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Safety-Seeking Behaviours: Fact or Function? How Can We Clinically Differentiate Between Safety Behaviours and Adaptive Coping Strategies Across Anxiety Disorders?

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Abstract. Safety-seeking behaviours are seen as playing a key role in the maintenance of various anxiety disorders. This article examines their role in panic disorder and social phobia and suggests that, whilst there are clear theoretical differences between safety-seeking behaviours and adaptive coping strategies, the difficult issue in clinical practice is being able to distinguish between the two. It builds on previous work by Salkovskis and colleagues and provides a detailed discussion of the problems in distinguishing between safety-seeking behaviours (direct avoidance, escape and subtle avoidance) and adaptive coping strategies in clinical practice. The suggestion is made that topology can only be a guide to categorizing the two types of responses and they can only be fully distinguished by taking into account the intention of the individual and their perceived function to that individual in the specific context. It is suggested that further analysis of the use of safety-seeking behaviours aimed at avoiding a variety of outcomes at differing levels of catastrophe may provide useful information that would clarify our understanding of the role of such behaviours in maintaining anxiety disorders.

Keywords: Safety behaviours, safety-seeking behaviours, coping strategies, anxiety disorders, panic disorder, social phobia.

Introduction

Our anxious patients often arrive at the first session and describe disabling anxiety permeating throughout their lives. Whole lifestyles can be constructed around specific fears. A recent clinical example was a 29-year-old woman who had avoided virtually any activity without a trusted adult present for over 13 years due to fears of having a heart attack. She had never experienced her feared outcome throughout the history of her disorder. However, at assessment she reported that at times during the previous week she had believed more strongly than ever that she had to keep performing specific behaviours in order to prevent a heart attack. Current cognitive models of anxiety disorders emphasize the role of such behaviours, labelled

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"safety behaviours" or "safety-seeking behaviours" (Salkovskis, 1991), in reducing short-term anxiety, but more importantly in preventing longer-term cognitive change (Gelder, 1997). In other words, these models propose that people continue to believe, for example, that they may have a heart attack because they have prevented themselves from having the opportunity to disconfirm their worst fears (Clark and Ehlers, 1993).

Safety-seeking behaviours are central in our understanding of the maintenance of anxiety disorders and, as such, many current treatments concentrate on gradually dismantling these behaviours and helping patients design opportunities to test out their beliefs (Clark, 1999). This is in contrast to earlier treatments, which emphasized the teaching of "appropriate" skills and strategies to patients to control their anxiety. Indeed some effective current treatments for panic disorder include elements (e.g. breathing control) that could, under some circumstances, function as safety behaviours for some individuals (e.g. Craske and Barlow, 2001). Salkovskis (1996) has noted that some specific responses to anxiety (e.g. distraction) have been viewed both as helpful components of behavioural anxiety management programs *and* also as problem behaviours that have to be removed in order to allow effective exposure or belief testing to take place.

Many patients also have idiosyncratic strategies that they have learned from either mental health professionals (e.g. distraction techniques, breathing control) or self-help materials, or have developed themselves. This is not surprising, given that the majority of us have our own coping strategies that we deploy to reduce our anxieties in different situations. For example, one can imagine an inexperienced public speaker who experiences some anxiety might adaptively spend considerable time preparing for a presentation as a way of coping. In a socially phobic individual, the same behaviour could function as a safety-seeking behaviour.

How can we recognize when a given behaviour is a safety behaviour and when it is an adaptive coping strategy? Rather than considering these as dichotomous behaviours, however, perhaps the same behaviour could function, for any given person, both as an adaptive coping strategy *and* as a safety behaviour, but to differing degrees and in different contexts. With repeated, excessive, or situationally inappropriate use, it is possible that the behaviour shifts along a continuum from adaptive coping strategy to safety behaviour, depending upon the intention, actual function and objective benefit to the individual.

Given the proposed role of safety behaviours in maintaining various anxiety disorders, it becomes important to distinguish between safety-seeking behaviours (that would need to be gradually dropped) and adaptive coping strategies (that would continue to help the individual with no long term cost). This article examines current theoretical understanding of the two and highlights ways that aid in their discrimination and may increase the effectiveness of CBT at an individual level.

Definitions

Before attempting to distinguish between coping strategies and safety behaviours, clear definitions are required.

Safety behaviours or safety-seeking behaviours

Early behavioural attempts to discuss avoidance concentrated on not entering or escaping from situations (e.g. Marks, 1987). Safety signal theory was extensively developed and applied to

agoraphobia by Rachman during the 1980s (e.g. Rachman, 1984a, 1984b) and can be viewed as a precursor of the current concept of safety behaviours in cognitive models developed in the late 1980s and early1990s. By 1999, the Oxford Group described safety behaviours in panic as those that: "are intended to avoid *disaster*, and these responses have the secondary effect of preventing the disconfirmation that would otherwise take place" (Salkovskis, Clark, Hackmann, Wells and Gelder, 1999, p. 573).

Note that safety behaviours are here defined with reference to both their "intended purpose and their consequences". Salkovskis, Clark and Gelder (1996) identified three main types of safety behaviour in panic (though these classifications can also be applied to other anxiety disorders): "direct avoidance" of situations; "escape" from situations; and, "subtle avoidance" within the anxiety-provoking situation. Clark (1999) highlights that, although labelled "behaviours", there are numerous examples where safety behaviours are internal processes or cognitive strategies (e.g. using distraction when panicking, cognitive rehearsals of conversation in social phobia).

There have been several attempts to create typologies of safety behaviours using factor analytic approaches (e.g. Kamphuis and Telch, 1998; Hughes, Budd and Greenaway, 1999). The derived factors can be approximately mapped onto the smaller number of categories described by Salkovskis et al. (1996) but appear to be based on a combination of function and topology and, as such, may be clinically useful but less valid at a theoretical level. For example, relaxation as described by Kamphuis and Telch (1998) could represent both subtle avoidance or an adaptive coping strategy, depending on its idiosyncratic function for the individual. Furthermore, without detailed information about an individual, would avoiding caffeine (avoiding somatic arousal) be an adaptive behaviour or a safety behaviour? This illustrates the difficulty in trying to categorize responses to anxiety based upon a topological description of the behaviour rather than upon an idiosyncratic understanding of its function for the individual.

Clinically, it has long been observed that it is the "availability" of safety behaviours rather than their "usage" that limits new learning and maintains threat beliefs (e.g. carrying anxiolytic medication without using it). It has been suggested that patients misattribute the lack of a feared catastrophe to the safety behaviour (Salkovskis, 1991). Recently, however, it has been suggested that the availability of safety behaviours for patients with claustrophobia "interferes with treatment by redirecting patients' attentional resources away from the threat, thereby reducing the processing of threat-relevant information" (Powers, Smits and Telch, 2004, p. 448). This additional mechanism requires further experimental investigation across anxiety disorders. Finally, recent thinking suggests that positive cognitions in panic mediate the relationship between bodily sensations and anxiety (Casey, Oei and Newcombe 2004). Research is needed to investigate whether safety-seeking behaviours influence positive cognitions (e.g. perceived self-efficacy) as well as threat-related cognitions.

Adaptive coping strategies

Although there appears to be widespread agreement on what constitutes a safety behaviour at a theoretical level, it is more difficult to define an adaptive coping strategy. There is a notion that it is something that individuals do in order to reduce anxiety, and which does not maintain or worsen future responses to the same stimulus or stimuli. In other words, in the same way that safety behaviours may be defined, at least to some extent, by their consequences, coping

behaviours are at least partially defined by their longer term impact or, more precisely, their lack of negative impact. There is a danger that the definitions may become dependent upon each other or tautological.

Davey, Burgess and Rashes (1995) have distinguished between avoidance-based coping (which would be included within safety-seeking behaviours), coping by excessive monitoring for information (which appears similar to some of the safety behaviours observed in anxiety disorders), and coping strategies that allow the individual to change the meaning of a threat. In a similar manner, Hughes et al. (1999) included a category labelled Effective Coping in response to anxiety and panic. This included such strategies as "I tell myself that I can cope with the anxiety" and "I try not to think about how I am feeling", which appears to combine elements of "effective coping" and subtle avoidance.

To summarize, safety behaviours seek to "prevent or minimize a feared catastrophe" (Clark, 1999, p. 7), whereas adaptive coping strategies seek to reduce anxiety but do not seek to prevent an "imagined" catastrophe and therefore do not prevent disconfirmation of unhelpful beliefs.

Whilst the above distinction could be seen as somewhat arbitrary to the non-cognitive therapist, it is of critical clinical significance. Initial evidence suggests that reducing safety-seeking behaviours can increase the effectiveness of therapeutic interventions (e.g. Morgan and Raffle, 1999; Salkovskis et al., 1999). However, it may raise ethical issues to encourage patients to reduce helpful coping safety behaviours that are not having deleterious effects in the long term. Thus, from a clinical perspective, it is essential to be able to discriminate between safety behaviours and coping. This paper examines exactly how to distinguish between them in the context of therapy for panic disorder and social phobia.

Distinguishing between safety behaviours and helpful coping strategies

There are three key dimensions. First, the "topology" of the behaviour; what does the behaviour look like? Is there something inherent in some behaviours that cause them to operate as safety behaviours rather than helpful coping strategies? Does this vary according to context? Second, what is the "intention" behind the behaviour? Does the behaviour become a safety behaviour due to the individual's purpose behind the act? Third, what are the "consequences of the behaviour"? Do the consequences allow us to distinguish between them?

Panic disorder

A cognitive model of panic

Despite Rachman's call for experimental analyses of the strength of safety signal during the 1980s (Rachman, 1984a), the first studies of the current cognitive concept of safety behaviours in panic were not carried out until the 1990s. One of the first such studies found correlations between subtle avoidance behaviours and specific panic cognitions (Salkovskis et al., 1996). For example, cognitions related to fainting were associated with holding onto both people and objects. Cognitions about losing control and acting foolishly were associated with efforts to keep control, moving slowly and looking for an escape route. Supporting this, Kamphuis and Telch (1998) similarly found specific associations between anxiety cognitions and safety behaviours.

To date, there is limited evidence supporting the hypothesis that safety behaviours maintain anxiety cognitions. Importantly, Salkovskis et al. (1999) found that even a 15-minute period of exposure during which the panic patient attempted not to perform safety behaviours was associated with significantly greater reductions in anxiety and anxiety cognitions than a similar 15-minute period in which safety behaviours were continued. Although the sample size was small, this study provides support for the central hypothesis that safety behaviours maintain erroneous anxiety beliefs by preventing their disconfirmation. Finally, a recent study found that the severity of panic attack was better predicted by fearful cognitions than by beliefs about self-efficacy and coping ability (Richards and Richardson, 2002). The authors concluded that enhancing coping strategies would be less effective than reducing anxious cognitions, consistent with the notion that some attempts to cope or to control panic are at best ineffective and at worst unhelpful.

Direct avoidance behaviours

Some of the most obvious safety behaviours in panic are those that involve direct avoidance of a situation or stimulus and there is an extensive literature examining the relationship between panic and direct avoidance (see Craske and Barlow, 1988; Clum and Knowles, 1991). For example, we commonly hear patients talk of avoiding particular places (e.g. city centre) or of staying in particular places (e.g. at home in a "safety zone"). In addition, patients talk about avoiding situations that have particular characteristics, including those that are busy (e.g. city centre on Saturdays), hot (e.g. shopping centre) or those in which a rapid exit may be impeded (e.g. cinema, theatre). Earlier accounts of avoidance stressed the role of factors such as social demand and secondary gain (Craske and Barlow, 1988) as well as gender and co-morbidity (Clum and Knowles, 1991). However, recent accounts have emphasized misinterpreted stimuli and idiosyncratic catastrophic beliefs (Salkovskis et al., 1996). For example, an individual who first notices a sense of increased body temperature, which then leads to a fear of passing out, is more likely to avoid hot environments than an individual who notices dizziness and depersonalization, which then leads to fears of going mad. The latter is perhaps more likely to avoid situations in which people may witness him going mad or losing control. In panic disorder, it appears relatively unlikely that direct avoidance could be an adaptive coping strategy. Complete avoidance of a situation to prevent a perceived catastrophe will, at best, maintain the anxiety cognition or, at worst, strengthen it. Both the intention behind the behaviour (prevent feared catastrophe from occurring) and the outcome (maintain or strengthen belief) mark this type of avoidance as a safety behaviour. However, to use the suggested criteria of Salkovskis et al. (1996), if the direct avoidance behaviour had been intended to avoid the anxiety rather than the feared outcome, would this be classed as a coping behaviour? Might an individual want to avoid the unpleasant effects of panic *without* an associated catastrophic belief? Salkovskis et al. (1996) have suggested that responses intended to avoid anxiety alone are potentially adaptive coping strategies. This clearly would not apply to individuals who believed that anxiety itself could be harmful (Salkovskis, 1991).

Escape behaviour

Escape behaviour in panic disorder is similar to direct avoidance and is extremely common amongst individuals who experience recurrent panic attacks. A clear example was exhibited

by a recent patient recovering from severe panic disorder, who expressed surprise that having reduced direct avoidance, he was still extremely anxious leaving his house, despite no recent panic attacks. Investigation revealed that whilst in the city centre, he would begin to notice an increased heart rate, which would cause him to feel even more anxious due to fears of having a panic attack and the associated depersonalization and derealization. His catastrophic thoughts were based on how "weird" he felt, and revolved around other people being able to see him looking like a "weirdo" and then being vulnerable to assault. One safety behaviour was to leave the situation and get home as quickly as possible. He was aware that he had no idea what would actually happen if he stayed in town rather than heading for his "comfort zone". Clearly, examples such as fleeing a situation fulfil the definition of a safety behaviour in that it prevents a catastrophic outcome and prevents disconfirmation.

Depending upon the feared outcome, escape behaviour in panic can include leaving a particular room, leaving a building or area (e.g. shopping centre) or having to return to a perceived place of safety. It is difficult to imagine an escape behaviour for an individual with panic disorder that is not intended to avoid a perceived catastrophe, although there may be a plausible alternative rationale that has social acceptability or face validity, such as discomfort due to heat.

Subtle behaviours

Distinguishing between adaptive coping strategies and safety behaviours can be more difficult in this category. The behaviours are often idiosyncratic, and so it becomes harder to identify them and increasingly difficult to determine their function. These behaviours include both those that are planned in advance (e.g. carrying a bottle of water or anxiolytic medication) and those performed once the anxiety is experienced (e.g. leaning against the wall, sitting down).

In theory, there is nothing inherent in the topology of any of these acts that automatically identifies them as safety behaviours. However, in practice, certain examples can be more easily identified as safety behaviours based on the frequency with which they are reported by panic patients. Examples of these behaviours include sitting near exits in pubs and restaurants, only going into certain situations with a companion, and sitting down when legs feel weak. However, most people are likely to have purposefully sat near an exit in a pub or restaurant at some point in their lives, with a "commonsense" logic to this behaviour (e.g. waiting for friends, preferring quiet), rather than to prevent a catastrophe such as getting trapped, having a panic attack and dying. It is clear that "surface motivation" cannot be used to distinguish safety behaviours and coping strategies. Two individuals may both choose to sit near the door to avoid the heat and to get more fresh air. One may do this because he does not want to get too hot or smell of cigarette smoke, whereas the other may perform the same behaviour due to a wish to avoid breathlessness and choking to death. The complication arises when an individual presents both of the previous rationales for sitting by the door. Sometimes patients will justify their behaviours by reporting "rational" reasons for their actions (especially when out of the situation and so less anxious). Safety behaviour can also become so engrained for some individuals that they have difficulty identifying them (Kamphuis and Telch, 1998). Again, the key questions are of the type "What was the worst thing that could have happened if you had sat in the middle of the pub?" To access the anxiety-related rationale for the behaviour, heightened levels of emotion may need to be evoked via cognitive exposure or actual exposure to the stimulus.

The context of the safety behaviour, whilst clearly associated with the intention, deserves specific discussion. The same behaviour by the same individual across different contexts could be both a safety behaviour and an adaptive coping strategy. For example, sitting down in response to a novel physical sensation and associated fear of collapsing may be adaptive if the stimulus is sufficiently different and/or is preventing a feared outcome that differs in important ways. Therefore, in addition to the intention of the individual in performing the behaviour, one must also consider whether the feared outcome is imagined, exaggerated or perhaps even objectively realistic in this situation.

Finally, what then for an individual who has learned about the panic cycle (e.g. from self-help material or from health professionals) and then visualizes the panic cycle in order to help stay in an anxiety provoking situation? At what stage could visualization become a safety behaviour? It may be argued that if the individual continues to do this on every such occasion, it has indeed moved from coping to safety behaviour.

Social phobia

The cognitive model of social phobia

The model developed by Clark and colleagues (e.g. Clark, 1997; Wells, 1997) suggests that an individual with social phobia holds dysfunctional beliefs about him/herself and, more specifically, about him/herself in relation to social situations (Clark, 2001). As in other anxiety disorders, safety-seeking behaviours are hypothesized to play a central role in maintaining social phobia. People often believe that the feared social catastrophe would have occurred had they not performed the safety behaviour. Again, the behaviour reduces the anxiety in the short term but actually maintains the anxiogenic beliefs in the long term (Heimberg, 2002). In social phobia, patients often engage in a multiplicity of safety behaviours attempting to prevent feared outcomes at several levels. For example, an individual could perform safety behaviours to prevent the feared outcomes of, first, the face going red (e.g. keep cool, avoid eye contact), second, other people noticing (e.g. wear high necks and make up, put hand over face) and third, people who have noticed the redness thinking badly of her (e.g. provide an alternative explanation of red face) (Clark, 2001).

As in other anxiety disorders, safety behaviours can lead to an accentuation of feared symptoms or "contaminate" the situation. For example, wearing a jacket to hide underarm sweating can cause increased sweating (Clark, 2001), while excessive self-monitoring and attempting to memorize what has been said can cause the individual to appear cold or disinterested. In this case, an unfriendly or critical response from others may result (Clark and McManus, 2002). Certain safety behaviours can thus make the feared outcome objectively more likely.

Research has begun to empirically evaluate the role of safety behaviours in the maintenance of social phobia. In a case series of eight socially phobic patients, Wells et al. (1995) found that, as predicted, exposure plus decreased safety behaviours was significantly better than exposure alone in reducing anxiety and catastrophic beliefs. In a small sample of 14 patients, Morgan and Raffle (1999) found that patients in a CBT group treatment for social phobia benefited significantly more when instructed to drop safety behaviours in addition to the standard exposure.

In a recent article discussing aspects of the Clark and Wells model of social anxiety, Hughes (2002) suggested that "while 'counter-productive' safety behaviours should indeed, be given

up, calming tactics (e.g. breathing control, postural practice) might have a valuable role and need to be distinguished from undesirable safety behaviours" (p. 428). Although Hughes does not discuss the practical difficulties of attempting to distinguish between the "calming tactics" or the coping strategies that he advocates and safety behaviours, his suggestion is consistent with previous theoretical discussions relating to panic (Salkovskis et al., 1996). The following section will discuss various types of safety behaviours in social phobia and then suggest that further work is required to guide clinicians in the differentiation between helpful coping strategies (e.g. calming tactics) and subtle safety behaviours.

Direct avoidance behaviours

Direct avoidance has been hypothesized to play an important role in the maintenance of social phobia. Wells (1997) refers to the limited "bandwidths" within which social phobics commonly operate. For example, there may be long-standing patterns of avoiding specific "unsafe" situations (e.g. talking in groups, eating in front of others) or certain "threatening" behaviours (e.g. disagreeing with people, making a complaint). There is likely to be nothing inherent in the topology of such behaviours that causes them to function as safety behaviours, but clinicians can usually discriminate between "rational" avoidance (which may avoid objectively negative outcomes and/or have no impact on unrealistic fears) and direct avoidance (which maintains an unrealistic fear). Standard questions will usually suffice (e.g. What do you believe/fear may happen? How likely is this to occur? What if you hadn't [performed behaviour]?).

However, it is likely that there are situations with some ambiguity and where the line between rational avoidance of situations and direct but subtle avoidance becomes blurred. Consider the recent example of a socially phobic individual who avoided phone calls using a normal telephone at home and instead made phone calls from a speakerphone in his car when driving. This made the call easier for him in that pauses were more acceptable. It is further hypothesized that the distraction of concurrently driving also reduced his self-focus and consequent anxiety. Indeed, the strategy of decreasing self-focus has been reported as useful in reducing anxiety (Wells and Papageorgiou, 1998). The patient viewed this phone call strategy as helpful, yet it may also be considered direct avoidance, a subtle safety behaviour, and adaptive coping strategy to differing extents at the same time. Whilst, this allowed him to actually make important phone calls, it was probably maintaining a number of negative beliefs that may need addressing before the end of therapy.

Escape behaviour

Like direct avoidance of situations, escape behaviours are commonly reported by socially phobic patients, and again they are generally unlikely to function as adaptive coping strategies. Leaving a situation when both anxiety and the belief in a feared outcome is high, is likely to cause the incident to be perceived as a near miss (e.g. "If I hadn't got out of the that room then I would have [x] and people would have thought [y]"). The topology of such acts does not inherently identify them as safety behaviours, but it does provide an indication of their likely function. Further, escaping from a situation is less ambiguous than some subtle behaviours. Once again, the intention behind the behaviour and the function are crucial.

Subtle behaviours

The majority of subtle safety behaviours in social phobia can be distinguished from adaptive coping strategies on the basis of outcome. For instance, behaviours that actually contaminate

the social situation and are obviously counter-productive are unlikely to be adaptive. For example, for individuals who fear drinking in public due to shaking, gripping a glass tightly is usually a counter-productive strategy. What about behaviours, however, that may have an adaptive function in a specific situation but are used over-frequently or in too many situations? For example, for an important phone call, a list of points that need to be discussed may be extremely helpful. However, if the same behaviour is applied to all phone calls or conversations, at what point does this move from adaptive strategy to subtle safety behaviour? The same situation would apply for an individual that repeatedly practised a presentation. When would adequate preparation become a safety behaviour? Salkovskis et al. (1996) have suggested that this would depend on the intention of the individual (i.e. "what the person believes they are avoiding" (p. 458). However, the related context, function and cost of the behaviour are also important. At what point does the additional improvement to actual performance diminish to the extent that the behaviour is now serving as reassurance rather leading to improvement? For example, practising a presentation 10 times may be adaptive for someone who rarely presents but less so for an experienced public speaker. Also, the novelty of the situation is an important factor: if an individual were to over prepare for every public speaking situation (e.g. regular teaching), this is more likely to be functioning as a safety behaviour. However, if this strategy is used selectively, such as for new situations or when the "objective" stakes are high (e.g. first keynote address), this would suggest that it may be an adaptive coping strategy. It is likely that through discussion, patient and therapist could reach agreement not only on the intention of the behaviour, but also on the novelty of the situation, the objective risk or likelihood of feared outcome, the cost and actual function and outcome, and thus determine when an adaptive coping strategy would become a safety behaviour. What then for the suggestion that patients should be taught "calming techniques" (e.g. Hughes, 2002)? Whilst this is not inconsistent with the cognitive model, the therapist would need to be clear how this would fit an individual formulation to avoid teaching safety behaviours. It may be difficult to do within the group format as described by Hughes. What is the intention? Does it aim to prevent the physical symptoms, to prevent others from noticing, or to change their interpretation? Although most of the calming strategies advocated would aim to reduce anxiety (adaptive), they may also prevent the individuals from disconfirming beliefs predicated on the existence of these anxiety symptoms. This is a complex issue and further research would be invaluable in determining how coping strategies actually influence the degree of belief in the various idiosyncratic catastrophic outcomes.

Conclusion

This article has discussed the role of safety-seeking behaviours across two anxiety disorders and attempted to clarify the difference between them and adaptive coping strategies. Although at a theoretical level there are clear differences between them, it may be less clear in clinical practice. The division by Salkovskis et al. (1996) of safety behaviours into direct avoidance, escape behaviour and subtle avoidance has proved a useful framework in the examination of safety behaviours across panic disorder and social phobia and has been applied to OCD elsewhere (Thwaites and Freeston, in preparation).

Although each disorder may be characterized by an increased likelihood of specific types of safety behaviours, there are a number of key clinical principles that apply across disorders. First, the topology of a behaviour does not automatically distinguish between a safety behaviour and

coping strategy. For experienced clinicians, topology may be used as a guide, but ultimately each set of behaviours should be approached with an open mind.

Second, it is likely that safety behaviours and adaptive coping strategies can only be distinguished on the basis of the intention of the individual, their perceived function to that individual in the specific context, and the subsequent impact on positive and negative cognitions. The clinician needs to engage the patient in a detailed discussion to identify exactly what the patient is trying to avoid or prevent. If the behaviours have become habitual or the patient is unable to access relevant cognitions, an appropriate task exposing to the situation and/or the affect may be necessary. In the theoretically possible, but clinically rare, case when the individual is trying to avoid anxiety alone without any avoidance of further consequences, this behaviour could be considered adaptive (Salkovskis et al., 1996). However, even in these cases the reduction in anxiety may be detrimental to change in that it can prevent dysfunctional beliefs from being accessed and subsequently tested if access and level of belief are functions of anxiety. This paper suggests that the distinction is made more complicated by the fact that some behaviours can concurrently function as both adaptive coping strategies and safety behaviours with respect to different feared consequences.

Third, Clark (2001) has emphasized that subtle avoidance behaviours in social phobia can function at a variety of levels, all of which are aimed at avoiding a perceived catastrophic outcome or outcomes, but at different stages in the process. This same detailed analysis could be applied to behaviours in other disorders where there may be a range of possible catastrophes, albeit some more "catastrophic" than others. An individual with panic disorder could perform a variety of safety behaviours in order to prevent a feared outcome. For example, she could use direct avoidance of busy shops to avoid the initial symptoms of anxiety (that she fears could lead to going mad) but also to avoid the people who would see her losing control. This is similar to panic patients who fear dying, but if the panic attack did not kill them they would "die of embarrassment". Although most definitions of safety behaviours specify that the behaviour is to avoid a feared outcome rather than just the initial anxiety, it is possible to categorize safety behaviours further, based on the inference chain leading to the perceived catastrophic outcome. For example, safety behaviours in panic could be intended to avoid the initial stimuli, the physical response to the initial stimuli, perceived consequences of the physical response, the environmental reaction to physical response and so on. It is possible that this type of categorization could provide clinically useful detail in planning experiments but may be highly idiosyncratic.

A number of questions remain at both theoretical and clinical level. For example, to date there is no research investigating how coping strategies influence levels of belief in catastrophic outcomes. At a clinical level, are there still occasions when it is appropriate to encourage clients to perform behaviours that have the potential to function as safety behaviours (e.g. breath control, use of anxiolytic medication)? Does this purely depend upon the idiosyncratic formulation of the individual and/or the stage of therapy?

Despite the emphasis on safety-seeking behaviours in current treatments of anxiety, we are still in an early stage in our understanding of their role in maintaining anxiety and the precise mechanisms involved. Current theory would suggest that clinicians should devote time and attention to understanding the idiosyncratic function of patient behaviours in order to discriminate between helpful (or harmless) coping strategies and safety behaviours that are believed to hamper new learning by the patient and thus limit the benefit received from CBT.

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