Archives of Psychiatry and Psychotherapy
Volume 6, Issue 4, December 2004
pages 31–40

The use of imaginal exposure and fear reduction with unexpected aversive events: the case of the Frozen Man

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Summary

Imaginal exposure and other methods of fear reduction have been applied to various situations with great success. While the majority of these situations have involved relatively concrete circumstances (i.e., fear of heights, travelling, crowds), less is known about how to apply it to more abstract circumstances, such as cases in which the fear is connected to unexpected aversive events. The following article briefly addresses the literature on the topic of uncertainty, or unexpected aversive events, and offers a case example, using imaginal exposure and cognitive–behavioral techniques to reduce the fear of the unexpected aversive events following a startling experience. The subsequent discussion section addresses some of the unusual aspects of the case and outlines some suggestions for future direction in the area of unexpected aversive events.

Key words: Fear reduction, intolerance, uncertainty, unexpected, cognitive–behavior therapy.

The majority of clinical cases treated for fear reduction to anxiety-producing situations involve a circumscribed stimulus, whether external (heights, animals, etc.) or internal (autonomic activity, fear, losing control, etc.). It is rare for a stimulus to be nonspecific. Cases of "unexpected (uncued) panic" are an exception, but, even then, developing a mental image can prove challenging, and designing an exposure hierarchy very difficult [1].

An area that has been used successfully with anxiety disorder is thought suppression. Most of the work done on thought suppression has been concentrated in the area of obsessive-compulsive disorders (OCD). One of the early studies [2] indicated that, when used with OCD clients, thought suppression actually increased the frequency of the intrusive thought. Subsequent studies examining the effects of suppression of observational thoughts focused both on immediate thought enhancement during sup-

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AUTHOR'S NOTE: The author wishes to express his appreciation to Eric Frey for his assistance with the literary search.

pression and rebound effects in general [3, 4, 5, 6]. Salkovskis also published a more recent article comparing the difference between neutralization of and distraction of intrusive thoughts with a group of 29 OCD patients [7]. The results indicated that neutralizing an obsessional (intrusive) thought is associated with an apparent decrease in discomfort (relative to a distraction control) while such neutralizing is in progress.

In essence, these findings supported the hypothesis that the obsessional problems persist because of the development of neutralizing responses. The cognitive-behavioral theory applied here emphasizes the importance of motivated neutralizing (including both overt and covert responses to intrusive cognitions).

Although this is pertinent to OCD, the intervention appears less applicable to other states of anxiety, such as panic, due to the involvement of specific autonomic symptoms and the perceived risk of bodily harm.

With respect to the concept of the "intolerance of uncertainty," the professional literature seems to focus on attempting to address this more in the specific contexts of worry or generalized anxiety disorder (GAD) than with other anxiety disorders. For example, GAD subjects were shown to evidence more catastrophized thought and higher levels of mood following worry interviews than their non-anxious counterparts [8]. The key feature of GAD has also been hypothesized to be worry and its production of threat-related information-processing in the domains of attention, interpretation of ambiguity, and problem-solving [9]. According to the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (1994), GAD is characterized by excessive and uncontrollable worry, and it is among the most common anxiety disorders [10]. The intolerance of uncertainty has become a point of research in the area of GAD. Much of the research in this area has centered on the specifics of two types of worry in GAD: (1) worry about immediate problems, and (2) worry about improbable future events [11,12,13]. These researchers suggest that for worries about improbable future events, cognitive exposure may be used to address cognitive avoidance of threatening mental images.

Since intolerance of uncertainty has been designated as a key consideration in the treatment of worry in GAD, there is some question as to how this might also be applied when the situation includes shock, or unexpected events, such as those involving posttraumatic stress, acute stress reaction, or less severe circumstances. There has been some application with obsessive-compulsive disorder (OCD) [14,15] in the realm of decision-making difficulties and the rise of obsessive ruminations. However, there is less discussion in the professional literature about the actual reduction of fear of unexpected aversive events, particularly where catastraphization is involved. Several researchers have attempted to address the issue of looming vulnerability in a specific model of anxiety [16,17,18]. This model proposes the idea that the mental activity of catastraphizing is related to both the general looming maladaptive styles and looming vulnerability to potential catastrophes [19]. Further research in this area with subclinical OCD subjects suggests that the use of a "freezing" via mental imagery (the rate at which threats can advance) may serve as a way of blocking looming vulnerability and reducing fears of contamination and decreasing avoidant behavior [20].

The real challenge seems to come with exposing such individuals to a specific stimulus during the course of fear reduction. This is particularly difficult when the event is nebulous, yet still generates a debilitating level of anxiety.

This special nuance is demonstrated in the following case example in which a woman belatedly developed a fear of being shocked by an unexpected aversive event after having discovered a dead body on her back porch one morning. This scenario posed a difficult challenge in treatment due to the lack of mental images that could be drawn upon for fear reduction purposes, and the aspect of less circumscribed stimulus during exposure. The case was complicated by the fact that the patient developed anxiety attacks almost two years after the triggering event in response to the generalized anticipation of being startled.

Case Example: The Frozen Man

Rozina, a middle-aged woman, migrated to the United States with her family when she was 10 years of age. An only child, Rozina was raised by her parents, both of whom died young due to coronary artery disease. Rozina was characterized by her friends and family as a tough, independent individual. She was described as being vociferous about her feelings and beliefs. She was perceived by many of her friends and coworkers as not easily intimidated. Rozina did extremely well for herself in life, graduating from college with a professional degree. She quickly worked up through the ranks to a position in sales with a high-tech business equipment distributor, and eventually became a regional manager. Since she had always been on the fast track with her career, Rozina had little time for personal relationships. In many ways, she tended to be a loner, and although she dated occasionally, she never developed any serious intimate relationships. An extremely diligent woman, Rozina took pride in her work. She lived a comfortable life and was well traveled. However, Rozina's life changed suddenly one morning as she left for work.

The previous night, as Rozina slept soundly, a fire ravaged through a state mental facility several miles from her neighborhood. The facility's mental patients were evacuated, but in the process a 32-year-old man suffering from severe schizophrenia escaped. Wearing just a pair of shoes and his underwear, the man apparently crisscrossed the town on foot in a frenzied state of confusion. A severe case of hypothermia finally brought him to a halt on the back porch of Rozina's home. The man crouched down in a corner of the porch and fell to rest. Sometime in the early hours of the morning, he died with his head between his knees, covered in a thin coat of ice.

Shortly after dawn, Rozina was leaving for work through her back door when she came upon the frozen figure huddled against the elements. Upon encountering this scene, she screamed in shock, but managed to get herself back into the house to catch her breath. As incredulous thoughts raced through her mind, she realized that she should call the local police. She then waited until the police and the local coroner arrived to recover the body. Most of the morning was consumed with the police investigation and by attempting to quell her anxiety over the shock of the incident. As a result, Rozina took the day off from work.

During the following night, Rozina was in a chronic state of anxiety, manifesting both in difficulty sleeping and concentrating. Surprisingly, her symptoms fell short of posttraumatic stress disorder in that there was little autonomic activity and she only experienced flashbacks of the deathly image for approximately one day. Even her existing problems seemed to abate quickly so that she had almost no difficulty sleeping just two nights after the incident.

However, less than two years later; during the summer months, Rozina had a panic attack out of the blue, which involved several of the classic symptoms, such as increased heart rate, difficulty breathing, and so on. The symptoms, as she recalled, were similar to her reaction upon finding the young man's dead body years before. This episode of panic caused her to anticipate additional anxiety attacks and, as a result, she developed a preoccupation with potential future symptoms. Rozina's anticipatory anxiety began to generalize to other situations. For example, she had trouble going into certain rooms of her home or opening closet doors for fear of what she might encounter. Although Rozina realized that, on one level, the feelings were "silly," she still had anxiety each time she was in similar situations.

Rozina's anxiety occurred approximately two years after her traumatic experience rather than within the usual six-month period, nonetheless, the attacks occurred on a regular basis, at least two to three times per week. The autonomic symptoms consisted of increased heart rate, difficulty in breathing, lightheadedness, tingling in the hands and feet, and a feeling of faintness. The symptoms emerged spontaneously within a 10-minute period, and could last as long as 90 minutes. During these episodes, Rozina felt out of control of her faculties, and sometimes feared that she would lose control entirely and possibly even die.

It was surmised that the abrupt onset of panic two years after the initial trauma may have mirrored the unexpectedness of that earlier shock. This explanation for why Rozina suddenly and powerfully revisited the anxiety so much later seemed the only plausible one given the information available.

Assessment

Rozina's family physician conducted a thorough physical examination, including blood studies and an electrocardiogram. Upon obtaining normal results, the physician started her on an initial dose of Alprazolam (0.25 mg, one tablet three times per day) and referred her to a clinical psychologist specializing in cognitive-behavior therapy to treat her panic symptoms.

First, the psychologist conducted a complete intake, with life history. A psychological test battery was administered, including the Anxiety Disorder Interview Schedule for DSM-IV [21] and the Body Sensations Questionnaire (BSQ) [22]. Rozina was also administered the Beck Depression Inventory-II (BDI-II) [23] and the Beck Anxiety Inventory (BAI) [24]. The results of the second assessment yielded a diagnosis of panic disorder, which took into account the fact that Rozina's symptoms failed to meet the diagnostic criteria for PTSD. It was determined that she did experience panic symptoms, but with unusual behavioral sequelae. There was also some mild depression and

compulsive personality features. A detailed history indicated no past experiences of anxiety or childhood phobias, depression, or behavioral problems. She also reported no history of mental illness in her family-of-origin.

Unfortunately, Rozina's own rigidity prevented her from completing any additional inventories. During the second session, she made her feelings clear, saying: "Enough of this paperwork, I need to get over this problem as soon as possible." She found the self-report inventories a waste of time and refused to do them. Despite the psychologist's emphasis on the importance of the inventories, it was decided to forgo the measures given Rozina's attitude.

During the subsequent sessions, Rozina was introduced to the SAEB system, which stands for "Symptoms, Automatic thoughts, Emotion, and Behavior." This choice of words reflects what many panic victims describe as the ingredients that contribute to the accelerating sense of alarm that precipitates a panic episode. The SAEB system follows the standard method of cognitive-behavior therapy, but is specifically designed to provide a visual aid in tracking panic symptoms and recording automatic thoughts, emotions, and behaviors and their correlation to the symptoms.

The SAEB system was developed as an extension of Clark's Model [25] in response to the numerous clinical cases in which panic sufferers were frustrated by their inability to convey to others, including the treating clinician, the exact sequence of events that occur during a panic attack [26,27].

In this system, patients identify the initial symptoms that trigger the panic episode [28]. These symptoms are determined through the use of such inventories as the BSQ and the BAI, or other empirically derived panic measures, supplemented by specific questioning of the patient during the interview phase. If the patient has experienced more than one attack, uncovering the SAEB sequence can help expose their repetitive pattern. If recalling the symptoms presents a problem, either because the patient is blocking or simply has a poor memory, then the use of panic-induction exercises may be helpful, as defined by Clark [25] and as portrayed in additional case studies [26,29,30]

Once the symptoms have been identified and their sequence established, the therapist aligns each symptom with specific automatic thoughts and accompanying emotions and behaviors. These can be obtained firsthand from the patient or with the help of a panic-induction exercise. The clinician can also refer to the patient's own reports made in a weekly panic log [27].

The assembled sequence of panic attack elements – symptoms, automatic thoughts, emotion, and behavior – can then be represented in a diagram, to show the patient how in combination they work to escalate the attack.

The diagram in Figure 1 illustrates how Rozina's sequence of events unfolded. First, an abrupt increase in heart rate led to difficulty in breathing and subsequent lightheadedness, tingling in the hands and feet, and feeling faint. Once the sequence was established, the automatic thoughts accompanying each symptom were listed in a corresponding vertical column. Finally, the third vertical column listed the associated emotion and behavior. Vectors were then drawn to illustrate to Rozina how the catastrophic thought content might occur in reaction to autonomic symptoms and how

these thoughts contribute to the subsequent behavior and escalation of these symptoms – [26]. This strategy is demonstrated in detail in a videotape presentation [31]. This outline was very helpful to Rozina, who needed to see things laid out for her visually due to her rather obsessive nature.

Treatment

Rozina was taught a course of progressive muscle relaxation that included deep breathing (inhaling through the nose and exhaling slowly and continuously through the mouth). She was taught to regulate her breathing in this manner and was instructed to practice it at least once a day for 20 minutes using an audiocassette tape that she and the therapist made together. This style of relaxation is similar to the one outlined by Borkovec and Matthews [32].

Figure 1: **Rozina's Panic Sequence Using the SAEB System**

Symptom (1)	Automatic Thought (2)	Emotion/ Behavior (3)
Abrupt increase in heartrate	What's going on?	Worry
Difficulty in breathing	What's wrong with me?	Fear/Concern
Lightheadedness	I'm getting worse	Fear/Upset
Tingling in the hands and feet	I'm going to lose control	Extreme Nervousness and Hypervigilence
Feeling of faintness	Thought of losing control and dying	Petrified

The treatment sessions then consisted of helping Rozina reconstruct Columns 2 and 3 of the SAEB system, replacing them with more balanced responses that had a less catastrophic tone.

Once Rozina had acquired some of these coping skills, the next step was to utilize in vivo exposure to situations that might cause fear. For example, Rozina was nervous about opening closet doors in her home, anticipating that she might find something that would startle her. When questioned in detail about her thinking regarding the closets,

her logic was: "I know it sounds silly, but finding a frozen dead man on the back of my porch is also something uncommon. Therefore, why would I not expect that something else could happen like that upon opening a concealed area in my home?" However, when asked specifically what she imagined finding, she could not articulate a particular image. It was just the notion that, "I might be startled by something, who knows?"

Consequently, a Subjective Units of Discomfort (SUD) scale was collaboratively constructed with Rozina. The scale consisted of a list of possibilities, ordered hierarchically, ranging from 0 (no anxiety-producing situation) to 100 (the most anxious situation imaginable) with interim measures in units of 10.

Rozina's hierarchy included items such as opening the back door of her home prior to sunrise, opening storage closets that she had not used in some time, and venturing into a dark cellar or attic and turning on the light. All of these tasks involved the potential for being startled by something unexpected, which on one hand, Rozina would describe as "irrational," but would then add: "then again, you never know and it's that uncertainty or the unexpected that I fear." The notion of being taken aback by a shock was disconcerting for Rozina, and so, she was instructed to repeat to herself, "I don't know what I am going to find when I open this door or this cupboard, but I have to deal with whatever I encounter." In fact, Rozina was reminded of how well she did cope with finding the dead man on her porch. She was able to contact the authorities and then to assist them in their investigation. The goal of treatment was for the therapist to remain sensitive to the emotional component that was present, yet to keep the client focused on her cognitions and behaviors and allow her to develop a coping mechanism that would allow her to deal with whatever might occur.

The objective in treatment was to expose Rozina to potential anxiety-producing situations while helping her to regulate her anxiety, particularly her anticipatory anxiety, which caused her to feel unsettled. This was done by teaching her controlled, deep breathing (inhaling through the nose and exhaling slowly and continuously through the mouth) while, at the same time, being instructed to reassure herself of the unlikelihood of encountering anything traumatic. Once she was confident that her breathing and anxiety were well under control, she was imaginally exposed to the lowest level of the hierarchy. Rozina and the therapist walked through the hierarchy, all the way up to the most severe anxiety-producing images, until she was able to imagine being in this situation with little or no anxiety. Once scaling the hierarchy was accomplished successfully on an imaginal level, Rozina was exposed to the situations *in vivo.* At this point, the psychologist actually came to Rozina's home and accompanied her through the hierarchical events, helping her utilize cognitive-behavioral coping skills at each level.

Rozina eventually reached the point where she could open doors and cupboards without anxiety or the anticipation of a panic attack. Part of the treatment also included considering the unlikely possibility that she might indeed be confronted with another unusual event and helping her decide how she might cope with it. Again, given the trauma of having discovered a dead man at her home, she actually handled the situation quite well. One of the issues that surfaced during treatment was the concept of "being out of control." Rozina was the type of individual who always needed to be in

"complete" control of her life, but this trauma seemed to bring home the reality that there are some things in life that one simply cannot control.

Treatment lasted approximately three months (a total of 12 sessions), over which time Rozina became panic-free. She subsequently attended two sessions, one month apart, in order to address the general issue of control in her life and how to let go in the face of events that she could not affect. The aforementioned cognitive and behavioral strategies appeared to work well with Rozina because they appealed to her practical side and provided her with a structured method for alleviating her distressing symptomatology. They also created a foundation for helping her confront the more global control issues in her life.

Discussion

This unusual case study presents with atypical characteristics in the sense that the target of fear reduction was to the unexpected; in other words, that which would not likely happen. Some might argue that the focal point was actually fear reduction to the loss of self-control, however, this aspect was apparently the residual sensation from the shock that Rozina experienced when encountering a dead body on her back porch. A confounding factor with this case was Rozina's long asymptomatic period of two years following the tragedy. It was not until Rozina experienced a subsequent panic episode and an image of the event that triggered her fear of unexpected aversive events that there was a problem. In a sense, it was not clear if Rozina's panic attacks and the discovery of the frozen man on her porch were related. One explanation might have been that Rozina was engaging in an exercise of "effort after meaning," a sort of post hoc reasoning, allowing her to conclude that her panic attacks were similar to previous unpleasant and unexpected events in her life. In Rozina's mind, the two events appeared to be somehow causally related, or at least her compulsive nature induced her to associate them.

Of particular interest here is the concept of how to expose a patient to a stimulus that is as diffuse as "unexpected aversive events." In essence, this was conceptualized as a fear of loss of control and anxiety surrounding Rozina's anticipation of unforeseeable aversive events. To prepare one for that which cannot be predicted is an unwieldy paradox. Since life is full of unexpected occurrences, some of which are very unpleasant, most individuals "expect the unexpected" in life, prompting them to develop certain coping mechanisms for unforeseen events. This case required some creativity in devising a strategy for exposure, especially since Rozina was a tough-minded individual who was not always cooperative with the procedure for tracking her thoughts and anxiety symptoms. It was determined that this tendency to be a rather dichotomous thinker contributed to her inability to be flexible enough to handle unexpected situations. Rozina had always been a control-oriented person used to being in the "driver's seat." This seemingly ingrained schema was in place to help her deal with the "disorderliness of holding uncertainty in life," but at the same time it made her unyielding and, therefore, vulnerable to it. It was suggested that she participate in longer-term therapy to find better solutions for coping with such issues. However, her many obsessive-compulsive personality characteristics made treatment rather arduous. She was often reluctant to expand on additional aspects of her personality,

frequently reminding the psychologist, when he would attempt to probe, that she was only interested in overcoming the specific problem for which she sought treatment. In turn, it was explained to Rozina that her anxiety might reemerge if she didn't look at the deeper issues underlying her problem.

Rozina was contacted on two occasions, once six months after the end of treatment, and then at the one-year follow-up mark. She reported to be anxiety-free with no problems.

This case illustrates fear reduction procedures with a stimulus that is rather uncircumscribed and with a patient who is dichotomous in her thinking. Her narcissistic need for control, which also served as a means of self-protection, meant that she wanted things to be on "her terms," including the course of treatment. This was in keeping with the unusual situation of presenting with anxiety and fear that were not obvious in their origins and required some innovative thinking to address. Creativity is sometimes an essential ingredient in treatment design and an essential part of being successful as a cognitive-behavior therapist.

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