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## SAFETY BEHAVIOURS

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There is evidence to suggest that people with anxiety disorders adopt certain behaviours in order to prevent some feared catastrophe (Clark, 1996; Salkovskis, 1991, 1996; Wells et al., 1995). The model of psychosis utilised throughout this book (Morrison, 2001) implicates cognitive and behavioural responses, including safety behaviours, in the maintenance of distress. Safety behaviours, whether cognitive or behavioural in nature, can serve to maintain dysfunctional interpretations of intrusions. Therefore, a full exploration of safety behaviours should be undertaken, and they should be considered in detail. If they appear to be involved in the maintenance of problematic interpretations, then experiments can be employed in order to help the client evaluate their short-term and long-term utility. In this chapter, we will consider some of the safety behaviours that we have observed with high-risk clients and some of the experiments that we have undertaken.

### ASSESSMENT OF SAFETY BEHAVIOURS

A thorough assessment should be undertaken in order to explore all aspects of a person's safety behaviours. When working with panic patients, the best way to achieve this is to induce panic-like symptoms in order to observe what the person does to prevent the onset of a panic attack (Wells, 1997); similar strategies can be utilised with clients who are considered at risk of psychosis. It can be useful to see what the individual does in a situation where they consider themselves at risk of losing control or being in a feared situation that may induce symptoms. Encouraging an individual to lose control in an attempt to induce the onset of madness can also be useful, although people are frequently extremely uncomfortable about taking part in this type of experiment because of the feared outcome. Therefore, using other more accessible and less feared situations can have greater success in the initial stages of challenging safety behaviours. It can be useful to go with the individual into a feared situation, or induce a similar situation in session, so that safety behaviours can be observed. Some examples of events, their interpretation and subsequent safety behaviours can be seen in Figure 9.1.

<i>Experience</i>	<i>Interpretation</i>	<i>Safety behaviour</i>
Saw people laughing whilst out walking.	People in the street are talking about me.	To keep head down, walk fast and purposefully.
Visual hallucinatory experience, seeing a man sat on a chair.	I am going mad.	Not to look at the chair and get out of the room as quickly as possible.
Shopkeeper looking at me.	They know I am going mad.	Say very little (if I talk it will confirm I am going mad).
Visual hallucination of dead body on wardrobe.	I am going mad/losing control.	Hide head under covers.

**Figure 9.1** Examples of safety behaviours

## EXPERIMENTING WITH SAFETY BEHAVIOURS

Clearly, these behaviours lend themselves to experiments in order to test out whether they are useful. However, participation in experiments of this kind requires the individual to have some belief in the model, or at least in the fact that their behaviours may be maintaining some of these beliefs. There are numerous metaphors that cognitive therapists have developed and utilised over the years that can help to sell the concept of safety behaviours. These metaphors are shared with clients in order to help convey the concept of safety behaviours and how they may maintain a problematic belief. Some of the stories include the village of vampires, the man keeping elephants off train tracks by tearing up paper, or a workman holding up a wall to prevent it from falling down (see Wells, 1997, for further details). The first of these stories is described below:

*There is a remote village in the depths of Transylvania and all of the villagers believe in vampires. They believe in vampires so much that all of the villagers keep strings of garlic around their necks at all times in order to keep the vampires away. They do this because, as everyone knows, vampires are afraid of garlic. The villagers have always done this for as long as anyone can remember, and no one in the village has ever seen or been attacked by a vampire. Because no one has seen a vampire, they*

*know that the garlic is working. They would never want to be without their garlic as this may allow the vampires into the village.*

Once the story has been told a number of questions could be asked:

- What do you make of the villagers' belief about the vampires?
- What do you make of the villagers' belief about the garlic?
- Are there any problems with their situation? How would they react if there were a shortage of garlic?
- How could the villagers find out whether vampires actually exist?
- Are there any similarities between some of the things you do and the garlic used by the villagers?
- What could you do in order to test out these behaviours?
- How would you go about that?

These questions utilise a Socratic approach to enable the individual to recognise that their behaviours may have a similar effect to that of the garlic for the villagers (i.e. it makes them feel safe in the short term, but may keep them believing in a distressing idea in the long term). Such stories can, at times, enable the person to have sufficient courage to try out an experiment. This may, initially, be a very small test or change of behaviours, and may require the individual to engage in testing their behaviours within session before they can get the confidence to attempt this outside of the therapy sessions.

In order to examine assessment and treatment in greater depth, a specific case will be discussed in order to examine how safety behaviours may become established and, as in anxiety disorders, maintain the problem.

## CASE EXAMPLE (1)

Henry, a 26-year-old man, was referred to the project after being assessed by a local casualty department, which he reluctantly attended at the persuasion of his relatives, who felt that he had become increasingly anxious, angry and unpredictable. In casualty, the staff felt uncertain about his presentation, although they felt that he might meet the criteria for our project. In view of this, he was referred to the study and also for an outpatient appointment with a consultant psychiatrist. The initial assessment took place a few days after the referral when he was seen at the family home where he lived. Henry was quite reluctant to discuss his problems, although his family (who were very keen to be involved) prompted Henry to disclose some of the difficulties he had been experiencing. After the initial assessment, Henry felt that there was no need to be involved with the project. Despite this, his family maintained telephone contact with the project team and were concerned that he should receive some kind

of help and they wanted to learn ways of managing some of the difficulties he was experiencing.

By maintaining contact with the family, Henry eventually agreed (although still quite reluctantly) to meet with the therapist in the project. The initial meetings were spent engaging Henry in therapy. Many of the techniques discussed in Chapter 5 such as negotiating the time and location of meetings, using a shared language, and demonstrating a willingness to listen and understand were utilised alongside a guided-discovery questioning style, which enabled Henry to think about the development of his difficulties. Henry began to acknowledge that something had been wrong and that he had been under a lot of stress although he wanted to forget about his problems. This was consistent with a sealing-over coping style as described by McGlashan (1987).

Despite wanting to forget about his psychological problems, a shared problem list allowed Henry to prioritise the things that he could work on:

1. Wanting more money
2. Wanting a job
3. What happened

The therapist suggested problem number 3, and it was agreed that this could be put on the problem list, although at that time it was viewed as a low priority. Henry also saw the psychiatrist around this time and, following the appointment, Henry and his father felt there had been little opportunity to discuss matters and he was subsequently discharged from psychiatric care. Significantly, Henry had been adamant that he did not wish to take medication as a treatment option, but was content with a psychological intervention strategy and appeared to be gradually engaging with the therapist as time went on and trust was established.

It transpired that at the point that he was having his 'breakdown', Henry had been reasonably convinced that people were following him. Henry reported that he had developed this belief after seeing a camera move, which had appeared to follow his movements late one night in a car park. Subsequently, he began to believe that people he knew may be controlling these cameras. This belief was then maintained, because friends and relatives really did start to keep an eye on Henry (because of their concerns about his increasingly erratic behaviour). Henry picked up on the concerns of family and friends, but also became convinced that other people were following him (because of selective attention to and monitoring of the speech and behaviour of other people). Henry agreed to spend some time examining evidence in relation to specific situations, in an attempt to discriminate between factual evidence and unsubstantiated conclusions. A critical incident was identified, which had occurred when he had driven to a friend's house some distance away. During this journey, he became concerned that a large number of people who were also driving on the

motorway had been monitoring his progress throughout the journey. Henry believed that these people had been instructed to do so by a specific person. It transpired that his evidence supporting this belief was that people had looked at him whilst he was driving on the motorway. In an effort to examine whether this appeared to be the correct interpretation of these experiences, Henry was asked questions surrounding his belief. Questions about the belief – such as the number of people required for this conspiracy to succeed, the difficulty of organising them, and the costs involved – were carefully explored. When working with psychotic clients, this is termed *peripheral questioning* (Kingdon & Turkington, 1994). Previously, Henry had not considered these peripheral aspects of his belief, and he quickly began to consider alternative explanations for the experiences he described. Over time, other incidents that had previously led Henry to believe that there was some form of conspiracy involving him were examined in a similar way. The process of challenging these beliefs was emphasised so that Henry could utilise this strategy himself (analogous to becoming his own therapist).

Later sessions were spent working on Henry's problem of wanting a job. Although he did secure a job, it paid significantly less than his previous one prior to his illness. The process of rehabilitation was discussed in the context of a physical illness and how this may be pertinent to his situation; however, despite this it became apparent that experiences of loss and rejection had led to depressive thoughts. Henry also disclosed that he experienced suicidal thoughts, although these had been highly intrusive in nature. He was clear that he had no desire to end his life, but worried that, if he had these thoughts for long enough, he was bound to act on them. Normalising information about intrusive thoughts was important (as discussed in Chapter 7), and this was provided, based on the paper by Rachman and De Silva (1978). This process challenged the catastrophic interpretations of his suicidal thoughts, which led to a reduction in the frequency, duration, distress and preoccupation associated with these thoughts.

Henry was close to being discharged from therapy when a close friend died suddenly. Whilst Henry was drinking in a local pub with friends who knew the deceased, he started to experience symptoms similar to those experienced during a panic attack. Following this and combined with his previous experiences and the family history he started to believe that he was 'going mad'. To prevent others from seeing that he was 'going mad' he started to avoid people and increasingly isolated himself. At this point his sleep pattern deteriorated as he spent long periods of time awake at night worrying about what was happening to him. In the session immediately following this event, Henry was clearly having difficulty communicating and his speech was slow and vague.

It took some time to isolate what his concerns were but eventually thoughts associated with the panic attack, and the key catastrophic misinterpretation of 'I am going mad',

were discussed. It was also clear that his behaviours of reduced speech and social isolation were safety behaviours, designed to prevent the outward signs of madness from being recognised by others (this is similar to the conceptualisation of negative symptoms as safety behaviours; see Morrison et al., 2003). A formulation of these behaviours and experiences was presented to Henry. Audiotapes were utilised to record sessions on a regular basis, and this enabled an experiment to be set up to test out one of his safety behaviours regarding his slow, considered speech, which he believed prevented others from seeing he was going mad. In the session a typical experiment was set up, in which Henry was encouraged to manipulate his safety behaviours and then observe how he communicated by reviewing the tape. During the experiment Henry was asked to try out three conditions:

1. His current method of communication, which utilised slow, considered speech. He was asked to maintain this for five minutes.
2. He was to increase his safety behaviours and exaggerate them (if they are helpful doing more of them may make things even better), and maintain this condition for a further five minutes.
3. Lastly, he was to drop all safety behaviours and communicate as he would have done previously; again, for five minutes.

At the end of this process the tape was reviewed, and both he and the therapist discussed how his communication skills had appeared in each of the conditions. It was blatantly obvious, after reviewing the tape, that his speech whilst maintaining his safety behaviours appeared disjointed, uncertain and awkward. This became further exaggerated in the next condition, where he increased his safety behaviours. In the final condition, when his safety behaviours were dropped, his speech appeared much more relaxed and comfortable. After this experiment, Henry felt that his original belief about his slow, considered speech might, in fact, have produced the opposite effect. His behaviours could have been considered as negative symptoms and would have given people cause for concern; however, their initial function was to prevent people becoming concerned about him. Subsequently, we discussed other behaviours, such as isolation, and Henry agreed that these might have a similar effect. He decided that they might not be as useful as he had originally thought.

Henry quickly recovered from this episode, significantly reducing his safety behaviours and increasing his activity levels. His worries declined about 'going mad', which, alongside his increased activities, assisted with his sleep problem.

At the end of his contact with the project, Henry had obtained a job similar to the one he had prior to the emergence of his symptoms. He had no further suicidal thoughts and he recognised the process of therapy and how this should be implemented. Henry was provided with an 'early warning signs' package and a blueprint of therapy. This was provided on audiotape, since this is the media Henry preferred (as opposed to written material).

## SELECTIVE ATTENTION AS A SAFETY BEHAVIOUR

*Selective attention* has frequently been identified as a safety behaviour, in our experience of working with this client group, and is usually implicated in the maintenance of distressing interpretations, as would be predicted by the S-REF model of emotional dysfunction (Wells & Matthews, 1994). If we consider the above case, Henry was clearly concerned about the impending onset of madness and wanted to avoid letting others see he was going mad. He therefore initiated his safety behaviours and looked for signs of others perceiving him as 'going mad'. He reported frequently seeing other people looking at him and that they were looking at him oddly.

In this example, his safety behaviours, in conjunction with selective attention, contributed to the maintenance of the problems. His safety behaviours increased the chances of people actually looking at him. Selective attention only allows him to register those people who do look at him, and ensures that he fails to process the people who do not look at him for various reasons. One of the aims of treatment would be to highlight the vicious circles that are operating and maintaining this problem.

In treatment, we frequently draw on existing techniques (Wells, 1997) that highlight selective attention and how it may well contribute to the maintenance of problems. There are a number of ways of enabling a person to recognise the effects of selective attention. One way is to discuss the idea of selective attention in therapy by highlighting the way that it works. Simply asking the individual to concentrate on their bottom, and how it feels on their chair, can begin to illustrate the processes involved. When you ask someone to do this, they immediately start to notice sensations in their bottom that they were previously unaware of. This illustrates that, once attention is directed towards something, you will notice much more information about it. Asking if these sensations have only just begun can start to illustrate the fact that we have mental filters, which operate to disregard information that is not considered pertinent at the time. This does not mean that the information is not available; rather, that we choose not to pay attention to it. Some education about filter mechanisms of attention can also be useful.

Another method of demonstrating the effects of selective attention is to find something significant that has changed in the person's life, such as becoming pregnant, or the purchase of a new car. The usual line of questioning would be something like:

- Before X happened, how many did you notice?
- After X happened, how many did you notice?
- Do you think that there were actually more of X?
- What do you think was the reason for this?
- Could it be that your attention was directed to look out for X?
- What do you make of this?
- Could anything similar be happening with your current concerns?

This line of questioning allows the individual to recognise that what is happening to them is part of a normal process. Their attention may be directed by their current concerns, and this may increase the frequency of an occurrence being noticed, rather than the actual frequency of this occurrence.

Behavioural experiments can be undertaken to test out the effects of selective attention. Simple experiments, such as asking the person to tell you how many post boxes they pass on the way to the appointment or how many people wear certain kinds of trainers, can assist in enabling clients to understand attentional processes. In these examples, they should be encouraged to provide an estimate of the number of post boxes or how many people may wear certain types of trainers. The experimental part encourages them to specifically look out for these things and record the actual number. This should be discussed in the following week's homework review. Frequently, people are surprised at the number of times they have noticed a specific thing once their attention has been directed towards it. This can then be discussed in relation to their own experiences.

## CASE EXAMPLE (2)

A young man, Peter, was referred to the project with beliefs centring on the film *The Truman Show*. In this film, Truman Burbank has a nice house with a white picket fence, set in the idyllic oceanside community of Seahaven; a loyal wife; an even more loyal best friend; and a cushy desk job. Unbeknown to Truman, the entire life he has lived is mere programming for a 24-hour television network. Seahaven is one large soundstage, where all events are scripted and all the inhabitants are actors (i.e. except for Truman, who was adopted as an infant by the Omnicam Corporation, and has had every step of his life traced and moulded by the show's creator). Since seeing this film, Peter started to wonder if a similar experience could be happening to him, although this was a fleeting thought.

However, other things seemed to be happening around the same time, such as the UK Channel 4 television programme *Big Brother*, in which 10 people live together in a house and are filmed 24 hours a day for television. This served to exacerbate his concerns about being watched, and he increasingly searched for any evidence to support his beliefs. Around this time he was walking down the road when someone called his name very clearly ('Hey, Peter!') as he was walking towards them. The person who called his name did not approach him, but walked straight past him, despite giving him a sideways glance. Peter appraised this as evidence that other people knew who he was and that he may be famous. As a consequence, his beliefs in *The Truman Show* increased. He felt that he should try to collect more evidence to support his theory that people knew him, which would in turn support his *Truman Show* hypothesis. He started to look around at people out of the corner of his eye, and if he caught glimpses of people looking at him, then this reinforced his beliefs and

## GENERATING ALTERNATIVES

Name: Peter

Date: 26. 12. 01

Intrusive thought identified

People look at me when I am out on the street

Current explanation for thought; belief rating

I am in a kind of 'Truman Show'; belief rating 80%

Current mood associated with this belief

Anxious

It can be helpful if we look at all of the possible explanations for this thought. I am aware that you have indicated the belief above as being the main reason for this although if there are any other alternatives for this I would be very keen to understand them.

Explanation for intrusion	Belief rating (1-100) <small>1 - this is not the reason I am having this thought 100 - this is definitely the reason I am having this thought</small>	Associated mood
<i>The Truman Show</i>	80%	Anxious/fear
Previous drug use	60-75%	Scared
Stressed and confused	40%	More relaxed

Figure 9.2 Form for generating alternatives

he would quickly avert his eyes. As he began to accumulate this evidence, he became more and more anxious and confused; this was the point at which he was referred to the team.

The initial sessions focused on assessment and developing a list of problems and goals. Peter believed that his experiences could be potentially due to a number of things and these were explored using the generating alternatives form and can be seen in Figure 9.2. Also, at this point he was introduced to the concept of safety behaviours and selective attention.

After being exposed to the inductive methods associated with CT, and the concepts of selective attention and safety behaviours, Peter decided to undertake a different experiment to test out his beliefs that people were watching him.

He had started to feel more uncertain as to whether people were watching him or whether this could be his mistaken perception of things because of misinterpreting normal social cues. He felt that he should test this out, and decided that he should try to see what it would be like if he was entirely sure that people were looking at him. He could then compare this with his current experiences, and see if there were any differences. He wondered what he could do to ensure that people looked at him and to eliminate any uncertainty. Eventually, he decided to dye his hair green and then go out, which he felt should attract sufficient attention from others. He planned to go out in the morning with his normal hair colour, and then go out again in the afternoon with green hair. When he did this, he noticed a significant difference in not only the number of people looking at him, but also the quality of the experience. Previously, he had felt that glances were an indication of people looking at him; however, following the experiment he was able to distinguish the difference between normal social interactions and people actively looking at him. This experiment served to indicate that he was potentially misinterpreting data and enhanced his awareness of the need to subject such experiences to greater scrutiny.

### ACTIVITY SCHEDULING TO COMBAT AVOIDANCE

Avoidance is commonly used as a safety behaviour in order to prevent a feared outcome (such as 'going mad', worsening of symptoms or humiliation). Frequently, in the development of psychosis, people can become preoccupied with their experiences or fearful of what others may say (Moller & Husby, 2000). This can lead to an enforced isolation, where people spend increasing amounts of time alone, perhaps in their room. This reduction in frequency and duration of contact they have with other people can lead to increased preoccupation with their experiences and thoughts. Such isolation can also reduce the possibility for external sources of generating and evaluating alternatives, which has been suggested to contribute to the development of psychosis (French et al., 2001). The isolation can also lead to increased feelings of depression. The use of activity scheduling can be a valuable means of monitoring and impacting upon activity levels. Frequently, individuals feel that the isolation is a consequence of their difficulties; however, it can also be a maintaining factor. Encouraging people to become more active can be a significant step forward. However, this is usually best achieved through behavioural experiments rather than direct instruction. Initially, the individual should be encouraged to chart their levels of activity on an activity schedule (see Appendix 4 for a suitable template, p. 129). During the activity, individuals should be encouraged to rate themselves on two dimensions:

- the level of mastery associated with the task in hand
- the amount of pleasure associated with the task (Beck et al., 1979).

Undertaking this baseline assessment frequently demonstrates that periods of inactivity can often be related to reduced levels of mood. It can also be the case that

reduced levels of activity can also be associated with increased levels of psychotic experience. Setting up an experiment to test the effects of increased activity levels on someone's mood and frequency of psychotic experiences can be an effective means of increasing activity levels, with an accompanying reduction in psychotic experiences and increase in mood.

### SUMMARY

Throughout this chapter we have emphasised the importance of safety behaviours as described in the anxiety literature and their similar contribution in the model of psychosis presented. These safety behaviours, whether cognitive or behavioural in nature, can serve to maintain dysfunctional interpretations of intrusions. Thorough assessment is required, which may necessitate the induction of a feared situation in session in order to explore all aspects of a person's safety behaviours. The importance of testing these behaviours through experiments is discussed and case material is utilised to emphasise the approach.

This chapter also examines the role of selective attention as a specific behaviour frequently utilised by this client group and again utilises case material to highlight the role of this behaviour in the maintenance of distress.

Finally, we discuss avoidance and encourage activity scheduling as a useful intervention to combat this behaviour.