

Panic Disorder & Agoraphobia

by William C. Sanderson, Ph.D., Founding Fellow, ACT

What are Panic Disorder & Agoraphobia?

Panic Disorder (PD; with or without agoraphobia) involves the experience of recurrent, unexpected panic attacks. Panic attacks are episodes of intense fear or discomfort accompanied by at least four of the following symptoms (rapid heartbeat, sweating, trembling or shaking, shortness of breath or smothering sensations, feeling of choking, chest pain or discomfort, nausea or abdominal distress, dizziness, unsteadiness, lightheadedness, or faintness, feelings of unreality, numbing or tingling sensations, chills or hot flushes, fear of going crazy or losing control, and fear of dying). Panic attacks are followed by a period of at least one month of persistent concern about having additional panic attacks or a change in behavior as a result of panic attacks (e.g., avoidance of situations where the attacks have occurred). Panic Disorder is typically accompanied by agoraphobia. Agoraphobia is the avoidance of situations due to concern about experiencing a panic attack or panic-like symptoms. People with agoraphobia often avoid public transportation, elevators, crowded places, stores, restaurants, theaters, traveling far from home, and being alone. In any given year it is estimated that between 1.0% and 3.5% of the population will experience Panic Disorder.

The Cognitive Model of Panic Disorder

The cognitive model of PD proposes that panic attacks occur when individuals perceive certain physical sensations as considerably more dangerous than they truly are, and then interpret those physical sensations to mean that they are about to experience sudden disaster. For example, individuals may develop a panic attack if they misinterpret heart palpitations to mean that they are about to have a heart attack or if they misinterpret jittery, shaky feelings to mean that they will lose control or go crazy.

The vicious cycle that ends in a panic attack develops when something perceived as threatening creates a feeling of apprehension or nervousness. If the sensations that accompany this state of apprehension are catastrophically misinterpreted, “I’m going to die; I’m having a heart attack; I’m having a stroke,” the individual experiences a further increase in apprehension, followed by elevated physical sensations and so on, until a full-blown panic attack occurs.

Common “misinterpretations” include:

Heart palpitations = I’m having heart attack!

Dizziness = I have a brain tumor!

Breathlessness = I am going to suffocate!

Blurred vision = I am going blind!

Evidence Supporting the Effectiveness of Cognitive Therapy for Panic Disorder

Cognitive – Behavioral Therapy (CBT) for Panic Disorder has been well established as an effective treatment. To date, 25 controlled trials exist supporting its efficacy. CBT is endorsed as a first-line treatment for Panic Disorder in consensus treatment guidelines developed by the [National Institute of Mental Health](#) and the American Psychiatric Association.

Medication Treatments For Panic Disorder

Although CBT has not been compared to each of the proven effective medication treatments for Panic Disorder (benzodiazepines such as Xanax, Ativan; tricyclic antidepressants such as Tofranil, selective serotonin reuptake inhibitors such as Paxil, Prozac, Zoloft, Celexa), comparisons that have been made have essentially shown that CBT is equivalent to state-of-the-art medications. Some studies show that CBT is more effective than medication in treating P.D.

While conventional wisdom suggests that using cognitive therapy and medication together is the most effective approach, research studies have found that cognitive therapy is effective on its own and including medication may not be necessary in most cases. Of course, those not responding to cognitive therapy should consider medication as an alternative or adjunctive treatment. One caution: It appears as though the use of benzodiazepines (e.g., Xanax, Ativan) during cognitive therapy may limit Cognitive Therapy's efficacy leading to an increased risk of relapse.

Treatment Description: Primary Strategies used in Cognitive Therapy

Step 1. Educating the Patient

By the time Panic Disorder clients consult with a mental health professional, they typically have been to many different doctors without receiving a clear diagnosis and explanation of PD. In the absence of such information, these clients often imagine that they are going to die, go crazy, or lose control. They often suspect that the doctor has overlooked some life-threatening physical condition that would account for their symptoms. Therefore, the psychoeducation phase consists of providing information about Panic Disorder.

During the initial session(s), anxiety, panic, and agoraphobia are defined. Each symptom is identified as a feature of Panic Disorder and shown to be harmless. Common myths about the danger of panic attacks (e.g., panic attacks are a sign of an undetected brain tumor, palpitations cause heart attacks, hyperventilation leads to fainting, etc.) are addressed. The development of the disorder is understood as a psychological response to stress, and avoidance behavior and anticipatory anxiety are viewed as ways to prevent the panic attacks from occurring.

Written materials, such as pamphlets and books, are valuable [educational tools](#) since they may be reread whenever the client desires. We recommend several excellent web sites that offer valuable information about Panic Disorder

(www.adaa.org, www.anxieties.com, <http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>).

Step 2. Cognitive restructuring.

The cognitive restructuring component of cognitive behavioral therapy (CBT) is based on the idea that a person's thoughts and beliefs (some adaptive and some maladaptive) are associated with anxiety and avoidance behaviors. Therapeutic change is achieved as maladaptive cognitions (i.e., thoughts, beliefs, and assumptions) are identified and altered.

- Identify how cognitions provoke panic. In this part of the treatment, the client is helped to identify how their cognitions (their thoughts, their beliefs, their interpretations) are associated with their panic. This is done by examining the thoughts, beliefs, and assumptions that are present during a panic or anxiety episode.

- Develop profile of client's typical panic sequence. A detailed discussion of the first and most recent Panic Attack is a useful place to begin this examination. Through a series of questions, the therapist tries to determine the client's personal panic sequence and to uncover panic inducing, catastrophic thoughts. The validity of these cognitions is then examined.

Example of a typical panic sequence:

- I was sitting in the movie theater watching an exciting movie.

- I noticed my heart began to beat faster (physical symptom).

- I assumed this rapid heart beat was the early signs of a heart attack or panic attack. I thought that I would lose control and start to yell. Everyone would think I was crazy! (catastrophic thought).

- I became even more anxious and worried about losing control, and started to sweat a lot (escalation of physical symptom).

- I left the movie theater (escape and avoidance).

- I felt depressed and discouraged because I could not even cope with watching a movie (hopelessness).

- Explore client's thoughts. This part of cognitive therapy reveals the Panic Disorder client's self-talk. In therapy, it is necessary to make private thoughts explicit. In the beginning of treatment many clients are unaware of their own thinking. For the most part, people process information and think automatically. The therapeutic setting should promote the client's sense of comfort and

acceptance in order to facilitate learning and disclosure. Clients are asked to self-monitor their cognitions (thoughts, beliefs, perceptions) during episodes of panic and to write them down. A written, numbered format may be used, as in the example above. After several sessions of reviewing these panic-related cognitions, a clear panic sequence emerges, and clients begin to appreciate the role that their thoughts and beliefs play.

- Evaluate the accuracy of thoughts and identify distortions. Once the client becomes aware of the importance of their cognitions (thoughts, beliefs, perceptions, interpretations) in contributing to and fueling their panic attacks, they are in a position to evaluate the accuracy of these cognitions. Catastrophic misinterpretations of panic-related physical sensations are targeted. Another common misinterpretation that may be targeted is the overestimation of the consequences of panic (e.g., public humiliation, losing one's job, interpersonal rejection). "Thought Records" may be used to quickly identify the client's thoughts, examine their validity, and challenge the client to respond with more adaptive, less anxiety-producing thoughts. It is important to note that cognitive restructuring is not "positive thinking," but instead is a focus on teaching people to think realistically and adaptively (i.e., weighing out evidence).

- Decatastrophize. The final phase of cognitive restructuring is to decatastrophize or to think in more adaptive ways. This is accomplished through a series of questions: What if your worst fears came true -- would it really be as bad as you imagine? Consider the person who believes they will have a panic attack on a plane, causing them to scream wildly while they try to escape. In fact, if their worst fears were realized and they did have a panic attack, the most likely outcome would be a feeling of great discomfort, not screaming, attempts to escape, and embarrassment. Decatastrophizing can greatly reduce the avoidance that is often associated with panic.

3. Respiratory control/breathing retraining

Respiratory control or breathing retraining helps people regain a sense of control over the physical features of panic and anxiety. Clients are taught a method of breathing that increases relaxation and prevents hyperventilation.

- Hyperventilation, or short, shallow breaths, initiates disturbing physical symptoms such as dizziness, chest pain, breathlessness, and a tingling sensation that may culminate in panic. These symptoms instill a frightening sense that one's body is out of control. Under stress and anxiety, respiration rate often increases, characterized by the use of chest muscles and short, shallow breaths.

- To combat the tendency to hyperventilate, the client is taught diaphragmatic breathing (i.e., breathing which involves in-and-out movement of the abdomen, not chest) at a regular rate (i.e., approximately 12 breaths per minute). This exercise is then practiced outside of the session in many different situations. Clients learn to control their breathing and come to recognize that this is an effective strategy that they can rely on in panic-provoking situations.

4. Progressive Muscle Relaxation

Relaxation training through progressive muscle exercise is also intended to help clients gain a greater sense of control over their bodies. It is practiced daily as a way to identify and decrease tension that might otherwise escalate into a full-blown panic attack. The basic technique involves tensing and relaxing muscles to achieve a more serene state. Specific step-by-step details regarding this exercise may be found in an excellent text by Barlow and Cerny. (See appendix.)

5. Imaginal exposure/visualization

It is often beneficial to discuss anxiety-provoking situations and experiences in great detail with vivid images, associations, and emotion. This can help to foster real change. Visualization can help in this regard. When a client closes their eyes and imagines anxiety-producing situations in detail, they are often flooded with anxiety. By confronting such anxiety-provoking situations in the mind's eye, the client learns how to cope before they confront the situation in real life.

·The therapist helps the client to visualize the situation in as much detail as possible. As the client describes the feared image, the therapist asks relevant questions about the associated thoughts and feelings. This is meant to elaborate the image and to help the clients feel less anxious and more in control.

·In time, the client is asked to visualize effective coping techniques and responses. In this way, visualization serves as an inoculation -- if the client can handle small amounts of manufactured anxiety in the therapist's office (the anxiety that arises during the imagery exercise), they will be better prepared to handle anxiety in a natural setting outside of the therapist's office.

6. Exposure

Exposure is the final component of Cognitive Behavioral Therapy (CBT), in which the client confronts anxiety and panic-provoking stimuli. These phobic (avoided) stimuli may be external situations or internal sensations (dizziness, rapid heartbeat, etc.).

·By repeatedly facing their anxiety in a structured situation, clients learn to develop appropriate coping mechanisms and become less anxious and more capable of responding without anxiety or panic. Based on the client's individualized list of feared situations, he or she is exposed to each of these situations in a progressive, systematic fashion. The therapist guides the client to use coping skills when confronting anxiety-provoking situations. For example, an external situational exposure exercise may involve creating a list of increasing distances from which a client will drive from their home on a highway or other feared road. Similarly, exposure to internal disturbing sensations is based on the client's individualized list of feared internal sensations (e.g., dizziness, palpitations). Creation of these sensations may be achieved using methods, such as over breathing, spinning, and physical exertion during the therapy session. (e.g., ride an exercise bicycle for 2 minutes).

·The use of a list of least feared to most feared situation allows the therapy to progress and build on past accomplishments The use of a hierarchy of least feared to most feared situation allows the therapy to progress and build on past accomplishments. The client first learns to cope with mildly anxiety-provoking situations and later faces the more difficult situations. Facing anxiety with a supportive, understanding, caring therapist helps clients use newly developed coping skills. The client learns to tolerate anxiety without the need to escape. This lesson is passed on from one anxiety-provoking situation to the next.

·Practice between sessions is expected and essential for rapid progress. Clients are encouraged to confront avoided (phobic) stimuli at least 3 times during the week between sessions. First, the client completes the exposure exercise with the assistance of the therapist, such as inducing heart palpitations by walking up and down stairs for 3 minutes, and later practices this exercise at home. The client's self-confidence often increases as they realize that they can handle this formerly anxiety-provoking experience on their own.

Cognitive-Behavioral Therapy for Panic Disorder is highly effective. Pursuing this type of psychotherapy involves a considerable amount of work on your part and a willingness to confront anxiety. So the first necessary step is to commit yourself to the treatment and to using the strategies that work for you. If you are committed to getting better and continue with the therapy it is likely that you can live panic free.

For those with moderate to severe panic symptoms, this treatment is best implemented by a cognitive - behavioral therapist trained in the approach. It is easy to become overwhelmed with the symptoms and frightened engaging in the treatment strategies. The goal of the therapist is to structure the treatment and prepare the client to deal with each step in an effective manner. The therapist provides encouragement and support to motivate the client, but never pushes the client to do something he/she is not ready for. Finally, the therapist is always ready to problem-solve when something is not going as expected. If you are ready to make the commitment, and the treatment sounds sensible to you, then there is no reason to believe you can not get better. The good news is that nearly all clients involved in this type of treatment program will benefit and feel significantly better.

William C. Sanderson, Ph.D.
Professor of Psychology
Director, Anxiety & Depression Treatment Program
Hofstra University
Hempstead NY11549
(516) 463-5633
psywcs@hofstra.edu

FOR THOSE WHO WANT TO READ MORE ABOUT PANIC & COGNITIVE THERAPY

Wilson, Reid. Don't Panic: Taking Control of Anxiety Attacks.

Craske, M. & Barlow, D.H. Mastery of Anxiety and Panic.