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ANXIETY BRIEFS

In This Issue:

Panic Disorder

- Jennifer's Story
- Definition
- Agoraphobia
- Avoidance
- Rates of Panic
- Costs of Panic
- CBT
- Treatment
- Conclusions

Robert Safion, M.Ed.
37 1/2 Forrester St.
Newburyport, MA
978 462-1519

rsafion@verizon.net
www.robertsafion.com

Cognitive and Behavioral Treatment of Anxiety

OBSESSIVE-COMPULSIVE DISORDER
•
PANIC DISORDER
•
GENERALIZED ANXIETY DISORDER
•
SOCIAL ANXIETY DISORDER
•
HEALTH ANXIETY
•
PHOBIAS

Jennifer's Story

Jennifer is a 28 year-old married mother of two. She is sitting in her first therapy session, nervous and tearful. She reports that she has had panic attacks, on and off, since the age of 18. Over the past year, however, her panic has increased in severity: she now experiences panic on a daily basis and is terrified of being alone. She is able to go to work nearby; but after work, she cannot go anywhere without her husband or a close friend. Many panickers fear death, heart attack or stroke; but others fear "going crazy". Jennifer is terrified that during panic she will lose control of her mind. Jennifer, in other areas of her life, can be quite the rational person. But her panic has her trapped in a prison of fear, walled in by her belief that insanity could occur at anytime if she ventures out beyond the boundaries of the extensive safety behaviors she has constructed. A week ago, however, she decided that she did not want to go on like this and has taken the courageous first step to face her fears and push back the bully of panic.

Definition

The DSM-IV (America Psychiatric Association) defines Panic disorder as a psychological condition characterized by recurring panic attacks or sudden flooding of intense fear. The "fight or flight" reaction that is triggered is a primitive survival mechanism that is part of our neurobiology.

Panic attacks are defined by a combination of physical symptoms and catastrophic beliefs that may include palpitations, shortness of breath, dizziness, trembling and/or a feeling that things around you are not real, fear of dying, going crazy or losing control.

Panic researcher, David Barlow's model proposes that some of us have a biological and psychological predisposition to develop recurring fight or flight responses even in the absence of real threat.

Barlow emphasizes that this over-estimation of threat activates a "false alarm" fight or flight mechanism. The mind and body are thus tricked into reacting as if there were an immediate threat to the survival of the individual. The exact cause of panic is not yet known. Studies of panic have shown, however, that panic can run in families and is thus thought to have an important genetic and biological component.

Stress is often associated with onset of panic: up to 70% of individuals describe clear stressors when panic began. This combination of biological predisposition and stressful life moments can create the perfect storm for panic onset.

Agoraphobia

Agoraphobia is characterized by avoidance or endurance with dread of situations from which escape might be difficult or where help might not be available in the event of a panic attack. Sufferers often require a companion or rely on Safety behaviors to face these situations. Agoraphobia usually follows the onset of panic symptoms, as the person starts to associate panic attacks with situations and/or activities. Studies show that 95 % of agoraphobics have a history of panic disorder. Common agoraphobic triggers can include large stores, malls, highways, bridges, cars buses, planes, trains or even being at home alone. It is important to note, that in agoraphobia the focus of concern is the symptoms associated with the situation, not the situation itself. This fear of Panic has been termed "fear of fear"

Avoidance

Avoidance is a centerpiece of anxiety in general and panic disorder in particular. Research, in recent years, has identified the role of three types of avoidance tactics associated with the onset and maintenance of panic disorder: *Situational*, *Interoceptive* (involving perception of body sensations) and *Experiential avoidance*.

In *situational avoidance*, the person refuses to go to certain places. Situational avoidance is one of the hallmark of panic and agoraphobia and can result in significant impairment.

Interoceptive avoidance involves not engaging in activities (running, walking up stairs, etc.) or using substances (caffeine) that cause sensations that resemble symptoms of panic.

Experiential avoidance entails minimizing or blunting exposure to phobic stimuli through the use of tactics called *safety behaviors*. These involve numerous distraction activities (cell phones, proximity to exits) thought distraction techniques (singing a song, humming, imagining not being in the phobic situation) or having to be with someone else such as a friend or family member. Safety behaviors can also include dedicating significant attentional resources to assuming and scanning for perceived threat information.

Rates of panic disorder

Panic disorder in not rare. The estimated 12-month prevalence rate for Panic disorder is 2.3% while the lifetime rate is 3.5%. Roughly 5% of the population experiences an occasional panic attack. As with most anxiety disorders, women are affected twice as often as are men. Average ages of onset are between 15 and 19 or 25 and 30 years.

Costs of Panic

The physical, social and economic costs of anxiety and panic disorder are significant. Panic disorder is the leading cause for seeking psychiatric services. Panickers use primary care services at three times the rate of other patient groups . In one recent study, it was reported that more than half of patients with panic disorder changed their everyday activities because of fear of a panic attack. Panic patients were also ten times more likely to be unable to work than patients with no current diagnosis. It is unfortunate, and quite dramatic, that in spite of toll it takes, only 27% of those with panic disorder ever receive treatment. Untreated, 67% will have a recurrence within the first year

Cognitive and Behavior Therapy

Fortunately, for sufferers of panic disorder, today there are clinically proven and very effective treatment methods available. The most effective of the psychotherapy approaches, *Cognitive and Behavioral Therapy* (CBT), has been shown to significantly reduce or eliminate symptoms of panic disorder. CBT seeks to effect change by challenging and modifying thoughts (cognition) and behaviors.

The pillar of the *cognitive component* of treatment is *cognitive reframing*, a powerful treatment tool that involves learning to dispute, or question, fearful thoughts, interpretations and beliefs in order to find another perspective based on facts and evidence rather then emotion. In treatment, one learns to reframe (change) three common types of thinking errors that occur in panic disorder: *Catastrophic thinking*, *jumping to conclusions* and *emotional reasoning*. In all the thinking errors, but particularly in emotional reasoning, the experience of fear, not facts, becomes the justification for avoidance. Through treatment, the individual develops an awareness of how she or he gets stuck in repetitive loops of fear-based reasoning, where avoidance reinforces the belief that “because I am afraid there must be something dangerous” and “there must be something dangerous, because I am avoiding”.

The Behavioral Component of CBT consists of exposure exercises and behavior experiments. Exposure involves facing both feared situations and activities as well as body sensations with the goal of becoming desensitized. A cognitive component is also introduced in exposures, where the person learns not only desensitize, but to test specific beliefs as well. Facing previously avoided situations and sensations, allows one to disprove old beliefs in favor of new non-catastrophic beliefs. Exposure exercises thus lead to corrective experiences and cognitive shifts (changes in thinking) which result in new patterns of behavior and thinking. These changes in thought and behavior are the key components leading to remission of panic symptoms and often to long-term recovery.

Treatment

Jennifer is ready to take her first steps toward a new life: she understands how she has stayed trapped in a cycle of avoidance and panic; she has learned how to treat thoughts as a guesses rather than facts to be automatically believed; she has learned to talk back to her catastrophic thinking; she been able to identify the imaginary narrative or story that is built on these fearful beliefs; and she has constructed an alternative story not based on catastrophic assumption and imaginary doubt but based in the world of the senses and evidence.

Jennifer has chosen a driving exposure from her list of feared situations and will do this with the support of a friend. She has agreed to drive beyond her zone of safety, far enough away from home to bring on a panic attack. As she drives farther away, and notices the distance she has traveled, she starts to feel the rumble of fear climbing up from her stomach. Her heartbeat increases, her breathing becomes more shallow and beads of sweat start to form on her forehead. The rush of fear begins: her heart is pounding; things around do not feel real; and she is flooded with thoughts of losing her mind. Tears run down her face. She does not believe she can continue. She thinks of turning back; but her friend notices that she is in panic. She reminds Jennifer to look at the cue card of strategies she has prepared. She pulls over; reads the card; breathes slowly; anchors her thinking to the evidence that she is safe; allows the fear to just be there and sits with it. Jennifer gently re-directs her mind to the moment and then starts to drive again with soft prompting from her friend.

Over a period of weeks, Jennifer repeated this exposure, eventually without her friend. She then chose progressively more challenging exposures from her list of feared situations. Jennifer continued to desensitize to these increasingly challenging situations over the next two months. As this happened, her beliefs shifted away from catastrophic expectations to a perception that she was, in fact, safe. New beliefs then became woven into a new “story”, a non-panic story that became lived-in. As natural behavior replaced avoidance, Jennifer began to recover lost areas of her life. Story and behavior merged at this point, moving Jennifer along the path of recovery. As panic retreated, the richness of life returned to Jennifer's world. New interests and life directions started to come into focus. Finally, coaching in problem-solving further helped Jennifer think in new and strategic ways about her valued life direction.

Conclusion

Jennifer's story is common in several ways: 1) She used *avoidance* as a natural first-line coping strategy. 2) But panic worsened and *compromised the quality of her life* to the point that 3) she became *motivated* to seek help and *was ready to change*. 4) *Commitment to change*, hard work together with the *tools of Cognitive and Behavioral Therapy* all led to a *successful treatment experience*.

Panic bullies, intimidates and ultimately deceives. Treatment, on the other hand, pulls back the curtain and reveals panic to be merely an imaginary opponent. Jennifer’s story captures the ability we all have to be authors of a new reality.