Interoceptive exposure

- Headrolling – 30 seconds - dizziness, disorientation
- Hyperventilation – 1 minute - produces dizziness lightheadedness, numbness, tingling, hot flushes, visual distortion
- Stair running – a few flights – produces breathlessness, a pounding heart, heavy legs, trembling
- Full body tension – 1 minute – produces trembling, heavy muscles, numbness
- Chair spinning – several times around – produces strong dizziness, disorientation

Interoceptive exposure for treatment of panic disorder was moderately effective and superior to control/pill placebo treatments and applied relaxation (Haby, Donnelly, Corry, & Vos, 2006; Furukawa, Watanabe, & Churchill, 2007).

Interoceptive exposure for panic disorder is often combined with cognitive skills such as learning that physical sensations are not necessarily always harmful and learning to reappraise the meaning of physical symptoms instead of catastrophizing (Craske and Barlow, 2007).

A meta-analysis on panic disorder did not find a difference in effectiveness whether cognitive therapy techniques were included or not with exposure-based therapy, but the author did find improved results with the addition of cognitive components in patients with comorbid depressive symptoms (Gould et al., 1995).

Biran and Wilson (1981) – found that cognitive therapy was ineffective at decreasing avoidance in subjects with a fear of heights, lifts or darkness. Compared to in vivo exposure few subjects completed all takes in a post-test.

Maintaining processes in anxiety disorders

- Safety seeking behaviour – including avoidance
- These are intended to prevent harm and there are several effects on beliefs – they prevent disconfirmation and can increase preoccupation and rumination. They are meaningfully and idiosyncratically linked to the person’s perceived threat.
- Attention
- Imagery – intrusive thoughts
- Emotional reasoning – If I feel anxious there must be something to be anxious about
- Memory processes – PTSD
- Worry/rumination – health anxiety