Chapter 1

The Nature of Panic Disorder and Agoraphobia

Goals

- To understand the nature of panic attacks, panic disorder, and agoraphobia
- To learn about factors that cause panic disorder
- To learn about this program for overcoming panic and agoraphobia
- To determine whether or not this program is right for you

Do You Have Panic Disorder or Agoraphobia?

Do you have rushes of fear that make you think that you are sick, dying, or losing your mind? When these panicky feelings happen, does it feel as if your heart is going to burst out of your chest or as if you cannot get enough air? Or maybe you feel dizzy, faint, trembly, sweaty, short of breath, or just scared to death. Do the feelings sometimes come from out of the blue, when you least expect them? Are you worried about when these feelings will happen again? Do these feelings interfere with your normal daily routine or prevent you from doing things that you would normally do?

If these descriptions apply to you, then you may be suffering from panic disorder and agoraphobia. The rushes of fear are called panic attacks. Usually, panic attacks are accompanied by general anxiety about the possibility of another attack. Together, the panic attacks and general anxiety are called panic disorder. Agoraphobia refers to anxiety about, or avoidance of, situations where panic attacks or other physical symptoms are expected to occur. These terms are described in more detail later. Here are some examples of how panic disorder and agoraphobia can affect people's lives.
Case Studies

Steve

Steve was a 31-year-old sales manager who suffered from attacks of dizziness, blurred vision, and heart palpitations. The first panic attack occurred at work, in the presence of his coworkers, and began with feelings of weakness, nausea, and dizziness. Steve asked a colleague to call a doctor because he was afraid that he was having a heart attack since his father had recently died of one. In addition to this personal loss, Steve was dealing with a lot of stress at work. Several months before the first panic attack, there were times when Steve had been nervous and his writing had become shaky; but apart from that, he had never experienced anything like this before. After a thorough physical examination, his doctor told him that it was stress and anxiety. Nevertheless, the panics continued, mostly at work, and in trapped situations. Sometimes they were unexpected or “out of the blue,” particularly the ones that woke him out of deep sleep. Steve felt tense and anxious most of the time because he worried about having another panic attack. Since his third panic attack, Steve had begun to avoid being alone whenever possible. He also avoided places and situations, such as stores, shopping malls, crowds, theaters, and waiting in lines, where he feared being trapped and embarrassed if he panicked. Wherever he went, Steve carried a Bible, as well as chewing gum and cigarettes, because glancing at the Bible, chewing gum, or smoking cigarettes made him feel more comfortable and better able to cope. In addition, Steve took medication with him wherever he went to help deal with his panic attacks.

Lisa

Lisa was a 24-year-old woman who had repeated attacks of dizziness, breathlessness, chest pain, blurred vision, a lump in her throat, and feelings of unreality. She was afraid that these feelings meant that something was wrong with her brain, such as a tumor, or that she was losing control of her mind. The problem began about five years before. While at a party, Lisa smoked some marijuana, and within a short while, she began to feel very unreal and dizzy. Never having had these feelings before, Lisa thought that she was going insane or that the drug had damaged her brain. She asked a friend
to take her to the emergency room. The physicians did some tests and reassured Lisa that her symptoms were due to anxiety. Lisa never touched marijuana or other recreational drugs after that. In fact, she became nervous about any chemical substances, even ones prescribed for allergies and sinus infections. The panic attacks waxed and waned over the years. At one point, she had no attacks for three months. However, she continued to worry about having another panic attack almost all of the time. She felt uneasy in situations where it would be difficult to get help if another panic attack occurred, such as in unfamiliar places or when she was alone, but she did not actually avoid many places. Her method of coping with panic was to get as involved as she could in other things so as to keep her mind off panic.

Judy

Judy was a 41-year-old, married woman who was unemployed because of her panic attacks. Judy quit her job as a paralegal several years ago because it had become increasingly difficult for her to leave her house. Judy’s panic attacks involved strong chest pains and feelings of pressure on her chest, numbness in her left arm, shortness of breath, and heart palpitations. Each time she panicked, Judy was terrified that she was dying of a heart attack. In addition, Judy frequently woke up out of deep sleep with similar feelings, particularly pressure on her chest, shortness of breath, and sweating. Judy lived with her extended family, which was of Chinese descent and believed that the nighttime events represented demons descending on her. Her grandmother convinced Judy that she would die if she did not wake up in time. Consequently, Judy became very afraid to go to sleep. She would spend many hours pacing the floors when everyone else was asleep. Instead, she napped throughout the day, when other people were around. Her life had become very restricted to the house, with occasional outings to stores and doctors as long as a family member or friend accompanied her. Judy had seen many doctors and cardiologists, and she had undergone several cardiovascular stress tests and a halter recording to measure her heart over extended periods of time. Nothing was detected, and yet Judy remained convinced that she would have a heart attack or that she would die in her sleep.
Diagnosis and Definition of Panic Disorder and Agoraphobia

The mental health classification system used in the United States and many other countries, referred to as the *Diagnostic and Statistical Manual for Mental Disorders*, fourth edition, text revision (DSM-IV-TR; APA, 2000), identifies the problem addressed in this workbook as panic disorder with or without agoraphobia. The key features of panic disorder are: (1) one or more episodes of abrupt, intense fear or discomfort (i.e., a panic attack); and (2) persistent anxiety or worry about the recurrence of panic attacks, their consequences, or life changes as a result of the attacks.

Panic attacks refer to an abrupt rush of intense fear or discomfort accompanied by a number of physical and cognitive symptoms, which are listed below. Occasional panic attacks are common. However, not everyone who experiences occasional panic attacks develops panic disorder. Details about the frequency of panic attacks and panic disorder in the general population are described in a later section.

**Panic Attack Symptoms**

- Shortness of breath or smothering sensations
- Heart palpitations or a racing or pounding heart
- Chest pain or discomfort
- Trembling or shaking
- Feelings of choking
- Sweating
- Feeling dizzy, unsteady, lightheaded, or faint
- Hot or cold flashes
- Nausea or abdominal distress
- Feelings of unreality or detachment
- Numbness or tingling
- Fears of dying
- Fears of going insane or losing control
Panic attacks occur as a part of many different anxiety problems. However, in other anxiety problems, panic attacks usually are not what the person is most worried about. In panic disorder, the panic attacks become the major source of concern and worry.

Continuing with the technical definition of panic disorder, at least one of the panic attacks must be unexpected or occur for no real reason. In other words, the panic seems to occur from “out of the blue.” A good example of an unexpected panic attack is an attack that occurs when relaxing or when deeply asleep. For some people, panic attacks continue to occur unexpectedly, and for other people, the panic attacks eventually become tied to specific situations.

Another feature of panic disorder is avoiding, hesitating about, or feeling very nervous in situations where panic attacks or other physical symptoms (such as diarrhea) are expected to occur. Typically, these situations are ones where you may not be able to escape or find help. A common example is a crowded shopping mall, where it might be hard to find the exit and difficult to get through all the people if one has to leave suddenly because of a panic attack. A list of typical agoraphobia situations is provided in the list below. Avoiding situations because of fear when no real danger exists is called a phobia. Avoiding situations from which escape might be difficult or where help may be unavailable in the event of a panic attack or other physical symptoms is called agoraphobia. This is fitting because the agora was the ancient Greek marketplace—the original shopping mall. However, as can be seen from the list below, places and situations avoided by people with agoraphobia are not limited to malls.

**Typical Agoraphobia Situations**

- Driving
- Traveling by subway, bus, or taxi
- Flying
- Waiting in lines
- Crowds
- Stores
- Restaurants
- Theaters
- Long distances from home
- Unfamiliar areas
- Hairdressing salon or barbershop
- Long walks
- Wide, open spaces
- Closed-in spaces (e.g., basements)
- Boats
- Being at home alone
- Auditoriums
- Elevators
- Escalators

In most cases, agoraphobia develops after panic attacks, resulting in *panic disorder with agoraphobia*. However, some people never develop agoraphobia; they have *panic disorder without agoraphobia*. Occasionally, agoraphobia is present without panic attacks, in which case the official term is *agoraphobia without history of panic disorder*. In this case, the person may experience one, two, or three symptoms from the list of panic attack symptoms but never has had four or more symptoms at one time (which is the technical requirement for a full-blown panic attack). Nevertheless, one or two symptoms can be as distressing as four or more symptoms. For example, lightheadedness is sometimes the only symptom experienced, but anxiety about feeling lightheaded can be as severe and disabling as the anxiety about having a full-blown panic attack. Putting it another way, the person who has lightheadedness only may end up becoming as agoraphobic as the person who has lightheadedness plus many other panic attack symptoms.

Another example of agoraphobia without panic disorder is when abdominal distress is the primary symptom, resulting in hesitation about entering situations where restrooms are not easily accessible. Abdominal distress may be part of *irritable bowel syndrome*, which involves a chronic disturbance in bowel habits and includes nausea, stomach cramping, constipation, or
diarrhea. These types of symptoms are not due to a medical condition and are often intensified by stress, such as the stress of an agoraphobia situation.

Agoraphobia without history of panic disorder also refers to avoidance of situations because of other bodily symptoms that are not on the list of panic attack symptoms, such as visual disturbances. A list of these symptoms is shown here.

**Other Physical Symptoms That Might Lead to Agoraphobia**

- Headaches
- Tunnel vision or sensitivity to light
- Muscle spasms
- Urinary retention problems
- Weakness
- Fatigue
- Diarrhea
- Sensations of falling

The overriding notion is that agoraphobia comes from being anxious about uncomfortable physical symptoms in certain situations. These situations are ones in which it seems difficult to cope with the uncomfortable feelings because of the feelings of being trapped or of there being no way of getting help.

It is possible to be anxious about and avoid these types of situations for reasons unrelated to uncomfortable physical symptoms. For example, many people refuse to fly because of concerns about crashing or being hijacked. Or, difficulty driving can be based on concerns about being hit by other drivers. Similarly, avoidance of being alone or of leaving one's safety zone can be related to concerns of being attacked, mugged, or other external dangers. This workbook is *not* written with these kinds of fears in mind. Instead, this workbook is for fear and avoidance behavior due to uncomfortable physical symptoms and panic attacks.
Medical Problems

Certain medical problems can cause panic attacks, and controlling them eliminates panic attacks. These medical problems include hyperthyroidism (overactive thyroid gland) and pheochromocytoma (a tumor on the adrenal gland, which is very rare). Other medical problems include extreme use of amphetamines (such as benzedrine, which is sometimes prescribed for asthma or weight loss) or caffeine (10 or more cups of coffee per day). However, these medical problems are different from panic disorder. In panic disorder, the panic attacks are not caused by medical problems. (We recommend that those who feel that they are suffering from panic attacks undergo a full physical exam to decide whether the panic attacks are caused by these types of medical problems or whether they are part of panic disorder.)

There are other medical problems that cause panic-like symptoms, but controlling these medical problems does not eliminate panic attacks. These include hypoglycemia (low blood sugar), mitral valve prolapse (flutter of the heart), asthma, allergies, and gastrointestinal problems (such as irritable bowel syndrome). It is possible to have one of these medical problems as well as panic disorder. For example, low blood-sugar levels may cause weakness and shakiness and thus lead to panic, but correction of blood-sugar levels through diet does not necessarily stop all panic attacks. In other words, these types of medical problems may be a complicating factor that exists alongside panic disorder, but removing these medical problems does not always remove panic disorder.

If you have not had medical tests in the past year, it may be wise to undergo a full medical examination to check for possible physical causes of panic-like symptoms and to identify other physical conditions that might contribute to panic and anxiety. These factors can then be taken into account during the treatment program.

How Common Are Panic Disorder and Agoraphobia?

Panic attacks and agoraphobia are very common. The most recent large-scale surveys of the adult population of the United States show that from 5 to 8% of individuals experience panic disorder and/or agoraphobia at some time in their lives. This means that somewhere between 15 and 25 million people in the United States alone suffer from panic disorder and/or agoraphobia.
One out of every 12 people suffers from panic disorder and/or agoraphobia at some time in his or her life.

In addition, many people have occasional panic attacks that do not develop into panic disorder. For example, over 30% of the population has had a panic attack during the past year, usually in response to a stressful situation, such as an examination or a car accident. Moreover, a significant number of people experience occasional panic attacks from “out of the blue” or for no real reason—estimates range from 3 to 14% in the last year.

Panic attacks and agoraphobia occur in all kinds of people, across all social and educational levels, professions, and types of persons. They are also present across different races and cultures, although panics may be described and understood differently according to specific cultural beliefs. Recognition of panic disorder in other cultures has led to the translation of this workbook into several other languages, including Chinese, Spanish, Korean, and Arabic.

### Unhelpful Ways of Coping With Panic Attacks

We already mentioned a common way of coping with panic attacks: avoiding situations where they might occur (i.e., agoraphobia). Although avoidance of situations decreases anxiety in the short term, in the long term it contributes to anxiety. The same is true for several others ways of coping with panic attacks, including distractions, superstitious objects and safety signals, and alcohol.

#### Avoidance

In addition to avoidance of situations from which escape is difficult or help is not easily available (i.e., agoraphobia), avoidance extends to avoiding activities and other things. For example, consider the following behaviors.

- Do you avoid drinking coffee?
- Do you avoid medication of any kind, even if prescribed by your doctor?
- Do you avoid exercise or physical exertion?
- Do you avoid becoming very angry?
Do you avoid sexual relations?

Do you avoid watching horror movies, medical documentaries, or very sad movies?

Do you avoid being outside in very hot or very cold conditions?

Do you avoid being away from medical help?

Do you avoid being rushed?

Usually, these activities are avoided because they produce symptoms that are similar to panic attack symptoms. Again, while avoidance helps relieve anxiety and panic in the short term, it contributes to anxiety in the long term.

**Distraction**

Many people attempt to “get through” anxious situations by distracting themselves. There is no limit to the methods used for distraction. For example, if you feel yourself becoming anxious or panicky, do you:

- Play loud music?
- Carry around something to read?
- Pinch yourself?
- Snap an elastic band on your wrist?
- Place cold, wet towels on your face?
- Tell somebody who is with you to talk about something—anything?
- Keep as busy as possible?
- Keep the television on as you go to sleep?
- Imagine yourself somewhere else?
- Play counting games?

Chances are that these types of distractions have helped you get through a panic attack in the past and may well help you in the future. However, they can become a crutch. For example, if you forget your reading material or your elastic band, you may have to go home to get it. Also, in the long run, these strategies are not very helpful. Distraction is like placing tape around
a broken table leg without fixing the break. We will discuss this further in chapter 5.

Superstitious Objects and Safety Signals

Superstitious objects or people are specific items or persons that make one feel safe. (They are also called safety signals.) Examples include other people, food, or empty or full medication bottles. If these objects or people were not around, you would probably feel more anxious. The reality is these superstitious objects do not actually “save” you because there is really nothing to be saved from. Other superstitious objects are listed below.

Superstitious Objects and Safety Signals

- Food or drink
- Smelling salts
- Paper bags
- Religious symbols
- Flashlights
- Money
- Cameras
- Bags or purses
- Reading material
- Cigarettes
- Pets
- Portable phones

As with distractions, these objects become a crutch and can contribute to anxiety in the long run.

Alcohol

Perhaps you use a far more dangerous coping strategy—alcohol. We now know that many men (moreso than women) drink to get through situations where they might have a panic attack. In fact, from one third to one
half of people with alcohol problems began the long road to alcohol addiction by “self-medicating” anxiety or panic. Using alcohol to cope with your panics and anxiety is extremely dangerous. This is because while alcohol works for a little while, you are likely to become dependent on the alcohol and require more and more of it. As you drink more and more, the anxiety-reducing properties of alcohol become less and less. Instead, anxiety and depression tend to increase. If you drink to control your anxiety, make every effort to stop as soon as possible, and ask your doctor or mental health professional for help.

How Does This Program Help You Cope With Panic and Agoraphobia?

Instead of relying on avoidance, distractions, superstitious objects, alcohol, or other unhelpful methods, this program is designed to educate you and to teach constructive ways of coping. This program focuses on ways of coping with panic, anxiety about panic, and avoidance of panic. The kind of treatment that is described in this program is called cognitive-behavioral therapy (CBT). CBT differs from traditional psychotherapies in several important ways.

Unlike traditional psychotherapies, CBT teaches skills to manage anxiety and panic. Specifically, you will be taught ways of slowing your breathing, ways of changing the way you think, and ways of facing the things that make you anxious so that they no longer bother you. For each set of skills, we begin with educational information and then outline exercises to be practiced. Then, we build on the previous practice by developing new skills. Finally, the skills are used to cope with panic and anxiety.

Unlike traditional psychotherapies, you will be given homework assignments. Thus, CBT is much like attending class and continuing to learn on your own by further study between classes. In many ways, it is the self-study program that is the most essential to your success.

Unlike traditional psychotherapies, we do not emphasize your childhood memories and experiences (unless they are directly related to your panic attacks, as might occur if witnessing someone die of a heart attack when you were a child led you to fear that you will also die of a heart attack). Instead, CBT emphasizes interruption of the factors that currently contribute to
your panic disorder and agoraphobia. As you will see, it is this method that has proven to be highly effective.

A good beginning to CBT is education about what causes panic attacks.

**What Causes Panic, Anxiety, and Agoraphobia?**

The question of what causes panic, anxiety, and agoraphobia is very difficult, and we do not know all of the answers just yet. We will discuss the subject in more detail in chapter 2, but it is important to say several things here about the causes of panic and anxiety.

**Biological Factors**

First, the research does not suggest that panic attacks are due to a biological disease. Of course, there are the relatively rare examples mentioned above where a medical condition does cause symptoms that resemble a panic attack, such as hyperthyroidism or a tumor on the adrenal gland. However, common panic attacks do not seem to be due to biological dysfunction.

Many people ask whether panic attacks are due to a chemical imbalance. Neurochemicals are substances in the central nervous system, including the brain, which are involved in sending nerve impulses. Neurochemicals that may influence panic and anxiety include noradrenalin and serotonin. While these types of substances may be present in greater amounts in the midst of anxiety and panic, there is no evidence to suggest that a neurochemical imbalance is the original or main cause of panic and anxiety. Some recent evidence using “brain scan” procedures called Positron Emission Topography (PET) and functional magnetic resonance imaging (fMRI) has shown that certain parts of the brain seem to be particularly active in anxious patients. However, it is not at all clear whether these findings are the effect of anxiety or the cause of anxiety.

On the other hand, certain biological factors that may be inherited or passed on through genes may lead some people to be more likely to panic. Many believe that what is inherited are overly sensitive parts of the nervous system which lead to a tendency to experience all negative emotions, including anger, sadness, guilt, and shame, as well as anxiety and panic. However, inheriting vulnerabilities to experience negative emotions does
not guarantee that you will experience panic attacks or panic disorder. In other words, panic is not inherited in the same way that, say, eye color is inherited. If you inherit the genetic structure for blue eyes, then you will have blue eyes. You do not, however, inherit panic disorder in this way. People probably inherit a tendency (or a vulnerability) to panic disorder—something that increases the chances of developing panic disorder but does not guarantee it. Furthermore, even with a vulnerability to panic, it is possible to think and act in ways that prevent panic attacks from recurring (which is exactly what we teach in this program).

Biological factors (whatever they may be) probably help explain why panic disorder tends to run in families. In other words, if one family member has panic disorder, then another person in the same family is more likely to have panic disorder than are others in the general population. That is, whereas 5–8% of the U.S. population has panic disorder and/or agoraphobia, 15–20% of first-degree relatives (parents, siblings, children) of someone with panic disorder themselves develop panic disorder.

**Psychological Factors**

Psychological factors are important also. People who experience panic attacks tend to have certain beliefs that lead them to be especially afraid of physical symptoms, such as racing heart, shortness of breath, dizziness, and so on. The beliefs are that physical symptoms are harmful, either mentally, physically, or socially. Examples of such beliefs include thoughts that a racing heart could mean heart disease, that lightheadedness could mean that you are about to pass out, that a growling stomach could mean you will lose control of your bowels, that strong emotions mean that you are out of control, or that a sense of unreality means that you are losing control of your mind or going insane.

The sources of these beliefs are not fully known, but personal experiences with health and illness may be one important contributor. For example, parents who are overprotective about their child’s physical health may contribute to a general overconcern about physical well-being in the child that gradually develops into beliefs that physical symptoms are harmful. Or, the sudden and unexpected loss of close family members to physical problems, such as heart attacks or stroke, may increase the likelihood that someone
believes that their own physical symptoms are harmful. Another example is to observe another family member suffer through a prolonged, serious illness.

However, beliefs are not the sole cause of panic attacks. As with the biological factors described previously, beliefs that physical symptoms are harmful probably increase the likelihood of panic attacks and panic disorder but do not guarantee them. Furthermore, this type of psychological vulnerability can be offset by learning to think and act in different ways.

Most likely, the vulnerability to panic is based on a complex interaction between psychological and biological factors. What we do know is that a panic attack is a surge of fear that by itself is a normal bodily response. What makes it abnormal is that it occurs at the wrong time; that is, when there is no real reason to be afraid. Again, the response itself is normal and natural, and it would be the same kind of reaction you would have if you were to face a real danger (such as being attacked by a person with a gun). In addition, it is normal and natural to become anxious about having another panic attack and to avoid places where you think that panic attacks are likely to occur, if you believe that panic attacks are harmful to you.

What About Stress?

For most people, their first panic attack happened when they were under a lot of stress. In addition to negative stressful events, such as job loss, stress can be positive as well, such as moving to a new home, having a baby, or getting married. This probably explains why panic attacks are more likely to begin in the 20s, since that is when we tend to take on new responsibilities, such as leaving home and starting new careers and relationships.

During stressful periods, everyone is more tense, and even little things become harder to manage. Stress can increase overall levels of physical tension and can lower your confidence in your ability to cope with life. Additionally, having to deal with many negative life stresses can cause us to think of the world as a threatening or dangerous place. For all these reasons, a situation that may normally be very manageable becomes much more stressful when it occurs in the context of other ongoing stress. Think of a woman who has recently lost her job and whose marriage is breaking up. Within that background of stress, it may be much more difficult for her to
deal with traffic delays than if there were no background stress. So, as a result, stress increases the chances of panic attacks. However, stress alone is not an adequate explanation. Some people do not panic even though they are under a lot of stress. Instead, they have other reactions to stress, such as headaches, high blood pressure, or ulcers. It seems that stressful events increase the likelihood of panic attacks in people who are vulnerable or susceptible to panic. These vulnerabilities include the biological and psychological factors already described.

Furthermore, stress is rarely the reason why panic attacks persist. For example, although panic attacks may have begun during a time of a lot of marital problems, they are likely to continue even after the marital problems have been resolved. This is because panic attacks and anxiety tend to take on a negative, self-maintaining cycle of their own. This set of maintenance cycles is described in detail in chapter 2.

Is This Program Right for You?

The following list will help you to determine whether you can benefit from this program.

Consider if you have experienced any of the following.

- Episodes of abrupt and extreme discomfort or fear (i.e., panic)
- At least some of the panic attacks include physical symptoms and fears, such as:
  - Shortness of breath or smothering
  - Heart palpitations or racing or pounding heart
  - Chest pain or discomfort
  - Trembling or shaking
  - Feelings of choking
  - Sweating
  - Feeling dizzy, unsteady, lightheaded or faint
  - Chills or hot flushes
  - Nausea or abdominal distress
  - Feelings of unreality or detachment
  - Numbness or tingling
- Fears of dying
- Fears of going insane or losing control
- At least one panic attack was unexpected or came from out of the blue
- Persistent anxiety or worry about panic attacks, their consequences, or life changes as a result of the attacks
- Avoidance of different situations (such as driving, being alone, crowded areas, unfamiliar areas) or activities (such as exercise) in which you expect to panic
- The panic attacks are not the direct result of physical conditions or diseases

As already mentioned, panic attacks can be a part of all types of anxiety problems, such as social phobia, obsessive-compulsive disorder (OCD), generalized anxiety, posttraumatic stress disorder (PTSD), and specific phobias. Panic attacks may also occur in mood disorders, such as depression. The distinguishing feature of panic disorder is that the panic attacks themselves become the main source of anxiety and concern. If you experience panic attacks but are not anxious about having panic attacks, and instead, you are worried about other things, then consult with your mental health professional to learn if a different treatment is more appropriate. You fit this program if your main concern is the panic attacks themselves and, of course, if the panic attacks are not the direct result of physical conditions or diseases.

**Are You Receiving Other Psychological Treatments?**

This program may be appropriate for you even if you have had contact with other mental health professionals in the past for panic and anxiety. We have used this program time and time again with people who have been through many different forms of treatment. However, some consideration must be given to other treatment that is ongoing with your participation in this program. We recommend that this program not be combined with other psychotherapy that specifically addresses your panic and anxiety. The reason for this is that messages from different treatments for the same problem can become mixed and confusing. We find it much more effective to do only one therapy for panic disorder at a time. On the other hand, if you
are receiving ongoing general therapy or therapy focused on a different problem area (such as marital problems), then there is no reason why you cannot participate in this program as well.

If you are involved in another psychotherapy that specifically addresses your panic attacks and anxiety, we recommend that you pursue that treatment until you are sure that either it is effective (in which case, no more treatment is needed) or that it is ineffective (in which case, our program can be tried). As you will soon see, our program has been shown to be very effective for many people, but that does not mean that other psychotherapies should not be given a fair trial. Different forms of therapy are more or less effective for different people. You must make this decision if you are involved in another treatment for panic disorder and agoraphobia. To aid this decision, the National Institute for Mental Health published an official statement in 1991 in which it was recommended that decisions about whether psychological treatments for panic disorder are beneficial or not should be made after about six weeks, when the beginnings of improvements should be evident. Furthermore, they recommended against continuing for years in psychotherapy for panic disorder when there is no evidence for improvement.

Are You Taking Medications?

This program will be appropriate even if you use medications to control your anxiety and panic, assuming that despite the medication, you continue to be anxious about panic attacks. We say this because medications are not always fully effective. For some people, medications are only mildly to moderately effective or not effective at all. For others, medications are effective initially, but then relapse occurs when the medication is stopped. Fortunately, medication treatments can be successfully combined with this program, and we discuss ways of achieving this in chapter 10. In addition, this program has been found to be helpful for persons who want to stop their medications. For those who have an interest in stopping their medications, we make some suggestions in chapter 10 that can be combined with direct medical supervision of the withdrawal process. It is definitely not wise to stop taking medication on your own.
In this program, you will learn how to manage your panic attacks, anxiety about panic, and avoidance of panic and agoraphobia situations. The program is divided into 11 chapters, and several of the chapters have a number of different sections. In each chapter, you will learn specific skills. An outline of the content of each chapter is presented below. The skills build upon each other, so that in each new chapter or each new section, you will use skills that you have learned previously. The program is obviously structured, but there is room for individual tailoring.

A self-assessment section at the end of each chapter or each section lets you test whether you have understood the information. If you have not, go back over the material again. This is important, because each new step is based on the previous steps. If you have understood the material presented in the chapter or chapter section, then continue to the next. In addition, homework exercises are outlined at the end of each chapter or section. Their importance cannot be emphasized enough, as the success of the program is based largely on your completing them.

The pacing is somewhat up to you, but we recommend the following general pace. The first phase, called the Basics, takes one week, in which you are to read chapters 2–4 and the first section of chapter 11. These chapters provide all the necessary background information for you to begin learning specific strategies and will also get you going in terms of recording your panic and anxiety. After at least a full week of recording, you begin the Coping Skills phase that is devoted to developing your hierarchy of agoraphobia situations (chapter 5) and learning regulatory breathing (chapter 6) and thinking skills (chapter 7). The Coping Skills phase should take about three weeks. Then, the subsequent six weeks or so should be devoted to the Exposure phase, which involves repeated practice in facing agoraphobia situations (chapters 8 and 9) and facing frightening physical symptoms (chapter 10). The amount of time in the Exposure phase is very much dependent on the number of agoraphobia situations and the number of symptoms which cause you to feel anxious. Considerations about how to stop medication (chapter 11, section 2) and strategies to maintain your progress in the long term (chapter 12) are covered in the last phase, Planning for the Future. Here is the list of chapters:
The following outline presents a recommended pace, although you should once again recognize that the pace is likely to shift based on your own profile of panic, anxiety, and agoraphobia. For example, you will spend much less time on chapter 8 if you avoid only a limited number of agoraphobia situations.

Week 1  Chapter 2: Learning to Record Panic and Anxiety
Chapter 3: Negative Cycles of Panic and Agoraphobia
Chapter 4: Panic Attacks Are Not Harmful
Chapter 11, Section 1: Medications (Education)

Week 2  Chapter 5: Establishing Your Hierarchy of Agoraphobia Situations
Chapter 6, Section 1: Breathing Skills (Diaphragmatic Breathing)
Chapter 7, Sections 1 and 2: Thinking Skills (Basics; Realistic Odds)
Week 3
Chapter 6, Section 2: Breathing Skills (Slow Breathing)
Chapter 7, Section 3: Thinking Skills (Putting Things Into Perspective)
Week 4
Chapter 6, Section 3: Breathing Skills (Coping Application)
Chapter 7, Section 4: Thinking Skills (Review; Memories)
Chapter 8, Section 1: Facing Agoraphobia Situations (Planning)
Chapter 9: Involving Significant Others
Week 5
Chapter 6, Section 4: Breathing Skills (Review)
Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
Chapter 10, Section 1: Facing Physical Symptoms (Assessment and Practice)
Week 6
Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
Chapter 10, Section 2: Facing Physical Symptoms (Review and Practice)
Week 7
Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
Chapter 10, Section 2: Facing Physical Symptoms (Review and Practice)
Week 8
Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
Chapter 10, Section 3: Facing Physical Symptoms (Review and Practice, Activities Planning)
Week 9
Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
Chapter 10, Section 3: Facing Physical Symptoms (Review and Practice, Activities Planning)
Finally, we recommend that you work on this program with your doctor or mental health professional. That person can provide additional information, advice, and guidance as you learn the various skills and conduct the different exercises. Furthermore, your doctor or mental health professional can help to tailor the program to your own needs.

For the period of time that you give to this program, it must become a priority. Just as up until this time, fear has been your major focus, achieving mastery of your anxiety and panic should now be your major focus.

What Benefits Will You Receive From This Program?

What should you expect to get out of this program? This information is important in your decision to participate in our program. Research that we have conducted over the last 20 years shows this treatment to be very successful. The percentage of people who report that they are free of panic at the completion of a program similar to this one is 70–90%. This rate of success has been replicated by other researchers around the world who have tested treatments similar to this one. What is even more exciting is that these results seem to persist over long periods of time—up to 24 months after treatment, which is the longest period we have examined. One of the reasons for this long-term benefit is that the treatment is essentially a learning program. When something is learned, it becomes a natural part of your reactions and therefore is carried with you even after the formal program.
has been completed. You may have ups and downs, but by completing this program, you will be able to handle the downs much more effectively and return to normal functioning more easily.

On the basis of results obtained as early as 1991, the National Institute of Mental Health came out with an official statement recognizing that the treatments of choice for panic disorder are either this type of program (CBT) and/or medication therapy. Obviously, there is never a guarantee that this treatment will be the one for you or that you may never panic again, but from the success rates, it would seem that this program is worth trying.

These numbers refer to the success with which panic attacks are controlled. Remember that many people who panic develop agoraphobia as well. Treatment programs focused on agoraphobia per se produce significant improvements in 60–80% of our patients. Again, this rate of improvement is maintained—and, in fact, improvement usually continues—up to two years after treatment completion. (Again, this is the longest duration that we have evaluated.)

What Is the Cost?

Knowing how effective these programs are, the question for you becomes, “What is the cost?” Mainly, the cost is time and effort over the next 10–12 weeks. One (and perhaps the only) factor known to predict the effectiveness of this program is the amount of practice that is conducted. The more you put in, the more you will get out of the program. It is not the severity of your panic and avoidance, how long you have been panicking, or how old you are that predicts success; rather, it is your motivation to learn to change. Do you have the motivation at this time to give it your best shot? One point to keep in mind is that you are probably putting out as much energy and effort into trying to manage your life with panic and anxiety as you would by going through this program. But the big plus from this program is that the energy and effort result in positive changes.

If you really do not have the motivation right now, then it is better to wait, because you will be defeating yourself by beginning a program like this halfheartedly.

Finally, even if your fear and anxiety diminish quickly as you proceed through the program, we recommend that you finish the program. It will
prove more effective in the long run to complete the entire program, in the same way that it is more effective to complete a prescription of an antibiotic even if bacterial symptoms clear up early on.

**Homework**

- Read chapters 2–4 and chapter 11, section 1.

**Self-Assessment**

Answer each of the following by circling T (True) or F (False). Answers are given in the appendix.

1. It is possible for people to have panic attacks but not have a diagnosis of panic disorder. T F
2. In addition to the unpleasant physical symptoms, panic attacks involve thoughts of going insane, losing control, or dying.  

3. Panic attacks and agoraphobia are very rare problems, affecting less than 1% of the population.  

4. Children of parents who have panic disorder are at no greater risk for developing panic disorder than children whose parents do not have panic disorder.  

5. Superstitious objects, distractions, alcohol, and methods of avoidance have one thing in common—they contribute to anxiety and panic in the long term.  

6. You are born with panic disorder, and there is nothing you can do about it once you have the genes for it.