worthwhile from the patient's perspective.
- Without a consensus on how to work on the problem, we cannot work together.

I offer here a metatheory to use for building a therapeutic alliance before you propose your particular model of treatment. These metatheoretical principles for alliance building require common foundational skills. Perhaps the most fundamental principle is that we reinforce change and not the behaviors that prevent it. All therapies reinforce one thing and not another (Lundh 2014). Thus, we must be clear about which patient and therapist behaviors promote change and which do not.

For example, in any effective therapy, patients must face their fears to master them (Lambert 2013). Here, we show how to help patients face the fears that would otherwise prevent them from forming a therapeutic alliance. Perhaps the patient is afraid to declare a problem, his wish to work on it, or a positive goal. We must address all those fears first so that the patient can form a therapeutic alliance.

The goal here is not to follow rules slavishly. That leads to poor outcomes (Vacoch and Strupp 2000). Instead, if we understand the basic principles of relationship building and the skills associated with them, we can apply those principles and skills flexibly to develop a healing relationship.

*For an overview of the relational principles that guide all therapies, see HTRBook.com/IntroAV*.

## WHAT PATIENTS NEED: A GOOD RELATIONSHIP WITH YOU

Ample research shows that the key to a better outcome in therapy is the healing relationship you co-create with your patient, not the treatment model you use (Norcross and Wampold 2019). This makes sense since if "relational damage is the core of trauma, . . . the relationship is the core of healing trauma" (Norcross and Wampold 2019, 4). In other words, what was harmed in a relationship we must heal in this relationship.

Models differ very little regarding patient outcomes (Benish, Imel, and Wampold 2008; Gerger, Munder, and Barth 2014; Tran and Gregor 2016). But therapists differ a lot within each model (Wampold and Imel 2015). For example, patients with the best therapists change ten times faster

than the average patient. But patients with the worst therapists get worse (Okiishi et al. 2003). This is not an isolated study (see Baldwin and Imel 2013; Wampold and Brown 2006; Minami et al. 2012; Wampold and Imel 2015).

If your model does not guarantee your effectiveness, what does? Your relational skills as a therapist. And what differentiates the best therapists from the rest? They engage in deliberate practice of relational skills (Chow et al. 2015).

But don't all of us have relational skills? Of course! Everyone knows how to relate to people. That's how children survive: they learn to connect to the people they depend on for their survival. So, the question then becomes, what relational skills did we acquire, and what results do they create?

Securely attached therapists get better alliances and outcomes with more highly impaired and distressed patients (Schauenberg et al. 2010; Strauss and Petrowski 2017). When invited to form a therapeutic alliance, these highly impaired patients present with anxiety and avoidant responses. More securely attached therapists become less anxious and defensive when this occurs, with fewer negative countertransference reactions. To help you be less anxious and defensive with patients, we will examine why patients become anxious and hesitant when starting therapy.

## The Universal Relational Problem Patients Present

Every therapy begins with the offer of a healing relationship. We offer a secure attachment (Bowlby 1969) where the patient can safely reveal himself. First, we ask about the problem for which he wants our help. Then we look into his difficulties, their origin, and their history. But what if that is impossible? Some patients may flood with anxiety before they arrive at your office. They might assume you are another abuser and equate you with a perpetrator in their past. We want to co-create a conscious alliance. But the patients' fears created a misalliance. What happened?

He seeks a healing relationship, but past relationships prepared him for pain (Bowlby 1973, 1980). If depending on a parent for help was dangerous, he learned to hide his need so his parent could love him (Bowlby 1969, 1973; Hartmann 1965). We conceal our needs through thought distortions, maladaptive behaviors, defenses, or "security operations" (A. Beck 1967; Freud 1923; Sullivan 1947, 1953). The patient reduced his parents' anxiety to restore security in their insecure relationship by hiding his needs. Unfortunately, if he hid his needs with them, he might hide them with you too.

These responses of anxiety and avoidance strategies in therapy are not wrong. Instead, every response precisely expresses the patient's need at this moment so that we learn where he needs our help. Our task is to discover why his reaction is perfect. If depending makes him anxious, we can regulate his anxiety, so he can feel safe depending on a therapist.

He wants help. But his anxiety signals that seeking help can lead to pain. Thus, he may avoid asking for help by not telling you the problem he wants your help with. When he does not declare

a problem, he is not resisting you. Instead, he is collaborating with you *according to the rules of insecure attachments*. He learned that he should hide his need to keep a relationship (Bowlby 1973, 1980; Evans 1996; Sullivan 1953). He fears you cannot love him if he doesn't cover up what cannot be loved: his need for help (Post and Semrad 1965). That's why he avoids declaring a problem, revealing his separate will to get better, or setting a positive goal.

## Moving from an Insecure Attachment to a Secure Attachment

Since every therapy model involves a relationship, therapists need to understand what happens when we form one.

With every patient, we find the same pattern:

1. The therapist invites the patient to depend on the therapist.
2. Depending triggers anxiety in the patient, a sign that depending was dangerous.
3. Anxiety mobilizes avoidance strategies that show the therapist how the patient learned to handle that danger in the past to keep a relationship.

When we invite a patient to share a problem, he often hesitates. He isn't afraid to put a problem into words; he is afraid to depend on you. His body speaks to us through its secret, silent, wordless language: anxiety. Anxiety tells us the patient's history: depending was dangerous. His treatment-interfering behaviors—his avoidance strategies—tell us how he dealt with that danger. For instance, he might avoid sharing a problem, change the topic, or become vague. Thus, anxiety and treatment-interfering behaviors are how the past speaks to the present through bodily reactions (anxiety) and automatic avoidance strategies.

Patients who grew up in insecure attachments had to adapt to insecure connections. When caretakers hurt, abandoned, abused, or neglected them, they learned that relationships lead to pain, not help. So, they act accordingly. These automatic relational behaviors of anxiety and hiding their needs were adaptive in their original traumatic relationships. In fact, those behaviors may have saved their lives in the past. But today, these same avoidance behaviors create their problems.

A therapist might mistakenly think that anxiety or avoidance behaviors are obstacles. They aren't. They are the pathway to healing. Anxiety and avoidance strategies show you where the patient needs your help in this moment. *By revealing his insecure attachment behaviors, the patient is already collaborating perfectly in therapy*. Therefore, we must focus on the therapist's relational behaviors.

This book will show you how to regulate anxiety so it is safe for patients to depend upon you. You will learn skills so you can help patients with avoidance patterns they don't see. And you will learn how to invite, promote, and strengthen behaviors that will lead to a healing therapeutic alliance.

## MYTHS ABOUT THE THERAPEUTIC RELATIONSHIP

There are many myths about the skills we need to be good therapists. And those myths can prevent us from improving as therapists. Let's examine some of the most common myths about therapy skills.

*Myth*: A teacher once told me, "All you need is to log enough hours."
*Reality*: Time doesn't create a good relationship. Two people relating well create a good relationship. It's not the amount of time. Patients can be in therapy for decades but never form a therapeutic alliance. How can this be? For instance, if the patient takes a passive position, therapy reinforces passivity instead of actively working toward a goal. Or if the patient blames others for his problems, he will get better at blaming, not at changing. The more we practice, the better we get. If we practice bad relating, we get better at that. Thus, always ask yourself, "What are we doing with our time in this session?"

*Myth*: "All you need is good social skills and to be a warm person."
*Reality*: I was afraid of my first placement in graduate school because I had never worked as a therapist before. When I brought up my concerns to my teacher, she replied, "If your social skills have taken you this far, they'll take you through this." But my social skills didn't tell me how to respond when a schizophrenic patient hallucinated a devil in my office. If social skills were enough, the patient's family and friends would already have healed him. And if social skills were sufficient, all therapists would have excellent outcomes. But we don't. The top 20 percent of therapists are consistently more effective *than the other 80 percent combined* (Miller and Hubble 2011). It's not general social skills but specific therapeutic skills that account for that difference (Norcross and Wampold 2019).

*Myth*: "The patient didn't want to do therapy."
*Reality*: Every patient's response shows how *she is already doing therapy*. It's just that the patient might not do therapy the way *you* want. It's not her job to do therapy your way. It's the patient's job to show us how she relates with everyone. But when the patient responds in a way we don't like, we may think she is doing therapy wrong. In fact, she is doing therapy right. She always shows us the precise problems she needs help with. She reveals her implicit relational learning (Lyons-Ruth 1996), how she learned to relate in earlier relationships. For instance, suppose we ask the patient what she wants to work on, and she doesn't tell us. We can get frustrated and mistakenly think that the patient doesn't want to do therapy with us. Instead, she shows us how she learned not to depend on people. *That's* her problem.

We often get frustrated because we are waiting for the patient we want to work with rather than working with the patient we have. When we say that the patient resists therapy, we may

be failing to accept the patient the way she is and the responses she asks us to help her with. Completely accept the patient as she is, problems and all.

*Myth*: "All the patient needs is empathy."
*Reality*: Does a chef need only salt and pepper? Relating, like cooking, is far more complex. Consider empathy. Empathy for what? Suppose a depressed patient wants to divorce her abusive husband. If you empathize only with her anger toward her husband, she may become excessively anxious. If you empathize only with her wish to divorce, she may focus on her husband's good qualities. If you empathize only with her anxiety, she may remain stuck. Patients need complex empathy with *all* aspects of their conflict, not just simple empathy with one part of it. For instance, the patient might need empathy with her wish to divorce, her fear of doing so, and her ways of avoiding that wish. Only then will she feel more fully heard and understood.

*Myth*: "This patient is not motivated to do therapy."
*Reality*: Patients always have multiple motivations. Our job? Figure out what those motivations are. People who are not in conflict don't come to therapy. Every day, seven billion people successfully stay out of therapists' offices. Patients come to you precisely because they are in conflict: they want to change and fear change. They hope you will help them and fear you will hurt them. Thus, patients' motivations often conflict with one another. If the therapist does not see both sides of the patient's conflict, she might claim the patient does not want to do therapy. But that's not true. The therapist sees only the patient's treatment interfering behavior. She does not see the patient's simultaneous desire for and fear of help.

Patients almost always want to do therapy. The problem is that they have a conflict about asking for help. "If I reveal my problems to you, will you judge, hurt, or abandon me?" Patients want a new relationship but fear an old one. They are motivated to do therapy but not to have another bad relationship. Since they may not know how to create a relationship for positive change, they need your help.

Patients do not resist therapy. Nor do they resist you. *Instead, they resist the bad relationship they fear they will have with you*. Therefore, it makes no sense to encourage the patient to have a relationship with you if she fears it will bring pain. That's why we need to sort out the expectations that therapy stirs up. Once the patient relates to you instead of an image of someone else, she can then stop hiding and reveal her desires.

*Myth*: "If I follow this model of therapy, my patient will get better."
*Reality*: No therapy model has been proven to be more effective than any other (Norcross and Wampold 2019; Wampold and Imel 2015). Further, ritualistic following of manuals

leads to a worse outcome (Vacoch and Strupp 2000). The best therapists within each model have excellent relational skills that lead to good therapeutic alliances (Tracey et al. 2014). Thus, the quality of the relationship is the most important factor that the therapist can contribute to the effectiveness of therapy.

If you follow a model and forget to build the alliance, you will lose the patient. Models don't heal patients. Relationships do. Since the relational skills of co-creating a therapeutic alliance are so important, this book will not teach rules to follow but principles to apply flexibly.

*Myth*: "I asked him what his problem was, and he didn't have one. So, this intervention didn't help."
*Reality*: Sometimes, therapists imagine that you'll get the answer you are looking for if you ask a question once. That is magic. A patient is not a soda machine where you push a button, and a bottle of soda pops out. In therapy, when we ask a question, we may get a wide variety of responses that may not appear to answer the question you asked. Why?

When you inquire about the patient's problem, you invite the patient to depend on you. But if depending led to pain, a patient may become anxious and deny that he has a problem. He will do what he was told to do as a child: "Stop bothering me," "Why are you complaining?" or "Shut up." *Not depending on you is how he tries to collaborate with you!*

In an insecure attachment, he learned to collaborate with caretakers by not depending. This behavior occurs automatically and habitually. He does not do it on purpose. Nor does he do it consciously. However, as an adult, this form of relating makes him lonely, anxious, and depressed.

What his caretakers considered collaboration, you might mistakenly call resistance. But he may never have had a relationship where another form of relationship was possible. That's why co-creating a healing relationship takes persistence and patience.

What do we mean by patience? Accept him as he is with his conflicts, problems, and relational patterns. Then you can form a healing relationship. If you reject the patient you have, he will have to drop out to find a therapist who can accept him and his problematic behaviors. To work effectively, we must accept reality: the patient as he is with the conflicts he has.

## Relating, Not Just Intervening

These skill-building exercises will teach you many techniques. A technique usually refers to a procedure applied to an object to achieve a specific result. But in therapy, techniques refer to the ways we connect with patients who fear connecting. We do not *do* a technique to a patient. Rather, psychotherapy interventions are *how we relate, how we work together*. Do not try out a technique; offer a relationship. We intervene to build a healing therapeutic alliance. Let's develop those relational skills!

CHAPTER TWO

# How to Use These Exercises to Become More Skillful

To develop skills, we must engage in deliberate practice. What happens if we don't? Standard psychotherapy training causes no change in trainees' outcomes with patients (Nyman, Nafzinger, and Smith 2011). Ninety-three percent of psychotherapy supervision is inadequate, and 35 percent is harmful (Ellis et al. 2014)! As a result, 70 percent of therapists after graduation say that they lack the skills to motivate patients to work hard in therapy and don't know how to use specific techniques for specific patients (Orlinsky and Ronnestad 2005). And in that study, how many of these highly educated and experienced clinicians felt a sense of mastery? Fewer than 47 percent.

Other fields also find that students acquire theoretical knowledge but not practical skills. Many studies show that medical school training results in substandard clinical skill acquisition among physicians (Joorabchi and Devries 1996; Lypson et al. 2004; McGaghie and Kristopaitis 2015; Cohen et al. 2013; Wilcox et al. 2014; Bell et al. 2009). Clinical experience during training does not guarantee clinical competence (Kyser et al. 2014; Ericsson 2014).

Age, gender, experience, and degree do not correlate with patient outcome in psychotherapy (Chow et al. 2015). Only one therapist factor correlates with patient outcome: the time spent practicing specific clinical skills (Chow et al. 2015). However, psychotherapy training often focuses primarily on learning theory, not gaining clinical skills. To address this problem, medical schools have developed simulation-based learning models for residents. Practicing specific skills led to dramatic improvements in skill mastery that traditional teaching settings did not achieve (McGaghie et al. 2014).

This book uses a simulation-based learning model to develop your mastery of specific clinical skills. We use the expert performance model (McGaghie and Kristopaitis 2015) to define the key skills of experts. Having studied videotapes of expert psychotherapists, we discerned their specific relational skills. Then we developed exercises to build those skills.

For each exercise, you will learn a piece of theory, and then you will learn a specific skill based on that theory. After that, you will practice each skill until you have mastered it. Each new skill builds on previous skills. And you will learn the skills in the order in which you usually use

them when developing a therapeutic alliance. This way, over time, you will master clinical skills of increasing complexity and difficulty.

Practicing specific, structured skill-building exercises gives you objective feedback on your progress. As you progress through the book, you will learn over forty skills that experts use when establishing a working alliance. By working through the exercises, you will learn which of your skills are strong and which you can improve, and by practicing, you will master those relational skills one at a time. The more you practice, the greater your mastery and the deeper your understanding will be.

Mastery-based learning has improved clinical skills in cardiac life support (Wayne et al. 2006), paracentesis (Barsuk et al. 2012), and central venous catheter insertion (Barsuk et al. 2009). However, it has never been used for the development of psychiatric skills. A pilot study (Frederickson et al. 2019) with drug counselors at an inpatient drug rehabilitation program found that targeted skill-building exercises for therapists reduced dropout rates from 40 percent to 23 percent in ten weeks. Six-month sobriety after treatment for the control group was 17 percent but 48.8 percent for the experimental group. These studies suggest that skill-building for therapists can improve patient outcomes.

Further, by practicing these skills, you will experience yourself, your patient, and the therapeutic role in new ways. When linked with your previous explicit knowledge, this implicit knowledge will make you a more skilled and flexible therapist, which will lead to improved outcomes (Vacoch and Strupp 2000). It is not enough to know theory; you must know how to put it into practice.

Why practice? To become more skillful and effective. Whether we are a musician, ballet dancer, or psychotherapist, we have the chance to practice basic skills until they are automatic. Yet, once mastered, we can apply our skills flexibly for good outcomes (Truijens et al. 2019). And as any musician can tell you, this persistent hard work is not easy. But the evidence is clear: people who practice specific skills constantly become more skilled (Ericsson 2014). Psychotherapy is no exception.

Deliberately practicing specific relational skills differs from the usual way we study. Usually, we can read a book, remember it, and write answers on a test. That's cognitive mastery. But to put theory into practice, we must be able to assess the patient's problem and intervene right away, not next week. The patient needs help now. And it takes practice to develop these quick assessment and intervention skills. You can't learn to play the guitar by only reading a book. You must pick up the guitar and practice playing it—a lot. Likewise, you can't learn to heal patients only by reading. You must practice skills to become skillful.

## HOW TO IMPROVE AS A THERAPIST: GUIDELINES FOR USING THESE SKILL-BUILDING EXERCISES

"How do you get to Carnegie Hall?" "Practice, practice, practice!" To become skilled like musicians, chess masters, and ballerinas, we can practice skills just like they do. We start with basic

skills and practice them repeatedly until we master them. If our basic skills are weak, we will have a weak foundation. Even skilled musicians, martial artists, and professional athletes practice basic skills as part of their daily warm-up.

Thus, this book starts with fundamental skills and leads gradually to more complex ones, each building on the other. Through stages, each chapter takes you through skills in the order in which you will need them in therapy:

1. Regulating anxiety so therapy is a safe place to explore
2. Helping the patient declare a problem to work on
3. Helping the patient declare his will to work on the problem
4. Deactivating misperceptions of the therapist or therapy
5. Building motivation to work toward a positive goal
6. Getting consensus on the therapeutic task

Don't jump around. Start with the beginning exercises and work your way through the book. Then your skills and understanding will develop in a stepwise, integrated fashion.

Since these skills involve cognitive and relational learning, we offer two forms of practice—both of which are necessary for optimal learning: (1) audio practice by yourself in a recording with me (Jon Frederickson) and (2) role-play practice with another person. The audio practice method will help you master the skills cognitively. The role-playing studies will help you learn relationally when you play both the therapist and the patient roles. Playing the therapist role with a colleague or fellow student will strengthen your ability to maintain a consistent therapeutic focus with your patients. Playing the patient role will strengthen your ability to identify with her experience of therapy.

## Audio Practicing While Alone

For audio practicing, you will read the initial material about the skill in this book. Then click on the audio link for the skill. As the recording plays, you will listen to me, Jon Frederickson. First, I will describe the relational skill we will work on together, and I will teach you the principle behind it. Then I will offer a sample answer so you will know how to intervene. Next, you and I will begin the skill-building exercise: I will play the patient, and you will play the therapist. On the first exercise, you will ask, "What is the problem you would like me to help you with?" Then I will offer a patient response, and you will intervene. After your intervention, I will provide the suggested therapist response. Then we will go to the following example, repeating the same pattern with you asking for the problem. That's it.

As you repeat each exercise, you will understand the relational pattern the patient offers, and you will get better at inviting a secure relationship. After you have gone through an exercise once, do it again. No basketball player ever learned how to shoot baskets after a single shot or even ten

shots. Repetition helps you improve until you reach 100 percent accuracy. Then you won't have to think so hard about what you are going to say before you say it. And you can be more present with your patient. When interventions occur to you easily, you can relate to the patient more flexibly and thoughtfully.

Repeating these skills also helps you experience the patient's relational struggle. They allow you to feel yourself relating to the patient, consciously inviting a therapeutic alliance. With every skill, you invite him to have a therapeutic alliance with you where depending, having problems, and needing help are normal, usual, and human.

Practice each skill repeatedly until you master it (Ericsson 2008). Then you can assess quickly how to intervene in therapy without losing focus while searching in your head for responses you can't remember. And you will be more effective the next time that problem comes up in therapy. Your work will automatically improve. Each skill you master builds the foundation for more complex skills. If your initial relational skills are shaky, the later phases of alliance-building will be too. So, master these skills one at a time to build a firm foundation for your growing expertise.

You can practice these audio skill-building exercises anytime you want, for example, while riding your bike or driving your car. We all have downtime we aren't using. That's an ideal time to practice your skill-building without adding any burden to your day. Many students have made their commutes more enjoyable by practicing their skills while on the freeway.

## Role-Play Practice with Another Person

You can also practice these skills through role-playing with a fellow student or colleague. The person who plays the patient role will read the patient scripts in this book. The person who plays the therapist role will not look at the script but will try to intervene using the skills learned from the book. If the therapist has trouble, the patient will read the suggested answer from the book, and then the two of you can repeat that exercise. Since you, as the therapist, do not have the script, you have to figure out how to respond—like you would have to with a patient. When you are in the therapist role, do not read the script during the exercise. Why? You will get better at reading, not intervening. These skill-building exercises help you relate without a script, just like you have to during therapy. If you find a particular skill difficult, read it together once with your colleague who plays the patient. Then have your colleague read the patient script while you respond as the therapist without the script. Practice that exercise several times until you have mastered it.

First, the person in the patient role reads the script to you, the therapist, and gives you the instructions. Then the person in the patient role tells you, the therapist, how to start. For example, if you are playing the therapist, you might ask, "What is the problem you would like me to help you with?" The person in the patient role then responds, and you intervene. If you make a mistake, your partner can read the suggested answer to give you immediate feedback. And then you can go on to ask the next question.

*See how to do these skill-building exercises with a partner at HTRBook.com/IntroBV.*

After the first time through, the two of you should do the same exercise a few more times *without any additional talking or commentary*. Try to recreate the situation you will face in therapy by maintaining a consistent therapeutic focus without stopping until you and the patient have achieved the next step in building the alliance. If the two of you start to chat, you won't get the in vivo exposure you need: working on a problem consistently until the patient can move to the next step. Chatting during skill-building helps you learn to chat, not to build your skills. So, keep focused on the task: doing skill-building exercises without stopping.

The person who plays the patient role should act like that patient, using facial gestures and vocal tones. Then you, as the therapist, will receive more in vivo exposure as you learn how to keep intervening effectively without stopping. Continue until you reach the end of the exercise. If you have trouble, the person in the patient role can offer the suggested answer (that's in italics) to help you understand the principle of the exercise. Then, after the first time through, do the exercise again without stopping. For mastery, you must be able to address patient responses as quickly as they occur in therapy.

Repetition is the key to achieving mastery in all arts and crafts. Once you can do these exercises automatically without thinking, your mind will be free to think about other aspects of the patient and the relationship. And repetition will also teach you to persist patiently when the patient has trouble.

No matter what kind of therapy we do, we must accomplish certain tasks to form a working relationship. The patient must declare a problem to work on, and her anxiety needs to be regulated to do the work. The patient must want to do therapy and relate to you realistically. Otherwise, she will have a misalliance with a misperception. When the patient has a positive goal that makes therapy worthwhile, it will motivate her to do therapy. The following skills are based on transtheoretical principles of therapy. You can incorporate these skills into any treatment model. Practice, practice, practice! Don't stop until you have mastered each exercise 100 percent. Now we'll go to the skills.

CHAPTER THREE

# Co-Creating Safety to Make It Safe to Depend

When we invite a patient to tell us her problem so we can help her, we invite her to depend upon us. But what if in her past depending brought pain instead of relief? What if it was not safe for her to depend on her loved ones? Then the dangers of the past cast a shadow on the therapy. The patient may know you are safe, but her bodily anxiety may make her feel unsafe. If so, we need to identify and regulate her anxiety first so she can feel safe with you. Only then will she be able to depend on you and do the work of therapy.

**Principle for High Anxiety:**

*Identify and regulate anxiety to co-create a sense of safety in a secure attachment.*

## WHEN DECLARING A PROBLEM TRIGGERS TOO MUCH ANXIETY

To develop a therapeutic alliance, we ask about the problem for which the patient seeks our help. Sometimes patients can tell us right away. However, some patients immediately become anxious, even before they have declared a problem. Why? When you invite a person to declare a problem, you invite him to depend upon you. Yet, for many patients, depending in the past led to harm rather than help. As a result, declaring a problem may trigger too much anxiety for the therapy to feel safe. Thus, sometimes we must regulate anxiety first to make the patient feel safe enough to reveal a problem. The first exercises show how to form a therapeutic alliance with patients whose anxiety becomes too high. By regulating anxiety together, we can co-create a sense of safety. Then the work of therapy becomes possible.

*See a demonstration of how to help patients regulate their anxiety at HTRBook.com/xxx.*

## STAGE ONE: REGULATING ANXIETY

The following exercise will help you assess the patient's anxiety.

### Skill-Building Exercise One: Assessing How Anxiety Appears in the Body

**Principle:** *When you ask for a problem to work on, assess anxiety to ensure it is not too high.*

Anxiety is not a thought in your mind; it's an experience in your body. We *feel* anxious. When our brain perceives a risk, the somatic and autonomic nervous systems activate our bodies to respond. They create the bodily symptoms of anxiety (Robertson et al. 2004).

When anxiety is regulated, it is triggered by the somatic nervous system, creating symptoms such as clenched hands, tension headaches, tension in the back and neck, and sighing (Abbass 2015; Davanloo 2002–2004; Frederickson 2013, 2021; Porges 2011; Robertson et al. 2004). The somatic nervous system makes our voluntary muscles tense up. Anytime we do something new or unfamiliar, we become anxious. Naturally, patients will be anxious in therapy when they face what they usually avoid. As a result, our goal is not the absence of anxiety but rather anxiety that is regulated while the patient explores difficult issues. That means anxiety in the somatic nervous system.

However, when anxiety is too high, the parasympathetic nervous system triggers anxiety symptoms such as migraine headaches, stomachaches, nausea, diarrhea, and the need to go to the bathroom. And when it is even more severe, patients suffer from symptoms such as dizziness, loss of memory, problems thinking, blurry vision, and ringing in the ears (Abbass 2015; Frederickson 2013; Porges 2011; Robertson et al. 2004). The parasympathetic nervous system activates smooth muscles in our digestive tract and blood vessels, creating many of these severe anxiety symptoms.

When anxiety is in the somatic nervous system, it is low. Therefore, you can explore the patient's problems freely. However, it is too high when anxiety is in the parasympathetic nervous system. The patient will not feel safe enough to form a therapeutic alliance. Thus, we need to regulate the patient's anxiety.

Many anxious patients cannot regulate their anxiety. After all, their caretakers often *caused* the patient's anxiety; they didn't regulate it. If patients grew up with people who ignored their anxiety, they often ignore it too. They are not used to someone trying to regulate their anxiety; they are used to people making them anxious. That's why your offer to pay attention to and regulate anxiety will seem strange to many patients.

To learn how to regulate the patient's anxiety, we need to assess whether her anxiety is too high. Anxiety in the somatic nervous system does not need to be regulated. Those symptoms include the following:

- Tension
- Clenching hands
- Sighing

Anxiety in the parasympathetic nervous system needs to be regulated. Those symptoms include the following:

- Migraine headaches
- Stomachaches
- Nausea
- Diarrhea
- The need to go to the bathroom
- Cognitive/perceptual disruption
- Dizziness
- Loss of memory
- Problems thinking
- Blurry vision
- Ringing in the ears

*Watch an exercise on how to determine the patient's level of anxiety at HTRBook.com/xxx.*
*Practice assessing where anxiety is discharged in the body at HTRBook.com/xxx.*

As the patient in this role-play exercise, read the following to your partner who is in the therapist role. "You will ask me what the problem is I would like help with. I will play the patient and offer an anxiety response. You, as the therapist, will assess whether the anxiety is going into the somatic nervous system, not needing regulation, or parasympathetic nervous system, needing regulation. Then you will ask your question again, I'll offer another anxiety symptom, and you'll assess it. And we'll keep doing that for a series of responses. Go ahead and ask, 'What is the problem you would like me to help you with?'"

| Patient Response | Partner's Assessment of the Response |
|---|---|
| Sigh. | Somatic nervous system, regulated |
| "I am getting sick to my stomach." | Parasympathetic nervous system, needs regulation |
| "I need to go to the bathroom." | Parasympathetic nervous system, needs regulation |
| Sigh. | Somatic nervous system, regulated |
| "I feel tense in my neck." | Somatic nervous system, regulated |
| "I'm getting a slight migraine headache." | Parasympathetic nervous system, needs regulation |
| "I'm feeling dizzy." | Parasympathetic nervous system, needs regulation |
| "I'm feeling a little nauseous." | Parasympathetic nervous system, needs regulation |
| Sigh. | Somatic nervous system, regulated |
| "My vision is getting blurry." | Parasympathetic nervous system, needs regulation |
| "I feel tension in my stomach." | Somatic nervous system, regulated |
| "What did you say?" | Parasympathetic nervous system, needs regulation |
| "Is there something wrong with this chair? My back is so tense!" | Somatic nervous system, regulated |
| "I need to go to the bathroom." | Parasympathetic nervous system, needs regulation |
| "My ears are ringing." | Parasympathetic nervous system, needs regulation |
| "I'm getting a tension headache." | Somatic nervous system, regulated |

Now let's continue the role-play exercise. The person in the patient role should read the following to the person in the therapist role. When you ask for the problem and the patient is already too anxious, regulate the patient's anxiety before asking about the problem again. The patient's body has already told you his first problem: his anxiety is too high and needs to be regulated. These symptoms will tell you whether you need to regulate anxiety. Let's do this exercise again. When you have done it three times, we'll change roles so I can master this exercise too. Repetition

can seem boring. But if we practice this several times, we will be calmer and more effective when assessing our patients' anxiety in the session."

**Questions to ask each other to strengthen your skills:** Now that you know specific physical signs of when anxiety is too high, how does this change your understanding of anxiety and how to regulate it? Now that you understand that anxiety is not a thought in the head but a physical experience in the body, how does this change your previous understanding of anxiety? And now that you understand that asking for help can trigger high anxiety, how does this change your understanding of what it means for the patient to depend on you?

## Skill-Building Exercise Two: Identifying and Regulating Anxiety

When patients are too anxious, we need to develop an anxiety-regulating relationship so that therapy becomes a safe place. To form a secure attachment, the patient must feel safe *with you*. For anxious patients, we do that by regulating anxiety.

We start by finding out where the patient feels anxious in the body. Then we know whether it is safe to explore the problem or whether we need to regulate anxiety first.

*Watch a demonstration of how to assess anxiety at HTRBook.com/xxx.*

We can regulate their anxiety by identifying an anxiety symptom as a sign of anxiety. Then we can describe the process: "When I asked about your problem, you became anxious, and the anxiety made you dizzy. Do you see that sequence too?" Therapy feels safer when we can show the patient why her anxiety makes sense. Now the patient learns that the therapist is not a threat, as people were in her past. What makes her anxious now is her wish to depend on another person. Describing the sequence that caused her anxiety symptoms brings her anxiety down until she sighs, tenses up, or intellectualizes again. Once anxiety is in this tolerable range, we can explore the problem.

Although these signs of anxiety may be new to you, if you ask patients about these symptoms, you will learn that a surprising number of patients try to do therapy when they are too anxious to do it. Many patients in outpatient clinics, hospitals, or drug rehabilitation facilities suffer from excessive anxiety. If you identify and regulate their anxiety, they can finally benefit from therapy. And you will have shown them that therapy can be a safe place.

Help the patient see the sequence of causality: (1) declaring a problem, (2) triggers anxiety, and (3) results in an anxiety symptom.

When she sees this sequence, her symptoms make sense, and she will calm down. If she does not see that declaring a problem makes her anxious, she could mistakenly think you cause her anxiety, and then she might drop out of therapy. However, if you can help her see that declaring a problem and asking for help makes her anxious, she will understand. Then you will have begun to form a relationship for change.

*Watch a demonstration of how to help patients recognize the cause of their anxiety at HTRBook.com/xxx.*

*Practice a skill-building exercise on helping the patient understand what causes his anxiety at HTRBook.com/xxx.*

As the patient in this role-play exercise, read the following to your partner who is in the therapist role: "In this skill-building exercise, you will help me as the patient understand what causes my anxiety. Each time you will ask, 'What is the problem you would like me to help you with?'" Here's how the role-play will unfold.

*Pt:* I am feeling anxious.

*Th:* Where do you notice feeling this anxiety in your body?

*Pt:* I feel shaky.

*Th:* This shakiness is a sign of anxiety. I asked about your problem. Something about my asking about your problem triggered this anxiety, and the anxiety makes your body shaky. Do you notice that sequence too?

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**Principle:** *Identify anxiety and describe causality (asking about a problem triggers anxiety symptoms) to regulate anxiety.*

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As the patient in this role-play exercise, read the following to your partner who is in the therapist role: "You will ask me, 'What is the problem you would like me to help you with?' I will respond with anxiety. Ask me where I feel the anxiety in my body. When I answer, identify my symptom as anxiety and then regulate my anxiety by showing me that declaring a problem triggered my anxiety. Go ahead and ask me, 'What is the problem you would like me to help you with?'"

## Role-Play One

*Pt:* I feel anxious.

*Th:* Where do you notice feeling anxiety in your body?

*Pt:* I am getting sick to my stomach. [*"This is a sign of anxiety. I asked about the problem you would like me to help you with. Describing a problem makes you anxious. And the anxiety makes you sick to your stomach. Do you see what I mean?"*]

## Role-Play Two

*Th:* What is the problem you would like me to help you with?

*Pt:* I feel anxious.

*Th:* Where do you notice feeling anxiety in your body?

*Pt:* [*Sighs*.] I feel tense in my stomach. [*"That's a sign of anxiety. So, what is the problem you would like me to help you with?" When anxiety is in the somatic nervous system, we can keep exploring. You do not need to regulate anxiety when it is in the somatic nervous system*.]

## Role-Play Three

*Th:* What is the problem you would like me to help you with?

*Pt:* I feel anxious.

*Th:* Where do you notice feeling anxiety in your body?

*Pt:* I need to go to the bathroom. [*"This is a sign of anxiety. I asked about the problem you would like me to help you with. Describing a problem makes you anxious. And the anxiety makes you need to go to the bathroom. Do you see what I mean?"*]

## Role-Play Four

*Th:* What is the problem you would like me to help you with?

*Pt:* I feel anxious.

*Th:* Where do you notice feeling anxiety in your body?

*Pt:* I'm getting a slight migraine headache. [*"This is a sign of anxiety. I asked about the problem you would like me to help you with. Describing a problem makes you anxious. And the anxiety gives you a migraine headache. Do you see what I mean?"*]

## Role-Play Five

*Th:* What is the problem you would like me to help you with?

*Pt:* I feel anxious.

*Th:* Where do you notice feeling anxiety in your body?

*Pt:* [*Sighs*] I'm getting a tension headache. [*"That's often a sign of anxiety. So, what is the problem you would like me to help you with?" When anxiety is in the somatic nervous system, it does not need to be regulated. We can keep exploring*.]

## Role-Play Six

*Th:* What is the problem you would like me to help you with?

*Pt:* I feel anxious.

*Th:* Where do you notice feeling anxiety in your body?

*Pt:* I'm feeling dizzy. [*"This is a sign of anxiety. I asked about the problem you would like me to help you with. Describing a problem makes you anxious. And the anxiety makes you dizzy. Do you see what I mean?"*]

### Role-Play Seven

*Th:* What is the problem you would like me to help you with?

*Pt:* I'm feeling a little nauseous. [*"This is a sign of anxiety. I asked about the problem you would like me to help you with. Describing a problem makes you anxious. And the anxiety makes you nauseous. Do you see what I mean?"*]

### Role-Play Eight

*Th:* What is the problem you would like me to help you with?

*Pt:* I feel anxious.

*Th:* Where do you notice feeling anxiety in your body?

*Pt:* My vision is getting blurry. [*"This is a sign of anxiety. I asked about the problem you would like me to help you with. Describing a problem makes you anxious. And the anxiety makes your vision blurry. Do you see what I mean?"*]

### Role-Play Nine

*Th:* What is the problem you would like me to help you with?

*Pt:* I have an upset stomach. [*"This can be a sign of anxiety. I asked about the problem you would like me to help you with. Describing a problem makes you anxious. And the anxiety makes you have an upset stomach. Do you see what I mean?"*]

### Role-Play Ten

*Th:* What is the problem you would like me to help you with?

*Pt:* I feel anxious.

*Th:* Where do you notice feeling anxiety in your body?

*Pt:* My ears are ringing. [*"This is a sign of anxiety. I asked about the problem you would like me to help you with. Describing a problem makes you anxious, and the anxiety makes your ears ring. Do you see what I mean?"*]

The sooner the patient can recognize an anxiety symptom, the sooner she can regulate it. Now therapy becomes a safe place with an anxiety-regulating therapist. Then together, the therapist and patient can look at the problem that triggered the patient's anxiety. Regulating anxiety helps co-create a sense of safety.

Now let's continue the role-play exercise. The person in the patient role should read the following to the person in the therapist role. "Let's do the exercise again. Whenever you intervene,

I, as the patient, will go immediately to the next patient statement. Let's make this exercise feel like a real session. We won't stop for chitchat. We'll go straight through so you get the experience of processing and intervening more quickly. We'll repeat it several times. After you master this exercise, we'll shift roles so I can master it too."

**Questions to ask each other to strengthen your skills:** How are these exercises changing how you assess whether anxiety is too high? What do you understand now that you did not understand before you did these anxiety exercises? What do you understand now about the relationship between having anxiety and depending on a therapist for help? Are you the danger, or has depending been dangerous for her? How does that change your understanding of the patient's plight? How do you experience your partner as an anxiety regulator? What suggestions could you offer your partner about the quality of the caring relationship being offered? How could your partner be more anxiety-regulating as a therapist?

*See how validating anxiety affects the patient at HTRBook.com/xxx.*

## Skill-Building Exercise Three: Regulating Anxiety by Paying Attention to an Anxiety Symptom

**Principle:** *Invite the patient to pay attention to an anxiety symptom to regulate anxiety.*

Now we will look at another way to regulate anxiety: directing the patient's attention to an anxiety symptom. Patients who grew up in an insecure attachment regulated their caretakers by hiding and ignoring their anxiety. Thus, to form a secure attachment, we teach patients to pay attention to the anxiety they usually ignore. Traumatic relationships cause anxiety; healing relationships regulate it.

*Practice a skill-building exercise on regulating anxiety at HTRBook.com/xxx.*

For this role-play exercise, read the following to your partner who is in the therapist role. "In this example, you will ask me about the problem I would like you to help me with. Again, I will respond with anxiety. First, identify my anxiety and then invite me to pay attention to an anxiety symptom. For example, when I respond with anxiety in the form of nausea, you could say: 'This is a sign of anxiety. Shall we see if we can regulate your anxiety? As you pay attention to that symptom in your stomach, what do you notice feeling in your stomach?'

"Now start the role-play exercise. Ask me, 'What is the problem you would like me to help you with?' Go ahead."

*Pt:* I am getting sick to my stomach. [*"This is a sign of anxiety. Shall we see if we can regulate your anxiety? As you pay attention to that symptom in your stomach, what do you notice feeling in your stomach?" Paying attention to an anxiety symptom often reduces and regulates the anxiety.*]

*Pt:* [*Sighs*.] I feel tense in my stomach. [*"Something about declaring a problem gets you anxious and tense. If we look under the tension, what is the problem you would like me to help you with?" When anxiety is in the somatic nervous system, it does not need to be regulated. You can explore safely*.]

*Pt:* I need to go to the bathroom. [*"This can be a sign of anxiety. Shall we see if we can regulate your anxiety? As you pay attention to that symptom in your stomach, what do you notice feeling in your stomach?"*]

*Pt:* I'm getting a slight migraine headache. [*"This can be a sign of anxiety. Shall we see if we can regulate your anxiety? As you pay attention to that symptom in your head, what do you notice feeling there?"*]

*Pt:* [*Sighs*.] I'm getting a tension headache. [*"Something about sharing a problem gets you tensed up. If we look underneath the tension, what is the problem you would like me to help you with?" When anxiety is in the somatic nervous system, keep exploring. There is no need to regulate anxiety*.]

*Pt:* I'm feeling dizzy. [*"This is a sign of anxiety. Shall we see if we can regulate your anxiety? As you pay attention to that symptom in your head, what do you notice feeling there?"*]

*Pt:* I'm feeling a little nauseous. [*"This is a sign of anxiety. Shall we see if we can regulate your anxiety? As you pay attention to that symptom in your stomach, what do you notice feeling in your stomach?"*]

*Pt:* My vision is getting blurry. [*"This is a sign of anxiety. Shall we see if we can regulate your anxiety? As you pay attention to that symptom of blurry vision, what else do you notice feeling in your body?"*]

*Pt:* My ears are ringing. [*"This is a sign of anxiety. Shall we see if we can regulate your anxiety? As you pay attention to that symptom of ringing ears, what else do you notice feeling physically in your body?"*]

Now let's continue the role-play exercise. The person in the patient role should read the following to the person in the therapist role. "Let's do the exercise again. Whenever you intervene, I, as the patient, will go immediately to the next patient statement. Let's make this exercise feel like a real session. We won't stop for chitchat. We'll go straight through so you get the experience of processing and intervening more quickly. We'll repeat it several times. After you master this exercise, we'll shift roles so I can master it too."

**Questions to ask each other to strengthen your skills:** What did you learn by being in the patient role? How does practicing this anxiety regulation skill for several minutes change your understanding of being an anxiety-regulating therapist? How is focusing on the patient's body changing how you used to focus on the patient's anxiety? What are you learning from each other about the role of your tone of voice in anxiety regulation? What suggestions could you offer your partner to

be more anxiety regulating? How do you experience the quality of the relationship your partner offers the patient? What suggestions could you offer your partner about the quality of the caring relationship being offered? How could your partner be more anxiety-regulating as a therapist?

## Skill-Building Exercise Four: Helping Patients Pay Attention to Rather Than Ignore Anxiety So They Can Regulate It

**Principle:** *Point out an anxiety symptom, then block the strategy of ignoring it by inviting the patient to pay attention to anxiety.*

Regulating anxiety works for most patients. But when it doesn't, an avoidance strategy usually perpetuates the anxiety. When this happens, we can help the patient see and let go of strategies that perpetuate her anxiety. Then we can help her regulate it.

One strategy that prevents anxiety regulation is ignoring anxiety. In traumatic insecure attachments, caretakers ignore, dismiss, and neglect the child's anxiety. So, the child does too. But then, as an adult, the patient can't regulate her anxiety. As a result, her anxiety remains too high, and she can't think properly. She can't remember what you say. She can't concentrate. For instance, you ask, "What's the problem you would like me to help you with?"

*Pt:* I've got some issues. [*Patient's leg is shaking.*]

*Th:* I notice your leg is shaking. That can be a sign of anxiety. Are you aware of feeling anxious right now?

*Pt:* I'm always anxious. It's no big deal.

*Th:* Could we take a look at your anxiety so we could help you bring it down? [*Block the dismissal of her anxiety ("It's no big deal.") by inviting the patient to form a healing relationship where we regulate anxiety together.*]

When patients ignore their anxiety, block this strategy and invite them to pay attention to their anxiety to regulate it. We can co-create a safe place in therapy only if we pay attention to anxiety together and regulate it. This is how we co-create a healing relationship.

*Practice a role-play exercise on helping patients identify their anxiety at HTRBook.com/xxx.*

As the patient in this role-play exercise, read the following to your partner who is in the therapist role. "In the following role-play, you will ask, 'What is the problem you would like me to help you with?' Each time, as your patient, I will respond with anxiety. You will ask: 'Are you aware of feeling anxious right now?' In each case, I will ignore, neglect, dismiss, talk over, or minimize my anxiety. Help me see my anxiety, and then block my ignoring strategy by inviting me to pay attention to my anxiety.

*Learn how to help patients recognize and pay attention to their anxiety at HTRBook.com /xxx.*

Go ahead and start the role-play exercise. Ask, "What's the problem you would like me to help you with?"

## Role-Play One

*Pt:* I'm a little dizzy.

*Th:* That's a sign of anxiety. Are you aware of feeling anxious right now?

*Pt:* Oh, I'm used to that. [*"I'm sure you are. Shall we take a look at your anxiety and see if we can regulate it so you don't have to get dizzy?"*]

## Role-Play Two

*Th:* What's the problem you would like me to help you with?

*Pt:* I am getting sick to my stomach.

*Th:* That can be a sign of anxiety. Are you aware of feeling anxious right now?

*Pt:* It's not so bad. [*"Sickness in your stomach is a sign of severe anxiety. Could we take a look at your anxiety and see if we can regulate it so you don't have to feel sick to your stomach?"*]

## Role-Play Three

*Th:* What's the problem you would like me to help you with?

*Pt:* [*Patient stares glassy-eyed at the therapist.*] How do I know if you can help me?

*Th:* Let's see if we can find out. Are you aware of feeling anxious right now?

*Pt:* I feel really uncomfortable. But I guess I'll have to get used to that. [*"Feeling uncomfortable is a sign of anxiety. Shall we take a look at your anxiety so we could help you bring it down? Then you won't have to get used to it."*]

## Role-Play Four

*Th:* What's the problem you would like me to help you with?

*Pt:* [*Patient rubs her head.*] I'm getting a slight migraine headache.

*Th:* That can be a sign of anxiety. Are you aware of feeling anxious right now?

*Pt:* Oh, it's nothing. My doctor gives me medication for it. I just forgot to take the pills before I came here. [*"This headache can be a sign of anxiety. Shall we take a look at your anxiety and see if we can regulate it? That can sometimes make a migraine come down."*]

## Role-Play Five

*Th:* What's the problem you would like me to help you with?

*Pt:* [*Patient looks scared*.]

*Th:* Are you aware of feeling anxious right now?

*Pt:* Yes. But that's not what I want to talk about. [*"Of course not. But if we don't talk about your anxiety, you will feel uncomfortable here, and I don't want you to feel uncomfortable. Could we take a look at your anxiety so we could help you bring it down?"*]

## Role-Play Six

*Th:* What's the problem you would like me to help you with?

*Pt:* I'm not sure I feel comfortable talking about it.

*Th:* That can be a sign of anxiety. Are you feeling anxious right now?

*Pt:* I'm feeling nauseous. But I really don't want to pay attention to that. If I pay attention to it, it will just get worse. [*"This nausea is a sign of anxiety. When you say that you don't want to pay attention to it, my concern is that your anxiety will get worse. Could we pay attention to it and see if we could bring it down? Then the therapy will feel a lot more comfortable."*]

## Role-Play Seven

*Th:* What's the problem you would like me to help you with?

*Pt:* I'm not sure I feel comfortable talking about it.

*Th:* That can be a sign of anxiety. Are you aware of feeling anxious in your body right now?

*Pt:* I feel sick to my stomach.

*Th:* That's a sign of anxiety.

*Pt:* I'm anxious all the time. My doctor says I need to relax, but I can't. [*"A sick stomach is a sign of anxiety. Since you can't relax, could we take a look at your anxiety so we can help you bring it down?"*]

## Role-Play Eight

*Th:* What's the problem you would like me to help you with?

*Pt:* What did you say? My mind just blanked out.

*Th:* That can be a sign of anxiety. Are you aware of feeling anxious right now?

*Pt:* Oh, my mind does that all the time. [*"Blanking out is a sign of high anxiety. Could we take a look at your anxiety so we could help you bring it down so your mind wouldn't blank out?"*]

## Role-Play Nine

*Th:* What's the problem you would like me to help you with?

*Pt:* I'm so tired. If I tried to stand up right now, I'm not sure my legs would hold me up.

*Th:* That can be a sign of anxiety. Are you aware of feeling anxious right now?

*Pt:* Well, as long as I'm sitting here, it's no big deal. [*"This is a sign of high anxiety. If we treat it like it's no big deal, your anxiety could get worse. Could we take a look at your anxiety instead so we could help you bring it down?"*]

## Role-Play Ten

*Th:* What's the problem you would like me to help you with?

*Pt:* I'm just really anxious.

*Th:* How do you experience this anxiety physically in your body?

*Pt:* My ears are ringing, but I can still hear you. Sometimes I can't even hear other people. [*"This problem with hearing is a sign of high anxiety. Could we take a look at your anxiety and see if we can regulate it so your ears don't ring?"*]

You can't regulate the patient's anxiety by yourself. You and the patient can only do it together. That's how we co-create a sense of safety in therapy. In an insecure attachment, the patient hides her anxiety to regulate the other person's anxiety. In a secure attachment, the therapist encourages the patient to reveal her anxiety so that together we can pay attention to it and regulate it. By doing so, the therapist lets the patient know, "You don't have to hide your anxiety to protect me. Let's pay attention to your anxiety so we can help you feel safe again." The patient often cannot regulate her anxiety by herself. She needs our help. Together we can do what she cannot do alone.

As long as you help the patient return to her anxiety so she can regulate it, your answer will be fine. The goal here is not to repeat the words in the book but to learn the principle guiding those words: block the ignoring of anxiety so the patient can pay attention to the anxiety.

Now let's continue the role-play exercise. The person in the patient role should read the following to the person in the therapist role. "Let's do the exercise again. Whenever you intervene, I, as the patient, will go immediately to the next patient statement. Let's make this exercise feel like a real session. We won't stop for chitchat. We'll go straight through so you get the experience of processing and intervening more quickly. We'll repeat it several times. After you master this exercise, we'll shift roles so I can master it too."

**Questions to ask each other to strengthen your skills:** What are you learning about how ignoring anxiety prevents its regulation? How does this exercise change your understanding of what prevents patients from regulating their anxiety? How did you experience the therapist's encouragements to pay attention to your anxiety? How did this exercise change your understanding of the complexities of anxiety regulation? Does your partner sound caring or distant? What suggestions

might you offer your partner so that this feels like a caring relationship? How could your partner be more anxiety-regulating as a therapist?

## Skill-Building Exercise Five: Blocking Strategies That Prevent Anxiety Regulation and Then Regulating Anxiety

**Principle:** *Block the strategy against paying attention to anxiety and invite the patient to pay attention to her anxiety.*

When patients ignore their anxiety, it remains chronically elevated, and they cannot regulate it. Thus, we need to interrupt any avoidance strategy that prevents the patient from paying attention to and regulating his anxiety. The patient is not aware of these automatic and habitual strategies. So, be patient and compassionate. These are just habits he learned to protect others from his anxiety.

*Learn to be an anxiety-regulating presence by watching HTRBook.com/xxx.*

*Practice a role-play exercise on blocking avoidance strategies at HTRBook.com/xxx.*

As the patient in this role-play exercise, read the following to your partner who is in the therapist role. "In the following role-play exercises, you, as the therapist, will ask me, 'Are you aware of feeling anxious?' In the patient role, I will avoid paying attention to my anxiety. First, block my avoidance strategy and then invite me to pay attention to my anxiety.

"Go ahead and start the role-play exercise by asking, 'Are you aware of feeling anxious?'"

### Role-Play One

*Th:* Are you aware of feeling anxious?

*Pt:* [*Speaking rapidly*] Oh yes, doctor, I feel tremendous anxiety in my whole body, from my feet to my head. I think I even feel it in the pores of my skin. Oh, doctor, it's absolutely horrible. I can't stand it; it's growing and growing constantly. . . . [*"Do you notice how you talk rapidly now? That's often a sign of anxiety. Could we pay attention to your anxiety now and see if we can help you with it?" In this example, when the patient speaks rapidly, make sure you speak very slowly to slow down and calm her. Be the calm you want her to feel. Repeat this example several times until the therapist can speak slowly and calmly when the patient speaks quickly and anxiously.*]

### Role-Play Two

*Th:* Are you aware of feeling anxious?

*Pt:* Before we get to that, can you give me medication? I'm really having trouble with withdrawal. [*"I can arrange for you to get medication if you need it after the session. To help you right now, can we take a look at your anxiety and see if we can help you with it?"*]

## Role-Play Three

*Th:* Are you aware of feeling anxious?

*Pt:* Can you help me, doctor? [*"I'd be glad to. To help you now, can we take a look at your anxiety and see if we can help you with it?"*]

## Role-Play Four

*Th:* Are you aware of feeling anxious?

*Pt:* Have you helped anyone like me before? [*"It sounds like you are wondering whether I can help you. Shall we pay attention to your anxiety and see if we can help you with it?" The fact that the patient quickly changes subjects suggests that she may be anxious. Thus, addressing anxiety right away might be a good idea.*]

## Role-Play Five

*Th:* Are you aware of feeling anxious?

*Pt:* Yes, but I'm always anxious, and I think it's because of this show I saw last night. [*"If we come back to your anxiety, could we pay attention to your anxiety right now and see if we can help you with it?"*]

## Role-Play Six

*Th:* Are you aware of feeling anxious?

*Pt:* There's always anxiety. That's just how I am. I've always been wired. ["*Wonderful that you notice. Could we pay attention to your anxiety right now and see if we can help you with it?"*]

## Role-Play Seven

*Th:* Are you aware of feeling anxious?

*Pt:* I'm a little wired, sure, but that's because I just had two cups of coffee before I came here this morning. [*"So, could we take a look at how you experience this wiredness, this anxiety in your body right now, to see if we can bring it down?"*]

## Role-Play Eight

*Th:* Are you aware of feeling anxious?

*Pt:* Not nervous, really. Just energized. I'm always going: go, go, go! [*"This energy is sometimes a sign of anxiety. Could we pay attention to your body right now and help you with your anxiety?"*]

## Role-Play Nine

*Th:* Are you aware of feeling anxious?

*Pt:* I wouldn't say anxious. I'm afraid. I'm so afraid of what will happen if I relapse. [*"If we come back to this moment right now, could we pay attention to this anxiety in your body and see if we can help you bring it down?"*]

## Role-Play Ten

*Th:* Are you aware of feeling anxious?

*Pt:* Wouldn't you be afraid, too, if your dealer said he was going to get you? [*"I'm sure I would. So, could we pay attention to this anxiety in your body and see if we can help you with it?"*]

## Role-Play Eleven

*Th:* Are you aware of feeling anxious?

*Pt:* Yes, but I think it's because I'm going to the psychiatrist today, and I don't think he will renew my prescription for methadone. [*"If we come back to this moment right now, can we pay attention to this anxiety in your body and see if we can help you with it now?"*]

*Pt:* Yes. This is new for me. I'm not used to a therapist caring about my anxiety.

Very good! Notice how inviting the patient to pay attention to anxiety can block avoidance strategies and promote regulation. Help highly anxious patients focus on their anxiety as a first step in regulating it. Practice speaking slowly and calmly so that the patient can experience you as a safe haven.

As long as you block the ignoring strategy and invite the patient to pay attention to anxiety, your answer will be fine. The goal here is not to repeat the words in the book but to learn the principle guiding those words: block the ignoring of anxiety so the two of you can regulate it.

Now let's continue the role-play exercise. The person in the patient role should read the following to the person in the therapist role. "Let's do the exercise again. Whenever you intervene, I, as the patient, will go immediately to the next patient statement. Let's make this exercise feel like a real session. We won't stop for chitchat. We'll go straight through so you get the experience of processing and intervening more quickly. We'll repeat it several times. After you master this exercise, we'll shift roles so I can master it too."

**Questions to ask each other to strengthen your skills:** What do you notice feeling when you keep the focus on regulating your patient's anxiety? In the patient role, what did you experience as the therapist focused on regulating your anxiety? What did you learn from this experience that was new for you? What are you learning about the effects of ignoring anxiety as a habitual strategy? Did you experience your partner as criticizing your avoidance strategy or as caring about your

anxiety? What advice might you offer your partner regarding slowness and calmness of speech? How are these exercises changing your previous understanding of the role of anxiety in therapy?

## Skill-Building Exercise Six: Building the Capacity to Pay Attention to Anxiety

**Principle:** *Return the patient's attention to the physical experience of anxiety in the body to regulate it.*

Highly anxious patients often did not have someone pay careful attention to their anxiety, so they did not learn to do it. We have to help them develop that capacity in therapy. First, we help the patient notice her anxiety symptoms and identify them as anxiety. Then we build her capacity to pay attention to the physical sensations of anxiety in the body. The longer the patient can pay attention to a sensation in the body, the sooner her anxiety will come down. Also, the longer she can pay attention to her bodily sensations without acting out, the sooner she will develop impulse control. So, paying attention to anxiety is essential for anxiety regulation.

Exploring issues when the patient's anxiety is too high only triggers more anxiety, thus making therapy feel unsafe. If the patient doesn't feel safe, she will avoid exploring anything that triggers unregulated anxiety. We want to explore issues with patients only within a context of safety. Anxiety in the form of tension and sighing in the somatic nervous system indicates that the patient feels safe.

*Practice a role-play exercise focused on helping the patient pay attention to her anxiety at HTRBook.com/xxx.*

As the patient in this role-play exercise, read the following to your partner who is in the therapist role. "In the next role-play, which is much longer, I will play a patient who has trouble paying attention to my anxiety. Through many interventions, you will continue to focus on my anxiety, encouraging me to return my attention to my anxiety until it is regulated. This exercise will teach you how to persist until you have regulated my anxiety. And it will also teach you how to address different problems that come up when you try to help a patient regulate her anxiety. Now ask, 'Are you aware of feeling anxious?'"

*Pt:* Before we get to that, can you give me medication? I'm really having trouble with withdrawal. [*"I can arrange for you to get medication if you need it. Since medication takes a while to have an effect, shall we take a look at your anxiety in your body now, and see if we can help you with it?"*]

*Pt:* I guess so. [*"Where do you notice this anxiety physically in your body right now?"*]

*Pt:* All over. [*"Okay. Good that you notice. Where do you notice feeling this anxiety in your body right now?"*]

*Pt:* But I'm always anxious. [*"So, could we pay attention to your anxiety right now in your body and see if we can help you with it? Where do you notice feeling this anxiety in your body right now?"*]

*Pt:* I think it has to do with my being in withdrawal. [*"I wouldn't be surprised if that is part of the picture, so could we pay attention to your anxiety right now in your body and see if we can help you with it? Where do you notice feeling this anxiety in your body right now?"*]

*Pt:* I don't know. [*"Wouldn't it be nice to know? Could we pay attention to your anxiety right now and see if we can help you with it? Where do you notice feeling this anxiety in your body right now?"*]

*Pt:* I'm feeling sick to my stomach. [*"That's a sign of anxiety. What do you notice feeling there as you pay attention to this symptom in your stomach?"*]

*Pt:* Kind of nauseated. [*"Nausea is a sign of anxiety. As you notice that sensation in your stomach, is it getting bigger or smaller?"*]

*Pt:* I'm thinking I may get worse. [*"If we come back to this moment, could we shift your attention to this anxiety in your body? What do you notice feeling in your body as you keep your attention there?"*]

*Pt:* It feels like a ball down there. [*"Wonderful that you notice that. As you notice that ball, what changes happen in the ball as you notice it?"*]

*Pt:* It feels like it is pulsating. [*"Excellent that you notice that. What changes in the pulsating do you notice as you keep paying attention to those sensations?"*]

*Pt:* It feels like it is clenching. [*"Excellent you notice that. What changes in the clenching do you notice as you keep paying attention to it?" "Clenching" suggests that anxiety is shifting back into the somatic nervous system muscles. A good sign*.]

*Pt:* It feels like two things are happening: a pushing and a pulling. [*"Excellent that you notice that. What changes do you notice as you keep paying attention to the pushing and pulling?"*]

*Pt:* [*Sighs*.] I'm getting tense. [*"Wonderful. That's a sign your anxiety is coming down." The sigh and tension let us know that the patient's anxiety has shifted into the safe zone: the somatic nervous system. These are signs of regulated anxiety*.]

As long as you help the patient pay attention to anxiety so it can be regulated, your answers will be fine. The goal here is not to repeat the words in the book but to learn the principle guiding those words: help the patient pay attention to anxiety so it can be regulated.

Now let's continue the role-play exercise. The person in the patient role should read the following to the person in the therapist role. "Let's do the exercise again. Whenever you intervene, I, as the patient, will go immediately to the next patient statement. Let's make this exercise feel like a real session. We won't stop for chitchat. We'll go straight through so you get the experience of processing and intervening more quickly. We'll repeat it several times. After you master this exercise, we'll shift roles so I can master it too."

**Questions to ask each other to strengthen your skills:** What have you learned about anxiety that you did not know before doing these exercises? How does this new understanding change what you understood before? What are you paying attention to now that you didn't pay attention to before working on these skills? What new skills will you use to make therapy a safe place for the patient in the future? How are you becoming a safer person for the patient to depend upon? How did your partner change as an anxiety-regulating therapist?

You have just completed the first exercises on anxiety regulation. When patients begin therapy with excessive anxiety, we cannot establish a therapeutic alliance. We need to regulate anxiety so that the patient feels safe enough to declare a problem and work on it together with you.