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Instructor's Manual

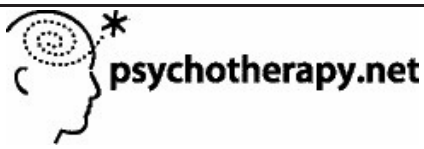
for

COGNITIVE THERAPY FOR OBSESSIONS

with

REID WILSON, PHD

Manual by
Ali Miller, MFT and Deborah Kory, PsyD



The *Instructor's Manual* accompanies the DVD *Cognitive Therapy for Obsessions with Reid Wilson, Ph.D.* (Institutional/Instructor's Version). Video available at www.psychotherapy.net.

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Instructor's Manual for

COGNITIVE THERAPY FOR OBSESSIONS WITH REID WILSON, PH.D.

Table of Contents

Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS

Make notes in the video **Transcript** for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION

Pause the video at different points to elicit viewers' observations and reactions to the concepts presented. The Discussion Questions section provides ideas about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS

Encourage viewers to voice their opinions. What are viewers' impressions of what is presented in the interview?

4. CONDUCT A ROLE-PLAY

The **Role-Play** section guides you through exercises you can assign to your students in the classroom or training session.

5. SUGGEST READINGS TO ENRICH VIDEO MATERIAL

Assign readings from **Related Websites, Videos and Further Reading** prior to or after viewing.

6. ASSIGN A REACTION PAPER

See suggestions in the **Reaction Paper** section.

PERSPECTIVE ON VIDEOS AND THE PERSONALITY OF THE THERAPIST

Psychotherapy portrayed in videos is less off-the-cuff than therapy in practice. Therapists may feel put on the spot to offer a good demonstration, and clients can be self-conscious in front of a camera. Therapists often move more quickly than they would in everyday practice to demonstrate a particular technique. Despite these factors, therapists and clients on video can engage in a realistic session that conveys a wealth of information not contained in books or therapy transcripts: body language, tone of voice, facial expression, rhythm of the interaction, quality of the alliance—all aspects of the therapeutic relationship that are unique to an interpersonal encounter.

Psychotherapy is an intensely private matter. Unlike the training in other professions, students and practitioners rarely have an opportunity to see their mentors at work. But watching therapy on video is the next best thing.

One more note: The personal style of therapists is often as important as their techniques and theories. Therapists are usually drawn to approaches that mesh well with their own personality. Thus, while we can certainly pick up ideas from master therapists, students and trainees must make the best use of relevant theory, technique and research that fits their own personal style and the needs of their clients.

PRIVACY AND CONFIDENTIALITY

Because this video contains actual therapy sessions, please take care to protect the privacy and confidentiality of the clients who has courageously shared their personal life with us.

Wilson's Approach to Treating Anxiety Disorders*

Wilson's "strategic cognitive therapy" draws upon cognitive behavioral therapy techniques to create a brief, aggressive, paradoxical treatment for people who suffer from anxiety disorders. He posits that the main obstacle for people suffering from anxiety disorders is their relationship to their anxiety—their resistance to discomfort and avoidance of feelings, situations and stressors that might lead them to feel anxious—and seeks, through cognitive restructuring and exposure, to help clients not only tolerate, but actively welcome their anxious feelings into their lives.

People who are prone to anxiety doubt that they have the inner resources to manage their problems, so they use worry to brace for the worst outcome in an erroneous belief that they are productively preparing for the negative event. According to Wilson, techniques that encourage clients to practice mindful acceptance of their anxious thoughts and feelings are often not strong enough to counteract their fear-based schemas. Drawing on Frankl's paradoxical intervention, Perl's gestalt therapy, Csikszentmihalyi's flow and the Mental Research Institute's second-order change, Wilson coaches clients to approach, exaggerate, personify and even ridicule their anxieties. This aggressive and yet playful approach helps them "fight fire with fire" and learn to override their habitual escape responses.

This anxiety game, as Wilson describes it, helps clients reframe their experience of anxiety so that it is no longer perceived as a serious threat, but rather a "mental game," in which clients lose as long as they play by anxiety's rules. The rules of the new therapeutic game turn the tables on the anxiety disorder:

1. Do not pay attention to the content of your worries ("the problem is my heart/ my debt/ the safety of the plane/ germs"). Engaging with content is a sure path to defeat.

2. Accept your worries unequivocally, as though they are here to stay.

3. Aggressively seek to be uncertain.

4. Aggressively seek to be anxious and stay anxious.

These behavioral practices are not only intended to help clients tolerate doubt and distress, but to reinforce the attitude of wanting them. The most important benefit of applying the skill of wanting is that it speeds healing by truncating the habituation process. The goal is to teach clients a simple therapeutic orientation that they can manifest in most fearful circumstances and to leave them with a sense of self-efficacy, so that they are the agents of their own change and growth.

*Adapted from

http://en.wikipedia.org/wiki/Exposure_therapy
www.anxieties.com/pdf/anxietydisordergame.pdf
Wilson, R. (2009). “The Anxiety Game: Crafting a Winning Strategy.” Psychotherapy in Australia, 15(2), pp. 36-42.

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Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

INTRODUCTION

1. **Chasing your tail:** What thoughts did you have as Wilson and Yalom spoke about the frustrations many therapists experience when they try to disprove clients' cognitive distortions? In your experience working with people's obsessive thinking patterns, have you felt yourself getting pulled into arguing with their beliefs? What has your experience been working with obsessions? What has been effective and what have you found to be not so helpful? What has been particularly challenging or rewarding? Do you find it to be true that arguing with the client's irrational beliefs is futile?

2. **Off content:** What do you think of the key idea in Wilson's approach of getting clients off content, and elevating them above it? Do you agree with his basic premise that with anxiety disorders the content is always irrelevant to the treatment?

3. **Tolerate uncertainty and discomfort:** What do you think of the emphasis in Wilson's approach on helping clients tolerate uncertainty and discomfort? Do you agree that this is essential to treating anxiety disorders? Why or why not?

4. **History:** Wilson stated that it's not necessary to get a lot of developmental history from the client, but more important to focus on their symptoms and belief systems. What do you think of this aspect of his approach? How important do you think it is to gather historical information in the beginning of treatment in general, and with people with anxiety disorders in particular?

SESSION ONE

5. **Gathering information:** What did you like and dislike about the way Wilson gathered information from Rita about her symptoms, their history, how she protects herself, and how she reassures herself? What did you notice about the way he honed in on her beliefs? What do you think about the level of detail they got into

about her day-to-day experience of the anxiety? Do you tend to get this specific with clients? Why or why not?

6. **Therapeutic alliance:** How would you describe the therapeutic alliance between Wilson and Rita? What did you observe Wilson doing or saying that contributed to or detracted from forming a therapeutic alliance with Rita? How does this compare with your general approach to building a therapeutic alliance with your clients?

7. **Two sides:** What do you think of how Wilson introduced the concept of "parts" to Rita—that there were two sides of her, which she labeled her "light side" and "dark side"? Do you use the concept of "parts" with your clients? Is it effective? How so?

8. **Comparing:** What reactions did you have when Wilson compared Rita to other clients he has worked with? Do you think it increased her sense of hope and optimism when he said she was different from most of his other clients because they've been troubled with anxiety since they were teenagers? What do you think the pros and cons are of comparing your client to other clients you've worked with? Is that something you do? Why or why not?

9. **Diagnosing:** Wilson told Rita directly that she has an anxiety disorder, and checked with her as to whether or not that was okay to say. What did you think of this? Do you tell clients up front what disorder you think they have? What do you think the benefits and risks are of explicitly diagnosing her in this way?

10. **Style:** What did you like and dislike about the way Wilson educated Rita about his perspective on how best to treat her anxiety disorder? Did you find him condescending at all? Supportive? Encouraging? What about his relational style worked and didn't for you? Do you tend to take as much of a psycho-educational approach to therapy with people with anxiety as Wilson did in this session? Why or why not?

11. **Embracing the anxiety:** What do you think of the concept that Wilson shared with Rita that she should assume she's going to worry about her health for the rest of her life? Do you see the merit in an approach that focuses on embracing the anxiety as opposed

to trying to get rid of it? Is this an approach you have tried either with yourself or with any of your clients? If so, what results have you seen?

12. **Trust issues:** How did you react when Rita told Wilson that she has trust issues? Did this stand out to you as significant? What do you think of the way Wilson responded? How do you think you would have responded if you were in Wilson's shoes? Would you have wanted to further explore her trust issues? If so, would you have, or do you think that would have taken you off track?

13. **Not about content:** How successful do you think Wilson was in conveying to Rita that "it's not about your health"? Do you think she understood his key point to his approach? Do you agree that her health concerns are irrelevant to the treatment? Why or why not?

14. **Guarantee:** Wilson guaranteed Rita that she would get better if she gets herself to want to have and keep the experience. Can you see yourself making a guarantee like this? Do you make predictions with your clients on whether the treatment will be effective? Why or why not?

15. **Trust and confidence:** How did you react when Wilson told Rita, "The biggest thing is that you have to trust me"? Wilson has the advantage of being known as an expert in treating anxiety—how much do you think his confidence and status contributes to Rita's success? How do you think your own level of confidence might impact the progress your clients make? If you have been seeing clients for some time, how has your confidence evolved, and how has this impacted your effectiveness as a therapist?

16. **Want it:** What reactions did you have when Wilson spoke about the need to stop fighting the anxiety and that Rita needs to want the worry and move towards it? Do you agree with him that all anxiety disorders remain when people resist them? Do you agree with him that the symptoms of Rita's anxiety will go away on their own when she withdraws the fuel of seeking reassurance and habituates to the fear? Does it makes sense to you why he wants her to want frequent, intense exposure to the distressing thoughts?

How do you think some of your clients with anxiety disorders would respond to this aspect of Wilson's approach if you shared it with them?

17. **Predictions:** At the end of session one, what are you predictions about what Rita will report in session two? Do you think she followed through with Wilson's instructions to practice not reassuring herself? How confident are you that she has understood Wilson's point about how to relate to her anxiety and will practice in the way he suggested? What challenges do you predict might come up for her?

DEBRIEF OF SESSION ONE

18. **Automaton:** How did you react when Wilson said that he wanted Rita to be like a robot and an automaton, to just follow his instructions? Do you think they have built enough of a therapeutic alliance for Rita to trust him enough to do what he says? Does your clinical approach require that clients do what you tell them to do? If so, how does this tend to work out for you and your clients?

19. **Pressure:** What are your thoughts on Wilson's comment that he wants to put pressure on his clients? Do you think clients generally benefit from a sense of urgency about changing their behavior? Do you have this sense of urgency or with your clients, or does your approach tend to be more laid back?

SESSION TWO

20. **Too aggressive?:** What reactions did you have when Wilson stated that their goal is for Rita to sweep away all of her "safety crutches," face the threat head on, take the hit, and learn that she can manage it? Is this aspect of his approach too aggressive for you? Can you see yourself encouraging your clients to get rid of all of their crutches? Why or why not? If you were working with Rita, what might your goals for her be?

21. **Attentional bias toward threat:** Wilson stated that people with anxiety disorders have an attentional bias toward threat. What do you think of this conceptualization of anxiety disorders? Does this match what you've seen with your clients or others you know who struggle with anxiety?

22. **Who cares?** When Rita asked, "How long does it take?" Wilson responded, "Who cares?" and encouraged her not to worry about how long. What did you think of this intervention? Did it seem insensitive to you? What point do you think he was trying to make when he responded this way? Do you think she understood his point?

23. **Personification:** What do you think of the way Wilson personified the anxiety disorder? Is this something you do with different disorders when you work with clients? Why or why not?

24. **Extinction:** What reactions do you have to the approach Wilson said he uses with parents of anxious kids, where he trains parents to respond to their kids' anxious questions once, reassure them one more time, and then not say anything to them or answer them at all? Does this technique of extinction appeal to you? Why or why not?

25. **Re-labeling sides:** What do you think of how Wilson invited Rita to re-label her "dark side" and "light side" in this session, so that she wasn't rejecting any part of herself? Did you like how she re-labeled them as her "strong side" and "weak side"? What other labels might you give for these two parts?

26. **Faith and courage:** Wilson makes it clear that the approach he's suggesting will require a great deal of faith and courage, and involves taking the risk of making a mistake. What reactions do you have to this aspect of his approach? Do you incorporate qualities like faith and courage into your work with clients? If so, how?

27. **No reassurances:** What do you think of Wilson's suggestion that Rita do no reassurances and zero checking? Do you think this is setting the bar too high or do you agree with him that "if you give them an inch, they'll take a yard"? Do you think Rita will be able to reach that goal? Why or why not?

28. **Logic versus feelings:** Rita repeated several times that logically she understood Wilson's approach. Do you think understanding it logically is enough for her to change, or do you think she needs

to get it on a deeper level before she'll be able to make any lasting changes? If you were working with her, would you have spent more time focusing on her feelings of fear related to all of this, or do you think that would feed the anxiety disorder?

29. **Self-disclosure:** What do you think about Wilson sharing his personal story of his own obsessive thinking on his hike and how he worked with it? What do you think the benefits and risks are of such personal self-disclosures from therapists? Do you tend to self-disclose with clients? If so, what factors do you consider when you do so?

30. **Cause isn't important:** How do you like how Wilson handled Rita's desire to know the cause of her anxiety? Do you agree with Wilson that knowing the cause isn't important? Did you like his explanation that it's likely a genetic predisposition plus some trauma? Does this match your understanding of the cause of anxiety disorders? How important is it to you to understand the root or cause of the issues you or your clients struggle with?

DEBRIEF OF SESSION TWO

31. **Rules:** What reactions did you have as Wilson spoke about the importance of creating clear rules and clients sticking to the rules? Do you think the emphasis on rules might trigger rebellion in some clients? If so, how would you deal with that? What has your experience been sticking to rules that you create for yourself when you're trying to change your behavior?

32. **Uncertainty:** A central part of Wilson's approach is helping clients tolerate the distress that comes with uncertainty. In your own life, how do you tend to relate to uncertainty? What helps you manage your own anxiety when something is unresolved or uncertain?

33. **Don't focus on results:** Wilson asks clients to follow the protocol no matter what, and not to focus on results. Is there any protocol or practice you have ever followed that required such a high degree of faith? If so, how did you deal with doubt when it arose? What effects did sticking with the practice have in your life?

34. **Interrupt the pattern:** What did you think of Wilson's examples

of ways to interrupt the compulsive pattern? Do you like the technique of postponement? Why or why not? What other ways do you work with compulsions?

35. **Predictions:** Based on these two sessions, what are your predictions for how Rita will do on her own? How successful do you think her treatment with Wilson was so far? What challenges do you anticipate her facing as she practices what Wilson suggested? If you were working with her in an ongoing way, how do you think you would approach her continued treatment?

36. **The model:** What are your overall thoughts about Wilson's approach to treating anxiety disorders? What aspects of his approach can you see yourself incorporating into your work? Are there some components of his approach that seem incompatible with how you work?

37. **Personal Reaction:** How do you think you would feel about having Wilson as your therapist? Do you think he could build a solid therapeutic alliance with you? Would he be effective with you? Why or why not?

Role-Plays

After watching the video and reviewing Wilson's Approach to Treating Anxiety Disorders in this manual, break participants into groups of two and have them role-play a therapy session with a client who is plagued by obsessive thinking, using Reid Wilson's approach.

One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. Clients may play themselves, or role-play Rita from the video, a client or friend of their own with obsessive thinking, or they can completely make it up. The primary emphasis here is on giving the therapist an opportunity to practice educating the client about Wilson's paradoxical approach to relating to anxiety, and on giving the client an opportunity to see what it feels like to participate in therapy coming from this approach.

Assessment

The therapist should begin by finding out, very specifically, what the client is obsessing about. What belief system has the client latched on to? Conduct a thorough examination of the symptom, how it manifested itself, when it manifests itself, and what coping strategies the client uses to deal with the symptom.

Goal setting

Then find out what the client wants in their life—what are they missing out on because of the obsessing? Who in their life is also suffering as a result of their obsessing? Get a good sense of what they're working towards so that can serve as a motivator. Ask the client what their long-term goals are related to treating their anxiety. What would they like to be able to do differently? What kind of value might there be for them in being able to tolerate uncertainty and discomfort?

Changing their frame of reference

This should be the bulk of the session. Therapists will raise the following points to help alter the client's frame of reference and prepare them for practicing on their own:The client is in control; the therapist is not going to do anything the client doesn't agree to.

- The anxiety disorder is fueled by you fighting it—you must stop fighting it.
- Go toward being uncertain and toward being uncomfortable, so you can practice increasing your tolerance of uncertainty and discomfort
- Stay with the anxiety and do not fight it.
- Elevate above content: Don't pay attention to the content of your worries. Engaging with the content is a sure path to defeat.
- Seek out situations that will make you anxious so you can practice embracing—rather than resisting—the anxiety.
- Focus on courage instead of confidence.

Assign homework for practice

After discussing the above points with the client, collaboratively come up with a homework assignment so the client can practice tolerating the uncertainty and discomfort that comes when they are feeling anxious. Is there a situation they can put themselves in to trigger the anxiety? Make sure the client is clear on how they will practice and what will support them in relating in this new way to the anxiety. When feeling anxious, they should say to themselves something like, "I'm going to stay with this feeling. I can handle this. I'm willing to feel this. The more I feel this the better I'm going to get."

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about Wilson's approach to working with anxiety in general and obsessive thinking in particular? Invite the clients to talk about what it was like to role-play someone plagued by obsessive thinking and how they felt about the approach. How did they feel in relation to the therapist? Did they understand the essence of Wilson's paradoxical approach? What worked and didn't work for them during the session? How confident are they feeling that they'll be able to practice being with the anxiety in this new way? Then, invite the therapists to talk about their experiences: How did it

feel to facilitate the session? Did they have any difficulty explaining the essence of the approach? How confident are they feeling that the client understood the point enough to practice? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about treating obsessions with Wilson's approach.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. At any point during the session the therapist can timeout to get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using Wilson's approach to treating anxiety.

Reaction Paper for Classes and Training

Video: *Cognitive Therapy for Obsessions with Reid Wilson, PhD*

• **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.

• **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.

• **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

What to Write: Respond to the following questions in your reaction paper:

1. Key points: What important points did you learn about Wilson's approach to cognitive therapy for obsessions? What stands out to you about how Wilson works?

2. What I found most helpful: As a therapist, what was most beneficial to you about the model presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. What does not make sense: What principles/techniques/interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4**. How I would do it differently:** What might you do differently from Wilson when working with clients? Be specific about what different approaches, interventions and techniques you would apply.

5. Other Questions/Reactions: What questions or reactions did you have as you viewed the therapy sessions with Wilson? Other comments, thoughts or feelings?

Related Websites, Videos and Further Reading

WEB RESOURCES

Reid Wilson's Website on Anxieties

www.anxieties.com

Mental Research Institute

www.mri.org

The Association for Behavioral and Cognitive Therapies

www.abct.org

International Association for Cognitive Psychotherapy

www.the-iacp.com

National Association of Cognitive-Behavioral Therapists **www.nacbt.org**

RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

Exposure Therapy for Phobias with Reid Wilson
Aaron Beck on Cognitive Therapy with Aaron Beck
Albert Ellis on Rational Emotive Behavior Therapy with Albert Ellis
Cognitive Therapy for Weight Loss with Judith Beck
Cognitive-Behavioral Therapy with Donald Meichenbaum
Mixed Anxiety and Depression: A Cognitive-Behavioral Approach with Don- ald Meichenbaum
Depression: A Cognitive Therapy Approach with Arthur Freeman
Cognitive Therapy for Addictions with Bruce S. Liese
Rational Emotive Behavior Therapy for Addictions with Albert Ellis
Cognitive-Behavioral Child Therapy with Bruce Masek
Cognitive-Behavioral Therapy with John Krumboltz
Arnold Lazarus: Live Case Consultation

RECOMMENDED READINGS

Barlow, D. (2002). *Anxiety and its disorders (Second Edition).* New York: Guilford.

Beck, A. & Emery, G. (1985). *Anxiety disorders and phobias: A Cognitive perspective.* New York: Basic Books.

Eifert, G. & Forsyth, J. (2005) *Acceptance & commitment therapy for anxiety disorders.* Oakland: New Harbinger.

Foa, E. & Wilson, R. (2001). *Stop obsessing!: How to overcome your obsessions and compulsions (Revised Edition).* New York: Bantam Books.

Frankl, V. (1985). *Man's search for meaning: An Introduction to logotherapy.* New York: Pocket Books.

Wilson, R. (1996). *Don't panic: Taking control of anxiety attacks (Revised Edition),* New York: HarperPerennial.

Wilson, R. (2003) *Facing panic: Self-help for people with panic attacks.* Silver Spring, MD: Anxiety Disorders Association of America.

Complete Transcript of Sessions 1 and 2

SESSION 1

Wilson: So, why are you here?

Rita: I'm here to try and get a handle on my health anxiety that I experience almost every day.

Wilson: So tell me more about that.

Rita: Oh it started about two years ago. I was in a yoga class and I got a skipped heartbeat, and I didn't know what it was. And so I just let it go and I kept getting them, and then I started freaking out that something was wrong with my heart. And I kept having thoughts in my head about dying and something was wrong with me. So that's when I went to a doctor and I had a couple EKG's. They said I was fine—skipped beats or heart palpitations are normal. So I would start researching them and then I ended up going to a cardiologist because I need to be reassured again. And I had the treadmill test and the echocardiogram and that's when they said I had two leaky heart valves. And they said the leaky heart valves are so minor that I can still run, I can still do anything I want with my life, but to me that was like a death sentence almost. I mean, I stopped running. I just became obsessed with, you know, looking up leaky heart valves on the Internet.

Wilson: So you didn't believe him—the cardiologist.

Rita: I believed him that I had them, but—

Wilson: But when he said you could do anything—

Rita: No, not really. I mean, they just are guys that learn this from a book.

Wilson: Yeah.

Rita: That's just me, you know. And I was doing half marathons at the time, running every day, vegetarian lifestyle. So, like, I was told I can't cheat death, but I thought I was doing everything I could to just be as healthy as I could for as long as I can.

Wilson: Mm-hmm.

Rita: Even though I do realize that I don't have heart disease. There is nothing debilitating about two leaky heart valves, but it just escalated from there.

Wilson: So back up. You said, "I felt like I was doing everything I could do to take care of myself." You said it almost like, "but that wasn't enough." Do you have some...

Rita: I felt—when he told me I had two leaky heart valves, I felt like my body let me down. You know, I...

Wilson: What do you think now about that? Your body let you down. You did everything you could, but...

Rita: Yeah. I've come to grips with the leaky heart valves. I mean, I still get the palpitations and all that. And when I do get the chest pains—I go towards heart all of a sudden, you know. I did get back into running though, but I'm not as into working out like I used to be before they told me that.

Wilson: Because you have a belief that you have to restrict yourself in some way to protect yourself from something...

Rita: Yeah, to protect my heart, which I understand is crazy because people have heart attacks and they are told to go out and exercise. People have heart attacks and they're back running a half marathon a year, a year and a half later.

Wilson: So how do you justify what you do then?

Rita: I can't figure it out.

Wilson: You just find yourself like—

Rita: I find myself...

Wilson: —compelled to restrict your activity.

Rita: Yeah, yeah. I used to get up in the morning—knowing that I had a school event or school function, I would go to the gym at 4:30 or 5:00 in the morning, get it out of the way. Now I just roll over at 4:30 or 5:00 in the morning. I don't have that desire in me.

Wilson: You lost that drive.

Rita: Yeah, I don't have the drive in me anymore to work out as hard

as I did.

Wilson: So, would it be safe to say, or can we consider saying, there is two sides of you? There's a part of you that knows this is kind of crazy—"I don't know why I do this. Everything's okay and this is annoying"—the part of you who's here today; and then there is another part of you that seems to be separated from it, that drives your restricted behavior and your checking and your reassurance. Is it fair to say that they are two sides of your thinking?

Rita: I feel like I sit on the fence all the time, you know, between...

Wilson: Between these two sides?

Rita: Yeah, between like the dark and the light. Like, the light knowing, "Oh, I can go run. I'm fine and I'm healthy." And then the dark when I get the chest pain going, "Ooh, but you should go get that checked out" type of thing.

Wilson: Okay.

Rita: So, yeah.

Wilson: So before two years ago, no precursors to this problem? No kind of aura about, "Oh this could show up." Never been anxious before? Not a worrier?

Rita: No, I've always been a worrier.

Wilson: Oh tell me a little bit of what that means—"I've always been a worrier."

Rita: Well, I was misdiagnosed with MS about 15 years ago. I have these spots on my brains that nobody knows why I have. So they diagnosed me with MS, you know. I went through all the testing and six months later they called me back and they said, "No, you don't have it." So that sort of threw me for a loop. And I'm not going to say that was the catalyst that started it all because I've always been more really in tune with my body. Like, everybody jokes that I can feel the blood flow, you know. I can feel when I have a bruise and I don't even need to get hit on it. I know I have a bruise there. So, I've always been more...

Wilson: Is there a curse to that? It seems to me there is a curse to that.

Rita: To being more aware?

Wilson: Mm-hmm.

Rita: Oh, definitely. It drives me crazy and I don't get the friends and the people that I meet. "Do you have heart palpitations?" They're like, "Oh, if I do, I don't know about it." I'm like, "How could you not know about them? This is your body." So, yeah, sometimes it is a curse, sometimes it's good, you know? I mean, maybe when I'm 80 and I get a chest pain it will be good to know. I don't know.

Wilson: Yeah. The interesting thing about anxiety is that you win over anxiety by sacrificing attention. And you have an inordinate amount of attention. You're hyper-attentive. And so something's going to have to happen around that. It's almost like your nature to be attentive to things so that's part of what we want to pay attention to in these two sessions about what to do with that.

Commentary: In addition to gathering history, at this early stage I want to build rapport with her. Simultaneously, I am looking for her beliefs and her patterns of analysis. I am sorting through them on-the-fly, then I am reflecting back to her the beliefs that I will want to leverage later in the session. The big ones so far are: first, "There are two sides of me: the light and the dark,"; second, "My tendency to worry precedes any of these physical symptoms," and third, "I am super-aware of the sensations of my body."

Wilson: So prior to 15 years ago—Worrier? Anxiety? You were like 28 or so. So prior to your mid-20's, did you have any kind of anxieties or...

Rita: No. I don't think I had anxieties. I think I...

Wilson: Again, that's what kind of broke through your defensive system and got you preoccupied. It kind of went on for a while because—how long was it before they figured out...

Rita: Six months.

Wilson: So that was a long time to be distressed.

Rita: Yeah, and I spent most of that time in the library because I was going to go the holistic route—doing the vitamins and all that stuff.

Maybe now they've come a longer way with MS than they did back then, but I've had a stillborn after that. So I don't know what it was, I just know that I've always been more aware of...

Wilson: So about this stillborn, you share that because—did that influence something as well?

Rita: I'm just thinking of, like, the big events.

Wilson: But how did that effect you in some way regarding your preoccupation with your body, your carefulness or...

Rita: No, I had a child, a two year old at the time that I had to take care of. So, maybe that's why, you know, I didn't get to just stay in bed for weeks on end grieving.

Wilson: Right.

Rita: I did grieve, but I was busy at the time. I had a two-year-old I still had to take care of.

Wilson: Well, you know, I just would share with you what we know about the research is that people who are in the middle of a responsibility during a trauma do a lot better than those who have nothing to do. You think about the guys getting caught in the cave, you know—the minds. The leaders tend to not have as much trouble as the workers—

Rita: Mm-hmm.

Wilson: —because they are managing. So, I think your sense about it is probably accurate in terms of it not causing quite as much disturbance for you, although—awful, awful to go through that.

Let me say a couple things about this experience. One is, I work for you. My job is to serve you. That's all I'm going to do in these two sessions is try to figure out what I can give you. I do this every day. Lot of things I don't do well. This, for almost 30 years—so I've got some things that I will bring to the table. They're not always easy things that I may offer you, but they're not complex.

Rita: Mm-hmm.

Wilson: So at least today I want to get a kind of framework of how all

this started. And what we want to look at next is how it goes day to day so I can get a little clear about that. And then we'll start talking about what we might do and what you might do to make some changes. So tell me day to day how all this, how it goes, how it affects you.

Rita: Well, when I wake up, I automatically have to say to myself, "You know, it's going to be a good day. I feel good. I feel healthy." Because I used to get out of bed just automatically going, "Where's the pain?" And then that would determine whether I'm going to workout or not. And there are lots of days that if I wake up and I get that chest pain or that little, I don't know, sharpness or something like that—I won't work out. My whole mindset just shifts.

Wilson: So let me back up. You wake up and you literally give yourself an instruction or a position about how the day is and who you are that overrides a kind of automatic message of "What kind of trouble am I going to have?" or "Let me do a body scan"—

Rita: Or the negativity, yeah.

Wilson: —and see how things are going. Then you said, "If I then have a sensation, that that will derail...

Rita: My whole day.

Wilson: Always?

Rita: Not always. You know, I've learned a little bit to go, "Okay, it's just a little twitch in my body. It's no big deal. I'm going to be fine." And then I can get past it sometimes. If it keeps happening throughout the day, that's when I start thinking, "Maybe there is really something wrong." And then that's when I get on the fence going, "Okay, you know there's nothing wrong because you have the test results." And then I have one message on my cell phone from a cardiologist that I had a really extensive test done. And so, I'll listen to that where he says, you know, "Your heart is"..

Wilson: So you saved it.

Rita: I saved it, yeah. Because I didn't talk to him verbally. I just got the message and I'm like, "Okay, that's all I need."

Wilson: So you get this kind of audio reassurance.

Rita: Yeah. So I listen to it, not often, but sometimes.

Wilson: As needed.

Rita: Yeah, as needed.

Wilson: And sometimes that helps and sometimes that doesn't.

Rita: Yeah. Nothing ever really helps 100%. I really have to work really hard inside myself and convince myself, you know, that everything is okay. It's really hard to explain, but...

Commentary: Here is her big mistake. She says, "I have to work really hard to convince myself that everything is okay." There is no earthly way she can recover from her severe health worry by trying to convince herself that she's healthy. She is focusing on the content of her worry. I have to find a way to redirect her attention over to the process of worrying. She needs to decide that the content of her worry is irrelevant. If she tries to solve this problem by attending to anything related to her health, she is destined to fail. This is the arduous task of treatment.

Wilson: Well so back to these two sides of you. That's what you're saying right now. There are two sides of me and I want this one side to override the other side. Again, is that an okay way to depict what you're doing?

Rita: Well, yeah. Yeah. I say it's like the lightness and the darkness.

And it's the angel and the devil are on my shoulders going, "You should get an EKG" —"Oh, no, but you're fine." So I'm constantly battling those two because I'm intelligent enough to know I'm okay. My heart's okay. I mean, I've done a half marathon, I run. You know, I just am not driven that much anymore—this whole health anxiety thing has pretty much taken over.

Wilson: You're more careful.

Rita: Yeah.

Wilson: Okay. And so, are there other factors or variables that determine whether or not the light side wins or not? I mean I'm assuming you use the same kind of strategies every time. Do you know what else? Is it a season of the year or other stressors? What do you know about how come sometimes you win and sometimes you don't?

Rita: It just depends on how strong I am that day.

Wilson: Tell me about that. Can you put words on what that means—"How strong I am that day"?

Rita: No, because then I want to say it depends on how dark my mind is that day.

Wilson: Tell me what that means.

Rita: Just the continual thoughts that just keep going in circles in my head about health. You know, it could be something as simple as, I get hit in the head by a ball and that will push me over to the dark side. So then I'm thinking, "Okay, I got those spots. Now what's that going to do? Do I have a tumor?" I mean, it just depends on the day, but any day that I live through to me is a good day, you know?

Wilson: Because you can die at any moment.

Rita: Well, yeah. I mean...

Wilson: Yeah. Lucky.

Rita: Yeah. Every morning I wake up I'm happy.

Wilson: So besides having what we call some kind of cognitive strategies, what else do you have in your bag of tricks to handle these kinds of events? Do you meditate? Are you in therapy? Ask for support from somebody around you?

Rita: Yeah, I'm seeing a counselor. And I read lots of books on anxiety and mantras and daily affirmations and, you know things like that.

Wilson: So you talked about the one daily affirmation. Do you have any others that you tend to lean on?

Rita: No.

Wilson: Okay. So you read about it, but not too many things grab you.

Rita: Yeah. Nothing has really just—like that "ah-ha" moment that people get, whether it be in therapy or in a self-help book they're reading or something like that—I haven't gotten that "ah-ha" moment yet.

Wilson: Yeah. Well maybe we should take that off the list as how it's

going to go.

Rita: Right. Because I'm expecting all of a sudden to—

Wilson: But maybe you have to be in the trenches.

Rita: —read a book and go, "Oh my gosh, I feel great. I'm going on a run."

Wilson: So the counseling that you're getting, to what degree does it focus on this issue?

Rita: In the beginning we were really focusing on it a lot. And then that helped me do a half marathon in addition to this big heart test that I had before I would do the half marathon. Now we're focusing a little bit on that because I keep going back to it. If I walk in and she says, "How's it going?" And I say, "Oh, I've had good days and bad days." And I immediately go to the bad days. "Oh, I had to go have an EKG and this and that."

But now we're touching a lot on, or we've been talking a lot about my home life with three kids and a husband, my upbringing with my parents. I mean, that wasn't very stable. Now I've always said I don't want to just pick one thing and pass the blame—"Oh, well, it's my parents that did this to me." Because maybe they did instill certain things in me, but I'm 45 years old, I can pretty much try and figure this out on my own. But I do think that there must be something in my background that makes me like this.

Wilson: So, I don't want to frame this incorrectly, but it sounds like maybe to some degree you and your counselor stepped away from centering on this issue now because you kind of ran the gamut and haven't figured out any other angles to use on it. So you're kind of backing up and punting and looking at childhood...

Rita: We go back and forth. It seems like I mix everything together all the time, you know.

Wilson: And what do you feel like you have gotten the most from that counseling regarding this theme?

Rita: I've gotten a lot of strength from my counseling on my good days. On my bad days, it feels like I never even had it because that can

override. Like, I'll take two steps forward and 20 steps back. It's never the opposite. You know, where I go for an EKG and it's like, "Okay, no big deal." Then I have 20 forward steps. But I have learned a lot in therapy, but I still feel there's something that's not—I don't know if it's come out yet or something that I just haven't figured out yet or...

Wilson: Well let's see if we can figure it out today. Would that be okay with you? I mean, you're open to that possibility I assume.

Rita: Yeah.

Wilson: So, well let's see if we can get a list of all the things you do to protect yourself or to keep things from happening or limit any threats and so forth. You mentioned some, but let's see if we can get a list. What would you say? Are you saying, "I don't run as..."

Rita: Oh, I don't run as often or as hard. I don't even workout as often as I used to.

Wilson: Okay.

Rita: I'm not driven as much as—I've become lazier throughout all this, getting things done, you know.

Wilson: What's that mean? "Lazier—getting things done." Is lazier the right word or is it more like careful?

Rita: No, no, no, more like unmotivated. It's not like I can't do the laundry because I'm careful of my heart. It's just—gets so down where I just—I'm not motivated to.

Wilson: So, that's kind of a side effect of all of this stuff. You've lost some drive and motivation because this kind of controls you somewhat. So let's set that aside for a minute, but let's look at other things that you do besides not working out as much, not running as hard and as frequently, that you think help protect you physically from...

Rita: That's I think pretty much it.

Wilson: Nothing else that you avoid, other than physical exercise? Does that seem right?

Rita: Yeah. Now, I will exercise, not to the extent I used to, you know.

Wilson: Right. But you avoid intensity and that kind of thing.

Rita: Yeah.

Wilson: And so tell me about reassurances that you use and how frequently.

Rita: Like the EKG's and the...

Wilson: EKG's and Internet and you have a friend or you talk to your partner.

Rita: Yeah. I have a friend who has a lot of the same issues. So, talking to her doesn't help, but—and then going on the Internet to these chat rooms, it only helps because it helps me realize I'm not the only one out there. Like, I'm not making this stuff up.

Wilson: And how often do you go to on the Internet chat room? And do you do Internet to search symptoms?

Rita: Yeah. I try not to that much. In the beginning I was on...

Wilson: Which side of you tries not to?

Rita: The light side.

Wilson: Oh, the light side.

Rita: Yeah. The dark side could sit there all day. But I haven't been to this one website that I go to in about two months.

Wilson: That does what for you, that website?

Rita: It just has all the people that have all these symptoms that I have.

Wilson: So that's a chat room or something else?

Rita: Yeah. It's not a chat room. You email back and forth online. There's every kind of room you can imagine. I type in leaky heart valves, whoosh, up comes all these people that had or have leaky heart valves. You know, heart palpitations, PVC's—I just type in that and here come all these people. I sit there and I read their stories and at least I know, "Okay, I'm not, I'm not making this stuff up."

Wilson: What drives you to do that repetitively as opposed to doing it once? Why do you go back and do it again?

Rita: I don't have an answer. Well, a continual reassurance...

Wilson: So you kind of have a half-life of a few hours or a few days that reassurance and then you get it again.

Rita: It's the same thing as the doctor saying, "Your EKG is perfect." "Okay, thank you." Then a week later I'm like, "Oh, I have a pain. I better go get another one." You know, it's short lived.

Wilson: Okay. And so how often do you get checked out?

Rita: Let's see, not as often as you would think. Probably over a month ago I had two EKG's in a week. Then prior to that, it was several months before I had one.

Wilson: Okay. So, you go to a cardiologist or you go to your family physician for those or...

Rita: Yeah, I go to my primary care doctor. Yeah. Only for like the major tests do I go to the cardiologist.

Wilson: And do you phone anybody—a medical person for reassurance?

Rita: No.

Wilson: Do anything else medically for reassurance?

Rita: No.

Wilson: Don't have a nurse that you consult or...?

Rita: No. That's where I go like on the Internet or friends or somebody—like if I'm having a really bad day, I'll call a friend and say, "Okay, try and work me through this. Talk me through this." And I have some friends that are really good with that.

Wilson: And that you'll be receptive. You'll be open to them when they talk to you. You do the best you can to be open to what they have to say.

Rita: I do the best that I can. I'm not going to say I get off the phone and I'm like, "Oh, come on kids we're going on out to play tag." Or I'm going to go do the laundry or get motivated. But it's better to get it out instead of just sitting in the house by myself or, you know, just to talk to somebody. Or I'll call my counselor or email or text or something.

Wilson: Okay. So lastly, before we try to put some shape on what's going on and what to do next, besides attending to your heart, what else can happen that will cause you to worry about your body or your brain or—you said something about "if I get hit with a ball, I would..."

Rita: Mm-hmm.

Wilson: So that would be your head gone with your brain.

Rita: Oh, yeah, I worry about my brain. I worry about my brain a lot because of those spots that are on my brain. I worry about my eyes. When my eyes get blurry I'm thinking—I don't automatically go to, "Oh, I'm getting older. I might need reading classes." I take it to the extreme, "Is there a tumor growing in my head? Am I going blind?" I just don't think of the—a couple bruises could mean leukemia as opposed to, "Oh, yeah, I was playing soccer with the kids." You know, things I really have to stop and focus and really think, "Okay, is it really a tumor in your head or it's just you have a headache because you got hit with a ball?" You know, "Is my stiff neck meningitis? Or is it because that's just how I always have a stiff neck. I need a chiropractor."

Commentary: I have most of the information I need now. It is quite obvious that Rita is devoted to seeking out reassurance and confirming that her worries about her health conditions are valid. She searches for stories from others to confirm "I'm not crazy." Think about the concept of "inertia": an object continues to move at its current velocity unless some form causes it to change. I need to generate friction or in some way shove her belief system off-track to interrupt her inertia. The other problem is reflected in the term "mass." When we talk about inertia, we know that the larger the mass of the object, the greater its ability to resist changes in its state of motion. Rita has very strong convictions—large mass—about the importance of paying attention to the content of her worries. We have a big project here.

Wilson: Rita, it sounds exhausting.

Rita: It is exhausting.

Wilson: Like hard to do everything else that goes on during the

day and doing this to. I'm so sorry that this happens to you. I know you're not in control of it as much as you'd like to be and that's part of what I'm in your life for a brief little moment. But it's awful. Is it contagious? What's happening with your kids around all this stuff? How do they handle it? Do they know?

Rita: Yeah.

Wilson: Do they go, "There's mom again." Or, "Come on, mom, let's go. Don't worry about it."

Rita: I think my older one...

Wilson: "Mom, I'm starting to feel a little lightheaded. What does this mean?" What are you noticing about your kids?

Rita: I'm noticing that my older one is complaining all the time she doesn't feel well.

Wilson: And and what happens with those complaints?

Rita: Well, she—

Wilson: She's 12?

Rita: —she's 12 and a half and she gets really bad stomach aches. Now, she's had these stomach aches since second grade. So it was prior to my whatever—making it public that I have all these anxiety issues. So we've taken her to the doctor and she has some irritable bowel syndrome. And she's also a perfectionist, straight A student, great athlete. So all those sort of tie into stomach issues and things like that. But I do notice that a lot of times, when she's going to bed at night, "Oh, Mom, tonight is going to be the night that I get sick in the middle of the night. I really think I'm going to throw up." That's her big thing every night.

Wilson: And does she throw up?

Rita: No, she hasn't.

Wilson: But she's got a little bit—kind of fears.

Rita: That breaks my heart because she's 12.

Wilson: Oh, I bet.

Rita: I've been dealing with this, you know, not since 12. And if she's going to have to deal with this, she's going to have a really tough road.

Commentary: So here is a hook. Now I'm thinking, "Can I use Rita's love and concern for her daughter as leverage? Can I help her shift her focus of attention away from "Oh my gosh, I hope there's nothing seriously wrong with me?" over to "I need to model for my daughter how to handle worries that are just noise, not signals that something is wrong."

In the next segment, I stumble upon one way that she says she completely "snaps out of it." But at the same time, she is going to illustrate just how big her mass is, her belief is, and how hard it is going to be for me to disrupt her inertia of, "I have no power over my obsessions."

Wilson: You know it's more common to be dealing with it since you're 12 as opposed to getting it when you're 27 or 28. Anything else with the other kids or any other ways—do you hide most of this stuff from them? Or are they aware of your complaints? Do you say things out loud?

Rita: Yeah. They know that I see my counselor.

Wilson: They go, "Mom, get over it."

Rita: No, because I don't think that they're mature enough yet to really say that. What I do notice is my younger two will say, "Oh, stop being so negative," which is good to have a little seven year old saying, "Don't be negative, Mom." And then that snaps you out of it for a second and I can act really well and play the role of, "Oh, yeah, you're right. I'm fine. Everything's fine." But I think they know in some level that a seven and a 10 year old and a 12 year old know that I always think that I'm sick.

Wilson: Now, you just said something that I'm going to pick up on—

"That snaps you out of it." You have any other examples of anything that you would say, "That snaps me out of it"?

Rita: Uh-uh.

Wilson: So, interesting little resource. I mean we want to see what we can do about the fact that we have an event: my seven year old says,

"Mom, don't be so negative," and "it snaps me out of it." So, what's your understanding of that? Why do you think that happens? All this other stuff, you have to work so hard, and there it is in a moment's notice. What's going on do you think? I mean, don't you think that's interesting?

Rita: Yeah, but not too interesting.

Wilson: Why not?

Rita: It's not like if I was on my way to an EKG and they said, "Oh, Mom, you know, you don't need it. Let's go get a shake instead." I'd be like, "Oh, yeah, okay." You know? I can go, "Oh, yeah. Okay. You're right. Yeah, I'm not, I'm not negative. Let's just"—

Wilson: So, what's it snap you out of?

Rita: The dark thinking, really quick.

Wilson: Okay. But, so, don't throw that away because maybe it's a small thing, but still, you're saying to me, "My seven year old says this." So you have an ability to have something hit you in such a way that competes with the dark side that you snap out of it. It's the only example you and I have in which there was an instant change in frame of reference so to speak.

Rita: Mm-hmm.

Wilson: And so, what do you think is behind that message? I mean, what do you think happens in your brain that allows you to take that message for that moment? What are you saying about the fact that you hear that? It's like, "Oh." I mean, is it something about "I don't want to be doing this to my seven year old?"

Rita: Well, I don't know if it's a conscious...

Wilson: Right, I know. You might not be conscious, but if we could unbundle it, what would you think?

Rita: Probably that I'm his role model. I mean, he's looking at his mom acting like a crazy person and that's not what these kids need, you know?

Wilson: Okay. Good. So there's a higher level value somehow that you

got to. Again, the reason I'm highlighting this is this is where we want to go. Wouldn't you like to be able to snap out of it more frequently?

Rita: Mm-hmm.

Wilson: So we want to see what we can do around that to package it in such a way that you have more frequent instances where that occurs. This is why you pay me the big bucks is to help you figure out how to do that particular piece. So how would you say your goals are in these two sessions with me here in general around this issue? What do you want to accomplish?

Rita: Oh, I'd like to just not think about health so much every day. I'd like to be able to have somebody tell me a health story and I have to just shut them down and say, "Oh, no, I don't want to hear about that."

Wilson: Okay. As opposed to how is it now?

Rita: Oh, I don't want to hear any health stories or watch Dr. Oz or any of those health shows on TV. I don't watch anything like that.

Wilson: Oh, I thought you said you wanted to—one goal is if somebody starts telling you a health story, your goal is to shut them down, not just to...

Rita: No, that's what I do now.

Wilson: Oh, okay. You want to tolerate. You want to not worry so much about health, but you want to be able to tolerate...

Rita: I have to be able to live in the world of health. It's every day, but, you know, somebody tells me that they know somebody who had chest pains that was a heart attack—all down the line I'm, "Oh, wow, wonder if that's me." Everything that somebody else has I worry that it could be me. I want to stop worrying. I want my drive and my motivation back to get things done and get to the gym at 5AM if I want to go. I don't have that. I'm perfectly fine going to the gym at 8:30 or 9:00 for 20 minutes and leaving.

Wilson: Mm-hmm. Now, you alluded to earlier part of this is mood, right? You have kind of a low mood. And so I'm going to back up and just ask you about that. So is there some—that must be on your goals too like, "not have my mood be so low where I don't have the drive."

What's the mood like? Is it there every day?

Rita: No, I'm not down every day. It may be cyclical too. But a lot of it depends on if I get the twitch or the chest pain or something like that. That can set my mood for the day and the week if it lasts, you know, more than a day.

Wilson: Okay. So, "I don't want to think about—dwell on health so much. I want to be able to tolerate living in the world where people are talking about health related issues and not have to stop them. I want to get my motivation and drive back in general." Anything else?

Rita: I just want to be happy—happier—or happy. I don't even think I'm happy, you know?

Commentary: Because I am operating within a brief treatment model in these two sessions, I need to set up a frame of reference that orients her to the possibility of rapid change. And, of course, that's what she wants too. So first I'm going to give her some "good news" about the potential for her to change more rapidly than others might. As I frame this up, simultaneously I'm watching her facial expressions and for her head nods as indications she's getting the message. Then you'll see me move directly into a confrontation where I tell her, "You're making a big mistake here"—which, at the risk of losing rapport with her, is going to get her attention. I follow that immediately with a quite simple model of the nature of the problem and then a simple, but difficult, therapeutic task.

Wilson: Now, one good news—you have a firm hand shake. When I first met you I thought "that's good." So—it represents something to me. And really it's been two years, which, in the big picture, isn't a lot of time. Most of the people that I see with severe illness worries have had them since they were 17, 18, 19 years old. Clearly you've had a couple if not three traumas that have instigated a lot of this.

Rita: Mm-hmm.

Wilson: Maybe you were worry waiting to happen. You know, and enough stress came that put a little crack in your defensive system and up it came. But one way to frame this is to say, "You know, it's been two years. It's awful, but it's not necessarily part of my character like

it is with some people." So that gives us a little better sense that you can make some changes that might take other people longer. You have anxiety disorder. It's really called a somatoform disorder, but we might as well call it an anxiety disorder. Would that be fair to say to you? So, you got an anxiety disorder.

One of the ways that this anxiety disorder dominates you is that it gets you to focus on content instead of the fact that you have an anxiety disorder and that it's about anxiety. So your content is "my heart, my body," and so forth. I think you're making a big mistake about how you operate with this stuff, which is you continue to focus on the content, thinking that you're going to get out of it through that approach.

Einstein said, paraphrasing, I didn't hear him say it, but "You can't get out of a problem through the same frame of reference that you put the problem in." So, we do want to therapeutically alter the frame of reference that you're looking at this. And one of the ways to do it, and you stop me if this seems crazy or confusing with what I'm saying, is we want to get off content. Wouldn't that be nice? Because that's actually part of your goal. You want to get off content. Do you know what I mean by content for you?

Rita: Mm-hmm.

Wilson: What would that be?

Rita: Thinking about my heart, my brain.

Wilson: So we're going to elevate above content, which is in at least two areas. One is you don't tolerate distress very well related to this content. And you don't tolerate uncertainty very well related to this content. In reality, lots of other content areas you can do both those things. You deal with uncertainty every day with your kids and work and money and everything. We all do and you're a mature, bright, adult and you know uncertainty is everywhere and you can't live in a world unless you can tolerate that.

But you have an anxiety disorder which causes you to not tolerate uncertainty about health related issues and then not tolerate distress. So we want to have some kind of model that perceives that as the

problem. What do you think about what I'm saying so far?

Rita: It makes sense, but how do you not think about your heart every day?

Wilson: It's fine to think about your heart. It's fine to think about.

We want to think about a few things. One is you are not in control of the thoughts popping up. You're in control of what you do next. And you go chase that rabbit down the rabbit hole and—I'm going to say this a few times to you not to insult you: You're making a mistake. Everybody makes the exact same mistake that you're making. So there's nothing different about you. It's a classic mistake, which is "I'm going to get out of this problem from the area of content." And really, you can't.

Rita: What do you mean by that exactly?

Wilson: You can't reassure yourself about health related issues in order to fix the problem. And you always do that. That is what you rely on. You argue with yourself. You seek reassurance from other people. You go online. You try to figure out what's going on—all related to the content. So we go back to your seven-year-old saying, "Mom, stop worrying." It's an example of that. It's you go to the level of, "Oh, I'm worrying." You know, for, if it lasts for 20 seconds or 20 minutes who cares?

Rita: Right.

Wilson: It snaps you for a minute. You go to another level of consciousness, which is, "Oh, here I am. You know, I'm a worrier. Here I am, I'm a worry making machine." And that's what you are. You're a worry making machine. Fair enough to say?

Rita: Mm-hmm.

Wilson: And you want to be able to recognize that about yourself if that's okay. How I would in part do it is I would say, "I'm going to assume that I'm going to worry about my health the rest of my life. And I'm going to worry about my heart. I'm going to worry about any little injury or presumed injury. I'm going to do it the rest of my life. I'm not going to get rid of that." The reason to do that is because it's the most pragmatic way to think about it. I'm not going to try to get

rid of my worries. I'm going to take another approach when they show up.

So we'll look at those a little bit. So first off, let's see if we can build a little platform here. One is this is not about health. This is about intolerance of uncertainty and intolerance of distress. How we doing about building that platform? Can you get that idea?

Rita: No, yeah, I get it. I get it. I just...

Wilson: Don't have to worry about what you're going to do next. Just go one step at a time.

Rita: Okay. I get it.

Wilson: So, I'm trying to do this. I'm building this platform with you. I don't know necessarily how it's going to be built, but we're building it second by second here. So that's the first one. What do you think about the fact that you have an intolerance of uncertainty? Does that make...

Rita: No, I understand. Yeah, I have intolerances—of uncertainty and I like to be in control type thing. So...

Wilson: Right. So if we got to a higher level of the abstraction like this one and we can deal with this one, everything underneath it begins to fall in place, right? If you train your kids to always be honest, then all those circumstances and they go, "Well, honesty is the best policy." Or whatever phrase. So "I have an intolerance of uncertainty." The way you are always going to lose is when you forget that and begin to address the issue based on the health. You have to remove health as the
theme.

Commentary: This treatment is an aggressive sport. I am now going to push into her belief system in order to change her mindset. I'm going to shove at her inertia to try to knock it off track or generate friction in its movement. I'm going to increase my intensity, increase my animation, and track her carefully to make sure I don't lose her. You may have noticed that I also stopped her from talking about how to apply these skills in the future. Because she does not yet believe that the strategy will actually help on a day-to-day basis. She is pessimistic about the future, so I use a "one step at a time" logic as

we build this new platform, this new orientation to the problem and its solutions.

Wilson: Health is merely what the severe illness worry—well the disorder—has picked health for you because it works on you. That's the reason it picked it. If you stay with this, it will always beat you. So we have to have another game board, which is intolerance of uncertainty. So how do you tolerate uncertainty about health? That's the next question I assume you would like. You got any thoughts? Let's say you got $10,000.00 for every idea you give me in the next one minute. How would you begin to tolerate uncertainty around your health issues?

Rita: I...

Wilson: Don't shrug your shoulders. I mean, don't go, "I have no idea." You can shrug your shoulders in the beginning.

Rita: Oh, other than wearing a 24-hour halter monitor all day.

Wilson: Why would that help?

Rita: Well, my printout of my heart would be there all day. So, it would be...

Wilson: That would give you reassurance.

Rita: Yes.

Wilson: We don't want reassurance. That gives you certainty. That's doing the same thing that the disorder wants you to do—looking for certainty around your health. We don't want you to look for certainty around your health. We want you to tolerate not being sure about your health. Let's back up. Do you understand? Don't want a printout. Don't want to be listening to the message from the cardiologist. Don't want to have a checkup every month on your heart because those are giving you reassurance. If you're going to do a treatment that will succeed for you—I assume you're tired of the things that just put Band-Aids on this—that's just putting band aids what you're doing.

Rita: Right.

Wilson: You've done a great job. You've done the best you can to figure out what to do and it's not working. You can't put Band-Aids

on the problem. You're going to have to go to a higher level to finish it off, which is not to know "what's going on with my health?" and to tolerate that. In other words, take the hit.

Commentary: I degrade the health topics as a red herring, as noise, as a very seductive way that the disorder manipulates her. Instead, tolerance of uncertainty and distress represent the higher-level frames of reference. I speak of "elevating above the content." If you can change at the level of frame of reference, and if you can give yourself messages that manifest from that bigger frame of reference, then you can direct your actions moment-by-moment. I am also personifying her disorder and conveying that it generates the health topic for her to worry about. She has control issues. And she's not in control of the health worry popping up; that is unconsciously mediated. Therefore, she has to be willing to "take the hit." This will probably be where she resists the model—she doesn't want to take the hit. She doesn't want to have fearful thoughts about her body and then sit with the feelings that they generate. She wants reassurance about health. She cannot have that and also get better.

Wilson: So, now for $10,000 can you imagine anything that you might do that would allow you to tolerate not knowing what's going on with your heart right now?

Rita: Well, if I was in church, I would say faith.

Wilson: How so?

Rita: Well, you know, those people just believe.

Wilson: Yeah. There is actually a phrase people use, "Let go and let God."

Rita: Right.

Wilson: You know that one?

Rita: Yeah.

Wilson: What's it mean?

Rita: Well, it means having trust and I have trust issues. So, I mean I try to have faith and it's like what's going to happen is going to happen, you know? No matter how much I...

Wilson: How do you like that phrase, "Let go and let God?

Rita: I like it.

Wilson: I mean, what if you walked out of here today and had that phrase that popped up in your head and that you fell into line with that? As soon as you said, "Let go and let God," you stopped searching for what's going on with my heart. How would that be for you?

Rita: Well, it would be good, but I don't think God gave me this.

Wilson: You know, how is that related?

Rita: Ah, good point.

Wilson: You know, "Let go and let God." I'm going to let go of trying to figure out what's going on and I'm going to let God handle that. So here comes the stimulus, "Oh, gosh, there's the palpitation. Huh, my gosh." So, here's what's going to come automatically for you. The physical sensation and then thoughts of impending doom. "Oh my God." Right? And then a compulsion. So you got an obsession, "Uh, oh." And then a compulsion, "Got to find out." So you're not in control of the obsession. It's going to pop up automatically. You with me on that?

Rita: Mm-hmm.

Wilson: But haven't you been trying to get rid of the obsession? Give that up. What do you think about that?

Rita: So, when I get the pain, what am I to do?

Wilson: What do you think?

Rita: Let go and let God?

Wilson: Yeah.

Rita: It's not easy.

Wilson: Oh, no, of course. I said it wasn't easy. It's not complex. It's very difficult. So first we've got, first platform is this is not about your heart, not about your body, not about your health. Is that true or false? This is not about your health, right? It's not about your health. This issue that you're having is not about your health.

Rita: But that's what the dark side's thinking. Why do I get the pains then? That's...

Wilson: Don't care about that. Don't care about that. That's content. That's about pain in your heart. It's irrelevant. You have an anxiety disorder, yes? If you have an anxiety disorder, the content is always irrelevant to the treatment. It's relevant to you. You've had these. You've had a couple blows that traumatized you. It's seductive. It causes you to worry. What's going to happen here is—am I going to be able to explain this well enough for you to grab it? But it's not about your heart, yes or no? It's not about your heart.

Rita: It's not about my heart.

Wilson: Right?

Rita: Right.

Wilson: Right. It's not about your heart. It's that you worry and you get caught up about your heart. So it's not about your heart. So when the thought about your heart comes up in one way or another you want a framework that goes, "Oh, it's not about this." What is it about? "Oh, I am having doubt about my health." Excellent. Great—having doubt. Great. That's where you want to go to. Tomorrow we're going to talk about how you do that, but where I'm going to ask you to go to, if you really want to wrestle this to the ground and get rid of it, is when you have a sensation that scares the bejeezus out of you—now, I'm from the South—you know what bejeezus—

Rita: Yeah.

Wilson: Okay. So, when you have a sensation about your body that scares the bejeezus out of you and then you go, "Oh my God, what is that? I got to figure this out." That's an automatic thing—we're not going to get rid of that, right? That's going to happen automatically. That's the next piece that goes here. The thoughts about my body or my heart or my health are going to be automatic thoughts. "Fine that I'm having those thoughts." How are you doing about that idea? "Fine that I'm having them." What do you think?

Rita: Yeah, I get it.

Wilson: Okay. “Fine, because I have a disorder. This is what we do.”

Rita: So, do I acknowledge them like...

Wilson: Sure, well you can. Yeah, well there it is. “I’m having this thought about my heart and I’m really scared and I’m really wanting to go search the Internet or tell somebody or call the doctor and get an appointment. It’s happening—fine that that’s happening.” You with me on that? Then we’re going to manipulate that even further tomorrow probably instead of today, which is, “Great that that just happened. Great. I actually want that thought to pop up” because—and I’ll give you the justification for that—there is a behavioral term called habituation. Have you heard that before?

Habituation means, really, habit. So, it’s how you get over a fear. If you have a fear of elevators, you habituate to it and then you get better. Which means you get on elevators frequently. You allow yourself to get distressed on the elevator and you stay distressed on the elevator for 45 minutes to an hour and a half every time you practice. So you get on the elevator and you get freaked out. You can step off of it and you can kind of cool out. Then you get on it again, but you hang out there for like 45 minutes, getting back on and off the elevator, even if you don’t ride on it. You just start to get used to it, right? So, you understand? That’s how you get over a phobia. If you’re afraid of water and you had a near drowning experience—

Rita: Yeah, yeah, yeah.

Wilson: —you have to do all that kind of stuff. And it takes these three variables and know this, clearly in the literature, frequent exposure to the feared stimulus, at least moderate distress with the feared stimulus, and hang out in it without running away and trying to avoid it. That’s habituation. You’re asking me to help you habituate to the threat of a heart problem. That is your request of me, isn’t it? You want to habituate to it so that when somebody brings this up you don’t freak out about it. That’s one of your goals.

Rita: Yeah. And when I feel the pain or the physical sensation, then I...

Wilson: Then it’s not so distressing that I become preoccupied about it.

Rita: Right.

Wilson: So what you're asking me in essence is, "please help me habituate to health related worries so that they don't preoccupy me and I can have my life back." Does that make sense to you?

Rita: It makes sense.

Wilson: That's what you're asking for.

Commentary: I'm continuing to build the platform on which she can stand as she does her behavioral practices. The first level: "What I worry about—all that health-related content—is irrelevant." Second: "My obsession, the topic of my worried thoughts, is going to pop up automatically. So is my distress and the urge to do my compulsion. I am not in conscious control of those popping up. Therefore, I'm going to accept those thoughts and feelings when they arrive—not fight them and not try to get rid of them." The third platform is the task of habituation: frequency, intensity, duration. Now, I present all of those principles as serving what she has declared as her goals: "Help me habituate to health-related worries so they don't preoccupy me and I can get my life back." And I then find out if she agrees.

Wilson: So, you need frequent exposures to what?

Rita: The cardiac unit at the hospital.

Wilson: No. Well that would work.

Rita: I can volunteer.

Wilson: Yes, that's good. That's excellent. But you also have a naturalistic exposure, which is frequent exposures to...

Rita: My own symptoms.

Wilson: Yeah. "I feel a threat." Does that make sense to you? You need frequent exposure.

Rita: And I have that, yeah.

Wilson: Right. So there's something missing because you have that, but you're not getting better. So you need frequent exposure to it. You need your distress level to be on the scale of zero to 100—a 50 or

higher. You get that already, right? You need to linger in it. Does that happen already?

Rita: Mm-hmm.

Wilson: So, geez it seems like you should be habituating. What are we missing? Is that you fight it. The only thing that's missing is you fight it instead of allow it. That's your mistake. It's everybody's mistake, which is you have a frequent exposure that lasts for a while and makes you distress and your position is, "I don't want this. I need to get rid of it." That's why you're not getting better. And you will get better I guarantee you. You will get better. I'm not saying you'll get best, but I guarantee you'll get better if you switch around your protocol to get yourself to want to have the experience and want to keep it.

So again, we're going to do more about this—you don't have to get it totally at this moment. Your position is, "I want frequent experiences of not knowing what's going on with my heart. I want my distress to be significant when it occurs and I want it to last." That's the position I'm asking you to take. And so, argue with me about that.

Rita: That sounds horrible. It sounds like the way I've been living.

Wilson: It is not.

Rita: But, yes, I experience them constantly. I get highly stressed out. And I'm in fight or flight constantly trying to figure out...

Wilson: Excellent. So you're only missing one piece. You got all the components but one piece. You don't want it. And the piece that you're missing is you need to want it. That's the only piece you're missing.

Rita: Why would I want all that?

Wilson: That's how you get better. This is paradoxical treatment.

Rita: Is it want or is it dealing with it when it comes up?

Wilson: It is want.

Rita: Well, I don't want these pains to come. They're—

Wilson: Then you're not going to get better. I mean I understand you don't want the pains to come.

Rita: It's a horrific feeling.

Wilson: But they come anyway whether you want them or not.

Rita: True.

Wilson: All anxiety disorders remain while people resist them. I'm only going to ask you to do one thing, which is to experience physical and emotional arousal. Let it come forward without resisting it. That's the only goal. If you think it's legitimately about your heart, you will resist it because it's scaring you. So we have to elevate it up to go, "I got a mental health disorder that causes me to focus on my heart. It's not about my heart. It's about my inability to tolerate this experience." I am in your life for a brief little moment to help you understand you only have one move to make—two moves really—"It's not about my heart. It's about intolerance of uncertainty and I am going to take these three variables and I'm going to add one thing to them, which is I'm going to seek them out and want them. That's all I'm going to do differently." And you will begin to get better. So, here we are, practically speaking.

Commentary: As a strategic therapist, I take a provocative stance:

I give her clear directions, and I even say that I "guarantee" if she follows my directions she will get better. Of course, I can't actually know that she will get better when she applies these principles, but we absolutely know that people maintain anxiety disorders by resisting. If she honestly welcomes the sensations (no easy feat), her odds of improving are significant—so I use all the leverage I can get to have her try this new approach. This method can be challenging to therapists who work in a less directive, more client-centered way. But these clients are really stuck in a faulty belief system. If we aren't aggressive in our tactics, then we are going to be at the work for a long time. I think these types of clients will benefit most when we help them in as direct a fashion as possible. The problem comes not from the directions failing to help them, but from them failing to experiment with the directions. That's why I push.

Rita: So are you saying that when—I really don't think I want to get in the car on the drive home and wish for chest pains.

Wilson: You don't have to.

Rita: But when they come...

Wilson: Well, it would be interesting to do it that way. But, you know, go ahead.

Rita: Well, no, I can get them. I can think them and get them. I mean...

Wilson: Okay. So when they come up, what?

Rita: So are you saying more to embrace them?

Wilson: Mm-hmm. Every time I have an experience of trouble with my heart is an opportunity to have an exposure treatment. Every single time.

Rita: So am I saying, "It's not my heart. I have a anxiety disorder."

Wilson: I wouldn't say that, no.

Rita: Okay, what do I say? I have to say something.

Wilson: Yeah. No, absolutely.

Rita: Because if I'm not going to do something like an EKG or, you know...

Wilson: I don't want you to reassure yourself about anything—in the moment. In the moment you don't want to reassure yourself because that's making yourself certain. So for you to go, "There's nothing going on with my heart right now," is the wrong thing to say in the moment. What you want to say is, "Oh, oh, there it is. There's the pain in my heart and I'm feeling scared about there's something wrong with me. I got to—I really want to figure out whether there is something wrong with me." Step back from that and go, "Oh, it's happening. Okay, well, this is an event. Alright, now I got two choices. I can either be part of the problem or part of the solution."

You're old enough to know what we used to say back in the Vietnam War. You know, if you do nothing, you're part of the problem. So are you either part of the problem or part of the solution? "I got two choices here. I'm having this experience now. Okay, so, what's that crazy doctor asking me to do? Okay, I'm supposed to embrace this. Okay. Fine this is happening. Fine." Here's the dance chorus that you get tomorrow, but I'll tell it to you.

Rita: Okay. Yeah. After I say fine, I'm experiencing it...

Wilson: And then you don't do anything else. You don't have to do anything else at that point. But if you...

Rita: Well, I have to make a choice the light or the dark side.

Wilson: Which is what? Yeah. No, you are. By you saying, "Fine, this is happening." That is the light side. That's all you have to do is "Fine this is happening."

Rita: But how is that going to get me on the light side path and not walking to the computer or taking my pulse or, you know...

Wilson: Any of those things that you do are going to give you reassurance. You don't want to do anything like that. Those are all the bad moves. This is why you're still having trouble after two years is because—

Rita: So, I embrace it and acknowledge.

Wilson: —as soon as it occurs you do a compulsion. You have an obsession and you do a compulsion. This is like obsessive-compulsive disorder. You don't want to do any compulsions and you want to be fine that you're having an obsession. You're having an obsession about your heart. If you really—if I thought I had palpitations in my heart and I thought it was really about my heart, I wouldn't be okay about it. I'd be going, "Oh my God, what is this?" But we don't have that issue with you. It's not about your heart. It's about intolerance of that stimulus. So, you want to do exactly the opposite of what you always do because this is paradoxically the opposite of instinct. This is why it's difficult. You're going to go against instinct.

Rita: Mm-hmm.

Wilson: Anything that threatens the heart or the lungs or the brain is going to kick in an emergency response that is genetically programmed in your hind-brain. So we are up against a mental health disorder that takes advantage of a very primitive response that anyone would have. But we know now it's not about the heart. If you don't elevate above that you cannot get better. Alright? That's what we're talking about.

Rita: Right. Right.

Wilson: So, fine, this just happened. Now, what do you do next? Hang out with it. Talking to your kids, you're driving, you do the best you can to keep doing those things. Soon as your mind comes back to it eight seconds later, "Fine, okay. There it is." You might still be very distracted by it. You may not be able to concentrate on other things, but that's nothing new. You weren't concentrating anyway. But all of that is good, healthy practice. So, you know what we'll talk about tomorrow is—we're going to personify the disorder and externalize it. That will be the move that I've just explained to you, but you don't have to worry about it today. We're going to—when I say I want frequency, intensity, duration, give that job to the disorder, okay? "Come on worries, please, please make me worry more right now. Can you, can you please make this symptom worse for me right now? It's not strong enough." I mean, that's where we'll go tomorrow, which is a lot more provocative and kind of an extreme position.

Rita: Yeah. I don't even really have to tell it to. It just appears.

Wilson: No, but when you ask it to, it starts messing with it because it fuels, it lives off of your resistance. That's what I want you to remember when you leave here. The disorder is fueled by you fighting it. You must stop fighting it.

Rita: So what you're saying, it's fueled by me going to the doctor, getting on the Internet. Like it's enjoying—this is what I talked to my counselor—it's sort of like adjoined living with me because this is how I feed it.

Wilson: Absolutely.

Rita: Every time I give it a EKG I feed and—I try and starve it and then it's like it comes back and then I feed it again.

Wilson: If you'll stick with me and just stick with me and kind of try to make me right, be a good student of work, I will teach you how to do it. And I'll teach it to you in two sessions—I will. And then we'll do a follow-up a month later or whatever. We'll do email. You can correspond with me, whatever you want to do, but we want in these two sessions to put this in place. And today, between now and when I see you tomorrow, I want you practicing this. So, how will the practice look like? Tell me what it will look like.

Rita: Oh, I'll get whatever it is, you know, headache, sharp pain, whatever. I'll embrace it.

Wilson: Tell me what that means.

Rita: Well, acknowledging it. Okay. I'm feeling the chest pain. I'll try and go, "Ah, okay, it's fine."

Wilson: What do you mean "It's fine?" Tell me what you mean when you say, "It's fine."

Rita: It's not my heart.

Wilson: No, I don't want you to say that.

Rita: Don't say heart.

Wilson: No. I don't want you to reassure yourself. "It's not my heart" is reassuring yourself.

Rita: I need to say something. It's my anxiety disorder?

Wilson: No. Sensation comes, right? "Oh my God." What would it be? Would it be a palpitation?

Rita: Yeah. A skipped heartbeat or—yeah.

Wilson: So you're going to have an automatic response. "Huh, by God, what is this? Oh, God, I got to get rid of this." So that's going to go on for 10 seconds to three minutes before you kind of even catch on to it. Soon as you catch on to it you step away and go, "Okay, it's happening. Okay, I'm having a little event. Fine, this is happening." That's all you have to say. Some reasonable facsimile of "fine this is happening." What is happening? "I'm feeling uncertain or worried about my heart. Fine." Now, don't say anything to reassure yourself about that because you want to practice this event. You want this moment to count towards you getting better. And the way it counts is for you to not to do anything around going, "It's not about my heart." Sitting here with me in this room you want to understand it's not about your heart. Got to have that understanding. But this is just the strategy session. Out there in the world—

Rita: Mm-hmm.

Wilson: —when you're practicing, you want to, "Okay, I need to stay

uncertain." So there will be this doubt that just keeps popping up and every time it pops up you have an event and if you don't reassure yourself it's going to keep showing up. "Hey, you're not paying attention to me. Hey, hey, there's something wrong." Right? So, it's like your kid—

Rita: So, I'm ignoring it basically. Well, I...

Wilson: You're not ignoring—acknowledge it every time.

Rita: Okay. I'm acknowledging it.

Wilson: Just don't satisfy the request so you can stay unsure.

Commentary: As you can hear, we are spending a significant amount of time focused on what she needs to say and do second-by-second. It can seem quite tedious. This is where the work is: in the trenches. I'm going to bounce back and forth between that overarching therapeutic frame of reference and its application in the moment of worry. It seems that Rita understands what she's doing wrong, that she is fueling the problem by seeking reassurance. What we don't know yet is if she can translate therapeutic principles at the moment of distress.

Wilson: Your job is to be generically unsure. It happens to be about your heart, but it's not about the heart. We're up here. My heart is down here. It's like picking up trash. You don't want to pick up trash the rest of your life. That's garbage down here. Don't go there. Go to, "Okay, great. I've got an event. Now, let me have this event work. Okay, I'm worried about my heart and I'm really wanting to go on the Internet or I'm really wanting to call somebody. Excellent. Okay. It's happening. Great." You don't do anything else. You just keep acknowledging it. That's fine. Don't do anything with it. And how are you going to feel if you don't reassure yourself?

Rita: I'm not going to feel good.

Wilson: Anxious. You're going to feel anxious, right? And so you—

Rita: I'm going to have a panic attack.

Wilson: —want to embrace that too. Okay. There's an intolerance of uncertainty, an intolerance of distress. So you're going to go toward

being uncertain and toward being uncomfortable. And the biggest thing is you're going to have to trust me. What's the worst that's going to happen if in the next 24 hours every time you have some kind of uncomfortable physical sensation, you go toward it and don't reassure yourself and let yourself be anxious, what's the worse that's going to happen do you think for 24 hours?

Rita: I'll just be crazy all night and not sleep.

Wilson: And anxious.

Rita: Yeah.

Wilson: Would it be worth it if that helped you begin to put the pieces together to get better? Would you be willing—do you have a sense of how to practice this?

Rita: I do. I don't quite get it because I'm thinking about other...

Wilson: Okay. I want you to get it enough to practice it.

Rita: Yeah, I have it enough to practice it. But I've spent the last two years with the positive thoughts, you know, "Okay, it's not my heart. Okay, go for a run." And so now I have to switch everything.

Wilson: To what?

Rita: To basically accepting that it's there, acknowledging it and...

Wilson: And then not doing any reassurance, okay? So, all you have to understand right now is how to practice for the next 24 hours. That's all you have to understand—how to be, do this crazy thing that he's telling me to do. "I don't really get how it's going to help me." You don't have to know that. I mean, to some degree you wouldn't do it, right? You have to know it's not really physically going to harm you, right? That's what we're just establishing right now. But in the moment you're trying not to remind yourself of that.

Rita: And then how do I stop it? Move on...

Wilson: How do I stop what?

Rita: You know, the pattern.

Wilson: Which pattern?

Rita: You know, well, when it comes, how do I move on to the next thing, you know, whether it be taking the kids...

Wilson: So, be specific about what you're talking about.

Rita: I get the pain. I acknowledge it. I embrace it. Okay. I'm not giving myself any reassurance.

Wilson: So, you're asking about moving on. Tell me what's your concern about moving on?

Rita: Let's say the kids are in the car waiting for me and I get this in the house. How do I make the shift from the embracing, the acknowledging, the not reassuring myself to go doing what my planned activity was with the kids or...

Wilson: How do you do it now when—I assume you go do whatever you're planning with the kids despite the fact that you're worried and you haven't figured it out.

Rita: Yeah, yeah. I have all the chatter in my head and the circular...

Wilson: Do it the same way. Just keep going.

Rita: But then I'm also checking my pulse going, "Okay, my heart's fine."

Wilson: Right. So, it's going to be similar, which is the stimulus comes up again and you keep going, "Oh, great. Excellent. It's still here. Good. Great that I'm still having that thought."

Rita: But I'm not reassuring myself. That's going to be—that's the main difference here.

Wilson: Because that's what? Frequency, intensity, duration. Every time you a have a negative thought, you want to say, "Good." Really different than what you've ever done, right? Every time you have a negative thought you want to say, "Okay, good. Good I have that because there I get another notch in my belt." That's another we'll practice. And then, "I'm not going to reassure myself. Fine this is happening." Is that alright to say? "Fine this is happening." And now I'm going to go do whatever I'm doing next. It will keep disturbing you. Every time it disturbs you at some level you're going to be going, "Okay, good." I know there will be another voice that will go, "Oh, God, this is so irritating."

You know—especially the first 24 hours you go, “Ugh.” Don’t get ahead of yourself. Don’t get ahead of us. Only practice this piece. Don’t get into like, “How is this possibly going to work?” Feel free to be skeptical, but don’t undo what we’re doing because we only got one more session. So you really have to practice so we can come in—this is not to get your—this is like an experiment. We’re going to gather some information about what happens. You’re going to notice some things if you’ll do it. I would immediately get in a car and try to explain, or whenever you can, to your husband or whoever you can what we just talked about because it will help. It will remind you. Or sit down and take some notes for yourself to do this because it’s not a simple thing and it can be easy to kind of get lost with it. What do you want to ask me before we stop for today?

Rita: I just think I’ve got it without being too skeptical and—

Wilson: Okay.

Rita: —you know, I just know how my brain is wired to think, to have to reassure myself. But that part is going to be really hard just to like...

Wilson: But it’s the main piece.

Rita: And to understand that by me just saying, “It’s fine,” is me winning not it winning.

Wilson: Right. You have to have this experience. You have to have the negative thoughts. You can’t go around this. You’re going to go through the eye of the needle, which is—this is not about the symptoms. This is about your response to the symptoms. We want to think about that. The only thing we want to do is modify your response, not the symptoms. The symptoms go away on their own when you withdraw the fuel. And we’re going to withdraw the fuel if you stay with me around the protocol. You know, and if it messes up, then we’ll start over tomorrow around how to do it. Okay?

Rita: Okay.

Wilson: Alright. I’ll see you tomorrow.

Rita: Okay. Thank you.

Wilson: You’re welcome.

SESSION 2

Wilson: Okay. Good morning.

Rita: Good morning.

Wilson: So, $64,000.00 question: Did you practice in the last 24 hours?

Rita: I tried to.

Wilson: Tried.

Rita: I did actually. You know, I would get the pains or whatnot and it was hard not to say, "Everything's fine. Everything's okay. Everything's okay." And just to, like, deal with it. But I felt like my mind was searching for a mantra or something.

Wilson: Mm-hmm.

Rita: It was out there randomly just lost, you know, because it seemed like it was empty, which was good because my mind is never really empty. Because I didn't really know which direction to...

Wilson: Right. But I think we should have a mantra for you. I think you should have one. Let's make sure we come up with one before we're done here—

Rita: Right.

Wilson: —because nature abhors a vacuum and it's looking. So you do need to have an interpretation of what's going on right now and an instruction to yourself. Otherwise, you will feel lost. And even if the instruction is, "Great. I'm feeling lost right now," that would work. So tell me more about how that went.

Rita: Well, it didn't last very long. You know, and I didn't...

Wilson: What do you mean it didn't last very long?

Rita: Like, you know, like the pain and then my—I didn't obsess about it, you know.

Wilson: Why not?

Rita: Because I really tried to implement what I learned yesterday. And

also, the pains weren't that bad, you know. I wasn't...

Wilson: You were saying that—implying what?

Rita: If they were worse, I don't know how I would have been. You know, so...

Wilson: Could they have gotten worse based on your response to them?

Rita: Yeah. I could make them worse.

Wilson: Could that account in part for why they weren't worse? Can we have a hypothesis that, "How I responded to them might have influenced how bad they were?"

Rita: Possibly.

Wilson: Okay. Just wanted to be floating out there, as we're looking for ways to understand things. Okay?

Rita: Now, I know I was supposed to not—it's hard to put yourself in that type of situation. You know, my mind—I don't always have to have like a chest pain or a head twinge or a bruise to make me think about health. I can just be driving down the road and then all of a sudden—you know, it's in my head all the time about health. So, when I'm supposed to put myself into situations—like one thing yesterday I was thinking of is, should I have gone on a really hard run? Should I have done those workouts I've been avoiding? Does that count as putting myself in that situation?

Wilson: What do you think?

Rita: I would think, yes.

Wilson: Okay. I agree. Yeah. Would you have put yourself on a really hard run yesterday?

Rita: Well, I thought about it.

Wilson: And what happened with the thought?

Rita: I had excuses.

Wilson: Uh-huh. Okay.

Rita: Yeah. It was too hot. I don't work out late in the day, you know...

Wilson: Right. So a couple things. For the most part you won't have to go looking for it because it occurs frequently enough for you. In other words, you don't have to go chasing after a lot of opportunities because throughout the day you're going to have events naturalistically that you can practice on. And then going out for a hard run is also a great thing to do. Go after some of the things that you have been avoiding because doing a lesser run or a lesser workout is a kind of safety mechanism to protect you. So we want to sweep away all those safety crutches and put you in a place where you face the threat head on without all these buffers and then take the hit and learn that you manage it. So that's our goal.

Rita: Mm-hmm.

Wilson: So did you have time this morning, when things didn't go very well in the last—since we were last here as you were trying to practice? Or were there times where you just didn't even realize you were supposed to be practicing and you got to your usual obsessiveness?

Rita: I didn't have a really bad night last night. Yeah, so...

Wilson: Sorry. Didn't get to practice as much, right?

Rita: But there was one part that I was reading was talking about heart and health and I was reading it out loud to my husband. I noticed myself going, "Oh, I can't read this part." That's when he said, "You need to read that part."

Wilson: Oh, he's such a good partner.

Rita: Yes.

Wilson: That's great. Don't you hate him for that?

Rita: Yeah. So I read it out loud to him and, you know, I caught myself just taking a breath, but I didn't catch myself saying, "Okay, this is"—well, I didn't say anything because I didn't have a mantra to say. So I tried not to say, "Okay, I'm reading this, but it's no big deal. It's somebody else's story." I mean, I didn't go into all that in my head, but I wanted to go to that in my head because I didn't know what else to go to or where else to go.

Wilson: You have a sense of what to go to, so far? I mean, I know you're paying me the big bucks to give you those things, but what would be your best guess about what to say in those moments?

Rita: Well, what I want to say is "I'm okay," but that's not—that's the old way.

Wilson: What do you want to say instead?

Commentary: We've been reviewing the past 24 hours to see what she has discovered and to see whether she can remember the protocol. She wants a mantra. Exactly! We must frame-up our therapeutic point of view into a simple message that either motivates her or gives her an explicit instruction. A motivational message could be, "I can handle these feelings." An instruction might be the command, "No reassurance!" If I don't help her shape the new messages, then by default she will seek reassurance in an attempt to get rid of bad feelings or fearful thoughts.

Rita: I know what I'm supposed to say.

Wilson: Which would be?

Rita: Which would be, "Okay, I might be having a heart attack, but the likelihood of it—you know, I've been to all the..."

Wilson: No, you're not supposed to say that either.

Rita: Oh, right. I can't use the doctor's reference.

Wilson: Not supposed to say, "I might be having a heart attack." How about this: "Great."

Rita: "Great." Because...

Wilson: I'm looking for frequent opportunities to be distressed about my health. I'm looking for my distress to be at a 50 or so out of zero to 100. And I'm looking for it to last for a while in order to habituate to my fear. I have to notch in a whole bunch of events in which I step toward the threat and hang in it. So two reasons to say, "Great." One is, "Oh, great, I get to practice now." You understand that one? "Great, I need my practice. I'm sick of having this. I want to move on. I've had this long enough. Gosh, two years and, you know, enough." So, "Okay, great."

And second is, “great” is opposite of what you’ve always said. This is paradoxical treatment. The anxiety disorder as we personify it wants to give you a sensation that you resist. That’s what its job is. Not give you a sensation—give you a sensation that you resist. So what we want to do in one martial art move is to instead of resist, welcome it and let’s go to an exaggerated place of saying, “Excellent. That’s what I’m looking for.” So, to go “excellent” is kind of a caricature of, “I’m willing to take this hit and I comprehend the objective here. I understand what I’m trying to do. I actually need to have this experience and sit with it and not fight it. That’s what I need to be doing.”

I’m going to go one step further and go, “Great. Holy mackerel, my heart—I can feel it skipping. I just now I’m feeling afraid that there is something really critically wrong with me. Okay. Whew. Excellent.” Commentary about that I’m afraid, but we’re going to the level of, “Gosh, I’m afraid. It’s about this topic.” Okay? “And I feel unsure about whether I’m okay. Great. Great.” Your husband will love this when you tell him that that’s what he should suggest to you. So let’s stay with this for a minute and tell me what seems confusing to you about that or to what degree did that make sense to you.

Rita: No, it makes sense. So what came to mind is when I’m in that mode I need something longer than “great.” So, what if I say, “I’m willing to accept this now. I’m willing to accept this feeling now.”

Wilson: Okay. How about, “I can handle this?”

Rita: Instead of that?

Wilson: Or something not—I don’t want it to be too wordy because what you and I want to keep in mind at this moment is when you get really distressed your mind turns to mush. And you don’t want to have a lot. You were talking yesterday about affirmations and affirmations are fine, but in the moment of threat we want to basically make affirmations secondary. Primary we want to be instructions about what to do at this moment, which is, “I’m going to stay with this feeling. I can handle this. I’m willing to feel this. The more I feel this the better I’m going to”—I’m giving you several suggestions. It’s not all of that. “The more I do this the better I’m going to get. If I want to

get better, I got to take the hit." So any reasonable facsimile that says, "Sit here, accept it, allow it to just wash over me. Don't fight it. Don't resist it. Don't go toward content." Any of those reasonable facsimiles.

Commentary: As I continue to personify the disorder, I pound away at a single theme: The disorder is not looking to give you an uncomfortable sensation; it's looking to give you an uncomfortable sensation that you resist. Your job is to find any other way to respond besides resisting. If I'm going to pass this protocol to her, then she must value the protocol so I keep returning the question, "Does this make sense?" Or I ask her to defend why this is a good strategy. She needs to own the work or I have not done my job.

Wilson: So what you and I want to do here is get a frame of reference that you understand the big picture of it, and then in the moment we want you to be able to reduce that down to three or four words in a sentence that reflect this. So you want to kind of understanding what's going on here. And then when you go, "I'm willing to feel this," it's like the head of a pin with a freight train behind it. "I'm willing to feel this." What would be the reasons if you were to analyze why you would say in the moment of threat, "I'm willing to have this feeling."

Rita: That's how I'm going to get rid of it.

Wilson: Okay. And does that make sense to you?

Rita: Yeah.

Wilson: Okay. So that's the bigger picture going to go toward it, you know. That's what, you know—when you have an anxiety disorder is people who have an attentional bias toward threat. You are looking for—you're sensitive to it. Your body gives you a little noise. We have noisy bodies. Have you ever squatted down and your knees crack? All these sounds that go on our bodies is just like noises that our normal body has, but you are scanning and taking anything that's noise and saying, "Is this a signal?" So we want to know that you're going to have some kind of noise that goes on your body. You're going to automatically call it a signal, automatically get scared. We're not changing any of that. You know what I mean?

Rita: Mm-hmm.

Wilson: Because that's going to happen. This is unconsciously mediated. It comes up because your mind and body are trained to sense something as a potential threat and begin to guard against it. And that's all one package and then you want to go, "Oh, it's happening. Okay."

Rita: That's when I accept it.

Wilson: Yeah. Just sit with it. "Yeah, but what if this is something? I'm not going to answer that question." So if you go to reassurance, you answer the question, "Is everything okay?" Now, if that works, you're no longer uncertain and you're no longer practicing. We want you to linger in not answering the worried question in order to get strong. And then you will.

Rita: And how long does it take to...

Wilson: Who cares? I don't mean to be sarcastic about the answer, but you know, what I mean is—let's create a protocol that you use every time this happens and don't worry about how long it happens or how often it comes back. We can pretty much guarantee if you start going, "That's fine—I'm not going to answer that question," that the questions will come more rapidly, more intensely, with more threat.

Because if the anxiety disorder is saying, "I don't want to lose her," it will escalate on you. So, we can pretty much guess that that will happen. You start doing this work. It's going to not like it and it's going to give you more trouble, right? Or it's going to give you a unique symptom, right? You're just all of a sudden you're going to have some little sharp jab above your ear and you're going to go, "Well, now, I've never had that before. Now, that could be something." Right? And there it is. What would you do if you had a sharp jab all of a sudden that came three times within an hour just above your right ear? What would you do?

Rita: What would I want to do? Freak out and go look it up.

Wilson: Sharp jab and stuff.

Rita: I'm sure there's thousands of people that get it.

Wilson: And what would it be like if you gave it 24 hours before you

looked it up? Would you think you might die within that length of time? Or would it be costly to wait 24 hours if you get three jabs within an hour above your right ear? Do you think that rationally would be costly to you?

Rita: No, no.

Wilson: If you had 95 jabs it would be different, but you had three. So part of what you would do is—you put it off. You postpone it. Don't answer the question for X period of time. And then you're going to practice for a limited period of time and that's okay too. You go, "Okay, this is brand new. Well, I'm going to note it, but I'm not going to go find anything because I want to practice."

Commentary: She does not have to go "cold turkey" about seeking reassurance. That's unrealistic. I want her to practice a skill. I'm willing for her to use a crutch if it helps her practice. One crutch is to allow herself to actually receive reassurance that she desires, but to postpone it. When we use postponing, we are throwing the symptom cluster a bone. We tell ourselves that we are allowed to get the reassurance, but we will be in charge of when we get it. So she makes a bargain with herself: "If I am still bothered by this sensation tomorrow morning, then I promise I will allow myself to get it. Until then I'm going to practice tolerating the experience of not knowing. And I'm not going to give myself any reassurance except the message that "tomorrow I can get reassurance." Until then, I'm going to let myself stay uncertain and stay uncomfortable and go about my business

Wilson: So, how are we around this finding something to say in the moment, some kind of mantra or...

Rita: No, I like that. I like that. Let's...

Wilson: You're absolutely right. You have to have something—you have to say something.

Rita: Let's define it though, or come up with it. I want to leave here with—

Wilson: Well, let's do it right now.

Rita:—my saying.

Wilson: Is it going to be different depending on what you notice?

Rita: No. It needs to be the same. Yeah. For me it needs to be the same consistency.

Wilson: Give it your best shot right at this very moment. What feels like—if you could put yourself in that situation what that threatened part of you—we're going to talk about that in a minute too. What would it be willing to abide by?

Rita: But my mind is still going back to, "I'm okay. I'm okay." That's where my mind just went to just now. It's hard to make that shift.

Wilson: Well, so, what about having that, "I'm okay." Let's use it. Let's just see where we go. "I'm okay." Now what?

Rita: I accept this feeling because sometimes it's not a pain or—well, sometimes it's not a feeling. Sometimes it's just a thought. So, I accept this...

Wilson: "I accept having this."

Rita: I accept having this.

Wilson: Or, "I accept this." Some reasonable facsimile of that. Well...

Rita: I'm okay. I accept this.

Wilson: So let your eyes close for a minute and give yourself a little scene where it's happening sometime in the future and go ahead and try that on. Just sit quietly for whatever, 30 seconds or whatever. Let yourself conjure up a scene. Try it on. See whether it fits. When you have information you need you can open your eyes.

Rita: No, I like it. I was saying, "It's okay. I accept this." Initially, honestly, my mind went to, "I'm fine," first. I guess I'm—yeah, I'm still used to trying to talk myself out of it instead of going towards it.

Wilson: Right. Well, so, I will grant you permission to say, "It's okay," or "I'm okay," or "I'm fine." As long as you only say that one time and don't argue with it. That's the only trouble because I think it'll work fine for you to go, "I'm okay," without going: "I'm okay because really this is nothing. I'm familiar with this feeling. It's nothing. Really, I've

had this checked out. I know the doctor"—we don't go down that path. But if you want to truncate all that to "I'm fine," because you're really not going to check it out so much in your head. You're just going to say, "I'm fine."

Rita: I accept this right now.

Wilson: Or, "I accept this." Or even—not to correct you because I want you to have something that fits right—"I want this. I'm fine. I want what's going on right now." Again you can work—you find what you want now, let it evolve later if you want. And you can email me and check things out and I'll confirm something or we'll talk on the telephone and try to get it worked out if that's okay with you. So we don't have to lock it in like, "I'll never get anymore feedback about it," right? Okay. So if you say, "I'm fine. It's okay to have this feeling" or whatever, what do you think will happen next in that scene?

Rita: Well it could either escalate or stop and I move on with my life at that moment. You know, meaning...

Wilson: If it escalates, what are you going to do or say?

Rita: Keep repeating what my mantra that I came up with.

Wilson: Okay.

Rita: And avoid doing the things that I've always done.

Wilson: Yeah. And what do you think will happen over time?

Rita: I won't even want to go do the things that I used to do anymore.

Wilson: Okay. So, you know, one of the things we know about working with kids is, if we get anxious kids who ask questions all the time, "Am I okay? Do I have—is there something wrong with me?" You know, and you go, "You're fine. You're okay." Then they go, "Well, am I alright?" "I just answered that. "I already asked you." "Mom, is it—" "I already answered that." Well, every time you say, "I've already answered that," you're reinforcing them asking.

So what we train parents to do is respond to them once, reassure them one more time and then don't say anything to them. Don't answer it at all. And that's extinction. That's where you're not giving it support. And the only thing you want to be clear about as the sensations

continue, that when you start saying, “I’m okay. I’m fine,” you’re not reinforcing this illness, you know, correcting, “No, no, you’re not ill. It’s just this.” That’s only thing you want to pay attention to over time, but that’s kind of a gradual work. We don’t have to worry too much about that. You have, I have one thing I want to talk about right now, but I want to see if there are other questions about…

Rita: No, I get that. Yeah. It’s clear.

Wilson: Yesterday you talked about the light side and the dark side. And after we left, I’m thinking that we might manipulate the label, “the dark side.” Because the dark side sounds like Darth Vader and ominous and big and bad.

Rita: Because that’s how it feels. That’s why…

Wilson: Right. But let me talk out loud with you and see if this makes sense to you. I’m thinking we want to diminish it some. So, there is a light side and what you’re labeling as the dark side I think is, you know, my discouraged side, my scared side, my younger side, my insecure side. Do you know what I mean? It’s really the part of you that feels worried or discouraged and to me that sounds a little different than “the dark side.”

The advantage of maybe considering relabeling it is that “It’s okay to have those sides of me. I’m not going to get rid of my insecurities. That’s crazy if you think I’m going to get rid of my insecure self.” Or, you know, when I say younger, I mean, a part of me that perceives me to have less resources than I actually have because that’s also what happens to you. You get something going on that seems worrisome and [snap] “I got to immediately go look it up and find,” which comes out of a manifestation in a sense of, “Oh, I can’t sit with this. I can’t manage this.” So, how are you doing around what I’m suggesting—that maybe stronger side, weaker side or mature, knowledgeable, whatever, executive, threatened…

Rita: Well, I like stronger and weaker because that’s how I feel too. When I go on a great run or have a great workout or don’t have the thoughts driving down the street, I feel really strong. And then when I get a pain, “Oh, I can’t get out of bed. No, I better not go fold the

laundry. I'm too lazy." I'm—and I come up with those excuses—that's weakness. But is it okay to think of yourself as strong and weak without—

Wilson: What do you think? Without what?

Rita: —without... messing up your self-esteem, your thought. I don't know.

Wilson: Well, I'll ask you a question in return. Is it okay to have a side of you that feels weak?

Rita: Well, yeah.

Wilson: Can you tolerate that occasionally you're in a situation where you've had a lot of stress or something's happened or there's been a loss or you haven't slept for a day or whatever and you feel less than strong and you feel insecure? You're feeling you need somebody to give you some support. Is that...

Rita: Yeah, that's human nature I guess.

Wilson: Right. So that's how I would think that we would want to frame that because when it—so two things: reframe it as that and the second is integrate it into your sense of self that it is okay that this is occurring. But when it does I want to help not let it run the show or kind of acknowledge it, but bring it on anyway.

Commentary: Here's another reframing. She allows herself to be swallowed up by "the dark side"; she is a victim of "the dark side." That is giving it far too much power, she ends up feeling overwhelmed and out of control. Let's reframe that into something like "my insecure side" or "my weak side." Then let's integrate that side into her sense of self. Everybody gets insecure; she gets insecure. That's okay. Now she just needs to take care of herself when she becomes insecure. She can feel insecure, but her stronger, executive side needs to be able to say, "I can handle these feelings." That is far, far different from feeling overwhelmed by "the dark side" taking her over.

Wilson: See because part of what you do, I think, which is common to a lot of people, is you set a goal and this commitment—"I'm going to

do this behavior"—and then you filter it through how you're feeling at the moment and then that determines your action. "Oh, I don't feel like—well, I really want to take a really hard run. Eh, I'm just not really in the mood." Don't run. Feel crappy. The other model that you could think about is, "My commitment is to go take a run today. I said I was going to do it and I think that's the right thing to do. I really just—I'm not in the mood. Well, isn't that interesting? Okay, my commitment is to run. I want to go run."

You can notice your hesitation, notice that you're not in the mood. It's not part of the equation. Let's let your feeling after the behavior come into the equation. So, let's say, "I'm going to do a hard run now. You know, I'm just not in the mood. Okay, well, that's interesting. Now I'm going to do my hard run." When you come back in from your hard run, how might you then feel?

Rita: I might feel good. Accomplished. Strong.

Wilson: Yeah. So, that's what we want to try to—hear this one, but not use it in the equation. Go, "Oh, yeah, of course a part of me is not in the mood. Eh." So, what do you think about changing this "dark side?"

Rita: No, that may work because I do only see the dark side and the light side. That's how...

Wilson: And you do a big thing. You go, "Oh, the dark side is here. Now, I'm—until it goes away I can't"—

Rita: Oh yeah. I can feel it like I see it.

Wilson: You know the experience has been "Once the dark side is here, I'll have to wait until it goes away," right? So it's kind of become the victim of—and I'm not diminishing at all people who get into low mood and being depressed and that kind of thing. I know those are—

Rita: No, that's what it does to me. It puts me in a depression and it also gives me the excuse that that's why I can't get things done and be productive.

Wilson: And I'm not saying every time you feel really depressed you can get around it and go do things. Of course, it's going to—you're

going to have to strategically go, “Okay. Well, this is going to win this one.” But so you want to consider calling it “the weak side?” Is that where...

Rita: Mm-hmm.

Wilson: Okay. Good. If we were ending at this second, what are you missing? Let’s get—I want to make sure I’m being a good consultant. So what do you want to make sure you have that you don’t have now as you walk out the door?

Rita: My mind works in a strange way. Like, I keep wanting to say to you, “But how do we really know these doctors were right?” How do I really know that the palpitations—but I’m going to fight them and I’m going to go on a jog or a run or take a class. How do I know...

Wilson: You’re doing so well here. You really are doing well because this is great. You know, one is you left here yesterday and just went right to work trying to explain it to your husband and went out and did practices. And now I’m saying, “Well, what are you missing?” And you go right to this and this is a great thing for me to respond to you, which is, if you want to do the treatment—if you want to get better, what’s the risk you have to take? That we’re wrong.

Rita: Oh, right. The uncertainty.

Wilson: Right. Because if you have an intolerance of uncertainty, it is, in a way, that the certainty center in the brain doesn’t close. Think of somebody who’s an obsessive-compulsive checker—not that you would have any reasonable facsimile of obsessive compulsive checking or anything—because you do, of course, right?

Rita: Mm-hmm.

Wilson: You know, they check the front door and they take three steps and they turn back around and they check it again 14 times. But we know they don’t have short-term memory loss. We’ve tested memory. It’s not about that. It is, “I step away and I get a sense of doubt and then I feel compelled to go check,” right? So we know that that’s going on. The question you’re asking is “How will I know?” You don’t have the capacity to know. You know, my mother would call it “your cross to bear.”

If you have a disorder in such a way that you can't get closure in that certainty center, then you have to courageously have faith in us and what we're talking about. Not just me, but the physicians and so forth because again and again and again the sense will come up of "How do I know? They don't really know me. He's not paying attention to this sensation. This is a new one. He's just a psychologist. He doesn't know about the physical things. Oh, he's just my primary care. He's not a cardiologist. Oh, she's a cardiologist, but she's been in practice only 10 years. He's a cardiologist and he's been in practice for 25 years, but I don't think I explained it"—It's endless.

Rita: Mm-hmm.

Wilson: So you really have to climb up on that platform of, "Oh, well. I want to get better badly enough that I'm willing to risk that I'm making a mistake." If you had panic disorder, every time you had a panic attack you had pain shooting down your left arm. You know, panic disorders are crippling to people. It's like three-tenths of a percent of the day and they will run their whole day about it. But if I want to get over panic disorder, I have to be willing to say, "I'm going to treat this as though it's a panic attack and it could be a heart attack and I miss it." Right? But they would. Otherwise, every single event could be an exception and really something tough. So, you know, we're not building confidence for you. We're building courage. What do you think about the risk of...

Rita: Well, I like when you said... Well, courage and faith stuck out.

Wilson: Okay. How does that stick out for you?

Rita: Those are two things I think I should use to lean on maybe.

Wilson: Absolutely. Yeah, because they both imply not knowing for sure.

Rita: Right.

Wilson: You're going to do that with your kids. Send them off to college or off to camp or let them go on a date or—maybe I shouldn't remind you of all these things coming up.

Rita: [laughter] Geez! Anxiety!

Wilson: All that's happening but at some level you're going to have, you know, trust in them. It's not like you absolutely know how it's going to go, but you're going to let them go. You're going to let them go find out, right? So you win over anxiety by sacrificing attention.

Rita: But it's like to try and win I may sacrifice life.

Wilson: Yeah. Exactly. You might have this, you know, genetic predisposition to some kind of neurological, subtropical disease that—

Rita: Oh, I would have it.

Wilson: Yeah.

Rita: But also sacrificing life not just with death. It's just—letting it control me so that...

Wilson: Oh, yeah, that side too.

Rita: Yeah, but both sides. Yeah. You know, because so many times either I want to do something or I want to do something with the kids and it's like, "No, I need to go take a nap," because I have to go in my mind or go listen to the recording of the doctor, go look something up on the internet. And before you know it, life gets away from me.

Wilson: Which do you want? You been doing this one for a while.

How do you like this one?

Rita: Not too well. Too many struggles.

Wilson: Logically speaking, how are you liking the direction that we're moving as an alternative to this?

Rita: Logically, it makes sense.

Wilson: And understand that if you want to do it completely, you have to risk not knowing something that you needed to know. Did that make sense?

Commentary: What we have just discussed here must be addressed with almost every client who has worries and obsessions. It is the nature of the disorder that they will doubt. Therefore, they cannot be sure that they should be letting this worry go. If we don't address this issue head-on, then they are going to continue to struggle in

treatment. They must recognize that when they start analyzing the situation, trying to be sure that their worry really is noise, that they are actually obsessing again. They must let it go, even though they are not feeling confident, and take the risk of being wrong.

Wilson: And this is where people get messed up around this work is they continue to operate under the frame of reference of, "I've got to know. This system is absolutely going to work and I am going to be safe." And you don't get to say that unfortunately because you have a health disorder that's not allowing you to say that. So if you're going to worship at the altar of knowing exactly that this is going to work for you, you're going to be in trouble. I'm going to be long gone. I'm going to be back in North Carolina. But you'll—what do you think? Leap of faith? Courage?

Rita: Yeah, courage. At this point it's...

Wilson: If you are courageous for a while, do you think you might actually start to develop some confidence? You might develop confidence that, "Oh, this little routine I'm doing is starting to work because the obsession that used to last for three days now sticks around for a half an hour and then disappears." I can predict for you that if you'll stick with this, you can be confident that that is what will start happening. Very rare for somebody to do what we're talking about and not get to the place that I'm speaking of because we're going to withdraw the fuel from the obsession. I'm going to suggest that you do no reassurances and zero checking about health. Zero. Just complete withdrawal. Only do things that are medically expected, you know, once a month doing a breast exam, once a year having a physical. What else should go on that list of things that you should have automatically going on in terms of medical?

Rita: Dental, eye exam once a year.

Wilson: Yeah, okay.

Rita: Cardiologist once a year.

Wilson: Wow, once a year a cardiologist, really? Is that recommended?

Rita: No.

Wilson: Oh, so, why is that on the list?

Rita: Because I've already been. I have two leaky heart valves I should keep on it.

Wilson: Is that what the cardiologist said? "Please come back once a year and see how it's going."

Rita: No.

Wilson: Oh. Well, why don't you find out what the cardiologist thinks one should do with leaky heart valves? What are you predicting that the cardiologist will say about the frequency of appointments with the cardiologist?

Rita: Three to five years.

Wilson: Oh, okay. I'd be surprised if they even said that, but you can find out. Any other medical thing that should be automatically on your routine?

Rita: No.

Wilson: Okay. What do you think about my request?

Rita: Scary. Yeah, honestly.

Wilson: What do you think about the logic of that?

Rita: Well, logically it makes sense. I mean, I get everything logically. It's the anxiety and the emotion just take over. It takes over my life—the anxiety and the emotion.

Wilson: Let's not let that happen anymore.

Rita: Yeah. But logically I understand. Sitting here with you for two days, I logically get everything. And I'm sitting here thinking, "I can't believe this is really me. I don't like who this is." So, I want it gone, but...

Wilson: But did you get any data last night when you tried to practice a little bit? Did you get any information about what it's like when you withdraw the energy from the obsession?

Rita: Well, like I said, I was looking for something in my head. But I can see with practice, I can see it just being like...

Wilson: Okay. So, it's not all theoretical. I just want to make sure it's not all theoretical. But you got a little data from it.

Rita: Right. Right. I mean, I can feel how it can change for me over time. I can't say it's going to happen in a week.

Wilson: And what about the statement of, "I want this"? What do you think about that message to yourself? At least know in a general way that—I understand that it may not be the command that you give yourself for what you say in that moment. But what do you think about the idea of wanting frequent, intense exposure to the distressing thoughts that last for a while? "Frequent little things that 'get me' around my heart or my health, that zing me up, up to 50 or above on a zero to 100 scale, and that stick around for a while—I want those." What do you think about that principle? Do you get that?

Rita: I get that. It's not something I look forward to.

Wilson: Don't have to look forward to it.

Rita: You know, I get it. I mean—I don't want to go sit down on the couch and think, "Okay, I want to feel a twitch right now." But I want to be able to go take a class that I haven't taken in two years because it's going to bring my heart rate to 165 and survive it and feel good about that and just—that's where I want. I want to be able to go to situations that I haven't done before like the workout situations, the stair climbing—things like that that aren't going to freak me out so much. But I really don't want to sit down on the couch and try and give myself a sharp pain in my head or something.

Wilson: Never wanting you to do that. Always wanting you to request it though. Great practice. Sit on the couch and go, "I want to have a twinge right now." Great, because now you're becoming like Teflon. You want to be like Velcro going, "Hope this day goes well. I hope I don't get any negative thoughts, because that will really spoil—and will bring the dark side up again. Boy, I hope everything...." You know, that's Velcro. The anxiety disorder loves that. So you want to start insulating yourself. You start being like Velcro. You go, "God, I haven't had a worry about some physical thing. Can you give me one of those sometime today? Kind of surprise me with it sometime before

the day's over." Really begins to bring—it's an aggressive way to go.

You're going to have to try it out and see. I know it sounds crazy, but it is a way to start developing a character that doesn't absorb and have the anxiety disorder cling to you. It is a way to go, "If it comes up every day, every hour of the day, that's great. I'll take that. I'm not in control of it popping up. Only in control of the way I respond to it. That's my job. I'm going to respond to it by going, 'Excellent. Great. Give me another one.'"

I'll tell you a story. We're going to stop soon. I'm going to make sure I've answered what you need. And we're going to follow-up in a month by a half-hour telephone call and it doesn't have to be a month if something happens in between then. And you can write me any time you want and I'll always respond to you. Just send me an email and I'll—as long as I don't have to write three paragraphs, I'll be fine to answer. Because, you know, as you're trying to explain things to your husband last night—it sounds good here, soon as you leave things start to fade away.

I was teaching up in Canada a few years ago and I went to—I like hiking and I have a bum knee so I can't hike very far with a backpack. So, I found a—Revelstoke is the national park and you can drive up 25 minutes to the top of the mountain so you only have about a three and a half mile hike. And so, I planned this outcome. I left the Canadian Rockies and I get bed and breakfast, rent a car and about four months I get it all ready. I go up there, drive up, park, no car is there. Beautiful. Pristine. A little sign about bear feeding. So I'm kind of as I'm hiking clapping and making sure I don't disturb anybody, surprise anybody. And so, here I am in this beautiful, pristine environment, snowcap mountains, October and I start obsessing. And I'm thinking about some stupid—I'm too embarrassed to tell you what it is. But it's like I'm missing something in my life. So here I am spending all this time and this money and setting it up and I'm totally not present too. Can you relate to that experience?

Rita: Mm-hmm. Oh, yeah.

Wilson: Totally not present. And this goes on and on and on. And after a while, I mean really a while, I go, "What do you do for a

living?" This is what I do every day with people—so, instantly I created an intervention and the intervention was as soon as I heard the obsession I would say to myself, "Thank you. Would you give that to me again?" And then I'd pay attention to hiking, whatever was my valued activity; just turn my attention there. Eight seconds later, boom, up comes the obsession. "Thank you. Would you give that to me again?" So I'm done with the transaction. I don't go, "Thank you. Would you do that to me again? Did that work? Is it gone? God, I hope it's gone." You know, I just don't care whether it goes or not. And that's what I was saying to you. Don't worry about how long it takes or whether you're going to have this all of your life.

Create a protocol. Stay with it. So, of course I'm telling you this story because I did it for a while and then eventually it just faded away because I was asking for it when it needed me to resist it. And then I had no expectation of it going away. I didn't care, and I wasn't listening in to see if it was gone. So, I tell you that story to kind of give you a model of that's what I want you to think about doing. The stimulus is going to come up and you're going to have any response opposite of what you've been having. We have a little range of things. And then don't care whether it disappears or not. If it stays around, more opportunity to practice.

Commentary: With this story, I am reinforcing this absurdly provocative skill of talking directly to the obsession. First, you are not in control of the obsession popping up; therefore, don't struggle with it showing up; be fine with that. Second, once you step back and hear the voice of the obsession, ask it to continue to say those fearful thoughts or questions. This is quite different from exposure therapy where we ask the client to generate more worries. No, turn it over to the disorder to perform that task. Third, you are now done with the transaction. Bring your attention back to whatever you want to be doing in the moment. Do not check in to see if your intervention is working by listening whether the obsession is quieting down. That's none of your business. The definition of "it's working" should be whether you are saying what you're supposed to say, not whether the obsession quiets down.

Wilson: And then any day you want or any event you want, if you just want to give into it and go check something—the only other thing I ask you to do is to say to yourself, "I'm not practicing. I'm just not practicing. I'm going to go look on the Internet."

Rita: Okay.

Wilson: "I'm just not practicing. I'm going to call the doctor and—just not." So, that's fine to not practice, but I would like you to get good at going, "I'm deciding not to practice." So we are really clean about what practice looks like. Instead of going, "Ugh, you know, I'm really not doing well. I'm choosing not to practice. You know, I'm tired. The kids are driving me crazy. This thing has been popping up. And I'm just going to go find out." Then it's—you're not practicing. You don't have to practice constantly. Does that seem okay to you?

Rita: Mm-hmm.

Wilson: Tell me two or three things that you're going to walk away with that you think would be most useful.

Rita: Changing my attitude I think is...

Wilson: To what?

Rita: To acceptance and not so much fear, I think.

Wilson: Okay. That's one.

Rita: Yeah. I think that's the main thing actually. It's the courage and the faith and also learning to accept the uncertainty. And that's hard for me because I'm more controlling and I do like closure. That's what you said, you know.

Wilson: Well, this is why we call it work. It is hard work, but it's not complex. It's not elaborate. It's relatively simple and it's hard. Okay: "So if I know what to do, even if it's hard, okay, well, at least I know what to do and it's not complex and I'm willing to work. I don't want my 12 year old to be modeling me. I want to model courage. She's been seeing something wrong with me. I want to show her. How am I going to help her? Let me get myself straightened out. Then when I go give her advice it's coming from experience." So that sounds good. And what about "content is irrelevant"? Is that included in what you're

saying? “My content around health is not relevant. That’s not what I’m working on.”

Rita: It’s the anxiety I’m working on.

Wilson: Yeah. It’s cloaked as a worry about health. Why? Because that works for you. It’s picked a topic that works for you. We can switch that topic out to a hundred other topics that other people have that look just like you, just have a different topic. So the topics can switch out. In fact, I work with people and they go, “Well, when I was 14 through college it was this. And then after I graduated college it became that.” So the topics can change, but the process is the exact same thing. Something happens, it gets me worried and I get caught up in it.

Rita: Isn’t there a reason why I’m like this?

Wilson: Sure. There is a reason why.

Rita: I’m trying to find that answer.

Wilson: But it doesn’t matter. Same thing with physical illnesses. How somebody gets a particular physical illness is not necessary to know how to intervene with it. Once the diagnosis is given, the interventions can be made even though there may be multiple causes of the disorder. I’m going to invite you to think that. You can go, “Why me?” Were
you breastfed?

Rita: I think so.

Wilson: Yeah, well, that’s why. There does that help? I mean, you noticed how it’s not going to help.

Rita: [laughter] Right.

Wilson: It’s not really going to offer you anything.

Rita: But it helps with acceptance. Like, if somebody—you hear that somebody gets lung cancer because they smoked their whole life. It’s easier for me to accept that. So if I had a reason why I’m like this, maybe I would be able to accept it.

Wilson: Have you had two traumas related to this theme in your life, your adult life?

Rita: Related to anxiety?

Wilson: Related to health.

Rita: Yeah, I've had health stuff.

Wilson: You had two major ones in your life?

Rita: I would think so.

Wilson: So let's combine those with a genetic predisposition to anxiety, and you've got the cause of why you're this way. There is a genetic predisposition for most people with anxiety disorders. And then for some people like you, there's markers in time and in which you had trauma that's reinforcing the need to be checking.

Rita: And it can come out years later like PTSD or something just...

Wilson: Yeah, sure. Can you run with that?

Rita: Mm-hmm.

Wilson: Okay. That's why I give that to you only because you feel like you need it. It really isn't necessary to get better except that you want to satisfy a curiosity inside you. You can run that out with 10 other specialists in anxiety disorders, and I think they'll all say the same thing. With a genetic predisposition plus some trauma and there...

Rita: It really doesn't matter about the trauma to pinpoint it or pass blame or...

Wilson: It matters, but we don't need to.

Rita: Right.

Wilson: We know what they are with you. So it's okay.

Rita: Okay. I get it.

Wilson: I look forward to finding out how things go, you know,

because we're doing things in two sessions. That's rapid. I do this a lot so it's not like a surprise to be sitting here with you. But then I never get—I don't always get to find out. So I hope you'll email me anytime even with questions.

Rita: Oh, well, I'm getting ready to go on a big long run...I'll send out an email to you.

Wilson: Well, I would like to know. And as I said to you, I'll answer every single one of them. I'm going to give you my email. I'm not going to give you my cell phone because we're not in crisis kind of things. But you can email me and I'm going to give it to you to make the initial contact for around the 30-day follow-up just because things are so. And I do want you do to that and I would want to sit on the phone and spend some more time with you.

Rita: Okay.

Wilson: Best of luck.

Rita: Yeah. Thank you very much.

Wilson: Have a great life.

Rita: I appreciate it.

Wilson: You're welcome.

Rita: Thank you.

Video Credits

Special thanks to Reid Wilson for sharing his expertise, and to Rita for bravely appearing on camera.

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