Don't Panic: Find the Control You Feel is Missing

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What Is Panic?

Panic Disorder is not one of the more common anxiety disorders. With a lifetime prevalence of 3.5 percent, it is preceded by Generalized Anxiety Disorder (5.1 percent), Agoraphobia without panic (5.3 percent), Specific Phobia (11.3 percent), and Social Phobia (13.3 percent). Only Obsessive Compulsive Disorder and Acute and Post-traumatic Stress Disorders are less prevalent. However, what Panic Disorder lacks in frequency, it makes up for with intensity.

Panic vs. Anxiety

Panic attacks are sudden (cresting in 10 minutes or less), relatively short periods of intense autonomic arousal accompanied by fear (a sense of impending doom) and an urge to escape. Autonomic arousal is the body's all or none response to challenges or threats. The intensity of arousal in a panic attack is comparable to how we might respond to life or death situations where it is important to either fight or flee, hence the term "fight or flight response". Fear is the emotional counterpart of intense autonomic arousal. It is a response to immediate threat or danger.

Panic often occurs against a backdrop of generalized anxiety. Generalized anxiety is a less intense and more sustained form of autonomic arousal. It is accompanied by apprehension or worry about some threat or danger in the future. This worry or apprehension often occurs in the form of "what if" thinking. Usually this "what if" thinking is directly related to concerns about having another panic attack. For example, "What if I have a panic attack while I'm driving?" or "What if get into line and start feeling panicy?"

Spontaneous Panic Attacks

Panic attacks are common in all anxiety disorders. For example, a panic attack may occur as part of one's phobic response to a feared situation such as speaking in front of a group, or part of a "flashback" to a traumatic event like an assault. However, the panic attacks must occur spontaneously and not be readily associated with a triggering situation or stimulus in order to receive a diagnosis of Panic Disorder. These spontaneous panic attacks are also referred to as "false alarms" since they occur in the absence of any apparent danger.

Predisposing Factors

A recent survey of college students found as many as 12 percent had spontaneous panic attacks at some point during their lives. The overwhelming majority of these students did not have Panic Disorder. The 49 dollar question then becomes "What is it that causes spontaneous panic attacks to be associated with Panic Disorder for some

people and not others?"

There appear to be several factors that predispose some people more than others. These predisposing factors or diatheses to having Panic Disorder are usually insufficient by themselves to bring on the condition. According to diathesis-stress model of illness, the onset of a condition like Panic Disorder is predicted by the combination of a diathesis and stress. This is consistent with what we see for people with Panic Disorder who tend to have a high rate of negative life events just before the development of their disorder.

Neuroticism
A diathesis proposed by Hans Eysenck was a personality trait called neuroticism. People high on neuroticism were believed to be cortically over-aroused, and to have especially sensitive autonomic nervous systems. This accounts for the common observation that Panic Disorder sufferers seem to be sensitive to everything, including medications. People with this predisposition are often described as "high strung", "nervous," or "overly emotional."

Anxiety Sensitivity
Two related concepts that have more recently been proposed are anxiety sensitivity and absorption. Anxiety sensitivity is defined as a fear of experiencing the physical sensations of autonomic arousal. It seems potential Panic Disorder sufferers quickly condition a fear response to relatively benign internal sensations. That is, the internal bodily cues take on fear-provoking properties by being paired with the triggering situation or stimulus in what is known as classical or Pavlovian conditioning. This may take place with as little as one pairing i.e., one-trial learning.

Symptoms of Panic Attacks (4/13)

Physical Sensations of Autonomic Arousal

1. Palpitations, pounding heart, or accelerated heart rate

2. Sweating

3. Trembling or shaking

4. Sensations of shortness of breath or smothering

5. Feeling of choking

6. Chest pain or discomfort

7. Nausea or abdominal distress

8. Feeling dizzy, unsteady, lightheaded, or faint

9. Numbness or tingling sensations

10. Chills or hot flushes

Associated Mental Symptoms

1. Fear of losing control or going crazy

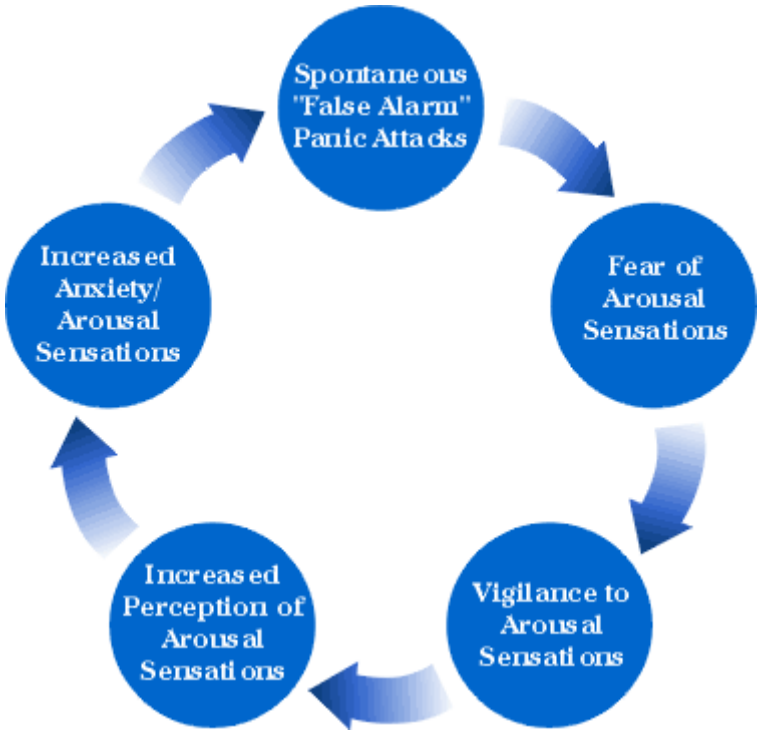
2. Fear of dying

3. Derealization (feelings of unreality) or

Depersonalization (being detached from oneself)

Thereafter, any one of these bodily cues may serve as a trigger because the Panic Disorder sufferer associates it with having a panic attack. These bodily cues retain their triggering properties regardless of what causes them. For example, the cues may arise from activities unrelated to anxiety such as physical exertion, sex, drinking caffeine, expressing strong emotions, going to hot places or seeing a thrilling movie. They would still retain their panic-triggering potential.

Figure 1: Dispositional Factors 1



Fear of arousal symptoms, in turn, lead to a shifting of attention from exterior to interior environments, resulting in a hypersensitivity or vigilance to these arousal symptoms. This heightened vigilance then increases the probability of bodily cues being perceived, leading to even greater autonomic arousal.

Absorption

Absorption is the propensity to become immersed in sensory and imaginative experiences. It accounts for something I see in clinical practice which is the ability of Panic Disorder sufferers to frighten themselves with their vivid imaginations. The positive side to absorption is that it can also facilitate pleasurable experiences such as

greater appreciation for art and music.

Distorted Thinking

Misinterpretation of Bodily Cues
Panic Disorder sufferers tend to misinterpret bodily cues because of their distorted thinking. They overestimate the probability of negative consequences, and make catastrophic predictions about how terrible (unmanageable) these consequences will be. For example, a Panic Disorder sufferer hiking to the top of Mount Finlayson may misinterpret their shortness of breath, heart palpitations and accelerated heart rate as signs of heart attack. Other common predictions are: fainting, going crazy and losing control.

Note: It isn't necessary to have panic attacks in order to acquire distorted, inaccurate beliefs about the negative consequences of arousal. It may also happen as the result of hearing someone express their fear of certain sensations, receiving misinformation, or witnessing a catastrophic event such as a heart attack.

Fear of Fear
Increased autonomic arousal and the physical sensations that accompany it are likely to increase the probability spontaneous or "false alarm" panic attacks. This vicious cycle spirals into repeated experiences of full-blown panic and a condition many people refer to as "fear of fear" - the worry or apprehension about having further panic attacks. Distorted thinking about the consequences of panic attacks and worry or apprehension about having further panics are other major requirements for a diagnosis of Panic Disorder.

Co-morbid Conditions

Panic Disorder co-exists with other kinds of problems, the most common of which are depression, drug and alcohol abuse, and other anxiety disorders. Approximately one-quarter to three-quarters of all panic disorder clients have an additional diagnosis of major depression. Although people with the combined symptoms of these two disorders report higher levels of subjective suffering and higher levels of impairment, preliminary findings from U.B.C. suggest they are no more difficult to treat in cognitive behavioural therapy.

Cognitive behavioural Therapy (CBT)

CBT for panic is a multi-component approach. Research has shown this approach to be more effective than the singular use of any one cognitive behavioural component. In other words, the sum of the parts is greater than the whole. The three main components are physical (relaxation training), mental (cognitive restructuring) and behavioural (exposure). The treatment itself is a form of talking therapy that guides the client into new ways of thinking and behaving by teaching them the necessary techniques, and having them practice extensively through homework exercises.

Step One: Psycho education
The entire CBT program can be thought of as a series of steps. The first step is to provide information as above, in addition to immediately dispelling some of the more common myths.

1. **Panic kills**. Although there are isolated accounts of people fainting, panic attacks have not been demonstrated as a cause of death or insanity.

2. **Panic is incurable**. Success rates for CBT fall in the 80 to 90 percent range, and gains have been maintained for up to two years following treatment.

3. **It's gone on too long**. There is no particular relationship between success in therapy and the time you had your panic attacks.

4. **I need more control**. You have more than enough control if you approach panic as a "let it go" problem as opposed to a "try harder" problem.

Step Two: behaviour Recording
Direct, on-the-spot observation helps identify: **conditions** under which panic attacks are likely to occur, specific **triggers** for panic, and **progress** being made. It is the first step toward managing panic attacks. Information about individual panic attacks is recorded on Panic Attack Record forms, and the level of generalized anxiety, depression, and anticipation/worry is recorded on the Daily Mood Record throughout the 12-week program.

Clients are taught to break panic into its components (physical sensations, major thoughts and major behaviours), and to monitor the development of these components within each attack. Ultimately, clients begin to understand the spiral effect of one component feeding into the other, for example when bodily sensations and cognitions feed into an escalation of fear, culminating in panic.

Example: palpitations, racing heart, chest pain or pressure - "I'll have a heart attack."

Step Three: Breathing Retraining and Relaxation
16 Muscle Group Progressive Relaxation

1. Right lower arm: tense the right hand and lower arm by making a tight fist with your right hand and pulling up on the wrist.

2. Left lower arm: tense the left hand and lower arm by making a tight fist with your left hand and pulling up on the wrist.

3. Right upper arm: tense your right upper arm by pushing your right elbow down and back against the chair/bed.

4. Left upper arm: tense your left upper arm by pushing your left elbow down and back against the chair/bed.

5. Right lower leg: tense the muscles in your right calf by extending your right leg and pulling your toes toward your head.

6. Left lower leg: tense the muscles in your left calf by extending your left leg and pulling your toes toward your head.

7. Right upper leg: tense the muscles in your right thigh by lifting your right leg slightly off the chair/bed.

8. Left upper leg: tense the muscles in your left thigh by lifting your left leg slightly off the chair/bed.

9. Abdomen: tense your stomach muscles by making your stomach hard as if expecting a punch.

10. Chest: tense the muscles around your chest by taking in a deep breath and holding.

11. Shoulders: tense the muscles in your shoulders and upper back by pulling your shoulders straight up toward your ears.

12. Neck: tense the muscles in your neck by pressing your head back against the chair/bed and pulling your chin down toward (but not touching) your chest.

13. Mouth: tense the muscles around your mouth and jaw by clenching your teeth and forcing the corners of your mouth back in a forced smile.

14. Eyes: tense the muscles around your eyes by squeezing your eye lids tightly together.

15. Lower forehead: tense the muscles across your lower forehead and upper cheeks by pulling your eyebrows down and toward the centre in a squint while wrinkling your nose.

16. Upper forehead: tense the muscles in your upper forehead by lifting your eyebrows as high as possible.

The first step of the active intervention is to learn methods for controlling some of the fear-provoking physical sensations. The major techniques that are taught for doing this are diaphragmatic breathing, and progressive relaxation. These techniques have their major effect on the early phase of a panic attack.

Step Four: Cognitive Restructuring

Clients are encouraged to challenge the beliefs that cause them anxiety by questioning the supporting evidence. This is done by teaching them to identify common forms of dysfunctional beliefs, dispute these beliefs using **dispute handles**, and replace these beliefs with healthier, more adaptive ones.

1. **Collect your thoughts**. Go through panic sequences in slow motion and try to determine what it was you were thinking that made you feel that way. Some clients argue the panics happen before they have a chance to think. While it is true that danger appraisals are made very quickly, it is more often the case that we don't remember. If you are really stuck, engage in backward reasoning: What kind of thought might have made you feel that way?

2. **Identify logical mistakes**. Question your interpretation of the events using dispute handles. Notice there are two main lines of inquiry, one directed at arriving at a more realistic probability estimation, and the other directed at decatastrophizing.

Probability Dispute Handles

(a) What are the other possible outcomes?

(b) What evidence do we have that _____ will happen?

(c) Does _____ have to equal or lead to _____?

(d) What has happened in the past? Any exceptions?

(e) What are the chances of it happening/happening again?

Coping Dispute Handles

(a) What is the evidence to suggest the consequences will be disastrous?

(b) Could there be any other explanation?

(c) Is _____ really so important that my whole future depends on it?

(d) Does _____'s opinion reflect that of everyone else?

3. **Provide a rational alternative.** You may be surprised to find the evidence supports an explanation that does not make you feel anxious.

4. **Use these alternatives proactively.** You will find the same cognitive distortions coming up repetitively in situations where you feel anxious.It therefore makes sense to incorporate some of your rational alternatives into your self-talk.

Examples: "Just because_____ does not mean_____."

"So what if_____."

Step Five: Exposure
The most powerful part of any anxiety treatment program involves testing out your catastrophic predictions about the consequences of panic symptoms. This is done through repeated, graduated exposure to the physical sensations, situations or memories, while simultaneously preventing avoidance until the fear subsides.

1. **Interoceptive exposure (sensations).** Aim for 10 (in the case of shorter exercises) to 30 (in the case of longer exercises) seconds of full sensation. It is important to accept and even enhance the experiencing of these sensations until they are no longer feared.

(a) head shaking (30-40 seconds)

(b) head lift (after head between legs for 30 seconds)

(c) step ups (1-1.5 minutes)

(d) breath holding (30-40 seconds)

(e) complete body tension (1-1.5 minutes)

(f) spinning (1-1.5 minutes)

(g) hyperventilation (1-1.5 minutes)

(h) straw breathing with nose pinched (1-1.5 minutes)

2. **In vivo exposure (situations).** List in a hierarchy, from least to most anxiety-producing real-life activities or situations that are either avoided or endured with distress. Precede live exposure with an imaginal rehearsal. Physical sensations encountered during real-life activities may be less predictable and less easily stopped than during the exercises BUT they are no more harmful.

3. **Memory exposure.** Debrief your worst panic in recent memory using a sequential analysis.

Step Six: Relapse Prevention

In the termination phase of CBT for Panic Disorder clients are encouraged to apply their skills on their own in new situations. It is also important to revisit old activities and situations to reduce residual avoidance.

- Be prepared for setbacks in the need for continued work. The skills learned in CBT are skills for life. Follow-up studies of CBT have consistently found continued improvement beyond the time limited program.
- Watch for what might be potentially harmful about resolving the problem. How do you fill the void left by the panics? How will being less dependent on others for support change your relationships with them?
- Check-in with your therapist for booster sessions if you find yourself unable to maintain the gains.

The Group Treatment Option

While cognitive behavioural therapy is certainly available on an individual basis, there are some compelling reasons to consider the group option. First, there is a sense of universality clients get in group from realizing they are not alone in suffering from their problems. Participants enjoy meeting other people with similar problems, and participating in group learning experiences.

Second, the group provides opportunities for vicarious learning from witnessing other people solve similar problems e.g., working together on disputing cognitive distortions. Third, the client's attendance in group for the first time is like a public declaration of their commitment to change. Last but not least, although group cognitive behavioural therapy is in many cases as effective as individual therapy, its cost is roughly one-third.

If you or someone you care about is suffering from excessive and uncontrollable worry, and would like more information about cognitive behavioural treatment programs, call Mary at 881-1206. A complimentary, 20-minute consultation with Dr. Cook is available on request. You may also wish to participate in the National Anxiety Disorders Screening Day at Dr. Cook's Broadmead office year round.

Recommended Reading

Barlow, D. H. (1988). Anxiety and its disorders. The nature and treatment of anxiety and panic. New York: The Guilford Press.

Barlow, D. H. and Craske, M. G. (1994). Mastery of your anxiety and panic II. New York: Graywind Publications, Inc.

Roth, W. T. (1997). Treating anxiety disorders. San Francisco: Jossey-Bass Publishers.

Zuercher-White, E. (1995). An end to panic. Breakthrough techniques for overcoming Panic Disorder. Oakland, CA: New Harbinger Publications, Inc.

Zuercher-White, E. (1997). Treating Panic Disorder and Agoraphobia. A step-by-step clinical guide. Oakland, CA: New Harbinger Publications, Inc.

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1 Schmidt, N. B., Lerew, D. R., Trakowski, J. H. (1997). Body vigilance in panic disorder: Evaluating attention to bodily perturbations. Journal of Consulting & Clinical Psychology, 65(2), 214-220.