Panic Disorder and Agoraphobia

GENERAL DESCRIPTION AND DIAGNOSTIC ISSUES

Panic disorder with (PDA) or without (PD) agoraphobia can be an extremely debilitating disorder that is associated with psychological, social, and occupational impairment and diminished quality of life. In essence, panic disorder can be thought of as a learned fear of certain bodily sensations, whereas agoraphobia is the behavioral reaction in anticipation of experiencing such bodily sensations or a full-blown panic attack.

Panic disorder is characterized by recurrent, unexpected panic attacks. According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR; American Psychiatric Association, 2000), a panic attack is a discrete period of intense fear or discomfort in which four or more of the following symptoms develop abruptly and reach a peak within 10 minutes: palpitations; pounding heart or accelerated heart rate; sweating, trembling, or shaking; sensations of shortness of breath or smothering; feelings of choking; chest pain or discomfort; nausea or abdominal distress; feelings of being dizzy, unsteady, lightheaded, or faint; derealization or depersonalization; fear of losing control or going crazy; fear of dying; paresthesias; and chills or hot flushes. In addition, at least one of the attacks is followed by 1 month or more of the following:
persistent concern about having additional attacks; worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”); or a significant change in behavior related to the attacks.

In an effort to prevent future panic attacks, people engage in safety behaviors, which often entails avoiding places they fear will trigger the panic attacks. Thus, many individuals with panic disorder also experience agoraphobia. DSM-IV-TR defines agoraphobia as significant anxiety about being in places or situations from which escape might be difficult or embarrassing or in which help may not be available in the event of having a panic attack or panic-like symptoms. Agoraphobic fears typically center on specific situations such as being outside the home alone, being in a crowd or standing in a line, being on a bridge, or traveling in a bus, train, or automobile. Such situations are avoided, are endured with marked distress about having a panic attack or panic-like symptoms, and often require the presence of a companion. Individuals’ avoidance of these situations may impair their ability to travel or work or to carry out various responsibilities (e.g., grocery shopping, taking children to the doctor). For both panic disorder and agoraphobia, the anxiety or phobic avoidance is not better accounted for by another mental disorder, the direct physiological effects of a substance (e.g., drugs), or a general medical condition.

Whereas panic disorder and agoraphobia frequently co-occur, they can exist in isolation. The fundamental characteristics of agoraphobia without accompanying panic disorder are similar to those of PDA, except that fear is centered on the occurrence of incapacitating or extremely embarrassing panic-like symptoms or limited-symptom attacks rather than full-blown panic attacks. The “panic-like symptoms” include any of the 13 symptoms listed above for panic attack or other symptoms that may be incapacitating or embarrassing (e.g., loss of bladder control).

In over 70% of cases, a specific stressor can be identified as the precursor to the development of PD/PDA. Most often stressors are interpersonal (e.g., argument with spouse) or related to physical well-being (e.g., death in family, adverse experience with drugs). Initial panic attacks also often occur outside the home in situations in which loss of control (e.g., driving), adverse appraisal (e.g., job interview), perceived unsafe location (e.g., unknown places), or entrapment (e.g., elevators) is particularly menacing. The panic symptoms are interpreted as dangerous and the patient develops a fear that they will return. In an effort to decrease the likelihood of the feared calamity, patients become hypervigilant, continually scanning their body, or engage in certain safety behaviors that includes avoidance.

Lifetime prevalence for PD/PDA is 3.5% to 5.3% (Kessler et al., 1994). Women are at a two-fold increased risk for developing PD/PDA compared
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to men (Katerndahl & Realini, 1993). The median age of onset is 24 years, although it can occur at any age. Symptoms are typically chronic, with an overall remission rate of 39% and recurrence rate of 82% in women and 51% in men (Yonkers et al., 1998).

Differential Diagnostic Issues

Panic symptoms and avoidance are not limited to PD/PDA, as these characteristics occur within several different anxiety and mood disorders. However, outside of PD/PDA, panic attacks are often situationally bound. In particular, specific phobia is characterized by fear and avoidance of a particular stimulus. Fears in social phobia are centered on a negative evaluation from others unrelated to panic, leading to avoidance of certain social situations. Posttraumatic stress disorder is distinguished by fears related to a specific, life-threatening event, and avoidance is a result of attempting to decrease one’s sense of impending danger. Thoughts of fear and resulting avoidance behavior to prevent the fear obsession differentiates obsessive-compulsive disorder. In generalized anxiety disorder, panic attacks are absent and anxiety is characterized by widespread worry. Depression can entail avoidance of situations, but this is related more to a decreased interest and depressed mood rather than fear of panic behavior or the loss of control.

Other psychiatric disorders must also be differentiated from PD/PDA. In schizophrenia, delusions and hallucinations may produce irrational and excessive fear of objects or situations, but these fears are not related to panic attacks. Similar to PD/PDA, paranoid individuals may isolate themselves and withdraw socially. However, unlike PD/PDA, this is caused by a perceived malevolent intent of another person.

Certain health conditions can present with panic-like symptoms and need to be ruled out before a diagnosis of PD/PDA becomes appropriate. Such medical ailments include endocrine disorders (e.g., hyperthyroidism, hypoglycemia, menopause), cardiovascular disorders (e.g., mitrovalve prolapse, cardiac arrhythmias), respiratory disorders (e.g., asthma, chronic bronchitis), neurological disorders (e.g., vestibular dysfunction, multiple sclerosis), and substance-related anxiety due to intoxication (e.g., cocaine, caffeine) or withdrawal (e.g., opiates, alcohol).

Co-Morbidity Issues

PD/PDA commonly occur in conjunction with other psychiatric symptomatology. Approximately 59% of patients have a comorbid mood or anxiety
diagnosis, including major depressive disorder (23%), generalized anxiety disorder (16%), and social or specific phobia (15%). Non-panic disorders typically precede PD/PDA, although the reverse may also be true. For example, depression may be related to a sense of helplessness that patients feel regarding their inability to control the panic attacks. In addition, 25%–60% of people with PD/PDA also meet criteria for a personality disorder, most commonly avoidant and dependent.

**ASSESSMENT OF DISORDER**

A detailed evaluation is important when working with persons with PD/PDA. Below are specific psychological assessments for this disorder (see Antony, Orsillo, and Roemer, 2001, for a review of such assessment tools).

**Clinician Ratings**

- *Panic and Agoraphobia Scale* (Bandelow, 1999): assesses severity of panic disorder with and without agoraphobia; can be administered by clinician or as self-report.
- *Panic Disorder Severity Scale* (Shear et al., 1992): assesses severity of panic disorders including frequency, distress during the attack, and associated avoidance.

**Self-Report Measures**

- *Anxiety Sensitivity Index-Revised 36* (Taylor & Cox, 1998a): assesses fear of anxiety-related symptoms with numerous subscales (e.g., fear
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of respiratory symptoms, publicly observable anxiety, cognitive discontrol).

- Daily Mood Record (Craske, Barlow, & Meadow, 2000): assesses emotional reaction to concerns about having a panic attack.
- Panic Attack Questionnaire-Revised (Cox, Norton, & Swinson, 1992): assesses numerous factors related to panic attacks (e.g., symptoms, cognitions, triggers, and coping).

GENERAL THERAPY GOALS

Ultimate Outcome Goals

Given the potentially severe impairment that can result from PD/PDA, ultimate outcome goals are focused on enhancing the patient’s quality of life and decreasing his or her social, occupational, and functional impairment. Treatment is geared toward decreasing panic attacks and agoraphobia. Furthermore, amelioration of interpersonal relationship difficulties and associated substance abuse (e.g., prescription or nonprescription drugs) may be important ultimate goals. Finally, therapeutic strategies involve enhancing adaptive and effective coping skills.

Major Instrumental Outcome Goals/Treatment Targets

Major instrumental outcome goals for PD/PDA include:

- Decrease catastrophic interpretations of arousal
- Decrease physiological arousal
- Decrease safety behaviors

Goal 1: Decrease Catastrophic Interpretations of Arousal

PD/PDA is often characterized as “fear of fear” where patients fear the recurrence of a panic attack. Such fear develops as a result of catastrophic interpretations of physiological arousal (Beck & Emery, 1985; Clark, 1986). Specifically, internal (e.g., bodily sensations) or external (e.g., place from
which escape is difficult) triggers stimulate the perception of threat. This perceived danger leads to apprehension, which stimulates somatic sensations (e.g., increased heart rate). The physiological arousal is interpreted as catastrophic, leading to greater anticipation of danger, and the sequence continues. Thus, a vicious, self-perpetuating cycle maintains the fear (Clark, 1986).

Ambiguous somatic symptoms are often interpreted as forecasting impending doom (Clark, Salkovskis, Öst, & Breitholtz, 1997). Catastrophic interpretations can take many forms. For example, heart palpitations may be interpreted as having a heart attack, dizziness as impending fainting, a lump in one’s throat as choking to death, or mental blocking as going crazy (Hoffart, 1993). Beck (1988) proposed that catastrophic interpretations fall into three categories: biological (e.g., death, heart attack), mental (e.g., insanity), and behavioral (e.g., loss of control).

Patients are often unaware of the interoceptive conditioning (i.e., fear associated with internal physiological arousal such as elevated heart rate) or the misappraisal of bodily feelings, causing a perception that panic attacks occur unexpectedly and without warning. Thus, there is a lack of perceived control over the panic, which leads to further increased arousal. It has been demonstrated that change in catastrophic beliefs results in decreased panic (Hoffart, 1998).

**Goal-Specific Assessment Tools**

- Agoraphobic Cognitions Questionnaire (Chambless, Caputo, Bright, & Gallagher, 1984): assesses fearful cognitions related to panic attacks and agoraphobia.
- Anxiety Sensitivity Profile (Taylor & Cox, 1998b): assesses cognitive features of anxiety sensitivity (e.g., physical sensations).
- Body Sensations Interpretation Questionnaire (Clark, Salkovskis, Öst, & Breitholtz, 1997): assesses misinterpretations about anxiety-related somatic sensations, other body symptoms (e.g., health), social events, and other external events (e.g., general worries).
- Dysfunctional Thought Record (Beck, 1995): identifies situations that trigger automatic thoughts, actual automatic thoughts, emotions, adaptive counter thoughts, and emotional and cognitive consequences.
- Agoraphobic Self-Statements Questionnaire (van Hout, Emmelkamp, Koopmans, Boegels, & Bouman, 2001): assesses frequency of positive and negative self-statements about agoraphobia avoidance.
Goal-Specific Potential Interventions

- Cognitive restructuring
- Interoceptive exposure
- Focused cognitive therapy

Cognitive Restructuring. Intervention strategies to help decrease unfounded catastrophic thinking are based on cognitive restructuring principles. Conceptually, cognitive restructuring can be thought of as an umbrella term that encompasses several specific therapy strategies: rational-emotive therapy (e.g., Ellis, 1994), cognitive therapy (Beck et al., 1985), and self-instructional training (Meichenbaum, 1977). Whereas differences among these three approaches exist, all involve helping patients to better identify and then alter maladaptive thoughts. When treating cognitive dysfunctions in persons with PD/PDA, individuals are asked to identify those situations that serve as triggers of panic (e.g., getting on an elevator) and then to identify various fear-related negative automatic thoughts (e.g., “I cannot escape if I have a panic attack. I will die in the elevator”). They are then asked to ascertain the consequences of such thoughts (e.g., increased heart rate, heightened feelings of anxiety). Once patients learn to identify distorted thinking, they are instructed to develop alternate, more rational thoughts and beliefs. For example, alternative hypotheses are developed that entail somatic symptoms being a cause of anxiety rather than a catastrophic event.

Interoceptive Exposure. Because “actions speak louder than words,” interoceptive exposure can facilitate a decrease in catastrophic interpretation of physical sensations. This therapeutic technique, in which patients are exposed to somatic cues, breaches the association between physical sensations and fear by demonstrating that such somatic sensations neither arise because of impending danger, nor result in the predicted catastrophic consequences.

In interoceptive exposure, patients experience panic-like sensations. Panic symptoms are induced that specifically mimic the patient’s panic attack. Because patients often report symptoms of hyperventilation, panic may be induced by having the patient breath rapidly into a paper bag or through a straw. However, other techniques may better mirror panic symptoms, such as spinning in a chair (dizziness), physical exercise (shortness of breath), or reading or listening to distressing feared cognitions.

During the experience of panic symptoms, patients are asked questions to allow them to discover that symptoms are not, in fact, a sign of impending
catastrophe. Questions may include: “How do you feel after this experience?” “What thoughts and images come to mind?” and “What conclusions can you make regarding the similarities between how you feel now and when you have a panic attack?” This allows patients to alter their catastrophic interpretations of the somatic sensations.

**Focused Cognitive Therapy.** Focused cognitive therapy is a manualized therapy (Beck, 1992) that specifically targets the catastrophic misinterpretations of bodily sensations. FCT uses a variety of techniques including psychoeducation, panic inductions, behavioral experiments, identifying and refuting misinterpretations, decreasing avoidant behaviors, and teaching adaptive coping skills (e.g., relaxation and controlled breathing). This specific intervention approach has been found to be effective in decreasing catastrophic misinterpretations and panic symptoms (Brown, Beck, Newman, & Beck, 1997).

**Goal 2: Decrease Physiological Arousal**

Patients with PD/PDA demonstrate enhanced awareness and fear of their physiological arousal, resulting in an increase in the arousal. Thus, a propagating cycle is formed. For example, as heart rate is perceived to increase, attention becomes more focused on this bodily sensation. Patients then become more anxious that something is wrong, causing an increase in heart rate. In addition, individuals with PD/PDA are often hypervigilant, continually scanning their bodies for signs of somatic problems. This heightened attention to somatic sensations serves to increase their presence and the worry that accompanies them. In an effort to stop this propelling cycle, intervention is aimed at decreasing a patient's heightened focus on and experience of physiological arousal.

Physiological arousal often involves hyperventilation. Hyperventilation results in lowered carbon dioxide levels in the blood, which can lead to feelings of dizziness. Hyperventilation has been implicated as an instigator of panic attacks.

**Goal-Specific Assessment Tools**

- **Body Sensation Questionnaire** (Chambless, Caputo, Bright, & Gallagher, 1984): assesses fear associated with somatic arousal sensations.
- **Body Vigilance Scale** (Schmidt, Lerew, & Trakowski, 1997): assesses level of attention on somatic sensations.
• *Panic Attack Record* (Craske, Barlow, & Meadows, 2000): assesses the severity of different somatic sensations related to panic attacks.

**Goal-Specific Potential Interventions**

- Distraction
- Relaxation training
- Respiratory control

**Distraction.** Distraction is beneficial in that it can be used both for immediate decrease in anxiety and to demonstrate patients' control over their angst. Patients are directed to use distraction when feelings of psychological and physical arousal occur. Examples include listening to or singing a song or having a conversation about a benign topic. Because attention is aimed elsewhere, distraction prevents the “downward spiral” of catastrophic thoughts, somatic sensations, and physiological arousal. Further, it provides evidence to patients that they *can* control their feared bodily sensations. It is important, however, to teach patients that distraction is not appropriate during other cognitive-behavioral techniques, such as exposure or cognitive restructuring.

**Relaxation Training.** Relaxation training is geared to help decrease physiological arousal in previously anxiety-provoking situations. To conduct this tactic, the patient is first taught to identify the signs and sources of physiological arousal. Then, progressive muscle relaxation is taught. Initially, patients learn to “tense–release” various muscles groups throughout the body; then “release only” these same muscle groups; and finally cued-control relaxation. Patients then practice applying the relaxation in stressful, nonphobic environments, and ultimately, in fear-related situations.

It is important to note that some patients with PD/PDA experience “relaxation-induced panic attacks” where relaxation paradoxically increases panic attacks. The reason for this is unknown. Thus, when providing relaxation training, the therapist should be attentive for the potential of this paradoxical occurrence.

Relaxation training is effective at reducing panic symptoms in both the short and long term (Ost, Westling, & Hellstroem, 1993). Moreover, relaxation also facilitates the retrieval of positive cognitions (Peverel & Johnston, 1986) which can aid other CBT interventions (e.g., cognitive restructuring).

**Respiratory Control.** The goal of breathing retraining, or respiratory control, is to inhibit the hyperventilation that can occur when patients
feel anxious and that can lead to panic. This technique may start with interoceptive exposure via a rapid succession of short breaths to demonstrate that hyperventilation can cause panic symptoms. A discussion ensues about the erroneous catastrophic interpretations of somatic sensations. The patient then learns that controlled respiration involves slow (8–12 breaths per minute) diaphragmatic breathing. It is highlighted that such respiratory control cannot occur at the same time as hyperventilation. Diaphragmatic breathing is encouraged as a coping tool when the patient starts to feel anxious about a panic attack in an effort to decrease physiological arousal.

**Goal 3: Decrease Safety Behaviors**

Patients with PD/PDA often engage in safety behaviors or behaviors aimed at decreasing their anxiety. Avoidance is one type of safety behavior that is manifested as either evading internal (i.e., interoceptive) or external (e.g., agoraphobic-related situations) cues. Avoidance may be directed at particular places, as well as specific activities. For example, regarding interoceptive avoidance, behaviors that increase somatic sensations (e.g., exercise, eating heavy meals, sexual relations) may be avoided.

Regarding agoraphobia, onset of this type of avoidance is usually within a year of the initiation of repeated panic attacks. Patients with PD develop agoraphobia due to their conviction that certain situations where panic would be particularly harmful or embarrassing must be avoided. If the panic attacks are resolved, the agoraphobia often resolves as well. However, in some cases, the agoraphobia becomes chronic whether or not the person continues to experience panic attacks due to the negative reinforcement associated with the avoidance behavior.

Safety behaviors can also be seen in other forms. For example, patients often believe they are better able to confront a feared situation when accompanied by a companion. This “safe person,” often a significant other, is perceived to be able to help the patient prevent the feared catastrophic events if panic symptoms develop. Additional examples of safety behaviors include clutching an object for fear of fainting, holding one’s breath while walking through a crowd, carrying medication “just in case,” or “white knuckling” the steering wheel while driving. These behaviors are negatively reinforced because panic usually does not occur while they are being performed. Further, magical thinking (e.g., “If I avoid public places, then I will not have a panic attack”) helps to perpetuate and maintain such safety behaviors.

Treatment of these safety behaviors is important. For example, safety behaviors perpetuate catastrophic beliefs (Salkovskis, Clark, & Gelder,
Furthermore, it has been demonstrated that global improvement following treatment is associated more with decreased avoidance than a reduction in panic (Basoglu et al., 1994).

**Goal-Specific Assessment Tools**

- **Behavioral Avoidance Test** (Craske, Barlow, & Meadows, 2000): assesses amount of avoidance and level of distress associated with confrontation of the previously avoided situations.
- **Phobic Avoidance Rating Scale** (Hoffart, Friis, & Martinsen, 1989): clinician rating that assesses severity of patient’s agoraphobic avoidance.
- **Mobility Inventory for Agoraphobia** (Chambless, Caputo, Jasin, Gracely, & Williams, 1985): assesses severity of agoraphobia and panic attacks and location of perceived safety.
- **Texas Safety Maneuver Scale** (Kamphuis & Telch, 1998): assesses safety behaviors performed by individuals with panic disorder.

**Goal-Specific Potential Interventions**

- Exposure
- Safety signal perspective
- Guided mastery therapy
- Behavioral experiments
- Self-instructional training

*Exposure.* Exposure therapy is important in the treatment of agoraphobic avoidance (Fava et al., 2001; van den, Arntz, & Hoekstra, 1994). The rationale for exposure of avoided situations lies in two-factor theory which posits that panic is paired with avoided situations via classical conditioning and then negatively reinforced via avoidance. Thus, patients do not learn to disconnect panic from these situations. Exposure for agoraphobia is usually conducted *in vivo* with systematically applied graded exposure. Patients develop a fear hierarchy that guides the exposure to progressively higher anxiety-provoking situations. Patients must remain in the fear setting until their SUDS level decreases at least 50%.

When conducting exposure, it is important for the patient to also stop performing safety behaviors. Discontinuation of safety behaviors during exposure predicts greater decreases in catastrophic thoughts and anxiety (Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999).

Exposure can be conducted effectively within different contexts. For example, therapy may be implemented individually or in a group milieu. Both are equally effective at reducing agoraphobia and panic symptoms,
although the former may better alleviate general anxiety and depressive symptoms (Neron, Lacroix, & Chaput, 1995). In addition, exposure can be massed, where treatment occurs in a significant block of time, or spaced, where intervention takes place over a longer period of time (e.g., 1 hour per week for several weeks). Whereas the former may be more effective, advantages of the latter include lower dropout and relapse rates.

As an important component of this intervention, patients are often assigned exposure assignments to perform on their own. Compliance with exposure homework predicts greater outcomes (Edelman & Chambless, 1993). In an effort to prevent safety behaviors, involvement in therapy from a significant other (e.g., during homework assignments) may be particularly important (Carter, Turovsky, & Barlow, 1994).

**Guided Mastery Therapy.** Guided mastery therapy is based on self-efficacy theory, which posits that safety behaviors are executed because of a doubt in one’s ability to cope effectively in the feared situation (Williams, 1990). That is, these safety behaviors are implemented in situations in which patients do not feel confident. Fear is conceptualized to be treated through successful performance-based treatment. Thus, the goal of guided mastery therapy is to enhance a sense of mastery of, or ability to effective cope with, feared situations. By encouraging patients to engage in increasingly more difficult activities, the therapist promotes proficiency in performance with the abandonment of safety behaviors. Therapist involvement needs to decrease quickly and patients are encouraged to engage in activities independently with the goal of increased self-efficacy. Guided mastery therapy has been found to be effective at decreasing safety behaviors, including avoidance (Hoffart, 1995a). Further, greater self-efficacy appears to predict less fear and avoidance following CBT (Hoffart, 1995b).

**Safety Signal Perspective.** Safety signal perspective (Rachman, 1984) suggests that an overall treatment plan might be more effective if patients have perceived control over the exposure. Applying this concept in therapy, safety signals are available to patients to help decrease distress during exposure. An example entails having a patient meet a significant other inside the previously avoided shopping mall. The idea of encouraging the use of such safety signals was previously believed to hinder the benefits of exposure. However, it appears that this type of exposure is effective at decreasing agoraphobic avoidance (Sartory, Master, & Rachman, 1989). Nevertheless, it is important that the use of safety signal exposure be followed by pure exposure in order to prevent the patient’s reliance on the safety signal.
Behavioral Experiments. Behavioral experiments can be used with diverse rationale (e.g., test catastrophic thoughts), but are discussed here regarding their role in decreasing safety behaviors. Because patients are not always aware of their assumptions related to safety behaviors, this technique allows patients to identify the use and purpose of such behaviors, including agoraphobic avoidance. After identifying beliefs about what would happen in the absence of safety behaviors, patients test these hypotheses to determine if their predictions come true. For example, patients can be taught to try to cause a panic attack by not engaging in their safety behaviors.

Self-Instructional Training. The goal of self-instructional training (Meichenbaum, 1977) is to replace maladaptive, self-defeating, anxiety-aggravating cognitions with more positive self-statements, which will then result in decreased reliance of safety behaviors. Patients are instructed to imagine themselves in fearful circumstances and articulate adaptive self-statements. For example a patient may imagine driving over a bridge without the accompaniment of a safety person. The therapist encourages the patient to repeat affirmations, such as “I can drive over this bridge all by myself. I will be OK.” Patients then practice verbalizing these positive self-statements when engaging in the real-life feared situations. Self-instruction training aims to inhibit negative cognitions, prompting decreased arousal and safety behaviors, as well as increased adaptive coping.

Additional Instrumental Outcome Goals/Treatment Targets

Secondary treatment targets for PD/PDA may include:

- **Enhanced Interpersonal Relationships.** Significant relationships can be severely and adversely affected by PD/PDA. For example, stress associated with panic and avoidance can strain relationships. Further, sexual relations may be avoided because of the resulting somatic sensations, and there appears to be a relationship between sexual dysfunction and PD (Sbrocco, Weisberg, Barlow, & Carter, 1997). In addition, patients may be hesitant to voice interpersonal problems for fear of losing their safe person. Problematic relationships not only decrease one’s quality of life, but can also hinder treatment (Carter et al., 1994). In treating PD/PDA, it has been demonstrated
that brief communication skills training with significant others results in decreased agoraphobia (Arnow, Taylor, Agras, & Telch, 1985). For persons reporting marital discord, incorporating marital therapy not only decreases PD/PDA symptoms, but also enhances marital concordance (Chernen & Friedman, 1993). (See chapter 14 for interventions geared to enhance relationships.)

- **Decrease Stress.** Distress and anxious arousal can instigate panic attacks. For this reason, decreasing overall stress in the patient’s life is an important additional goal. Interventions to attain this goal may include problem-solving therapy, coping skills training, engendering social support, and relaxation training.

- **Schedule Activities.** Related to the above goal, people with PD/PDA often experience pressure related to time management. In addition, as much of their time is spent around their psychopathology, pleasant events are often abandoned. Thus, scheduling activities, including time management training and commitment to participating in enjoyable events, can decrease distress and elevate mood.

- **Prevent Relapse.** Before termination, training in relapse prevention may be important. Patients are taught to identify potential future problems and how their newly learned skills can be applied to these situations. A specific plan can be developed for each patient to implement when future difficulties arise.

**ADDITIONAL CLINICAL CONSIDERATIONS**

CBT is an extremely effective intervention for treating PD/PDA, with 75%–90% of patients experiencing significant benefits (Clark, 1996). Further, CBT is effective at treating PD with co-morbid diagnoses (e.g., depression, generalized anxiety; Sanderson, Raue, & Wetzler, 1998; Brown, Antony, & Barlow, 1995). Although the benefits of CBT appear to be similar to psychopharmacological outcomes immediately following treatment, long-term follow up indicates CBT results in greater treatment gain (Clark et al., 1994; Marks, Swinson, Basoglu, & Kuch, 1994). Moreover, it is important to note that the use of medication during CBT predicts poorer outcomes (Brown & Barlow, 1996).

Panic control treatment (PCT) is a manualized therapy that incorporates many of the CBT interventions presented above (e.g., cognitive restructuring, breathing retraining, interoceptive exposure, and *in vivo* exposure;
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Craske, Barlow, & Meadows, 2000). PCT is effective at decreasing PD/PDA symptoms in both the short and long-term (Barlow, 1990).

Cultural factors may play a role in PD/PDA. For example, cultural acceptability may help to partially explain the elevated rates of this disorder in women as compared with men. That is, although it is acceptable for women to endorse fear and avoid certain situations in many cultures, it is less acceptable for men. Men appear to cope with anxiety more by using alcohol and other substances. Further, although rates of PD/PDA are similar between African Americans and European Americans, the former group tends to use healthcare more frequently and express greater concerns about death. Interestingly, Hispanic cultures have reported ataques de nervios (nervous attacks), similar to panic, that also often coincide with stressful events (Rivera-Arzola & Ramos-Grenier, 1997). It is important to point out, however, that ataques de nervios are perceived as culturally acceptable.

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