Pray, N. (2013) Assessment of Panic in Panic Control Treatment,
a Manualised CBT Format for Treating Panic Disorder and Agoraphobia
Journal of the New Zealand College of Clinical Psychologists, 23(2), 23-26.

Assessment of Panic in Panic Control Treatment, a Manualised CBT Format for Treating Panic Disorder and Agoraphobia

Dr Nicole Pray

Panic Control Treatment (PCT), developed by Barlow and Craske (1989, 1994), is one of the most studied treatments of panic disorder (PD) and panic disorder with agoraphobia (PD/A). PCT involves a cognitive behavioural model of treatment with a 12 to 15 week format. PCT is defined as a collaborative, education-based treatment that involves skills training and has significant research support. The treatment involves a combination of exposure, desensitization, and cognitive modification. PCT has the following 5 components:

- cognitive restructuring
- breathing retraining
- applied relaxation
- interoceptive exposure
- in vivo exposure.

PCT is classified as a "well-established" intervention for panic disorder by the Task Force on Promotion and Dissemination of Psychological Procedures of the American Psychological Association, Division of Clinical Psychology (APA, 1993). Several studies have demonstrated the efficacy of PCT, with estimates from 80 to 87% being free from panic at the end of treatment (Barlow et al., 1989; Klosko, Barlow, Tassinari, & Cerny, 1990, 1995) and remaining free of panic at 2-year follow up (Craske, Brown, & Barlow, 1991). A meta-analysis of 43 studies showed PCT had a greater mean treatment effect size and lower attrition rate than pharmacological treatments (Gould, Otto, & Pollack, 1995).

Application of PCT begins with a detailed assessment of the individual's panic and avoidance symptoms, including differential diagnosis and rule-outs for several medical conditions that are associated with panic. Assessing the topography of an individual's panic disorder requires a full appreciation of the physiological, cognitive, and behavioural components. A full account of the client's physiological sensations should be recorded, including but not limited to: heart palpitations, sweating, clamminess or heat/cold fluctuations, feelings of unreality, parasthesias (tingling in extremities), nausea or abdominal pain, or hyperventilation. Symptoms of panic develop abruptly and tend to reach a peak within 5 to 10 minutes, before retreating. Some clients are unaware of the specific timing of their panic attacks and will imagine their anxiety as ongoing, perhaps unending. These clients are gradually educated and encouraged to monitor their panic as different from their anxiety, and they become more familiar with the panic as discrete events that occur and sometimes are superimposed upon background anxiety that may be more prevalent and ongoing.

The antecedents of panic should be explored, including situational triggers (such as driving on the motorway, being alone at night, grocery stores, airplane travel, etc.) and internal triggers (hunger, stomach cramps, congested sinuses due to an infection or allergies, unsteadiness during an inner ear infection, heavy breathing during exercise, etc.). Addressing the client's misappraisal of his or her symptoms as being due to something dangerous will become the target of treatment during the educational phase of treatment, which will follow from a thorough assessment.

Dr Nicole Pray is a Consultant Clinical Psychologist for a DHB specialty regional service. She is also in private practice in the Wellington CBD: www.capitalmentalhealth.co.nz

The cognitive appraisal of bodily symptoms, which forms the core of panic, needs to be fully documented, such as, "This is it…the big one", or "I'm dying/going crazy/losing control". Clients may indicate specific medical conditions they believe they have acquired which are signaled by the various bodily pains or sensations. An interesting observation of this practitioner, not necessarily supported in the literature, is the awareness of several clients presenting with panic disorder who will have experienced the loss of one or more key family members or friends within the preceding years, often due to a medical condition or illness (such as stroke, aneurism, heart attack, or tumor). Whether or not this occurs, there does seem to have been an anecdotal pattern amongst the cases treated by this practitioner over the past 15 years.

Behavioural reactions to panic symptoms are then documented, including obvious escape methods (leaving the situation, pulling the car off the motorway, returning home from work), help-seeking (calling a significant other), or protection (turning on the air conditioning in the car, using benzodiazepines or other relaxants). Subtle avoidance behaviours should also be watched for, including such reactions as carrying one's mobile phone at all times, carrying an old medication around in one's bag, choosing seats around the perimeter of a theatre, traveling only at non-peak hours, and so on. Clients may take longer to disclose more subtle avoidance behaviours, and these can be addressed as they are revealed later in the treatment process.

The frequency (3 times/week, twice daily), intensity (0-8 maximum), and duration (a few seconds, 5 minutes) of panic attacks are documented. The client's average apprehension or worry about having panic (thoughts for 75% of the day), are also documented. Standardized inventories, such as the Mobility Inventory (Chambless, Caputo, Jasin, Gracely, & Williams, 1985) and the Body Sensations Questionnaire (Clarke et al., 1997) can be used to further assess the nature of panic, avoidance, and agoraphobic symptoms. These inventories can give a better picture of the functional pattern of panic for the client, including behavioural reactions to anticipating panic attacks (avoiding side roads, limiting social activity, trying not to think about or write down anything about anxiety, carrying "safety signals" such as medications). The consequences of panic are also assessed, including family (husband's concern, mother "thinks it's all in my head"), work (still go to work but cut back hours, or haven't worked in years), and general mood (some difficulty concentrating, sleep problems, restlessness and sadness, hopelessness, thoughts of suicide) concerns.

The panic record, introduced in the first treatment session, will serve to document all future panic episodes throughout treatment. The Daily Mood Record will record ongoing anticipation and worry about having panic, as well as daily ratings of anxiety and depression.

A similarly important component of the assessment of panic disorder is the rule-out for various medical conditions and/or contributing medical factors. Clients have often presented to ED various times and have been assessed and cleared for cardiac conditions. Some clients will have had many doctor visits for assumed conditions and have received scans or tests to rule out potential diseases or life-threatening conditions. Regardless, a client's medical history is an important component of the assessment phase and must be considered before treatment is started. Many clients have presented with complicating medical conditions, such as mitral valve prolapse, asthma, allergies, and/or lupus, and the associated sensations serve to trigger cycles of panic attacks and avoidance behaviours. It is important to first obtain clearance with the GP or treating medical practitioner in these situations, and a close teamwork approach can reassure clients about the safety of undertaking treatment. Education about the true versus assumed dangers in

treatment are essential and stem from a thorough assessment.

Contributing medical factors, such as thyroid conditions (hyperthyroidism), amphetamine abuse, drug withdrawal, or adrenal gland problems, should be explored and ruled out. Treating an underlying medical condition has often resolved the "panic disorder" symptoms in clients referred for treatment of panic. Familial history and history of symptoms can alert to whether these might be playing a role. The use of caffeine or diet pills should be queried as these can often trigger or exacerbate panic cycles.

Following a thorough assessment, PCT follows a rather straightforward, step-by-step approach to addressing and eliminating the client's panic disorder and agoraphobic symptoms. As stated above, the involvement of a treating medical professional, particularly in cases where a contributing medical condition is present, can reassure wary clients about the true versus perceived dangers associated with effective treatment. Building a trusting network of supportive others and treatment professionals depends on a thorough understanding of the client's context and how others are responding to their panic.

References

American Psychological Association. (1993). Task Force on Promotion and Dissemination of Psychological Procedures: a report to the Division 12 Board of the American Psychological Association. Available from the Division 12 of the American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

Barlow, D. H., Craske, M. G., Cerny, J. A. & Klosko, J. S. (1989). Behavioral treatment of panic disorder. *Behavior Therapy, 20,* 261–282.

Barlow, D. H., & Craske, M. G. (1994). Mastery of Your Anxiety and Panic II (MAP II). Albany, NY: Graywind.

Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracely, E., & Williams, C. (1985). The Mobility Inventory for agoraphobia. *Behaviour Research and Therapy, 23,* 35–44.

Clark, D. M., Salkovskis, P. M., Öst, L. G., Breitholtz, E., Koehler, K. A., Westlin, B. E., …& Gelder, M. (1997). Misinterpretation of body sensations in panic disorder. *Journal of Consulting and Clinical Psychology 65*, 203-213.

Craske, M. G., Brown, T. A., & Barlow, D. H. (1991). Behavioral treatment of panic disorder: A two-year follow-up. *Behavior Therapy*, *22,* 289–304.

Gould, R. A., Otto, M. W., & Pollack, M. H. (1995). A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review*, *15,* 810–844.

Klosko, J. S., Barlow, D. H., Tassinari, R., & Cerny, J. A. (1990). A comparison of alprazolam and cognitive-behavior therapy in treatment of panic disorder. *Journal of Consulting and Clinical Psychology, 58,* 77–84.

Klosko, J. S., Barlow, D. H., Tassinari, R., & Cerny, J. A. (1995). A comparison of alprazolam and cognitive-behavior therapy in treatment of panic disorder: correction. *Journal of Consulting and Clinical Psychology*, *63*, 830.

Telch, M. J., Lucas, J. A., Schmidt, N. B., Hanna, H. H., Jaimez, T. L., & Lucas, R. A. (1993). Group cognitive-behavioral treatment of panic disorder. *Behaviour Research and Therapy*, *31*, 279–287.