



AN ALL-ENCOMPASSING APPROACH TO TREATING ANXIETY AND RELATED DISORDERS

A Safety Aid Reduction Treatment Manual (START)



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This manual, which is based on an unpublished treatment protocol developed by Schmidt and colleagues, stemmed from our interests in preventing and treating anxiety and related disorders, namely anxiety, depressive, obsessive-compulsive, and trauma- and stressor-related disorders. We are interested in the development and dissemination of psychotherapies that can be applied to individuals with multiple disorders or to mixed diagnostic groups, as such protocols could overcome time and training barriers for clinicians within the VA and elsewhere. We would like to express our gratitude to the individuals and organizations that supported this work. Specifically, we would like to thank the following individuals who served as expert consultants providing content feedback on the manual – **Bunmi Olatunji, PhD; Frank Weathers, PhD; and Desirae Vidaurri, PhD** – as well as the following clinicians who reviewed the manual for clarity and ease of utilization – **Chelsea Ennis, PhD, and Chandler Habig, LMSW**. Additionally, we would like to thank the graphic designer as well as those individuals who edited/formatted portions of the manual – **Jessica Chambliss, MS, and Shelby McGrew, BS**. Finally, we are grateful for the support of the VA and the funding provided by a clinical educator grant from the South Central MIRECC. Without these individuals and resources, this product would not have been possible.

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BACKGROUND INFORMATION FOR CLINICIANS

The development of this treatment manual stems from a recognized need for treatments that are simple to learn and deliver and, thus, easy to disseminate. This manual is designed to be used by clinicians who have experience delivering cognitive behavioral therapy (CBT). The manual provides implementation guidelines for this transdiagnostic treatment, which is designed to target various anxiety and related disorders via the identification and elimination of safety aids.

ANXIETY AND RELATED DISORDERS

Anxiety and related disorders, a term used broadly to encompass *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* anxiety, depressive, obsessive-compulsive, and trauma- and stressor-related disorders, are a highly prevalent, debilitating, and costly category of mental illness (Lépine, 2002). Epidemiological studies suggest that around 42% of the population will meet diagnostic criteria for an anxiety and related disorder at some point during their lives, with past-year prevalence rates of 21% (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). Left untreated, these disorders often maintain a chronic and debilitating course leading to substantial impairment in social, familial, and occupational domains (Kessler, Chiu, Demler, & Walters, 2005). Further, when direct (e.g., medical) and indirect (e.g., work absenteeism) costs are considered, anxiety and related disorder expenditures are estimated to total tens of billions of dollars annually (Greenberg et al., 1999). Taken together, these findings underscore the need for effective treatments that can mitigate the emotional and economic costs associated with these disorders.

RATIONALE FOR TRANSDIAGNOSTIC TREATMENT

Notably, there are a number of empirically supported treatments (ESTs) available to effectively lessen the suffering associated with anxiety and related disorders. Indeed, at the turn of the 21st century, researchers began examining CBT as a front-line treatment for these conditions. Since that time, mounting evidence has demonstrated the efficacy of CBT for a spectrum of anxiety and related disorders (Butler, Chapman, Forman, & Beck, 2006). Despite these efforts, the majority of mental health clinicians, particularly those practicing in rural and underserved areas, reportedly do not use these validated treatment approaches (Gunter & Whittal, 2010; Hipol & Deacon, 2013). Factors contributing to underutilization of ESTs include the a) diagnostic specificity of these treatment protocols, b) training and supervision needed to master these treatment protocols, and c) time needed to deliver these treatment protocols. Thus, there remains a need to identify additional treatment approaches that could overcome these barriers.

One alternative is to use transdiagnostic treatment protocols. These approaches are based on the understanding that all anxiety and related disorders share a common etiology (Norton & Philipp, 2008). This is best evidenced by the high degree of current and lifetime comorbidity found across these conditions. Indeed, diagnostic comorbidity is often the rule rather than the exception, with rates as high as 81% when lifetime diagnoses are considered (Brown, Campbell, Lehman, Grisham, & Mancill, 2001). This degree of overlap can complicate diagnostic decision making and subsequent treatment selection. Transdiagnostic treatments were established as an all-encompassing approach to treating multiple anxiety and related disorders by focusing on commonalities across conditions (Craske, 2012). A strength of this approach is that a clinician can treat comorbid conditions within and across individuals in the same clinical hour. For instance, by targeting shared cognitions and behaviors, such as excessive checking of doors, windows, and locks, a clinician could treat a Veteran with comorbid trauma- and obsessive-compulsive and related disorders or treat multiple Veterans with one or both of these disorders in a group-based format.

In this regard, researchers have recently begun to examine the effectiveness of one transdiagnostic treatment focused on the reduction of safety aids. Safety aids are maladaptive cognitive and/or behavioral strategies designed to prevent, avoid, or alleviate anxiety and/or distress (Helbig-Lang & Petermann, 2010; Salkovskis, 1991). Examples include thought suppression, rumination, situational avoidance, and checking behaviors, as well as the use of alcohol and certain substances. Although useful in the short term, repeated use of such strategies in the long term is believed to contribute to the development and maintenance of various anxiety and related disorders, including panic disorder (PD; Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999), social anxiety disorder (SAD; Wells et al., 1995), generalized anxiety disorder (GAD; Beesdo-Baum et al., 2012), major depressive disorder (MDD; Moulds, Kandris, Williams, & Lang, 2008), obsessive-compulsive disorder (OCD; Deacon & Maack, 2008), and posttraumatic stress disorder (PTSD; Ehlers & Clark, 2000).

OVERVIEW OF ANXIETY AND RELATED DISORDERS

Before introducing the core components of this transdiagnostic treatment manual, we will first provide an overview of the diagnostic criteria for each anxiety and related disorder targeted within this protocol. It is important to understand the core features of each phenotype as the pattern and purpose of safety aids can vary across each condition.

DSM-5 SOCIAL ANXIETY DISORDER (SAD)

SAD is included in the *DSM-5* (American Psychiatric Association, 2013) as an anxiety disorder. SAD is characterized by pronounced fear or anxiety about one or more social situations due to fears that one will behave in a manner or display anxiety symptoms that will be negatively evaluated. As such, social situations are avoided or tolerated with extreme distress. Notably, the fear or anxiety is beyond what would be expected given the context of the situation. A diagnosis of SAD requires that such symptoms be present for 6 months or more and cause clinically significant impairment in major domains of life.

DSM-5 PANIC DISORDER (PD)

PD is included in the *DSM-5* (American Psychiatric Association, 2013) as an anxiety disorder. PD is characterized by persistent, unforeseen panic attacks (i.e., sudden surge of fear or distress which reaches peak intensity within minutes and involves numerous physical and mental symptoms) coupled with consistent fear or apprehension about additional attacks or their consequences (e.g., fears of having a heart attack) or a change in behavior as it relates to the attacks (e.g., avoiding stimuli that might bring on panic-like symptoms). Notably, such symptoms must be present for a month or more and cause clinically significant impairment in major domains of life.

DSM-5 GENERALIZED ANXIETY DISORDER (GAD)

GAD is included in the *DSM-5* (American Psychiatric Association, 2013) as an anxiety disorder. GAD is characterized by extreme and uncontrollable anxiety and worry about everyday events or activities. This anxiety and apprehension is associated with various physical (e.g., restlessness) and mental symptoms (e.g., difficulty concentrating) which must be present most days for 6 months or more and cause clinically significant impairment in major domains of life.

DSM-5 OBSESSIVE-COMPULSIVE DISORDER (OCD)

OCD is included in the *DSM-5* (American Psychiatric Association, 2013) as an obsessive-compulsive and related disorder. OCD is characterized by recurrent and persistent thoughts, urges, or images (i.e., obsessions) that bring about significant distress or anxiety, as well as repetitive behaviors or mental acts (i.e., compulsions) aimed at neutralizing or reducing the anxiety caused by obsessions. A diagnosis of OCD requires that such symptoms take up a significant proportion of time (i.e., more than 1 hour per day) and cause clinically significant impairment in major domains of life.

DSM-5 POSTTRAUMATIC STRESS DISORDER (PTSD)

PTSD is included in the *DSM-5* (American Psychiatric Association, 2013) as a trauma- and stressor-related disorder. PTSD is characterized by a myriad of symptoms that emerge following exposure to one or more extreme stressors. Symptoms are divided across four clusters and include intrusions (e.g., distressing memories), avoidance (e.g., of internal or external trauma reminders), negative alterations in cognitions and mood (e.g., negative beliefs about oneself or the world), and alterations in arousal or reactivity (e.g., hypervigilance). A diagnosis of PTSD requires that such symptoms be present for a month or more and cause clinically significant impairment in major domains of life.

DSM-5 MAJOR DEPRESSIVE DISORDER (MDD)

MDD is included in the *DSM-5* (American Psychiatric Association, 2013) as a depressive disorder. MDD is characterized by various cognitive, affective, and behavioral symptoms, the majority of which must be present most of the day, nearly every day during the same 2-week period.

EMOTIONAL PROCESSING MODEL

The specific nature of the relationship between safety aids and anxiety and related disorders can be best understood through an emotional processing model. According to this model, individuals develop (through experience) structural networks of fear and distress (Foa & Kozak, 1986) that are stored in memory. These structures comprise: 1) representations of the feared stimuli, 2) physiological and behavioral responses to the feared stimuli, and 3) meaning associated with the feared stimuli (Foa & Kozak, 1986). For example, a Veteran who experiences a severe trauma such as rape will develop a fear network that includes information about the trauma (e.g., what the assailant looked and smelled like), responses to the trauma (e.g., racing heart, escape behaviors), and maladaptive beliefs associated with the trauma (e.g., men cannot be trusted). When something in the environment matches one or more of these elements, the fear structure becomes activated. In the presence of a true threat (e.g., seeing the assailant again), this activation can be protective and crucial for survival in that it contains information about how to best respond. However, in the presence of a false threat (e.g., seeing someone who resembles the assailant), this activation can be pathological in that it interferes with adaptive behavior.

As noted by Foa and Kozak (1986), two conditions are necessary to correct pathological fear: 1) provocation of fear and 2) provision of corrective information. That is, the person's fear and anxiety must be activated; and new learning needs to occur. Overt safety aids, including situational avoidance and use of alcohol and certain substances, may hinder one's ability to correct maladaptive fear responses by limiting fear activation altogether. For example, an individual with SAD may avoid social situations altogether, thereby limiting fear activation. Additionally, the use of more covert safety aids, including thought suppression or checking behaviors in the context of a feared stimuli, may thwart one's ability to obtain disconfirming evidence. For example, an individual with PD who ingests benzodiazepines upon experiencing heart palpitations may be unable to learn that such behaviors are not necessary to prevent a heart attack. In either situation, anxiety and related disorders are maintained either through limited exposure to feared stimuli or an inability to procure disconfirming evidence in the presence of feared stimuli.

DEVELOPMENT OF THIS TRANSDIAGNOSTIC TREATMENT MANUAL AND EVIDENCE BASE

Having recognized this process, Schmidt et al. (2012) developed a group-based transdiagnostic treatment protocol, titled False Safety Behavior Elimination Therapy (F-SET), that is based solely on the identification and elimination of safety aids. F-SET includes many of the key elements found in ESTs for anxiety, including a) psychoeducation regarding anxiety and the fear response and b) exposure to internal and external stimuli that are connected to one's fear response via safety aid reduction. Another important component of F-SET is the utilization of "antiphobic" exercises, or approach behaviors that are directly opposite to the patient's phobic tendency. Unlike many of the current CBT protocols, F-SET does not focus on one specific anxiety and related disorder but instead focuses on cognitive and behavioral strategies that are common across these disorders.

In their initial trial, Schmidt et al. (2012) tested the efficacy of this group-based safety aid reduction protocol using a treatment-seeking sample of individuals ($N = 96$) with primary anxiety diagnoses (i.e., PD, GAD, and SAD). Relative to a wait-list control condition, participants in the group-based transdiagnostic treatment demonstrated improvements in overall anxiety, avoidance, depression, and clinician-rated severity. These treatment gains were maintained throughout the six-month follow-up period. Further, based on reliable clinical change scores, significantly more participants in the group-based transdiagnostic treatment demonstrated clinically significant improvement (88%) than those in the wait-list control (42%). Notably, effect size indices were comparable to those found in randomized clinical trials (RCTs) for individual anxiety diagnoses, suggesting that the treatment is capable of producing clinical benefits.

Extending these findings, Riccardi, Korte, and Schmidt (2017) examined the efficacy of this same safety aid reduction treatment delivered in a brief, five-week, individual format. Patients ($N = 28$) with primary anxiety diagnoses (i.e., PD, GAD, and SAD) were randomly assigned to receive the safety aid treatment or a wait-list control condition. Patients were assessed prior to, immediately after, and one month following treatment. Patients in the active condition demonstrated improvements in anxiety, depression, and functional impairment that were also maintained throughout the brief follow-up period.

More recently, evidence for the efficacy of this safety aid reduction treatment was found among Veterans. As part of a one-arm pilot trial, Veterans ($N = 22$) presenting to a community-based outpatient clinic (CBOC) for psychological services received this group-based transdiagnostic treatment, which was expanded to include additional anxiety and related disorders (i.e., OCD, PTSD, and MDD). Results revealed meaningful decreases across a range of outcomes, including overall anxiety, depression, and safety aid usage, that were maintained throughout a brief one-month follow-up period. Only five (23%) individuals dropped out, suggesting that treatment was well tolerated. Further, overall utility and recommendation ratings suggested that Veterans were accepting of the treatment. Taken together, these findings provide evidence for the acceptability, feasibility, and utility of this protocol among civilian and Veteran populations.

POTENTIAL RISKS AND BENEFITS OF THIS TREATMENT

Benefits: This manual is guided by decades of research into the causes and correlates of anxiety and related disorders. To date, hundreds of individuals have been treated using some form of this program. Posttreatment and follow-up assessments indicate that most individuals demonstrated clinically significant improvement in disorder-specific symptoms and overall functioning.

Risks: Some aspects of the treatment, including fading and eliminating safety aids, are likely to elicit moderate levels of anxiety and distress. However, extensive experience with exposure-based treatments suggests that this discomfort will decrease. Clinicians should, nevertheless, disclose to patients that symptoms may get worse before they get better.

ALTERNATE APPROACHES TO TREATING ANXIETY AND RELATED DISORDERS

A review of CBT for anxiety and related conditions is outside the scope of this manual. Nevertheless, decades of research have shown that CBT is effective in reducing symptoms of various anxiety and related disorders. As such, CBT is recommended as a front-line psychological treatment for most, if not all, anxiety and related disorders (see <https://www.div12.org>).

In addition, clinical researchers have begun to develop, evaluate, and disseminate other transdiagnostic treatment protocols, namely the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (Allen, McHugh, & Barlow, 2008) and Transdiagnostic Behavior Therapy (Gros, 2014). Much like the current protocol, these treatments are designed to focus on a variety of factors common across anxiety and related disorders (e.g., cognitive biases, behavioral avoidance, emotion regulation). Despite growing support for these treatments (Barlow et al., 2017; Gros, 2015), underutilization remains a pressing concern. Thus, efforts aimed at developing and validating novel treatment approaches are still needed.

OUTLINE OF TRANSDIAGNOSTIC TREATMENT MANUAL AND STRUCTURE OF SESSIONS

This treatment program consists of 10 weekly, group-based sessions, each lasting one hour. The manual is divided into chapters, each corresponding to a treatment session. Each chapter includes a materials list, session outline, treatment information and techniques, as well as homework. As with any treatment, it will be important to monitor Veterans' progress throughout treatment. This can be accomplished by having Veterans complete disorder-specific self-report measures at regular intervals in addition to the Safety Behavior Assessment Form (SBAF; see Appendix A). Equally as important, you will want to share the results of these measures with your Veterans while using them to assess progress over time. Although there are no concrete guidelines as to what constitutes "regular intervals," it is recommended that at a minimum Veterans complete measures pre-, mid-, and posttreatment. Finally, given the importance of therapeutic rapport to treatment success, it will be essential to foster an environment in which the Veteran feels safe and respected.

Session 1 will begin with a brief welcome, introduction, and review of group rules. Time will then be spent introducing Veterans to the various anxiety and related terms that will be used throughout treatment. Next, time will be devoted to learning about Veterans' individual experiences with anxiety. Finally, the session will end with an introduction to the various components of the fear response. For homework, Veterans will be instructed to review the Anxiety Terminology Handout and to complete the Fear Response Worksheet wherein they will monitor their physical, mental, and behavioral responses to at least one anxiety-provoking situation.

Session 2 will begin with a brief check-in and review of homework and Session 1 material. Time will then be spent introducing Veterans to the emotional processing model, in particular, how fear structures are created in memory. Next, time will be devoted to discussing how fear structures are maintained - that is, through the use of safety aids. For homework, Veterans will be instructed to review the [Fear Structures Handout](#) and to complete the [Safety Aid Checklist](#).

Session 3 will begin with a brief check-in and review of homework and Session 2 material. Time will then be spent reviewing the role of safety aids in treatment, in particular, how and why safety aids are damaging. Next, Veterans will be taught how to identify and eliminate safety aids throughout treatment. Time will be devoted to discussing the role of the antiphobic approach in treatment. For homework, Veterans will be instructed to review the [Phobic/Antiphobic Continuum Handout](#) and complete the [Safety Aid Fading Worksheet](#).

Session 4 will begin with a brief check-in and review of homework and Session 3 material. Next, Veterans will be reminded of the role of safety aids in treatment, in particular, how the purpose of this treatment is to identify and fade them out. Most of the session will then be devoted to discussing checking behaviors as a category of safety aids. Time will be spent identifying and discussing ways in which Veterans can begin to fade this category of safety aids for homework. Veterans will be encouraged to track their fading using the [Safety Aid Fading Worksheet](#).

Session 5 will begin with a brief check-in and review of homework and Session 4 material. Next, Veterans will be reminded of the role of safety aids in treatment, in particular, how the purpose of this treatment is to identify and fade them out. Most of the session will then be devoted to discussing situational avoidance as a category of safety aids. Time will be spent identifying and discussing ways in which Veterans can begin to fade this category of safety aids for homework. Veterans will be encouraged to track their fading using the [Safety Aid Fading Worksheet](#).

Session 6 will begin with a brief check-in and review of homework and Session 5 material. Next, Veterans will be reminded of the role of safety aids in treatment, in particular, how the purpose of this treatment is to identify and fade them out. Most of the session will then be devoted to discussing cognitive avoidance as a category of safety aids. Time will be spent identifying and discussing ways in which Veterans can begin to fade this category of safety aids for homework. Veterans will be encouraged to track their fading using the [Safety Aid Fading Worksheet](#).

Session 7 will begin with a brief check-in and review of homework and Session 6 material. Next, Veterans will be reminded of the role of safety aids in treatment, in particular, how the purpose of this treatment is to identify and fade them out. Most of the session will then be devoted to discussing physiological avoidance as a category of safety aids. Time will be spent identifying and discussing ways in which Veterans can begin to fade this category of safety aids for homework. Veterans will be encouraged to track their fading using the [Safety Aid Fading Worksheet](#).

Session 8 will begin with a brief check-in and review of homework and Session 7 material. Next, Veterans will be reminded of the role of safety aids in treatment, in particular, how the purpose of this treatment is to identify and fade them out. Most of the session will then be devoted to discussing companions as a category of safety aids. Time will be spent identifying and discussing ways in which Veterans can begin to fade this category of safety aids for homework. Veterans will be encouraged to track their fading using the [Safety Aid Fading Worksheet](#).

Session 9 will begin with a brief check-in and review of homework and Session 8 material. Next, Veterans will be reminded of the role of safety aids in treatment, in particular, how the purpose of this treatment is to identify and fade them out. Most of the session will then be devoted to discussing alcohol, substances, and certain medications as a category of safety aids. Time will be spent identifying and discussing ways in which Veterans can begin to fade this category of safety aids for homework. Veterans will be encouraged to track their fading using the [Safety Aid Fading Worksheet](#).

Session 10 will begin with a brief check-in and review of homework and Session 9 material. Next, time will be spent reviewing Veterans' progress and skills learned throughout treatment. Prior to saying goodbye, time will be devoted to discussing factors that contribute to relapse and what to do if the Veterans have a setback.



CHAPTER 1: SESSION 1

MATERIALS NEEDED

- Safety Behavior Assessment Form (administer prior to session)
- Anxiety Terminology Handout
- Fear Response Worksheet

SESSION OUTLINE

- I. Brief welcome, introduction, and review of group rules (10 minutes)
- II. Introduction to anxiety terms (10 minutes; see [Anxiety Terminology Handout](#))
- III. Onset and course of anxiety symptoms (15 minutes)
- IV. Introduction to fear response (10 minutes; see [Fear Response Worksheet](#))
- V. Review and homework assignment (5 minutes)

BRIEF WELCOME, INTRODUCTION, AND REVIEW OF RULES (10 MINUTES)

At the beginning of the session, introduce yourself and welcome Veterans to the group. Then direct Veterans to state their name and one thing they hope to gain or accomplish from participating in the group. You can give examples when needed (e.g., “My name is Joe, and I hope to attend a Saints game with my grandson”).

Next, review basic group rules including but not limited to the following:

1. Confidentiality - What happens in group, stays in group.
2. Attendance - Is crucial to success.
3. Respect - Yourself and others in the group with your words and actions.
4. Practice - What you learn in session is important, but what you do in between sessions is essential to success.
5. Willingness - Willingness and an open mind will be important, as some things you learn in treatment may be different from what you have practiced before.

INTRODUCTION TO ANXIETY TERMS (10 MINUTES)

Following a brief welcome, introduction, and review of group rules, Veterans will be introduced to various terms that will be used throughout treatment. These terms are important to outline for both insight and communication purposes. The following script can be used in conjunction with the [Anxiety Terminology Handout](#) to facilitate this process.

Let's begin by discussing some terminology that will be used throughout treatment. These terms are important, as they will help you to both better understand your experiences with anxiety and allow us to communicate effectively regarding your symptoms. Please turn to the Anxiety Terminology Handout and follow along with me.

*The first term is **STRESS**. Stress is more general than anxiety. Although it can exacerbate anxiety, it is not the same as anxiety. Stress is a response to perceived demands. These demands can be positive (e.g., getting married) or negative (e.g., losing a job). No matter what the stressor, the reactions to stress are the same and include emotional, physical, and behavioral responses. An important thing to remember is that stress is a normal part of life. Everyone has demands in life that result in stress.*

*The second term is **ANXIETY**. Anxiety is a normal, natural, and innate response designed to protect us from harm. Without anxiety, we would have no warning of future threat or danger. In this way, anxiety shows that we have a healthy brain.*

*The third term is **PANIC**. Like anxiety, panic is a normal, natural, and innate response designed to protect us from harm. Unlike anxiety, panic signals that there is an immediate threat in our environment. This alarm system protects us from danger by activating our "fight or flight" response. Once again, panic shows that our brain is healthy.*

*The fourth term is **WORRY**. Worry is the cognitive or mental (i.e., thought-based) response to future threat. Like anxiety, worry is a normal, natural, and innate response designed to protect us from danger by helping us problem solve.*

*Anxiety, panic, and worry all comprise what we call an alarm. Alarms, however, can be true or false. **A TRUE ALARM** is a response to a true threat (e.g., encountering a bear in the woods). **A FALSE ALARM**, on the other hand, involves the same physical, cognitive, and behavioral responses as a true alarm, but there is no real threat (e.g., seeing a bear in the zoo). We want to keep alarms for true threats and discard alarms for false threats.*

Take a moment for questions and comments before introducing each specific anxiety and related disorder. The following script can be used to facilitate this discussion.

Let's talk now about several disorders that are characterized by anxiety, panic, and worry. A disorder is a cluster of symptoms that affect our mood, thinking, and behavior, causing significant distress or impairment in major areas of life.

PANIC DISORDER is a learned pattern of false alarms that stems from an exaggerated fear of the physical symptoms or consequences of anxiety. For example, someone with panic may learn to fear physiological sensations that are similar to those experienced during a panic attack, such as heart palpitations. Due to this fear, the person may begin to avoid activities that are likely to induce such sensations, including consuming caffeinated drinks and exercising. Although panic attacks and/or the fear of physical symptoms does not mean you have panic disorder, it does put you at risk for developing it. Nevertheless, this treatment will address fears of physical symptoms.

SOCIAL ANXIETY DISORDER is a learned pattern of false alarms that stems from an exaggerated fear of negative evaluation. For example, people with social anxiety may overestimate the likelihood that others will perceive them negatively in a social situation. Due to this fear, the person may avoid social situations altogether or endure them with intense anxiety. Although a fear of negative evaluation does not mean you have social anxiety disorder, it does put you at risk for developing it. Nevertheless, this treatment will address fears of negative evaluation.

GENERALIZED ANXIETY DISORDER is a learned pattern of false alarms that stems from an exaggerated fear of low-probability catastrophes. For example, someone with generalized anxiety disorder will fear the worst, even when it is unlikely (e.g., “I won’t be able to pay my rent this month despite financial stability”). Individuals with generalized anxiety disorder often find it difficult to control their worry and are physically and mentally impacted by their worry. Although persistent concerns about everyday events does not mean you have generalized anxiety disorder, it does put you at risk for developing it. Importantly, this treatment will address fears of low-probability catastrophes.

OBSESSIVE-COMPULSIVE DISORDER is a learned pattern of false alarms that stems from an exaggerated fear of recurrent and unwanted thoughts, urges, or images. For example, someone with obsessive-compulsive disorder may have obsessive thoughts of contamination or harming someone that cause significant anxiety and distress. The individual may attempt to ignore, suppress, or neutralize these thoughts with some other thought or action. For example, the individual may engage in compulsive behavioral (e.g., excessive hand washing) or mental acts (e.g., praying) aimed at preventing or reducing the associated anxiety. Although having intrusive thoughts and compulsive behaviors does not mean you have obsessive-compulsive disorder, it does put you at risk for developing it. Importantly, this treatment will address fears of recurrent and unwanted thoughts.

POSTTRAUMATIC STRESS DISORDER is a learned pattern of false alarms that stems from an exaggerated fear of trauma cues. For example, people with posttraumatic stress disorder may avoid certain people, places, or things that

remind them of their traumatic event(s). Although avoidance of upsetting or distressing memories does not mean you have posttraumatic stress disorder, it does put you at risk for developing it. Importantly, this treatment will address these fears.

Although depression is not a fear-based condition, it often co-occurs with various anxiety and related disorders. In addition, individuals with depression often engage in avoidance behaviors (e.g., reassurance seeking, isolation), which serve to maintain the disorder. In this way, targeting these behaviors may also reduce distress, similar to the way targeting safety aids reduces anxiety.

*Another disorder that is not fear-based but does respond to this treatment is major depressive disorder. **MAJOR DEPRESSIVE DISORDER** is a condition in which individuals engage in few pleasurable activities, leading to decreased positive affect. For example, someone with major depressive disorder may avoid spending time with friends and family. Additionally, they may ruminate or attempt to suppress depressive thoughts, such as “I am worthless.” These attempts at avoidance (i.e., of people or thoughts,) in turn, lead the individual to feel more depressed. This treatment will address symptoms associated with low mood.*

ONSET AND COURSE OF ANXIETY SYMPTOMS (15 MINUTES)

An important component of all cognitive behavioral therapies is establishing rapport and allowing the Veteran to feel heard and understood. In the next section, take a moment to learn about your Veterans’ individual experiences with anxiety. Allow them the opportunity to reflect on their symptoms and the various ways in which their symptoms have influenced their lives and the lives of those around them. The following script can be used to facilitate this discussion.

Now I’d like to spend some time learning about your experiences with anxiety and how anxiety has impacted your day-to-day lives. When did you first notice the anxiety and/or distress? How has it affected your life? How has it affected those around you?

Next, to highlight the various components of the fear response, elicit Veterans’ recent experiences with anxiety. In particular, ask about Veterans’ cognitive, physical, and behavioral responses.

Next, I’d like for you all to take a moment and think about a recent time when you experienced anxiety. What was going through your mind? What was happening in your body? What did you do?

After this brief discussion, reflect on Veterans’ shared experiences by highlighting the similarities in anxiety responses. Specifically, although anxiety impacts everyone in a unique way, there are commonalities in how anxiety manifests regarding the physical, cognitive, and behavioral domains.

As you all see, although somewhat unique, anxiety affects us all in a similar way. That is, the fear responses for everyone includes a physical, cognitive, and behavioral response. Let's spend a little more time discussing these various components of the fear response in more detail.

INTRODUCTION TO THE FEAR RESPONSE (10 MINUTES)

Here you will walk the Veterans through the three main components of the fear response, specifically highlighting the physical, cognitive, and behavioral domains. To facilitate this process, direct Veterans to the [Fear Response Worksheet](#), which they will be asked to complete for homework.

*First, let's discuss the **PHYSICAL** response to fear, specifically, the "fight or flight" or panic response. Has anyone ever heard of this?*

Allow Veterans time to respond, and allow a short discussion to ensue.

There are two nervous systems in our body that are responsible for the "fight or flight" response: the sympathetic and parasympathetic nervous systems. The sympathetic nervous system prepares the body for "fight or flight"; while its counterpart, the parasympathetic nervous system, works to return the body to its relaxed state. For example, when the fear response is triggered, the sympathetic nervous system activates, causing your heart rate and breathing rate to increase. In the context of a true alarm (e.g., encountering a bear in the woods), these responses are key to survival. That is, they allow you to fight or take flight. However, in the context of a false alarm (e.g., seeing a bear in the zoo), these responses can be problematic in that they do not directly impact your safety and only serve to increase your anxiety. Regardless of whether our body is responding to a true alarm or a false alarm, our parasympathetic nervous system will eventually return our body to a relaxed state. The main thing to remember is that these two systems keep our bodies balanced and ensure that anxiety cannot continue to increase forever.

*Now let's move on to the second component of the fear response, the **MENTAL** system. There are two ways in which we mentally respond to fear: heightened attention and worry. A shift in attention allows us to locate the danger. Worry allows us to quickly problem solve. In the context of a true alarm (e.g., encountering a bear in the woods), these responses are key to survival. That is, they allow you to quickly locate the danger and plan your escape. However, in the context of a false alarm (e.g., seeing a bear in the zoo), these responses can be problematic in that they do not directly impact your safety and only serve to increase your anxiety. This results in your not being able to pay attention to or enjoy that moment with the people around you.*

*The third and final component of the fear response is the **BEHAVIORAL** system. That is, what you actually do in the moment. In the context of a true alarm (e.g., the bear in the woods), a behavioral response/action such as running can be key to survival. However, in the context of a false alarm (e.g., the bear in the zoo), this response can be problematic in that it does not directly impact your safety and only serves to maintain your anxiety. By running away from a bear at the zoo, your brain maintains that the situation is dangerous, making it less likely that you will ever be able to spend time at the zoo again.*

After covering this information, direct the Veterans to the [Fear Response Worksheet](#), which they will be asked to complete for homework. Briefly instruct Veterans on how to complete the worksheet, allowing time for questions or comments.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (5 MINUTES)

Lastly, briefly review the content covered in today's session before proceeding to the homework assignment. The following script can be used to facilitate this wrap-up.

Today, in Session 1, we learned about the differences between stress, anxiety, panic, and worry. In particular, we learned how these manifest in the context of a true alarm and a false alarm. We also talked about the various fear-based disorders and how the clusters of symptoms specific to each disorder can affect our ability to function in major areas of our lives. Finally, we talked about the three components of the fear response – physical, mental, and behavioral – and how these are common across all the anxiety and related disorders. It is important that we capitalize on what you've learned today. Therefore, between now and our next session, I will ask that you complete the following assignments, which we will discuss in group next week:

1. Review the [Anxiety Terminology Handout](#) until you feel comfortable with the material
2. Fill out the [Fear Response Worksheet](#) with your own physical, mental, and behavioral responses to anxiety



CHAPTER 2: SESSION 2

MATERIALS NEEDED

- Fear Structures Handout
- Safety Aid Categories Handout
- Safety Aid Checklist

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 1 material (10 minutes)
- II. Introduction to emotional processing model (10 minutes; see [Fear Structures Handout](#))
- III. Introduction to safety aids (5 minutes)
- IV. Types of safety aids (20 minutes; see [Safety Aid Categories Handout](#))
- V. Review and homework assignment (5 minutes)

BRIEF CHECK-IN AND REVIEW (10 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 1 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

INTRODUCTION TO EMOTIONAL PROCESSING MODEL (10 MINUTES)

Next, introduce Veterans to the emotional processing model. The following script can be used to facilitate this discussion.

Last week we talked about the fear response and the individual fears you each may hold. You may be asking yourself, how did I develop these fears and how do I change them? To answer this question, we need to discuss the emotional processing model. Emotional processing is a term used to describe how we create memories. When you form a memory with a strong emotion attached to it, you are more likely to remember it. To illustrate, tell me about some of your strongest memories...

Ask Veterans to briefly describe some of their strongest memories. Typically, they will report events that are associated with strong emotions, including happiness and fear. Take a few moments to point out that these memories typically include not just the facts, but also the emotions, thoughts, and behaviors associated with the event.

As you may have noticed, several of you reported strong memories for events in which you felt fear. It is natural to develop memories for fear-based events, as this could protect us from future danger. This memory will contain all the elements of the fear response, including the physical, mental, and behavioral systems, and when triggered will cause you to experience that fear again. Unfortunately, any experience or stimulus can be made into a fear-based memory structure and, thus, elicit anxiety. True fear-based memory structures are those that capture a truly dangerous stimulus or event (e.g., being raped). False fear-based memory structures are those that capture information about a stimulus or event that is not truly dangerous yet is connected to our fear response (e.g., smelling a cologne that resembles that of your attacker).

To further illustrate the concept of how fear structures are created, direct Veterans to the [Fear Structure Handout](#).

Let's look at the [Fear Structure Handout](#). As you can see, false fear-based memory structures are created when nondangerous stimuli or events are perceived as dangerous. Luckily, since fear structures can be created at any time, we can also dismantle them at any time. The goal of this treatment is to dismantle the link between these false fear-based memory structures and your fear response. To do this, we will have to look at what maintains them.

INTRODUCTION TO SAFETY AIDS (5 MINUTES)

Now that you have discussed how false fear-based memory structures are created, you will want to spend some time discussing how they are maintained. That is, you will want to introduce Veterans to safety aids. The following script can be used to facilitate this discussion.

Now that we have discussed how these fears developed, let's talk about how they are maintained. False fear-based memory structures are maintained through various behaviors we call safety aids. Safety aids are strategies that people use to prevent, avoid, or reduce anxiety. Safety aids can be behavioral or mental. Examples include avoiding situations, pushing away thoughts, and checking behaviors, as well as using alcohol and certain substances. Although useful in the short term for reducing anxiety, use of such behaviors in the long term maintains anxiety. Because of this, the focus of this treatment will be to identify and fade safety aids associated with your fear response. To do this, however, we will first need to differentiate between true and false safety aids.

A true safety aid is one that protects you from a true danger or threat in your environment. Examples include wearing a seat belt while driving and using a condom during sexual intercourse with a stranger. A false safety aid, on the other hand, is one that serves no safety function at all. Examples include avoiding a crowded grocery store for fears of having a panic attack or fears

regarding one's safety, as well as singing to yourself to avoid thinking about bad things that have happened. In these instances, safety aids reinforce that the situation itself (e.g., being in a crowded grocery store) or thought (e.g., trauma memory) is dangerous, when in fact it is not. This is one reason why, despite repeated exposure to certain situations or memories, your anxiety has not decreased. That is, safety aids reinforce the idea that these false threats are dangerous and maintain faulty fear structures by preventing you from learning that what you fear is not dangerous. Before we talk about how to eliminate safety aids, let's spend some time discussing the various types of safety aids and how they are classified.

TYPES OF SAFETY AIDS (20 MINUTES)

Finally, you will want to spend some time discussing the various types of safety aids that will be covered in this treatment. The following script can be used in conjunction with the [Safety Aid Categories Handout](#) to facilitate this discussion.

Safety aids are often classified according to their primary function. For instance, preventive strategies are performed to prevent future threat or increases in anxiety. Preventive strategies include situational avoidance, compulsive behaviors, and excessive preparation, just to name a few. Restorative strategies, on the other hand, are more subtle in nature and are performed to reduce anxiety and distress in the presence of a perceived threat. Restorative strategies include distraction, thought suppression, and neutralizing techniques (e.g., praying), to name a few.

In addition to this functional classification, safety aids are also categorized by type, that is, as behavioral or cognitive in nature. Behavioral safety aids include, but are not limited to, situational avoidance, compulsive behaviors, and reassurance seeking. Cognitive safety aids include, but are not limited to, distraction, thought suppression, and excessive mental preparation. Let's spend a few minutes going through some of the more common safety aid categories that will be covered in this treatment before identifying and discussing your own.

Compulsive Behaviors. *Compulsive behaviors, or repetitive acts, including checking and reassurance seeking, are a common group of safety aids shared across many of the fear-based disorders. They include things such as checking doors, windows, and locks more often than necessary, as well as excessively watching or listening to the news. While these behaviors may make you feel safer in the moment, they are detrimental to your mental health. That is, they prevent you from learning that such behaviors are not necessary to prevent harm. In the long term, these behaviors actually maintain your anxiety. What are some examples of compulsive behaviors that you have engaged in because of your anxiety?*

Avoidance of Situations. *Situational avoidance, or evading “frightening” situations, is one of the most common safety aids shared across the fear-based disorders. This includes things like avoiding crowded stores, social gatherings, or being far from home. While it makes sense to avoid a truly dangerous situation, when the situation is not truly dangerous, avoidance can be detrimental to your mental health. That is, avoidance prevents you from learning that there is no real danger in your environment. In the long term, this avoidance actually maintains your anxiety. What are some examples of situations you have avoided because of your anxiety?*

Avoidance of Thoughts. *Cognitive avoidance, or using thought-based strategies to reduce anxiety, is another common safety aid shared across many of the fear-based disorders. This includes things like thought suppression and rumination (or replaying the tape). While it may be uncomfortable to remember past experiences or think about future catastrophes, such thoughts are not dangerous. However, the avoidance of these thoughts can be detrimental to your mental health. That is, avoidance prevents you from learning that your thoughts are not dangerous. In the long term, this avoidance actually maintains your anxiety. What are some ways in which you have avoided thoughts because of your anxiety?*

Avoidance of Bodily Sensations. *Avoidance of bodily sensations, or avoiding physical responses, including heart palpitations, sweating, etc., is another common safety aid shared across many of the fear-based disorders. This includes things like avoiding caffeine or vigorous exercise. While it may be uncomfortable to experience certain bodily sensations, such sensations are not dangerous. However, the avoidance of these sensations can be detrimental to your mental health. In fact, avoidance prevents you from learning that these sensations are not dangerous. In the long term, this avoidance actually maintains your anxiety. What are some ways in which you have avoided bodily sensations because of your anxiety?*

Companions. *Companions, including people or animals, are another common safety aid shared across many of the fear-based disorders. They include things such as relying on someone to attend or complete everyday events/activities (e.g., grocery shopping). While your partner or dog may make you feel safer in the moment, their presence can be detrimental to your mental health if you believe that they are the reason you are able to survive a situation. What are some examples of ways in which you have used companions to reduce your anxiety?*

Use of Alcohol, Substances, and Certain Medications. *Alcohol, substances, and certain medications can also function as safety aids across many of the fear-based disorders. They include things such as drinking, smoking, or ingesting*

a medication prior to engaging in a feared activity. While alcohol may lower your anxiety in the short term, the use of such substances can be detrimental to your mental health in the long term. That is, the use of such substances prevents you from learning that you can handle your anxiety. In the long term, the use of such substances actually maintains your anxiety. What are some ways in which you have used alcohol, substances, and medications to reduce your anxiety?

After covering this information, direct the Veterans to the [Safety Aid Checklist](#), which they will be asked to complete for homework. Briefly instruct Veterans on how to complete the worksheet, allowing time for questions or comments.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (5 MINUTES)

Briefly review the content covered in today's session before proceeding to homework assignment.

Today, in Session 2, we learned about the emotional processing model, in particular, how false fear-based memory structures are created. In addition, we discussed how false fear-based memory structures are maintained - that is, via safety aids. Finally, time was spent discussing the various types of safety aids. To capitalize on what you've learned today, it is important for you to complete the following assignments between now and our next session:

1. Review the [Fear Structures Handout](#) and the [Safety Aid Categories Handout](#) until you feel comfortable with the material
2. Complete the [Safety Aid Checklist](#) noting which safety aids you use to prevent, avoid, or reduce anxiety



CHAPTER 3: SESSION 3

MATERIALS NEEDED

- Phobic/Antiphobic Continuum Handout
- Safety Aid Fading Worksheet

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 2 material (10 minutes)
- II. Role of safety aids in treatment (5 minutes)
- III. How to eliminate safety aids (10 minutes)
- IV. Role of antiphobic approach in treatment (10 minutes; see [Phobic/Antiphobic Continuum Handout](#))
- V. Review and homework assignment (15 minutes)

BRIEF CHECK-IN AND REVIEW (10 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 2 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

ROLE OF SAFETY AIDS IN TREATMENT (5 MINUTES)

Next, spend a few minutes discussing the role of safety aids in treatment, in particular, how and why safety aids can be damaging. The following script can be used to facilitate this discussion.

Last week we discussed the various types of safety aids and how they can be dangerous to our mental health. Let's take a few minutes to further explore why they can be damaging and why this treatment will focus on identifying and eliminating them.

First of all, safety aids reinforce the idea that false threats are dangerous when in fact they are not. Because of this, safety aids strengthen the link between various nondangerous stimuli and our false fear-based memory structures. In turn, this prevents you from learning that false threats are not really dangerous.

Second, safety aids create more anxiety because there is never a 100% chance that they will work. Therefore, there is always a sense of anxiety looming in the background.

Third, safety aids can interfere with your life. Avoiding certain situations, such as crowded stores or social gatherings, may prevent you from doing things that are important or that you enjoy.

Because of these and other reasons, this treatment will focus on the identification and elimination of safety aids.

HOW TO ELIMINATE SAFETY AIDS (10 MINUTES)

Now that you have reminded Veterans how and why safety aids can be detrimental to their mental health, you will want to spend some time discussing how to identify and eliminate them. The following script can be used to facilitate this discussion.

Now that we have discussed the negative impact of safety aids on your lives, let's talk about how you can eliminate them.

*The first step is to **IDENTIFY** them. In many cases this will be easy to do. You might have even been motivated to come to treatment because certain safety aids were getting in the way of you doing things that are important or that you enjoy. Other safety aids may be more subtle in nature and, thus, harder to identify. You will need to be very observant of your own cognitive and behavioral attempts at avoiding perceived threats. One question you can ask yourself to determine if a thought or behavior is a safety aid is, "Would someone without anxiety do this for the same reason?" Another way to determine if the thought or behavior is a safety aid is to engage in the activity without the use of the strategy to see if you become anxious. For example, if you often sing to yourself in the shower, try not engaging in this behavior to determine if, in fact, this behavior is being used to prevent, avoid, or reduce your anxiety.*

*Second, you will want to start **ELIMINATING** safety aids. Some of them you may be able to eliminate easily. These will likely be ones that do not really decrease your anxiety or ones that you do not use very often. Others may be harder to eliminate. These will likely be the ones that artificially decrease your anxiety or ones that you use often. Let's discuss some strategies that you can use to help eliminate these safety aids.*

*One strategy is to **DELAY THE USE**. For example, you might delay calling loved ones to check in on their whereabouts. That is, when you have an urge to engage in this compulsive behavior, try waiting a few minutes before calling.*

Another strategy is to **DECREASE THE FREQUENCY OF USE**. For example, if you smoke cigarettes throughout the day to decrease your anxiety, try smoking fewer cigarettes. That is, if you smoke 10 cigarettes a day, try smoking only eight.

A final strategy is to **DECREASE THE DEGREE OF USE**. For example, if you feel the need to sit facing the door, you could try sitting with your side to the door. That is, turn your body 90 degrees.

These changes will allow you to face your fear head on and learn that what you fear is not truly dangerous.

ROLE OF ANTIPHOBIC APPROACH IN TREATMENT (10 MINUTES)

Take time to discuss the role of the antiphobic approach in treatment, in particular, how developing an antiphobic attitude and approach will be necessary for recovery. The following script can be used in conjunction with the Phobic/Antiphobic Continuum Handout to facilitate this discussion.

Now that we have discussed safety aids and how to eliminate them, we will ask you to begin fading them this week. To do this, you will need to develop an antiphobic approach. You may be asking yourself, what is an antiphobic approach? Well, to really understand the antiphobic approach, it helps to start with the opposite, the phobic approach. One of the characteristics of anxiety and related disorders is a phobic approach. The phobic approach is characterized by avoiding, sometimes at all costs, anything that will trigger your fear response. For example, someone with posttraumatic stress disorder may avoid certain people, places, or things that remind them of their trauma. In addition, someone with panic disorder may avoid physiological sensations that are similar to those experienced during a panic attack. Further, someone with social anxiety disorder may avoid social situations for fear of being scrutinized or judged by others.

You can think of this phobic approach as a strategy you have used to prevent and cope with threat. While it is logical to avoid things that are truly dangerous, in these instances there is no true threat. Thus, by continuously acting in a phobic manner, you are reinforcing the false fear-based memory structure.

Since you are participating in this treatment, I can almost guarantee that you have a phobic approach. Up until this point, safety aids have been your go-to strategy for dealing with this fear. Yet, if you are engaging in this treatment, it means they haven't worked. That is, they have not taken away all your fear.

So how do we get rid of this fear? Well, the way to overcome anxiety is to shed your phobic attitude and develop an antiphobic attitude. An antiphobic attitude is one of welcoming and accepting what you fear.

In addition to this antiphobic attitude, we will want you to develop antiphobic behaviors. This is the opposite of what you have been doing. So, if your phobic approach tells you to avoid bodily sensations, social situations, and trauma reminders, we want you to do the opposite. I know this might sound silly, but remember, what you fear is not really dangerous and/or highly unlikely to occur. The phobic approach will only strengthen the link between the false fear-based memory structure and your fear response. The antiphobic approach, on the other hand, will weaken the link between the false fear-based memory structure and fear response.

To illustrate these concepts, let's look at the Phobic/Antiphobic Continuum Handout. You can think of the fading techniques we have discussed as falling on this continuum. At one end is the phobic approach that comes along with your anxiety and related disorder. At this end of the spectrum, you are actively avoiding what you fear and engaging in safety aid use. In the center of this is fading safety aids. At this part of the continuum, you are not using safety aids to avoid your fears, but you are also not actively seeking out your fears. This is an important step in recovery, but you will need to take it a bit further to fully recover. By being antiphobic you are not using safety aids and you are seeking out and welcoming what you fear. We know that this is a new concept for you, and we will give you all the strategies you need to get there. All that we ask is that you keep an open mind and be willing to give this a try.

Of note, Veterans may find the concept of opposite action somewhat scary. Take some time to discuss the importance of this approach for recovery and how such changes will occur on a continuum, starting with the fading of easier safety aids.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (15 MINUTES)

Briefly review the content covered in today's session before proceeding to homework assignment.

Today, in Session 3, we learned about the role of safety aids in treatment and discussed several ways to begin fading them. In addition, we discussed the role of the antiphobic approach in treatment. To capitalize on what you've learned today, it will be important for you to pick two safety aids to begin fading this week. Let's go around the room and state which safety aids we will be fading and how we will be fading them. Remember strategies for fading include delaying use and decreasing the frequency or degree of use.

1. Review the Phobic/Antiphobic Continuum Handout
2. Complete the Safety Aid Fading Worksheet

Take time to help Veterans select specific safety aids to fade, along with the specific techniques (e.g., delay) that will be used to fade. Instruct Veterans to record their fading on the Safety Aid Fading Worksheet.

CHAPTER 4: SESSION 4

MATERIALS NEEDED

- Safety Aid Checklist
- Safety Aid Fading Worksheet

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 3 material (15 minutes)
- II. Reminder of the role of safety aids in treatment (5 minutes)
- III. Safety aid to be covered: Checking behaviors (15 minutes)
- IV. Review and homework assignment (15 minutes)

BRIEF CHECK-IN AND REVIEW (10 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 3 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

REMINDER: ROLE OF SAFETY AIDS IN TREATMENT (5 MINUTES)

After a brief check-in, spend a few minutes reminding Veterans of the nature of safety aids and, in particular, how the purpose of this treatment is to identify and fade them out.

You may recall that safety aids are behavioral or mental strategies that you use to prevent, avoid, or reduce anxiety. Although useful in the short term for reducing your anxiety, use of such behaviors in the long term maintains your anxiety. Because of this, the focus of this treatment will be to identify and fade safety aids associated with your fear response. Beginning today, we will focus on one category of safety aids each week. Today, we will focus on one of the more common categories called checking behaviors.

SAFETY AID: CHECKING BEHAVIORS (15 MINUTES)

Next, introduce Veterans to checking behaviors as a safety aid. The following script can be used to facilitate this discussion.

Checking behaviors, just as it sounds, is a category of safety aids that involves checking. One common example is checking the presence or location of exits or bathrooms. This safety aid is common among individuals with panic disorder and/or posttraumatic stress disorder and is due to fears of not being able to escape during a panic attack or dangerous situation.

Another common checking behavior involves excessively calling relatives or loved ones to check on their health, safety, and/or whereabouts. This type of safety aid is common among individuals with generalized anxiety disorder and posttraumatic stress disorder and related to fears of low-probability catastrophic events.

Further, individuals with generalized anxiety disorder and/or posttraumatic stress disorder may excessively watch or listen to the news. Once again, these behaviors are related to fears of low-probability catastrophic events.

Individuals with obsessive-compulsive disorder may check already completed tasks, including turning the stove off and locking the door. Similarly, individuals with posttraumatic stress disorder may repeatedly check doors, windows, locks, and perimeters around their home more often than necessary. Such behaviors are often related to concerns about being responsible for harm, injury or bad luck, or fears regarding one's safety.

Another common checking behavior involves seeking reassurance. This safety aid is common among individuals with social anxiety disorder and/or major depressive disorder and is due to fears of being negatively evaluated. Typically, individuals will seek reassurance from friends or family but may also seek reassurance from authority figures and professionals (e.g., doctors). For example, individuals with social anxiety disorder might seek repeated reassurance from a friend regarding their appearance (e.g., asking "Do I look ok?") while individuals with panic disorder might seek repeated reassurance from their doctor regarding their risk of heart disease.

In all these situations, checking behaviors make you feel better in the short term. That is, in the moment they reduce your anxiety. However, in the long term they maintain your anxiety. That is, they prevent you from learning that the false threat is not really dangerous.

There may be other types of checking behaviors you use (e.g., checking already completed tasks, checking the time, or checking vital signs) that were not discussed. Let's spend some time identifying and discussing these before moving on to talking about how to fade them for homework this week.

Allow time for brief discussion.

Finally, you will want to spend some time discussing how Veterans might go about fading checking behaviors. The following script can be used to facilitate this discussion.

You may be asking yourself, how do I go about fading my use of checking behaviors? Well, if your tendency is to check your doors, windows, locks, or perimeters 10 times per day, you might start by decreasing the degree or frequency to which you use this safety aid by checking eight times per day. Further, if you frequently check in with friends and family regarding their health, safety, or whereabouts, you might try delaying this behavior for several minutes when you feel the urge. Now that we have reviewed some examples, let's spend some time discussing how you might fade the use of your own checking behaviors.

Once again, allow time for a brief discussion.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (15 MINUTES)

Briefly review the content covered in today's session before proceeding to homework assignment.

Today, in Session 4, we discussed checking behaviors as a safety aid. To capitalize on what you've learned today, it will be important for you to pick two safety aids from this category to begin fading this week. Let's go around the room and state which safety aids we will be fading and how we will be fading them. Remember, strategies for fading include delaying the use and decreasing the frequency or degree of use.

1. Complete the Safety Aid Fading Worksheet

Take time to help Veterans select specific safety aids to fade, along with the specific techniques (e.g., delay) that will be used to fade. Instruct Veterans to record their fading on the Safety Aid Fading Worksheet.



CHAPTER 5: SESSION 5

MATERIALS NEEDED

- Safety Aid Checklist
- Safety Aid Fading Worksheet

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 4 material (15 minutes)
- II. Reminder of the role of safety aids in treatment (5 minutes)
- III. Safety aid to be covered: Situational avoidance (15 minutes)
- IV. Review and homework assignment (15 minutes)

BRIEF CHECK-IN AND REVIEW (15 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 4 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

REMINDER: ROLE OF SAFETY AIDS IN TREATMENT (5 MINUTES)

After a brief check-in, spend a few minutes reminding Veterans of the nature of safety aids and, in particular, how the purpose of this treatment is to identify and fade them out.

Recall that safety aids are behavioral or mental strategies that you use to prevent, avoid, or reduce anxiety. Although useful in the short term for reducing your anxiety, use of such behaviors in the long term maintains your anxiety. Because of this, the focus of this treatment will be to identify and fade safety aids associated with your fear response. Today, we will focus on another category of safety aids called situational avoidance.

SAFETY AID: SITUATIONAL AVOIDANCE (15 MINUTES)

Next, introduce Veterans to situational avoidance as a safety aid. The following script can be used to facilitate this discussion.

Situational avoidance, just as it sounds, is a category of safety aids that involves avoiding certain situations. Logically, it makes sense to avoid a truly

dangerous situation (e.g., walking alone down a dark alley at night). However, when the situation is not truly dangerous (e.g., walking into a crowded store), avoidance can be detrimental to your mental health. That is, avoidance prevents you from learning that there is no real danger in your environment. In turn, this avoidance maintains your anxiety in the long term. In addition, it can prevent you from doing things that are important or that you enjoy. Let's review some common examples of situational avoidance.

One example of situational avoidance involves avoiding parties or social gatherings. This safety aid is common among individuals with social anxiety disorder, major depressive disorder, and posttraumatic stress disorder and can be due to fears of negative evaluation or perceived danger.

Another common example involves avoiding crowded stores or marketplaces. This type of safety aid is common among individuals with panic disorder and posttraumatic stress disorder and is related to fears of not being able to escape should one develop panic-like symptoms or fears of encountering a trauma-related cue.

Further, individuals with panic disorder and/or posttraumatic stress disorder may avoid long lines. Once again, these behaviors are related to fears of not being able to escape in the presence of panic-like symptoms or perceived danger.

Individuals with obsessive-compulsive disorder and/or posttraumatic stress disorder may also avoid using public transportation or driving on busy roads. Such behaviors are often related to fears of contamination or fears of encountering a trauma-related cue.

Another common avoidance technique involves avoiding stressful encounters whether they be at home, school/work, or in relationships. This safety aid is common among all the anxiety and related conditions and is typically related to fears of losing control or going crazy.

In all these instances, situational avoidance makes you feel better in the short term. That is, in the moment, avoidance reduces your anxiety. However, in the long term avoidance maintains your anxiety. That is, it prevents you from learning that the false threat is not really dangerous.

There may be other situations you avoid that we have not discussed. Let's spend some time identifying and discussing these before moving on to talking about how to fade them for homework this week.

Allow time for a brief discussion.

Finally, you will want to spend some time discussing how Veterans might go about fading situational avoidance. The following script can be used to facilitate this discussion.

You may be asking yourself, how do I go about fading my situational avoidance? Well, if your tendency is to avoid crowded stores altogether, you might start by visiting a crowded store during nonpeak hours or for smaller increments of time. Further, if your tendency is to avoid parties or other social gatherings, you might start by attending smaller events, working your way up to larger events. Now that we have reviewed some examples, let's spend some time discussing how you might fade the use of your own situational safety aids.

Once again, allow time for a brief discussion.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (15 MINUTES)

Briefly review the content covered in today's session before proceeding to homework assignment.

Today, in Session 5, we discussed situational avoidance as a safety aid. To capitalize on what you've learned today, it will be important for you to pick two safety aids from this category to begin fading this week. Let's go around the room and state which safety aids we will be fading and how we will be fading them. Remember, strategies for fading include delaying the use and decreasing the frequency or degree of use.

1. Complete the Safety Aid Fading Worksheet

Take time to help Veterans select specific safety aids to fade, along with the specific techniques (e.g., delay) that will be used to fade. Instruct Veterans to record their fading on the Safety Aid Fading Worksheet and to continue fading previously identified safety aids.



CHAPTER 6: SESSION 6

MATERIALS NEEDED

- Safety Aid Checklist
- Safety Aid Fading Worksheet

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 5 material (15 minutes)
- II. Reminder of the role of safety aids in treatment (5 minutes)
- III. Safety aid to be covered: Cognitive avoidance (15 minutes)
- IV. Review and homework assignment (15 minutes)

BRIEF CHECK-IN AND REVIEW (15 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 5 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

REMINDER: ROLE OF SAFETY AIDS IN TREATMENT (5 MINUTES)

After a brief check-in, spend a few minutes reminding Veterans of the nature of safety aids and, in particular, how the purpose of this treatment is to identify and fade them out.

Recall that safety aids are behavioral or mental strategies that you use to prevent, avoid, or reduce anxiety. Although useful in the short term for reducing your anxiety, use of such behaviors in the long term maintains your anxiety. Because of this, the focus of this treatment will be to identify and fade safety aids associated with your fear response. Today, we will focus on another category of safety aids called cognitive avoidance.

SAFETY AID: COGNITIVE AVOIDANCE (15 MINUTES)

Next, introduce Veterans to cognitive avoidance as a safety aid. The following script can be used to facilitate this discussion.

Cognitive avoidance, just as it sounds, is a category of safety aids that involves using mental strategies to avoid certain thoughts or images. Although it

may be uncomfortable and upsetting to remember past experiences, think about future catastrophes, or have certain images pop into your head, such experiences are not dangerous. However, avoidance of these thoughts and images can be detrimental to your mental health. That is, avoidance prevents you from learning that your thoughts are not dangerous. In turn, this avoidance maintains your anxiety in the long term. In addition, it can prevent you from doing things that are important or that you enjoy. Given that cognitive avoidance strategies can be very subtle and difficult to identify, let's spend some time reviewing and discussing some of the more common examples.

There are three main types of cognitive avoidance. The first is thought or image replacement, which involves replacing an unwanted or frightening thought or image with a neutral or pleasant thought or image. This safety aid is common among individuals with obsessive-compulsive disorder and posttraumatic stress disorder. For example, individuals with obsessive-compulsive disorder may replace certain thoughts or images (e.g., harming a loved one) with neutral or pleasant thoughts or images due to the belief that thinking about an unwanted event makes it more likely to happen. In addition, individuals with posttraumatic stress disorder may replace certain thoughts or images (e.g., of combat or sexual assault) with neutral or pleasant images due to the belief that they cannot handle "reliving the event."

The second type of cognitive avoidance is distraction. Instead of actually replacing unwanted or frightening thoughts or images with neutral or pleasant ones, distraction involves refocusing one's attention towards neutral or positive stimuli. This safety aid is common among individuals with social anxiety disorder, generalized anxiety disorder, and posttraumatic stress disorder. For example, an individual with social anxiety disorder may distract by thinking of excuses to leave a social situation early. In addition, an individual with posttraumatic stress disorder and/or generalized anxiety disorder may "stay busy" to distract from unwanted thoughts or images. In all these instances, cognitive avoidance makes you feel better in the short term. That is, in the moment, cognitive avoidance reduces your anxiety. However, in the long term cognitive avoidance maintains your anxiety and prevents you from learning that the false threat is not really dangerous.

The third type of cognitive avoidance is rumination. Rumination involves passively and repeatedly thinking about one's distress, including the causes and consequences. This safety aid is common among individuals with major depressive disorder, generalized anxiety disorder, and posttraumatic stress disorder. For example, an individual with major depressive disorder may ruminate about past perceived failures. In addition, individuals with generalized anxiety disorder may ruminate (or worry) about future catastrophes. Further, individuals with posttraumatic stress disorder may ruminate about past

traumatic events, blaming themselves for the outcome. In all these instances, rumination (or worry) is perceived as a problem-solving technique. However, this cognitive strategy is not solution focused.

There may be other types of cognitive avoidance that were not discussed. Let's spend some time identifying and discussing these before moving on to talking about how to fade them for homework this week.

Allow time for a brief discussion.

Given that cognitive safety aids can be more difficult to fade than some of the other categories of safety aids, you will want to spend some time discussing specific fading strategies. The following script can be used to facilitate this discussion.

You may be asking yourself, how do I go about fading the use of these cognitive safety aids? Well, if your tendency is to distract from or replace unwanted thoughts or images, we ask that you delay the use of these strategies, allowing yourself to accept and sit with the unwanted thought or image. This serves to retrain your brain and body that thoughts or images are not dangerous.

On the other hand, if your tendency is to ruminate, we would ask that you allow yourself to process the event itself, focusing on the facts rather than the causes and consequences. For example, a person with social anxiety disorder may find themselves ruminating about a recent social interaction. Rather than focusing on perceived mistakes (e.g., "I sounded nervous"), the individual should focus on readily observable facts (e.g., "I engaged in small talk with a coworker"). In addition, a person with major depressive disorder may find themselves ruminating about a recent event. Rather than focusing on perceived past failures (e.g., "I always mess up"), the individual should focus on the readily observable facts (e.g., "I made one mistake"). Further, a person with posttraumatic stress disorder may find themselves ruminating about a recent traumatic event (e.g., combat). Rather than focusing on the causes and consequences of the event (e.g., "If I would have done something differently, Lt. Dan would still have his legs"), the individual should focus on the readily observable facts (e.g., "Lt. Dan lost his legs as a result of an IED explosion"). Finally, a person with generalized anxiety disorder may find themselves ruminating about the health and well-being of a loved one. Rather than focusing on possible catastrophes (e.g., "He's been involved in a fatal car crash"), the individual should focus on the readily observable facts (e.g., "He did not answer his phone").

Lastly, if you notice yourself engaging in any of these cognitive avoidance strategies, you could try refocusing your attention on what it is you fear. This antiphobic approach will weaken the link between the false fear-based

memory structure and fear response. Now that we have reviewed some examples, let's spend some time discussing how you might fade the use of your own cognitive avoidance.

Once again, allow time for a brief discussion.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (15 MINUTES)

Briefly review the content covered in today's session before proceeding to homework assignment.

Today, in Session 6, we discussed cognitive avoidance as a safety aid. To capitalize on what you've learned today, it will be important for you to pick two safety aids from this category to begin fading this week. Let's go around the room and state which safety aids we will be fading and how we will be fading them. Remember strategies for fading include delaying the use and decreasing the frequency or degree of use.

1. Complete the Safety Aid Fading Worksheet

Take time to help Veterans select specific safety aids to fade, along with the specific techniques (e.g., delay) that will be used to fade. Instruct Veterans to record their fading on the Safety Aid Fading Worksheet and to continue fading previously identified safety aids.



CHAPTER 7: SESSION 7

MATERIALS NEEDED

- Safety Aid Checklist
- Safety Aid Fading Worksheet

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 6 material (15 minutes)
- II. Reminder of the role of safety aids in treatment (5 minutes)
- III. Safety aid to be covered: Physiological avoidance (15 minutes)
- IV. Review and homework assignment (15 minutes)

BRIEF CHECK-IN AND REVIEW (15 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 6 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

REMINDER: ROLE OF SAFETY AIDS IN TREATMENT (5 MINUTES)

After a brief check-in, spend a few minutes reminding Veterans of the nature of safety aids and, in particular, how the purpose of this treatment is to identify and fade them out.

Recall that safety aids are behavioral or mental strategies that you use to prevent, avoid, or reduce anxiety. Although useful in the short term for reducing your anxiety, use of such behaviors in the long term maintains your anxiety. Because of this, the focus of this treatment will be to identify and fade safety aids associated with your fear response. Today, we will focus on another category of safety aids called physiological avoidance.

SAFETY AID: PHYSIOLOGICAL AVOIDANCE (15 MINUTES)

Next, introduce Veterans to physiological avoidance as a safety aid. The following script can be used to facilitate this discussion.

Physiological avoidance, just as it sounds, is a category of safety aids that involves avoiding certain bodily sensations. You may recall that fear-based

memory structures contain all the elements of the fear response, including your physiological response, and when triggered can cause you to experience that fear all over again. This connection between your fear response and certain physiological sensations can be so strong that it causes you to fear benign bodily sensations, including heart palpitations. It makes sense to avoid sensations that are truly dangerous (e.g., avoiding walking on a sprained ankle to prevent pain and further injury). However, when the sensation is not truly dangerous (e.g., heart palpitations due to vigorous exercise), avoidance can be detrimental to your mental health. That is, avoidance prevents you from learning that there is no real danger in your environment. In turn, this avoidance maintains your anxiety in the long term. In addition, it can prevent you from doing things that are important or that you enjoy. Let's review some common examples of physiological avoidance.

One example of physiological avoidance involves avoiding vigorous exercise. This safety aid is common among individuals with panic disorder and is due to fears of physical illness, including cardiac arrest.

Another common example involves avoiding saunas, hot tubs, or steamy showers. This type of safety aid is also common among individuals with panic disorder and is related to fears of suffocation.

Further, individuals with panic disorder may avoid drinks containing caffeine as it increases heart rate. Once again, this avoidance is related to fears of physical illness.

Individuals with social anxiety disorder may avoid situations in which they sweat, tremble, or shake. This avoidance, while situational in nature, is related to fears of publicly observable symptoms of anxiety. In particular, individuals with social anxiety disorder fear that others will notice their anxiety and, in turn, think negatively of them.

In addition, it is not uncommon for individuals with posttraumatic stress disorder to avoid movies and media as a means of avoiding increased physiological arousal including increased heart rate and difficulty breathing. This avoidance is related to fears of trauma reminders.

It is also not uncommon for individuals with posttraumatic stress disorder and generalized anxiety disorder to avoid stressful encounters due to fears of certain physiological sensations that often accompany stress, including heart palpitations, blushing, and sweating. Such behaviors may be due to fears of negative evaluation, catastrophe, or even fears that one may lose control or go crazy.

In all these instances, avoiding these bodily sensations makes you feel better in the short term. That is, in the moment, avoidance reduces your anxiety. However, in the long term avoidance maintains your anxiety. That is, it prevents you from learning that the sensations are not truly dangerous.

There may be other bodily sensations that you avoid that were not discussed. Let's spend some time identifying and discussing these before moving on to talking about how to fade them for homework this week.

Allow time for a brief discussion.

Finally, you will want to spend some time discussing how Veterans might go about fading physiological avoidance. The following script can be used to facilitate this discussion.

You may be asking yourself, how do I go about fading my physiological avoidance? Well, if your tendency is to avoid exercise, you might start by taking a brief, yet brisk walk around your neighborhood. Further, if your tendency is to avoid caffeine at all cost, you might start by drinking a less caffeinated drink, such as decaf coffee or drinking only a quarter of a cup. Now that we have reviewed some examples, let's spend some time discussing how you might fade your own physiological avoidance.

Once again, allow time for a brief discussion.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (15 MINUTES)

Briefly review the content covered in today's session before proceeding to homework assignment.

Today, in Session 7, we discussed physiological avoidance as a safety aid. To capitalize on what you've learned today, it will be important for you to pick two safety aids from this category to begin fading this week. Let's go around the room and state which safety aids we will be fading and how we will be fading them. Remember, strategies for fading include delaying the use and decreasing the frequency or degree of use.

1. Complete the Safety Aid Fading Worksheet

Take time to help Veterans select specific safety aids to fade, along with the specific techniques (e.g., delay) that will be used to fade. Instruct Veterans to record their fading on the Safety Aid Fading Worksheet and to continue fading previously identified safety aids.

CHAPTER 8: SESSION 8

MATERIALS NEEDED

- Safety Aid Checklist
- Safety Aid Fading Worksheet

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 7 material (15 minutes)
- II. Reminder of the role of safety aids in treatment (5 minutes)
- III. Safety aid to be covered: Companions (15 minutes)
- IV. Review and homework assignment (15 minutes)

BRIEF CHECK-IN AND REVIEW (15 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 7 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

REMINDER: ROLE OF SAFETY AIDS IN TREATMENT (5 MINUTES)

After a brief check-in, spend a few minutes reminding Veterans of the nature of safety aids and, in particular, how the purpose of this treatment is to identify and fade them out.

Recall that safety aids are behavioral or mental strategies that you use to prevent, avoid, or reduce anxiety. Although useful in the short term for reducing your anxiety, use of such behaviors in the long term maintains your anxiety. Because of this, the focus of this treatment will be to identify and fade safety aids associated with your fear response. Today, we will focus on another category of safety aids called companions.

SAFETY AID: COMPANIONS (15 MINUTES)

Next, introduce Veterans to companions as a safety aid. The following script can be used to facilitate this discussion.

Companions is a category of safety aids that typically involves using people or animals to prevent, avoid, or reduce anxiety. This category of safety aid is

common across many anxiety and related disorders. For example, individuals with social anxiety disorder may have friends or family accompany them to social events due to fears of being negatively evaluated. Similarly, individuals with panic disorder may take a friend or family member with them when out and about due to fears of not being able to escape or get help in the event of a panic attack. Further, individuals with posttraumatic stress disorder may bring a pet along while running errands due to fears of encountering and not being able to handle a trauma-related cue.

You may be asking yourself, is spending time with friends, family, or Fido bad? No, but if you are using a companion as a safety aid, that is, to prevent, avoid, or reduce your anxiety, it can be detrimental to your mental health. That is, companions prevent you from learning that you can handle the situation on your own. In turn, companions maintain your anxiety in the long term.

The absence of a companion can also be a safety aid. In fact, some people may feel less anxiety when they are alone. For example, individuals with social anxiety disorder and panic disorder may fear what others will think of them if they show signs or symptoms of anxiety. In addition, individuals with posttraumatic stress disorder may worry about having to be watchful or on guard for themselves and others and, thus, prefer to go alone. Further, individuals with major depressive disorder may avoid enlisting social support for fears related to being a burden on those around them. In these instances, the absence of a companion is just as much of a safety aid as the presence of a companion.

It is also important to note that the person does not actually have to be present to serve as a safety aid. For many individuals, just the awareness that someone is available can be enough. This is often the case among individuals with generalized anxiety disorder who rely on their cell phones to be able to check-in on the whereabouts of others.

In all these instances, the presence or absence of a companion makes you feel better in the short term. That is, in the moment, they reduce your anxiety. However, in the long term they maintain your anxiety. That is, they prevent you from learning that you can handle the situation on your own. Additionally, the use of companions can interfere with your life and limit your social opportunities. Indeed, there may be many exciting and fun things to do that you are unable to do because of this safety aid. The constant demand for others' time and attention or the reduction in time spent with others may also put a strain on your relationships.

There may be other ways in which you use or do not use companions as a safety aid that were not discussed. Let's spend some time identifying and discussing these before moving on to talking about how to fade them for homework this week.

Allow time for a brief discussion.

Finally, you will want to spend some time discussing how Veterans might go about fading companions. The following script can be used to facilitate this discussion.

You may be asking yourself, how do I go about fading my use of companions? Well, if your tendency is to always have a friend or family member accompany you to your medical appointments, you might start by decreasing the degree to which you use this safety aid by asking them to wait in the car. On the other hand, if your tendency is to go alone, you might start by having someone accompany you to less anxiety-provoking situations while working your way up to harder ones. Now that we have reviewed some examples, let's spend some time discussing how you might fade your own use of companions.

Once again, allow time for a brief discussion.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (15 MINUTES)

Briefly review the content covered in today's session before proceeding to homework assignment.

Today, in Session 8, we discussed companions as a safety aid. To capitalize on what you've learned today, I would like for you all to pick one safety aid from this category to begin fading this week. Let's go around the room and state which safety aid we will be fading and how we will be fading it. Remember, strategies for fading include delaying the use and decreasing the frequency or degree of use.

1. Complete the Safety Aid Fading Worksheet

Take time to help Veterans select specific safety aids to fade, along with the specific techniques (e.g., delay) that will be used to fade. Instruct Veterans to record their fading on the Safety Aid Fading Worksheet and to continue fading previously identified safety aids.

CHAPTER 9: SESSION 9

MATERIALS NEEDED

- Safety Aid Checklist
- Safety Aid Fading Worksheet

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 8 material (15 minutes)
- II. Reminder of the role of safety aids in treatment (5 minutes)
- III. Safety aid to be covered: Alcohol, substances, and certain medications (15 minutes)
- IV. Review and homework assignment (15 minutes)

BRIEF CHECK-IN AND REVIEW (15 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 8 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

REMINDER: ROLE OF SAFETY AIDS IN TREATMENT (5 MINUTES)

After a brief check-in, spend a few minutes reminding Veterans of the nature of safety aids and, in particular, how the purpose of this treatment is to identify and fade them out.

Recall that safety aids are behavioral or mental strategies that you use to prevent, avoid, or reduce anxiety. Although useful in the short term for reducing your anxiety, use of such behaviors in the long term maintains your anxiety. Because of this, the focus of this treatment will be to identify and fade safety aids associated with your fear response. Today, we will focus on another category of safety aids, namely, alcohol, substances, and certain medications.

SAFETY AID: ALCOHOL, SUBSTANCES, AND CERTAIN MEDICATIONS (15 MINUTES)

Next, introduce Veterans to the use of alcohol, substances, and certain medications as a safety aid. The following script can be used to facilitate this discussion.

The use of alcohol, substances, and certain medications can also function as a safety aid across many anxiety and related disorders. Such safety aids include drinking, smoking, or taking medication prior to, during, or after a feared situation.

For example, individuals with social anxiety disorder may consume alcohol or smoke marijuana prior to or during a social engagement due to fears of negative evaluation. Further, individuals with generalized anxiety disorder may consume alcohol to distract from their worry while individuals with posttraumatic stress disorder may use opioids to numb the pain caused by trauma-related thoughts or images. In all these instances, the use of alcohol and substances makes one feel better in the short term. That is, in the moment they reduce anxiety. However, in the long term they maintain anxiety. That is, they prevent one from learning that they can handle the situation on their own.

Notably, the avoidance of alcohol and certain substances may also serve as a safety aid. For example, individuals with panic disorder may avoid alcohol as it produces uncomfortable and feared bodily sensations, such as blushing. Further, individuals with posttraumatic stress disorder may avoid alcohol for fears of not being in control/able to function should a crisis occur. In these instances, avoidance of alcohol and certain substances is a safety aid.

Although Veterans can be instructed to consume alcohol responsibly (e.g., having one glass of wine with dinner), this technique should be avoided for Veterans with a history of substance-use problems.

In addition to alcohol and substances, certain medications can also function as a safety aid. This is particularly true for medications that are prescribed on an as-needed basis. For example, individuals with panic disorder are often prescribed benzodiazepines for the treatment of panic due to their calming, sedating, and tranquilizing effects. Although medications can be useful for some individuals, there are significant drawbacks to using medications, including both physical and psychological dependence. Indeed, the use of certain medications can prevent you from learning that you can handle your anxiety on your own. Nevertheless, you should always consult a physician or psychiatrist prior to fading medication usage.

There may be other ways in which you use alcohol, substances, and certain medications that were not discussed. Let's spend some time identifying and discussing these before moving on to talking about how to fade them for homework this week.

Allow time for a brief discussion.

Finally, you will want to spend some time discussing how Veterans might go about fading their use of alcohol, substances, and certain medications. The following script can be used to facilitate this discussion.

You may be asking yourself, how do I go about fading my use of alcohol, substances, and certain medications? Well, if your tendency is to have two drinks before attending a party or social gathering, you might decrease your use of this safety aid by having only one drink. Further, if your tendency is to ingest benzodiazepines upon experiencing heart palpitations, you might start by delaying for several minutes before taking the medication. Now that we have reviewed some examples, let's spend some time discussing how you might fade the use of your own use of alcohol, substances, and certain medications.

Once again, allow time for a brief discussion.

SESSION REVIEW AND HOMEWORK ASSIGNMENT (15 MINUTES)

Briefly review the content covered in today's session before proceeding to homework assignment.

Today, in Session 9, we discussed the use of alcohol, substances, and certain medications as a safety aid. To capitalize on what you've learned today, it will be important for you to pick one safety aid from this category to begin fading this week. Let's go around the room and state which safety aids we will be fading and how we will be fading them. Remember, strategies for fading include delaying the use and decreasing the frequency or degree of use.

1. Complete the Safety Aid Fading Worksheet

Take time to help Veterans select specific safety aids to fade, along with the specific techniques (e.g., delay) that will be used to fade. Instruct Veterans to record their fading on the Safety Aid Fading Worksheet and to continue fading previously identified safety aids.



CHAPTER 10: SESSION 10

MATERIALS NEEDED

- Safety Behavior Assessment Form (administer after session)
- Safety Aid Checklist
- Safety Aid Fading Worksheet

SESSION OUTLINE

- I. Brief check-in and review of homework and Session 9 material (15 minutes)
- II. Review of skills learned and progress made (15 minutes)
- III. Defining and dispelling myths about recovery (10 minutes)
- IV. Relapse prevention (10 minutes)
- V. Goodbye (5 minutes)

BRIEF CHECK-IN AND REVIEW (15 MINUTES)

Begin the session by completing a brief check-in and review of homework and Session 9 material. In particular, ask Veterans how they have been doing over the past week and whether they had any questions or difficulties completing the homework assignment. Take time to troubleshoot any barriers, while offering praise for the Veterans' efforts and reflecting on lessons learned.

REVIEW OF SKILLS LEARNED AND PROGRESS MADE (15 MINUTES)

Next, spend some time reviewing the Veterans' progress and the skills learned throughout treatment. The following script can be used to facilitate this discussion.

The first goal of today's session is to review the skills learned during treatment. As you may recall, this treatment was designed to target various anxiety and related disorders via the identification and elimination of safety aids. By coming to treatment each week and fading your use of these various behaviors, you have learned the skills necessary to continue treating yourself. To further your treatment progress, you will want to continue designing fading exercises to address any remaining safety aids. The Safety Aid Checklist and Safety Aid Fading Worksheet can be used to facilitate this process.

Now let's discuss your progress. What behavioral changes have you noticed since starting treatment? How are you feeling about these changes? What have you learned? What was the most helpful aspect of this program? What was the

least helpful aspect of this program? Which safety aids have you had the most success fading? Which safety aids have you had the least success fading?

DEFINING AND DISPELLING MYTHS ABOUT RECOVERY (15 MINUTES)

Further, you will want to spend some time defining recovery and dispelling some of the more common myths surrounding recovery. The following script can be used to facilitate this discussion.

Recovery from fear-based disorders like panic, social anxiety, generalized anxiety, obsessive-compulsive, and posttraumatic stress, as well as distress-based disorders like major depression, does not mean that you will never again experience anxiety or distress. After all, anxiety is a normal emotional response designed to protect us from harm. Recovery does mean, however, that you should experience less anxiety and that your anxiety is more manageable. To further illustrate, let's spend a few minutes dispelling some common myths of recovery.

Take time to review the myths below. Ask Veterans if they have held any of these myths while reminding them that these statements are just not true.

"I should never be stressed again."

It is silly to think that you will never again be stressed. Remember, stress is a normal response to perceived life demands; and it would be impossible to eliminate all stressors. More important is that you do not allow stress to become a trigger for anxiety and false alarms.

"I should never be anxious or worried again," or "I should never again experience sadness."

The goal of this treatment is NOT to prevent you from experiencing anxiety or sadness, as these emotions are normal and a large part of what makes us human. Rather, the goal of this treatment is to teach you how to reduce your anxiety and manage your emotions so that they no longer interfere with your life. Does this make sense?

Allow time to dispute these and other myths the Veterans may vocalize.

RELAPSE PREVENTION (10 MINUTES)

Next, you will want to spend some time discussing relapse prevention. Veterans should understand that, to continue getting better and prevent relapse, they will need to continue identifying and fading the use of safety aids. The following script can be used to facilitate this discussion.

Although the treatment you just completed has high rates of success, it is possible to relapse. To prevent this, it will be important for you to continue using the skills learned throughout treatment. That is, you will want to continue

identifying and fading the use of any remaining safety aids. Let's spend a few minutes discussing factors that contribute to relapse.

- 1. Failing to continue eliminating old safety aids will increase your likelihood of relapse. As such, it will be important for you to continue identifying and fading safety aids covered throughout treatment.*
- 2. Adopting new safety aids will also contribute to relapse. Thus, it will be important for you to continue monitoring your behaviors to ensure that you do not replace old safety aids with new ones (e.g., quit drinking and start smoking).*
- 3. Becoming complacent with your current gains or "Complacency syndrome" can also contribute to relapse. You will want to monitor yourself to ensure you do not become so content with where you are now that you fail to continue practicing the skills learned throughout treatment.*
- 4. Worrying about getting worse, or "Don't rock the boat syndrome," can also contribute to relapse. As long as you continue to identify and fade the use of safety aids, your fear of getting worse will not happen.*

Remember that treatment is an ongoing process and that continuing to use the skills learned throughout treatment will ensure that you do not revert back to old habits.

Finally, spend some time discussing what the Veterans should do if they have a setback. The following script can be used to facilitate this discussion.

Sometimes people feel like they have failed if they experience anxiety. However, you should remember that anxiety is a normal and adaptive emotional response designed to protect us from harm. It is also important for you to remember that feeling uncomfortable does not equal danger. Nevertheless, if you do find yourself slipping into bad habits, that is, beginning to use old safety aids or picking up new ones, try to get back on track by using the skills and techniques learned during treatment. Further, try to challenge yourself by using the antiphobic attitude/approach. That is, welcome what you fear.

SAYING GOODBYE (5 MINUTES)

Working with Veterans with anxiety can be extremely challenging and rewarding. Take a few minutes to congratulate them for their efforts and progress and to say goodbye. The following script can be used to facilitate this discussion.

Although this program may have not always been easy to complete, you all stuck with it and made some significant progress. I want to congratulate you all on this accomplishment. I have enjoyed working with you all and hope that you will continue to apply the knowledge and skills learned. Should you have additional needs in the future or find yourself in need of a refresher, please do not hesitate to reach out.

CHAPTER 11

ADDITIONAL TREATMENT CONSIDERATIONS

AVOIDANCE VERSUS DISLIKE

It is important to highlight the difference between avoidance and dislike of situations when working with Veterans to identify and fade the use of safety aids. For example, many Veterans may not find inherent benefits from shopping at a crowded marketplace. However, their dislike is different from anxiety-related avoidance in that it is not fear-based and will not decrease with repeated attempts at exposure. If Veterans are unsure whether the cognitive or behavioral strategy is indeed a safety aid, work with them to design a behavioral experiment to determine the function of avoidance.

OVERESTIMATION OF THREAT

Some Veterans may be resistant to fading certain safety aids due to fears of low probability events. This is particularly true among Veterans and individuals with a trauma history who believe safety aids will keep them safe. With these individuals, it will be beneficial to explain the difference between *probably* and *possibly* while also highlighting the interfering nature of such behaviors. For example, Veterans should be encouraged to reflect on the frequency such events have occurred in the past and the likelihood that such events will occur in the future. Further, it may be useful to help the Veteran differentiate between true and false safety practices.

OTHER SAFETY AIDS

Despite the multitude of safety aids covered in this manual, there are likely others that were not discussed. Indeed, any cognitive or behavioral strategy used to prevent, avoid, or reduce anxiety can become a safety aid. For example, it is not uncommon for certain objects (e.g., weapons) to be used in the moment to reduce anxiety. Consistent with the techniques described in this manual, Veterans should be instructed to identify and fade the use of these idiosyncratic safety aids as they may contribute to the development and maintenance of various anxiety and related disorders.

JUDICIOUS USE OF SAFETY AIDS

Safety aids contribute to the development and maintenance of various anxiety and related disorders and negatively impact the exposure-based process. However, purposeful prescription of safety aids can facilitate treatment when Veterans are exceptionally fearful and avoidant, rendering them unwilling to participate in the fading exercises. Indeed, researchers have found that the strategic use of safety aids, particularly in the early stages of treatment, are helpful for overcoming fear and obtaining disconfirming evidence. For

example, a socially anxious Veteran may be advised to attend a party with a friend on several occasions (use of safety aid) before venturing out alone (elimination of safety aid). While prescribing aids can be useful, it is important to do so in a limited manner and only for a limited time.

FADING VERSUS EXPOSURE

As discussed in Chapter 3, fading is a systematic approach by which the degree and frequency of safety aid use is decreased. Although the Veterans may be asked to put themselves in a feared situation, they are not instructed to stay in the situation until their anxiety subsides, as they would be in traditional exposure-based exercises. For example, patients with PD who often avoid being far from home may be instructed to increasingly distance themselves from home when fading. On the other hand, in the context of exposure, they may be asked to drive an extended distance and stay there until their anxiety abates.



APPENDIX A

SBAF

Below is a list of behaviors that people sometimes use to make themselves feel more comfortable. For each behavior please pick the response that most accurately describes how often you engage in that behavior.

	Never 0	Sometimes 1	Often 2	Always 3
1. Scope places out before entering				
2. Over-plan for everyday events				
3. Call or contact loved ones to make sure they are ok				
4. Sit with back to wall				
5. Stay within certain distances from home (or other safe places)				
6. Prepare things to say while others are talking				
7. Rush through stores or go directly to desired items and leave as quickly as possible				
8. Call doctors' offices (or health-lines) frequently				
9. Check yard or the area around your home ("Perimeter Checks")				
10. Talk through silences or talk so that silences do not occur				
11. Check locks on doors or windows				

	Never 0	Sometimes 1	Often 2	Always 3
12. Procrastinate before I start something or make a decision				
13. Make up contingency plans in case someone is physically aggressive or there is some kind of emergency				
14. Take it easy when I exercise (or do other activities that require physical exertion) so my heart rate does not get too high				
15. Monitor others' reactions to things I say				
16. Stay on the outside of crowds and/or monitor for exits or escape routes				
17. Be overly polite or agreeable				
18. Attempt to hide anxiety (e.g., put hands in pocket because they are shaking)				
19. Check my body for problems (pain, discomfort, symmetry, discoloration, new growth, etc.)				
20. Carry medication in case I need it				
21. Research medical symptoms on the internet				
22. Check my body temperature				
23. Leave events or activities early				
24. Make little eye contact				
25. Respond to calls with text messages				
26. Research things before I start or before making a decision				

	Never 0	Sometimes 1	Often 2	Always 3
27. Monitor the clock				
28. Try to do things perfectly				
29. Plan and/or rehearse what I am going to say ahead of time				
30. Walk slowly to let someone pass who is close behind				
31. Make myself look busy while at work or when out in public so that others do not talk to me				
32. Cut conversations short				
33. Monitor what I say in conversations				
34. Watch others for signs of danger				
35. Ask others for reassurance (e.g., about a decision or worry)				
36. Check my pulse or heart rate				
37. Talk to others about my health or health-related activities				
38. Pay attention to body for physical symptoms or sensations				
39. Check that I can swallow without choking				
40. Pretend I do not see or recognize someone so that I do not have to speak with them				
41. Request specialized medical exams from providers				

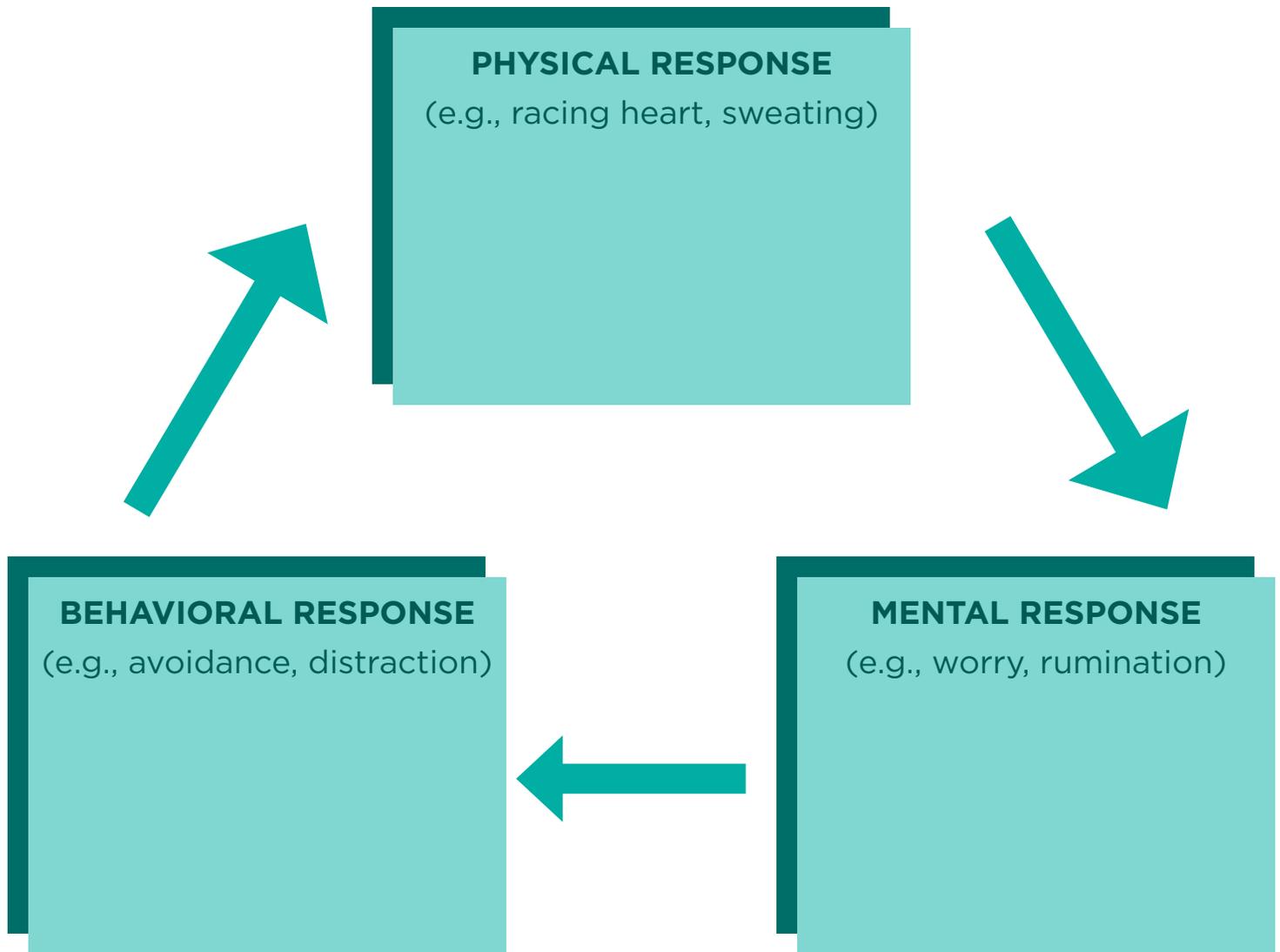
APPENDIX B

ANXIETY TERMINOLOGY HANDOUT

Stress More general than anxiety Response to life demands (both positive and negative)
Anxiety Normal emotional response designed to protect us from harm Warning that goes off when we ANTICIPATE danger
Panic Normal biological response designed to protect us from harm Alarm that goes off in response to IMMEDIATE threat (e.g., “fight or flight”)
Worry Normal mental response designed to protect us from harm Warning that goes off in response to FUTURE threat
True Alarm Physical, mental, and behavioral response to true threat (e.g., seeing bear in woods)
False Alarm Physical, mental, and behavioral response to false threat (e.g., seeing bear in zoo)
Panic Disorder Learned pattern of false alarms that stems from an exaggerated fear of physical sensations of anxiety (e.g., racing heart)
Social Anxiety Disorder Learned pattern of false alarms that stems from an exaggerated fear of negative evaluation
Generalized Anxiety Disorder Learned pattern of false alarms that stems from an exaggerated fear of low probability catastrophic events
Obsessive-Compulsive Disorder Learned pattern of false alarms that stems from a fear of recurrent thoughts, urges, or images
Posttraumatic Stress Disorder Learned pattern of false alarms that stems from a fear of trauma reminders

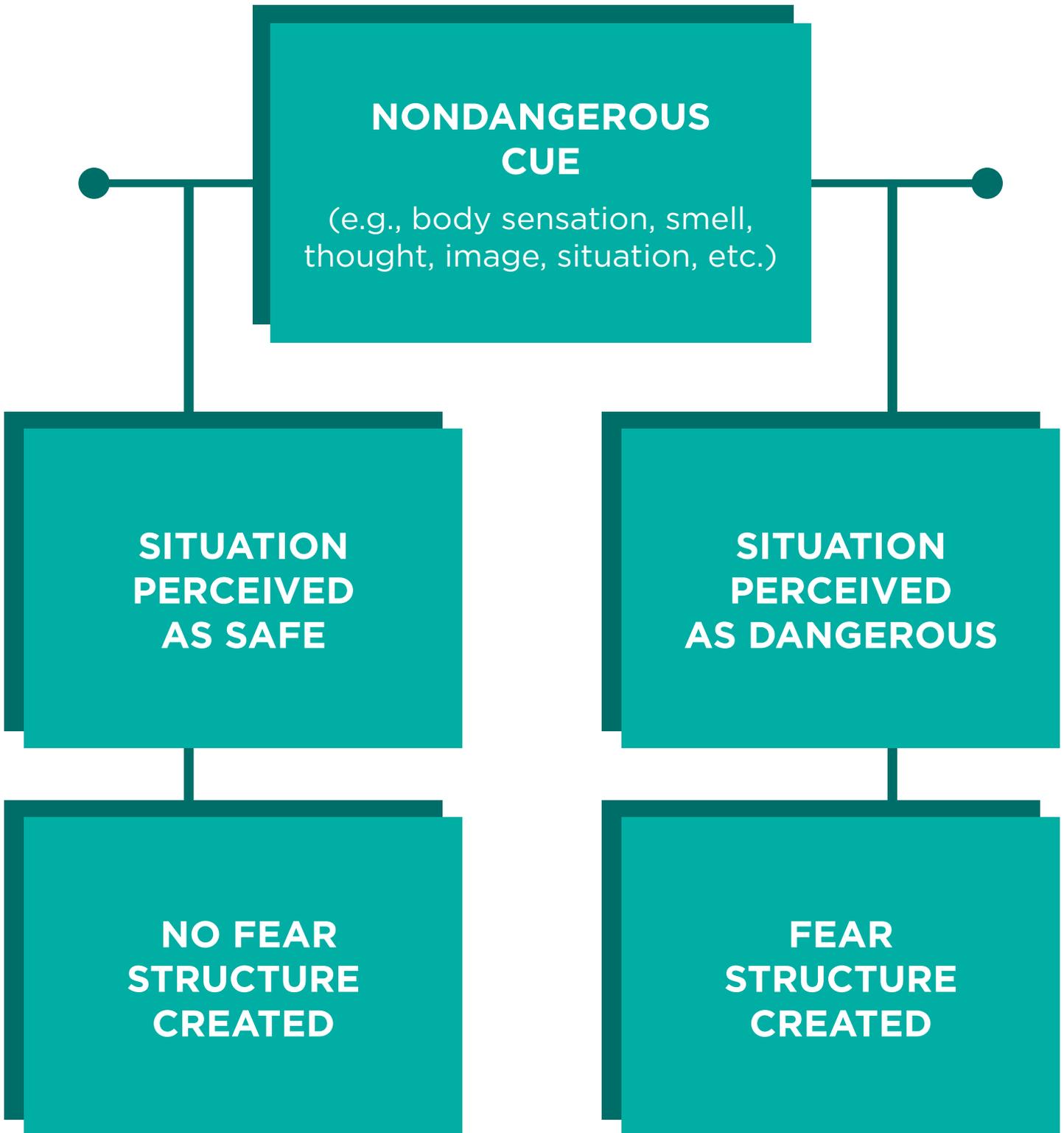
APPENDIX C

FEAR RESPONSE WORKSHEET



APPENDIX D

FEAR STRUCTURES HANDOUT



APPENDIX E

SAFETY AID CATEGORIES

Safety aids are behavioral or mental strategies that you use to prevent, avoid, or reduce anxiety. Below are some categories of safety aids that will be covered throughout this treatment.

COMPULSIVE/ CHECKING BEHAVIORS

Compulsive behaviors, or repetitive acts, including checking and reassurance seeking, are a common group of safety aids shared across many of the fear-based disorders. This includes things like checking doors, windows, and locks more often than necessary as well as excessively watching or listening to the news.

AVOIDANCE OF SITUATIONS

Situational avoidance, or evading “frightening” situations, is a common category of safety aids shared across many of the fear-based disorders. This includes things such as avoiding crowded stores, social gatherings, or even being far from home.

AVOIDANCE OF THOUGHTS

Cognitive avoidance is a category of safety aids that involves using thought-based strategies to reduce anxiety. This includes things like thought suppression and rumination (or replaying the tape).

AVOIDANCE OF BODILY SITUATIONS

Avoidance of bodily sensations, or avoiding physical responses, including heart palpitations, is another common safety aid shared across many of the fear-based disorders. This includes things like avoiding caffeine or vigorous exercise.

COMPANIONS

Companions, including people or animals, are another common safety aid shared across many of the fear-based disorders. This includes things like relying on a companion to attend or complete everyday events/activities.

ALCOHOL, SUBSTANCES, AND CERTAIN MEDICATIONS

Alcohol, substances, and certain medications can also function as safety aids across many of the fear-based disorders. This includes things like drinking, smoking, or ingesting a medication prior to engaging in a feared activity.

APPENDIX F

SAFETY AID CHECKLIST

Place a check next to any safety aid that you frequently use to reduce, prevent, or avoid anxiety.

COMPULSIVE/CHECKING BEHAVIORS	
Checking presence of bathrooms or exits	
Checking on friends or loved ones	
Checking already completed tasks	
Checking doors, windows, locks, and perimeters	
Checking the time	
Checking vital signs	
SITUATIONAL AVOIDANCE	
Avoiding crowded stores/long lines	
Avoiding parties/social gatherings	
Avoiding stressful events/encounters	
Avoiding eye contact with others	
Avoiding eating in front of others	
Avoiding public transportation/driving on busy highways	
COGNITIVE AVOIDANCE	
Thought or image replacement	
Worrying	
Ruminating (i.e., replaying the tape)	
Thought suppression	
Thinking positively	
Thinking of excuses to leave a situation early	

APPENDIX F

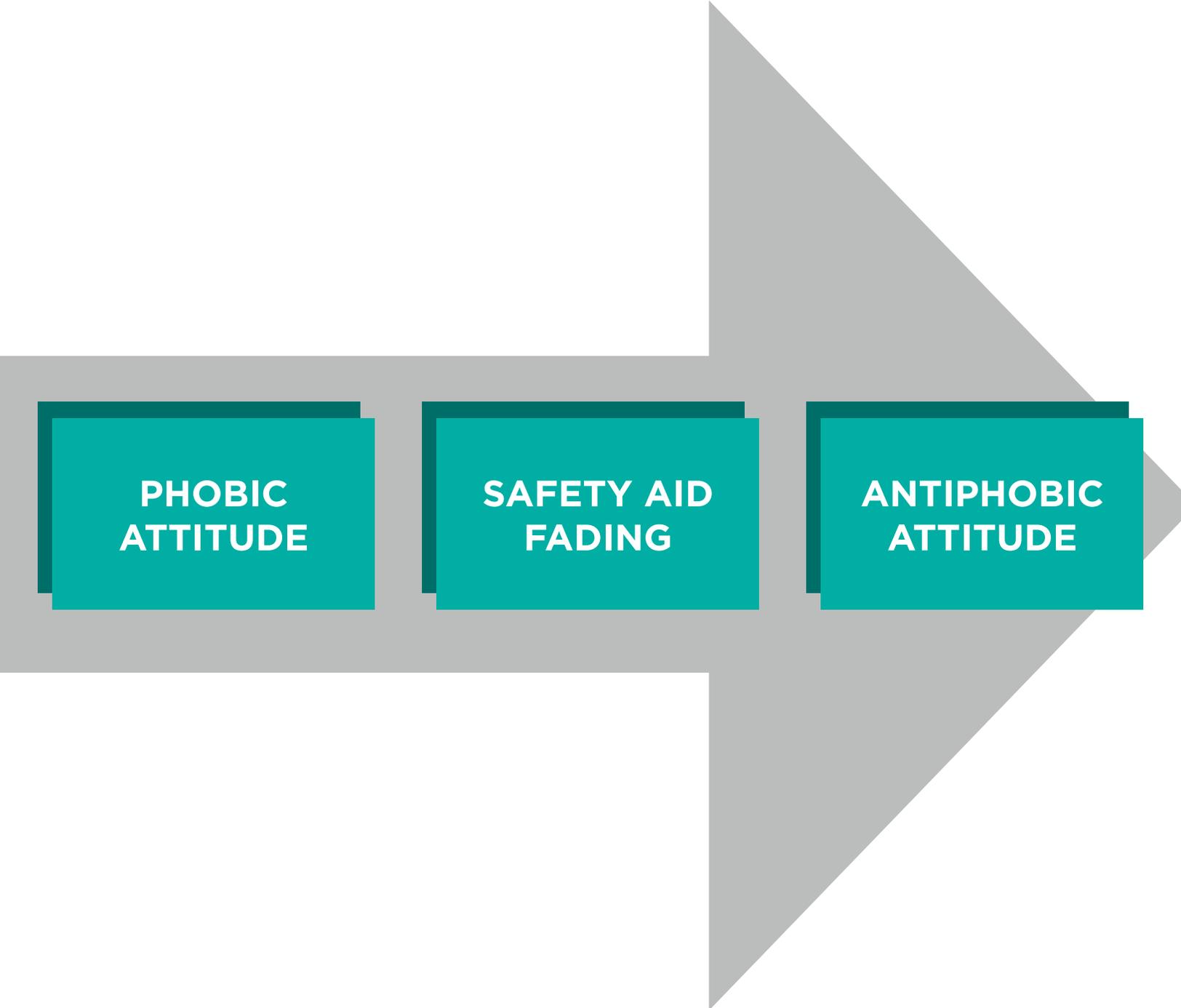
SAFETY AID CHECKLIST

Place a check next to any safety aid that you frequently use to reduce, prevent, or avoid anxiety.

PHYSIOLOGICAL AVOIDANCE	
Avoiding exercise	
Avoiding caffeine	
Avoiding hot showers	
Avoiding activities that might make you dizzy	
COMPANIONS	
Relying on someone to complete everyday activities	
Relying on an emotional support animal	
ALCOHOL MEDICATION AND CERTAIN SUBSTANCES	
Smoking cigarettes	
Consuming alcohol	
Using substances including marijuana	
Using certain medications on an as-needed basis (i.e., benzodiazepines)	

APPENDIX G

PHOBIC AND ANTIPHOBIC CONTINUUM HANDOUT



**PHOBIC
ATTITUDE**

**SAFETY AID
FADING**

**ANTIPHOBIC
ATTITUDE**

APPENDIX H

SAFETY AID FADING WORKSHEET

DATE PRACTICED	SAFETY AID TARGETED	STRATEGY USED TO FADE	FEARED OUTCOME What I Feared Would Happen.	ACTUAL OUTCOME? Did What I Fear Actually Occur?
<p>08/10/2020</p> <p>-----</p> <p>08/12/2020</p>	<p><i>Checking Behaviors</i> - Calling spouse to check on her whereabouts</p> <p>-----</p> <p><i>Companion -</i> Having wife accompany me to store</p>	<p><i>Delay - wait 10 minutes prior to calling</i></p> <p>-----</p> <p><i>Decrease degree</i> - increase physical distance between us while shopping</p>	<p><i>She got into an accident and is severely injured</i></p> <p>-----</p> <p><i>I can't handle my anxiety without her</i></p>	<p>No</p> <p>-----</p> <p>No</p>

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