
The Core Fear Interview

A practical manual and theoretical introduction

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This manual introduces the notion of core fears and how to identify them using the core fear structured interview.

It has three sections:

1. What are core fears?
2. Why is it important to identify them?
3. How are core fears identified?
4. The core fear interview

1 What are core fears?

People's reported fears are typically remote from their ultimate, underlying fear (Borkovec et al., 1998). For example, the fear of being hit by a car can reflect various underlying concerns. Some people may fear death, others pain, some worry about the impact on their careers, and still others fear for their loved ones. Experienced clinicians readily acknowledge the importance of determining this underlying fear. These underlying fears are often called core-fears (CFs; Gillihan et al., 2012; Huppert & Zlotnick, 2012).

We define CFs as the ultimate or underlying catastrophic consequences that are feared to occur and motivate avoidance, safety behaviors, compulsions, or other prevention strategies. Moreover, core fears reflect the meaning a person attributes to a specific stimulus or situation.

1.1 Surface Fears

The first step for identifying the core fear is to identify a surface fear. At it's simplest, the surface fear is the stimulus that triggers anxiety. It can be a person walking in the street (he might want to murder me), a dog (he is likely to bite me), or an aggressive thought (these thoughts mean I am bad). In pathological anxiety, the surface fear will invariably be objectively benign. Thus, the surface fear of a person that fears being murdered by a random person in the street is not being murdered but running into a person in the street. A dog phobic is likely afraid of leaving the house or walking into the street. However, in most cases the patient will present with some combination of stimulus and fear, such as I'm afraid to leave home because I might have a panic attack. For the purpose of identifying the core fear, we start from whatever level of fear that is available and begin the downward arrow questioning from there.

In many cases, it is easiest to investigate core fears by identifying an avoidant behavior or a safety behavior. Then, we can ask what would happen if the behavior was **not** avoided. For example: “what would happen if you left your house and walked down an unfamiliar alley?” Alternatively, we can focus directly on the feared outcome. For example: “what would happen if you encountered a dog?”

1.2 Core Fears

After identifying a surface fear, we want to discover the underlying core fear. The core fear is the perceived underlying danger that makes the surface fears *seem* dangerous. We thus distinguish between the feared stimulus (surface fear), and the motivation to avoid it (core fear). Typically, CFs are determined via the classic “downward arrow” technique (e.g., Dugas & Koerner, 2005), in which a patient is asked what they are afraid will happen if they don’t engage in any avoidance or safety behaviors. This question is followed by a succession of follow up question such as “and then what,” “and what is so terrible about that” and “and what does that mean to you.” This procedure is followed until a core fear is recognized (Beck, 2011; Leahy, 2003).

The introspection into the source of one’s fears is not easy, and patients may find it stressful or frustrating. However, in the hands of a skilled clinician, the experience can be positive and rewarding for the patient, making them feel understood. We encourage the therapist to ask questions in the spirit of curiosity and true exploration of the patients experiences (Padesky, 1993), and not to ask these questions mechanically. A good indication that one is on the correct track is the increased tension characteristic of emotional conversation. Oftentimes, patients have avoided thinking about their fears “all the way” and contemplating their ultimate fears activates their anxiety. The lack of tension or increased emotion is likely to be an indication that the patient is avoiding the central issue. At times, patients get side-tracked (possibly as a form of distraction or avoidance), so it is important to keep focus on the core fear and not follow into less a less relevant discussions.

In practice, the core fear interview typically produces a chain of fears. For example: If I don’t wash my hands, then I will be contaminated, and then I will get sick, and then I won’t be able to function, and that is terrible because my career will be hopelessly and permanently sabotaged. Or: A burglar might break into my house, and find one of my children, and hurt them, and maybe kidnap them, and I couldn’t live with that because my keeping my family safe and helping them grow is the most important thing in my life.

The core fear interview explores the association between a surface fear and a core fear. Widely speaking there are two types of association: prediction and equivalence.

The surface fear may be seen as a **predictor** of the core fear. If the surface fear happens, then it is more *likely* that the core fear will occur. Even a slight likelihood is often enough to motivate avoidance of the surface fear. For example, a patient may fear having aggressive thoughts because she fears they will

lead to aggressive behavior. We ask “and then what might happen?” to investigate expected future events.

Alternatively, a surface fear may be seen as **equivalent** to a core fear. The surface fear symbolizes the core fear, or is seen to belong to the same category. For example, a patient may be worried about having aggressive thoughts because to her, they directly mean that she is a bad person. Or, a student may be worried about failing a test because to him it means that he has failed his parents. In order to inquire about equivalence, we ask “what does that mean to you?” It is possible that a given patient can have both associations of prediction and equivalence.

2 Why are core fears important?

Core fears contribute to psychotherapy through three distinct pathways; 1) targeting the fear structure, 2) optimizing exposure, 3) improving alliance.

A traditional view of anxiety disorders may model them as multiple pairings of benign stimuli with threats (perhaps within a framework of conditioning, see Vinograd & Craske, 2020). However, anxiety disorders have a distinct internal structure and the traditional view has been extended to treat anxiety disorders as a *network* of stimuli, responses, and meanings (Foa & Kozak, 1986; Lang, 1977). Core fears are thought to have an organizing role in anxiety, such that the variety of symptoms may be motivated by the same core fear. Thus, targeting the core in psychotherapy is the best way to dismantle the fear network leading to better recovery (Murray et al., 2016), and generalization (Gillihan et al., 2012).

Identifying core fears further optimizes therapy by optimizing the design of exposures. This manifests in two ways. First, understanding the underlying fear allows choosing the correct target for exposure. Consider a blood-phobic patient. It would seem that exposure to sheep-blood would be appropriate. However, if the core fear centers around fear of AIDS and the consequential social rejection, a more theme-appropriate target for exposure should be sought. In this sense, core fears support disconfirming the true expectancies that patients have (Craske et al., 2022). Furthermore, even when an appropriate exposure has been chosen patients may avert their attention from important aspects of the stimulus. Explicit instructions to attend to the core fear can decrease this type of safety behavior.

Finally, identifying core fears can contribute to the alliance. Bordin (1979) described three aspects of alliance: bond, goals, and tasks. Finding a patients' core fear, can make them feel better understood thereby improving the *bond*. Patients often ask themselves where their anxious behavior comes from. Identifying the underlying motivation can alleviate this type of stress, increase motivation to stop anxious behavior without giving up one's values, and support agreement on common treatment *goals*. As described above, core fears are central to designing appropriate exposures and other interventions, clarifying them is likely to increase agreement on these *tasks*.

3 Identifying Core Fears

There are several common challenges when attempting to identify the core fears. Here, we review common challenges and how to deal with them.

3.1 When there are no consequences

Many individuals say that they have no feared consequences. This should not always be taken at face value. If there are no consequences, one should ask themselves what about the situation is so threatening that it motivates avoidance or heightened anxiety? Many times, the feared ideation is a hot cognition, and not readily available for recall in less emotional situations (David & Szentagotai, 2006; state-dependent recall; cf. Safran & Greenberg, 1982). Furthermore, the individual can intellectually or cognitively “know” that nothing will happen, but may still be afraid of some unrealistic consequence. Indeed, emotional reasoning is often quite distinct from cognitive reasoning and it is helpful to directly address this distinction by asking directly “What do you *feel* might happen?” instead of “What do you *think* might happen.”

P: I never speak in staff meetings at work.

T: What are you worried might happen?

P: Nothing will happen, I know I can speak up and everything will be fine

T: Alright, that is what you are *thinking*, but what are you *afraid* will happen?

P: Oh. I can imagine everyone mocking me for my stutter.

An alternative way to access hot cognitions is by imagining an anxiety provoking situation and noting what thoughts come up. When composing the image, it is important to emphasize the sensory qualities of the situation. Additionally it is helpful to suggest that the patient close their eyes and speak in present tense, (Hembree et al., 2003).

T: How about you try to imaging the situation and what type of thoughts come up?

P: alright.

T: You walk into the staff meeting and decide that this time you are going to take control of your life and not let anxiety determine what you do. You decide you will speak up. You sit down on your chair, you can feel its pressure on your backside, you can hear the air-conditioning humming in the background, and you see all your colleagues listening intently to the boss. Your turn to speak is coming up and you notice that your hands are becoming sweaty. What are you feeling?

P: I am anxious. I feel like running away.

T: What are you worried that will happen?

P: I'm going to fail in from of everyone, I will stutter and they will all think that I'm an idiot for ever.

There is a subset of individuals that truly do not have underlying fears (cf. Foa et al., 1999). In general these are often patients with difficulties in distress tolerance (Craske et al., 2014). They may worry about aversive sensory phenomena (Ferrão et al., 2012) or not just right experiences [NJREs; Coles & Ravid (2016)]. An illustrative case is an OCD patient that finds it excruciating if things are not organized exactly her way. Nothing will happen. It just doesn't feel right. Many times these individuals are worried about some unpleasant sensation lasting *forever*. This feeling of eternity transforms seemingly benign experiences to intolerable. Notably, not all cases of NJREs lack core fears, in many cases these patients are worried about how their suffering will affect their performance or have other adverse effects. Thus, even when a patient reports NJREs it is worthwhile to investigate their core fears.

3.2 Branching

When investigating core fears, patients often identify multiple fears for the same situation. This is in line with the notion that motivations are multiply determined. However, when seeking the core fear, we want to identify the most threatening consequence. Therefore, the therapist should investigate which of these fears is the most central emotionally.

T: And what might happen if you have a panic attack and lose control?

P: I'll throw up in front of everyone. I'll lose my mind.

T: Wait you described two different things here. Can you think which one you fear most?

3.3 Stopping Criteria

When does one stop asking for deeper fears? There is no clear criterion regarding the form of the fear that identifies it as a core fear. Thus, even when a patient reports fear of death we continue the interview: maybe they fear the afterlife, maybe they care about what would happen to their family, maybe death is indeed their core fear. We cannot know without asking. The accepted stopping criterion is that the patient cannot think of any further consequences or implications to their fear.

At times, in the process of searching for the core fear, the interview "overshoots" the core fear. The patient focuses on their reaction to the feared catastrophe rather than the core fear itself. To prevent these cases, it is useful to retrace the chain of fears and explicitly ask about the fear levels:

P: My whole family would be killed in a car accident.

T: And then what would happen?

P: I don't know. I would be depressed forever.

T: And what is terrible about that for you?

P: I would commit suicide. And that's it.

T: I just want to be sure that I understand. What do you fear more, depression or suicide?

P: Depression of course. Suicide is a relief.

T: And what are you more worried about, that car accident or getting depressed?

P: The car accident is way worse. It's why I'd get depressed in the first place.

4 The Core Fear Interview

4.1 Finding the Surface Fear

We start by identifying a focus for the interview. This is preferably a safety behavior or avoidant behavior, but sometimes a raw fear is enough. It is better to identify several behaviors so that we can later choose a central one.

Everyone suffers from anxiety or distress to some extent. In this interview, we will attempt to identify the core of your distress or fears.

Please think if there are activities that you avoid in order to avoid feelings of stress, anxiety or distress. For example, some people avoid social interactions such as meeting up with friends, others avoid crowded locations or taking public transportation.

Do you have personal rituals that you feel that you need to perform in order to prevent anxiety or distress? For example, some people feel the need to wash their hands again and again so that they do not feel contaminated. Others ask for reassurance from their friends that everything will turn out alright. Still others don't leave home without a bottle of water - just to be sure.

Of the situations that you described, which one is the most significant and distressing?

4.2 Finding the Core Fear

Let us get deeper into what drives your distress. What do you think would happen if you did not perform «avoidant behavior»?

At this point we start using the downwards arrow to identify the core fears. You may want to use any of the following:

- And if that would happen, what then?
- And what about that scares/worries you?
- And what does that mean to you?
- And that must not happen otherwise...

If the patient says that nothing will happen, ask:

- If so, what makes you so distressed?
- Well, that is what you *think*, what do you *feel* might happen?
- Sometimes, we know/think something (factually, cognitively), but still feel differently. What are you afraid could happen, even if you know it couldn't?
- Try to imagine yourself in the situation - what do you feel will happen now?

When the patient cannot identify any further consequences - that is their core fear. Please record the whole chain of fears.

In your own words please describe your motivation for avoidance, or the core of your fear.

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