

INTEROCEPTIVE EXPOSURE EXERCISES



Rationale

Interoceptive exposure exercises attempt to simulate feared bodily sensations to evaluate clients' danger hypotheses. Various interoceptive exercises can be tried to produce the feared symptom(s) and test the danger prediction. Inductions using more than one interoceptive exercise at a time are feasible and can help to activate fear. The more diverse the symptoms, the more generalized the learning. Therefore, exercises that produce symptoms the client doesn't typically experience can be helpful as well. The duration of the exposure is flexible, as the goal is for clients to do it long enough to experience their feared symptoms, test their fear hypothesis, and stay in the exposure longer than they believe they can handle. Allowing clients to quit the exposure only reinforces their fear, as it validates their hypothesis that if they had continued with the exposure, then a bad result would have likely happened.

Practice

Interoceptive exposures should first be done in the office followed by independent daily practice. Many clients find it helpful to vary the exposure exercise when practicing on their own in order to fully fortify themselves against their exaggerated and inappropriate fear of bodily harm.

Some Ideas

Dizziness, lightheadedness, tingling, nausea, sweating

- Hyperventilate/overbreathe (e.g., shallow breaths through the mouth and nose at a quick rate of 100–120 breaths per minute) for approximately one minute.
- Spin in a chair a few times.
- Stand up quickly from a sitting position.
- For sweating, turn a space heater on while practicing the above.

Breathlessness or smothering feelings

- Breathe through a stir straw with a round opening with the nose pinched for approximately 45 seconds.
- Hold breath for 30 seconds.
- Sit with a heavy blanket or coat covering the head.

Racing heart

- Run in place for two minutes.
- Do jumping jacks for two minutes.
- Run up and down the stairs for one minute.

Derealization/feelings of unreality

- Stare at self in the mirror for three minutes.
- Look at a florescent light and then try to read something.
- Stare at a small dot (e.g., the size of a dime) posted on the wall for three minutes.
- Stare at a herringbone pattern for three minutes.

INTEROCEPTIVE EXPOSURE GUIDELINES



1. Let clients know that you would like to do a diagnostic experiment with them to better understand their panic and help them cope.
2. If you have not done so already, review the specific anxiety symptoms they experience during a panic attack and identify their specific fear hypothesis.
3. Before starting the exposure, get a baseline measure of their distress by asking clients to rate their anxiety on a scale of 0 to 10.
4. Then, begin the exposure. Depending on the client's specific fears, you can start with any of the exercises on the **Interoceptive Exposure Exercises** handout. Remember, you are purposely trying to induce a panic attack. If it helps, you can practice the exercise along with them and coach them to continue. If the specific exercise you have chosen does not simulate their feared symptoms, then consider an alternative interoceptive exposure (e.g., holding their breath for 30 seconds, spinning in a chair, running in place, breathing through a small straw).
5. During the exposure, ask clients:
 - What physical symptoms are you experiencing?
 - How anxious are you on a scale of 0 to 10?
 - Are any thoughts racing through your head and, if so, what are these thoughts? What is your worst fear?
6. Once clients have finished the exposure, ask them to re-rate their anxiety on a 0 to 10 scale. Depending on the intensity of their anxiety and their ability to process the exposure, choose one of the following two options:
 - **Option 1:** Begin processing the experience (skip to step 7).
 - **Option 2:** If the client is experiencing overwhelming levels of anxiety that would interfere with the ability to meaningfully process the exposure, try one of the following anxiety management techniques first. However, remember that the goal is for clients to eventually confront their feared symptoms, so you don't want them using these techniques to control panic in the long run.
 - Use distraction for a few minutes and talk about something relevant and benign to the client, such as a TV show or movie.

- Ask clients to practice diaphragmatic breathing. Have them close their mouth and breathe in and out through their nose as slowly as possible for three breaths. A six- to 12-second breath is recommended.
 - Ask clients to quietly read a paragraph backward to themselves or to describe a picture on your wall.
 - Have clients name all of the states in the United States.
7. Ask clients how similar or different the exposure was compared to their actual experience of a panic attack. Have them rate the similarity on a scale of 0 to 10.
 8. Ask clients about their conclusions following the exercise. For example, what catastrophic thoughts did they have during the exposure? Did any of these come true? If the anxiety-reducing techniques in option 2 were used, what does that say about the medical seriousness or dangerousness of their symptoms? Remember, you are guiding the client to a new hypothesis: The symptoms are not dangerous. If clients conclude that they can control their symptoms, then they can realize that they are not dangerous.
 9. To help clients realize that they play a part in bringing on their panic attacks, point out how they play a role in exacerbating their symptoms by overly focusing attention to their feared thoughts or by overbreathing. For example, try to have clients bring on the symptoms simply by breathing rapidly in and out of their nose, and they will see it is impossible to produce the symptoms. Experiments that demonstrate the ability to manipulate the symptoms validate the hypothesis that these symptoms are not to be feared.
 10. Work with clients to collaboratively develop a coping card that summarizes their conclusions. The coping card should include a statement that reflects a new (and accurate) hypothesis regarding their feared symptoms, the data substantiating that new hypothesis, appropriate action (if warranted), and a clear statement specifying that the symptoms—no matter how uncomfortable—are not dangerous and will eventually go away without any intervention. For example, “I thought I was going to _____ [have a heart attack, pass out, suffocate, etc.] but it wasn’t true. These symptoms may be unpleasant, but they will not hurt me. They are driven by my scary thoughts and by overly focusing attention on my body. By breathing normally, I can make these symptoms go away. That tells me that these symptoms are not dangerous.” The sample coping card on the next page illustrates the new conclusions that the previous 60-year-old woman gained from interoceptive exposures. This coping card combines the work from cognitive restructuring and exposure.
 11. Once clients have completed interoceptive exposures in session, make sure they continue practicing them for homework so that new learning can continue between and across sessions. After every exposure, have clients continue writing conclusions and encourage them to read them regularly. You can also have them complete the **Panic Log** worksheet to see how their reactions to panic change over time with continued interoceptive exposure practice.