Although panic disorders and agoraphobia are widespread in the general population, almost half of those afflicted with these problems do not receive treatment for them. Additionally, there is no singular most effective and appropriate treatment for panic disorders and agoraphobia, the use of psychotropic medications having met with mixed success. This article reviews pertinent literature on this topic and presents an empirically based, nonpharmacological brief treatment model that has been shown to be effective in treating these disorders. A case study illustrates this model. [Brief Treatment and Crisis Intervention 1:29–41 (2001)]

KEY WORDS: panic disorder, agoraphobia, brief treatment.

Less than 5% of the general population experience panic disorder, and only 6% develop agoraphobia during their lives (Kaplan, Sadock, & Grebb, 1994), but more than a third of all clients coming for mental health services present with anxiety-related problems (Hales, 1995; Mclean & Woody, 2000). However, it is estimated that only one in four people who have anxiety disorders are correctly diagnosed and treated (Hales, 1995). This is particularly alarming because anxiety disorders are treatable. Many, perhaps even most, studies report short-term success rates in excess of 70% (Craske, 1999; Knapp & VandeCreek, 1994; Roth & Fonagy, 1996). To skillfully serve clients with panic disorders, mental-health service providers need to be knowledgeable about specific models and techniques that have been shown to be effective in treating these disorders. This article introduces a treatment strategy that is consistent with current literature about effective treatment for assisting persons suffering from panic disorder and agoraphobia. This time-limited treatment strategy uses a combination of exposure and cognitive restructuring. A case illustrating how this treatment strategy was used to address a panic disorder is presented.

Recent reviews of literature about the treatment of panic disorder and agoraphobia reinforce the usefulness of brief treatment models (Barlow, Esler, & Vitali, 1998; Craske, 1999; Roth & Fonagy, 1996). Two points suggest the impor-
tance of brief treatment models. First, psychopharmacological intervention alone does not appear to provide sustainable relief for those suffering from these disorders. As noted below, researchers are finding that brief nonpharmacological approaches, either alone or in consort with medications, seem to provide the most effective treatment. Second, recent literature suggests that panic disorder, with or without agoraphobia, is more chronic than previously thought. Thus, even though clients report great improvement from pretreatment anxiety levels, most interventions are not curative, and clients are likely to need additional help eventually (as in booster sessions). Brief models are eminently suitable for this kind of treatment.

**Panic Disorder and Agoraphobia**

Panic disorder is characterized by the recurrent, unexpected occurrence of panic attacks. Panic attacks are brief episodes during which the patient feels intense dread along with other physical symptoms such as a racing heart, sweating, dizziness, and hyperventilation. These attacks begin suddenly, and the symptoms peak quickly, usually between 10 and 20 min (American Psychiatric Association, 2000). Panic attacks are classified as unexpected (uncued), situationally bound (cued), or situationally predisposed. Unexpected attacks are not associated with any internal or external trigger; they are thought to be spontaneous. Situationally bound attacks are those that almost always occur as a direct result of exposure to (or anticipation of) a specific trigger. Situationally predisposed attacks are similar to situationally bound attacks, but they differ in that the attacks do not always immediately follow the introduction of the trigger. Some authors suggest that panic attacks are not truly spontaneous; they are the result of positive feedback physical sensations and fearful cognitions that give rise to thoughts of danger and anxiety (see Craske, 1999; Craske & Barlow, 1993; Wilhelm & Margraf, 1997). These attacks can be differentiated from fear because they are not associated with a known cause.

Panic attacks are not codable disorders in the *DSM-IV* in and of themselves. However, when a person experiences repeated panic attacks, along with anticipatory concern or fear about impending attacks a diagnosis of panic disorder is suggested (American Psychiatric Association, 2000). The frequency with which patients with panic disorder experience panic attacks varies from multiple attacks during a single day to only a few attacks a year. Persons suffering from panic disorder are at increased risk for attacks during stressful times such as the month of college exams or the weeks preceding an important business meeting (Craske, Miller, Rotunda, & Bartlow, 1990).

Panic disorder is commonly accompanied by agoraphobia. Agoraphobia is a condition in which a person fears or avoids places or situations from which escape might be difficult or embarrassing, or in which help might not be available in the event of a panic attack (American Psychiatric Association, 2000). Although “agoraphobia without history of panic disorder” is codable, agoraphobia is generally not coded by itself, but is a building block used to help define other *DSM-IV* diagnoses (Morrison, 1996).

Panic disorders tend to be chronic in nature (Barlow, 1988). Much of the data concerning treatment effectiveness relates to relative improvement rather than absolute improvement (Craske & Barlow, 1993; Jacobson, Wilson, & Tupper, 1988). Thus, clients should be seen as improved, not cured. The severity of pretreatment symptomology of persons suffering from panic disorders has some bearing on their prognosis, as those with more symptoms at the beginning of treatment tend to have poorer outcomes two years following treatment, regardless of the evidence of gains at three months post-
Treatment (Brown & Barlow, 1995). The prognosis for persons suffering from panic disorder with agoraphobia is even more guarded, as some studies report that fewer than half achieve symptom-free status (Burns, Thorpe, & Cavallo, 1986; Cohen, Monteiro, & Marks, 1984; Munby & Johnston, 1980; Williams & Falbo, 1996). As many as 50% of patients who have benefited clinically may relapse, although the relapse tends to be transient (Craske, 1999; Jacobson et al., 1988).

Treatment

Several medications have shown to be effective in reducing levels of panic, but their ability to address phobias (including agoraphobia) are more limited. Even when psychopharmacological agents are prescribed, the most effective treatment includes psychological intervention (see Stein, Ron Norton, Walker, Chartier, & Graham, 2000). This is in part due to the inability of medications to address anticipatory anxiety or the dread of future panic attacks (Reid, 1997). Agoraphobia appears to be best treated with a psychotherapeutic treatment that includes in-vivo exposure to the stimulus of the agoraphobia. Cognitive-behavioral interventions have been shown to be most effective in addressing panic disorder. A brief review of pertinent literature follows.

Pharmacological Treatments

Many antidepressant medications have demonstrated anti-anxiety properties independent of their antidepressant properties. In fact, serotonin-specific reuptake inhibitor (SSRI) antidepressants are the drug of choice for panic disorder (Ballenger, 1995), in part because the side effects of tricyclic and monoamine oxidase inhibitor (MAOI) antidepressants are more pronounced. Because these medications commonly take up to six weeks to have significant anti-anxiety effects (Reid, 1997), quicker-acting benzodiazepine anxiolytics (anti-anxiety agents) are still commonly prescribed. These drugs have demonstrated an ability to control or reduce panic for 70% of patients, on average (Craske & Waikar, 1994).

As reviews of literature supporting the use of these medications are available elsewhere (see Beidel & Turner, 1991; Mavissakalian & Ryan, 1997), they will not be detailed here. Regardless of which medications are used, they should not be prescribed “as needed,” but should be taken at regularly scheduled rates. Neither should their use be terminated in an unplanned manner. Tapering off these medications is almost always indicated.

While many, if not most, practitioners utilize medications to treat panic disorders, there are compelling arguments against their use. Relapse rates as high as 90% have been reported for patients withdrawing from some anti-anxiety medications (reported by Craske & Waikar, 1994). Roth and Fonagy (1996) note that behavioral interventions have higher success rates than those of placebo controls, and propranolol and low-potency benzodiazepines show no greater efficacy than placebos (success rates are reported to range from 30% to 45%). Clum and Surls (1993) found behavioral interventions to be equivalent to antidepressants and high-potency benzodiazepines.

Clark and his fellow researchers compared Imipramine, relaxation training, cognitive therapy, and a waiting list control group. They found that all of the treatments were effective, but cognitive therapy was significantly more effective than the other two treatments. At the one-year follow-up 85% of the cognitive therapy group were panic-free, compared to 47% of the relaxation training, and 60% of the Imipramine groups. Five percent of the cognitive therapy group sought further treatment.
during the follow-up time period, compared to 26% of the relaxation group and 40% of the Imipramine-using group (Clark et al., 1994).

Combining benzodiazepines and behavior therapy may even reduce treatment efficacy (Barlow & Barlow, 1995; Otto, Pollack, & Sabatino, 1995). At least two studies, Wardle (1990) and Marks et al. (1993), suggest that benzodiazepines interfere with the treatment process. Some studies have found that although Imipramine can enhance the effect of exposure during treatment, follow-up data indicate that this medication is (at best) neutral and may produce greater rates of relapse (Mavissakalian & Michelson, 1986; Mavissakalian, 1993). Wardle et al. (1994) suggest that the medication interferes with therapy through the mechanism of state-dependent learning, but Speigal, Roth, and Weissman (1993) contend that the doses employed by Wardle and company were excessively high.

A major issue presented by the use of medications for the treatment of panic disorder is the effect medications may have on cognitive-behavioral interventions. Because many of the medications prescribed for panic disorder lessen physical symptoms, behavioral interventions that emphasize exposure to fear-provoking stimuli may be compromised. Further, client gains resulting from their ability to overcome their fears may be falsely attributed to the effect of medications. This detracts from the intent to empower clients to compensate for or overcome their fears. It also has the potential to lead to unnecessary dependence on the medication (Craske & Waikar, 1994).

Psychological Treatments

Although approximately one-third to one-half of persons diagnosed with panic disorder also have agoraphobia, higher rates of comorbidity are common in clinical samples (Kaplan et al., 1994). Though there is evidence that panic and agoraphobic avoidance improve independent of each other (Basoglu, Lax, Kasvikis, & Marks, 1994), most psychological interventions include components addressing both issues. Cognitive-behavioral interventions are the primary therapy for persons presenting with panic disorder stemming from distortions or misperceptions of normal situations (Reid, 1997). In fact, a 1991 consensus statement from the National Institute of Health recommended referrals to cognitive-behavioral or medication treatments if changes are not observed within the first six to eight weeks of alternative (including hypnotherapy or psychoanalytic therapy) treatment (Barlow & Brown, 1998).

Typical cognitive-behavioral treatment for panic disorder includes cognitive restructuring, and in-vivo exposure components (Craske & Waikar, 1994). While some researchers have isolated and tested individual components of this package, practitioners rarely use pure versions of any psychotherapy in clinical settings, so the bundling of these therapeutic components as a “treatment package” should prove useful to those in clinical settings situations (Reid, 1997). Clients with severe agoraphobia tend to respond best to exposure and response prevention (Beck, Stanley, & Baldwin, 1994). Thus, clients with severe agoraphobia should receive cognitive therapy only in consort with exposure (Roth & Fonagy, 1996).

Cognitive Restructuring

Cognitive restructuring targets misappraisals of bodily sensations as being threatening. It is based on the concept that cognitions precede (or trigger) anxiety and panic, so the identification of aberrant cognitive structures, and the challenging of misinterpretations and biases through reasoning and experience can eliminate the anxiety. Margraf (1989) and Salkovskis, Clark, & Hackmann (1991) suggest that cogni-
tive strategies in the absence of exposure can be effective.

Others have noted that anticipatory anxiety plays a major role in panic disorders, as the people suffering from the attacks often report concern that they will “be found out” or that they will be humiliated if others discover their problem (Kaplan et al., 1994). As a consequence, the fear that others will discover their problem creates a panicky feeling in persons suffering from panic disorder. This phenomenon is crucial in my work with persons suffering from this disorder, as the anticipatory anxiety is based on the future probability of something occurring rather than the present situation.

One of my primary goals is to have the client experience the “here and now” of their situation. That is, one of the first steps of treatment is to have the client clearly identify that “right here, right now” he or she is feeling safe. During the first intervention interview I notice when the client appears to be relaxed. Once this is verified, I comment that he or she seems quite safe, “right here, right now.” I ask the client to repeat this phrase a few times, becoming comfortable with it. This statement becomes an anchor that clients use to assess the veracity of their sensations of panic. Some clients even wear loose rubber bands on their wrists during particularly stressful times so that they can snap them to remind themselves to focus on “right here, right now”—and that they are O.K. at that moment.

Persons suffering from phobias can be alert to specific situations or things that trigger their anxiety, but this is not the case for those who suffer from panic disorder. Because panic attacks can present at any time, learning to identify initial indications of panic, and how to reduce the physiological manifestations of that panic, is an important element of treating persons suffering from panic disorder. Of particular interest for those treating panic disorder is breathing retraining. Breathing retraining is an important component of treatment for panic disorder because nearly 50% of these clients report hyperventilation symptoms (Craske & Waikar, 1994).

**Exposure Treatment**

Early treatment of agoraphobia relied on systematic desensitization in which clients only imagined they were in their feared situations, as therapists feared that exposure to the real feared stimuli would be injurious to clients. It should not be surprising that this strategy was not very successful in helping clients overcome their problems in the real world (see Barlow & Brown, 1998).

Current practice standards indicate that behavioral therapy involving exposure and response prevention has been shown to be effective in reducing panic symptoms (Barlow & Brown, 1998; O’Sullivan & Marks, 1990). Exposure therapy has two primary forms, in-vivo and interoceptive. In-vivo exposure is appropriate for persons experiencing anxiety as a result of being in specific places or situations. It requires that the client “engage in exposure practices by which they systematically venture away from safe places and into the situations they had been avoiding” (Barlow, Esler, et al., 1998, p. 291). Interoceptive exposure is a model developed primarily by Barlow and Craske (see Barlow, Esler, et al., 1998; Craske & Barlow, 1990). It requires that the client be “systematically exposed to their own bodily sensations in a therapeutic context so that they might eventually learn at an emotional level that there was nothing [sic] to fear” (Barlow & Brown, 1998, p. 41). This form of exposure is recommended for those whose panic attacks are not related to specific situations or places.

There are many variations of exposure treatment, and no single model has emerged as superior to others. However, sessions must be sufficiently long to allow the client to fully provoke and reduce their feelings of panic (Chaplin &
Levine, 1981; Marshall, 1985; Stern & Marks, 1973). Massing sessions on a daily basis has been shown to be as effective as sessions spaced on a weekly schedule, suggesting that treatment can beneficially be offered as frequently as the schedules of the worker and client allow (Barlow, 1988; Chambless, 1989; Foa, Jameson, Turner, & Payne, 1980). Although Feigenbaum found a high-intensity (flooding) method effective, most practitioners favor a progressive model (Feigenbaum, 1988).

Exposure-based treatments can be administered by the therapist or by the client him- or herself. There is evidence that the two models produce comparable effects with some disorders (Al-Kubaisy et al., 1992; Ghosh, Marks, & Carr, 1988), and there are clear cost benefits for having the client self-direct in this regard. In fact, recent research findings suggest that telephone-administered self-directed exposure instructions for those unable to attend traditional therapy sessions can be very effective, and perhaps this medium could be used as a cost-saving alternative to face-to-face sessions (Swinson, Fergus, Cox, & Wickwire, 1995).

Exposure treatments usually require that the client and worker develop a short schedule of hierarchically ordered anxiety-producing situations relating to the panic attack. The client is encouraged to repeatedly put him- or herself in the least stressful situation, and remain in it as he or she experiences anxiety. The client is expected to use coping techniques learned in session to address and reduce the anxiety. This experience is repeated until the client no longer experiences unmanageable anxiety in the situation. He or she then engages the next most stressful situation on his or her hierarchy. Some clinicians accompany their clients to these situations (logistical restrictions notwithstanding), and others simply rehearse the sensations the client is likely to experience in their office. There is some evidence suggesting that including significant others or spouses in treatment as “coaches” has beneficial effects for the clients (Barlow, O’Brien, & Last, 1984).

The model I use consists of three phases: education about the nature of anxiety disorders and panic disorders specifically, cognitive therapy (including some work regarding identification of physiological indications of panic and relaxation), and exposure of some form. Because triggering events of agoraphobia can be either internal or external (Wilhelm & Margraf, 1997), I target both the physical sensations that the client identifies as being associated with his or her panic attacks (the psychological or internal aspect of these attacks) as well as physical situations that serve the same function.

**Case Illustration**

Ms. Anthony (some information has been changed to protect her identity) was a 35-year-old, White female. She was a secretarial support person at a local college while she took graduate courses in mathematics at the college in preparation to teach at the junior college level. Ms. Anthony’s husband worked as a marketing director at an advertising agency in town. They had been together for six years. Her husband was very concerned about Ms. Anthony and fully supported her decision to seek help. She was referred to the community mental health center by her medical doctor. The doctor concluded that Ms. Anthony was suffering from an anxiety problem, but she was unwilling to follow his recommendation to take tranquilizers to address her anxiety. She confided in him that she had been drinking moderate amounts of alcohol in order to reduce her anxiety and didn’t want to substitute one substance for another; she wanted to “get rid of the problem.”

Upon arriving at my office, Ms. Anthony indicated that she had been very anxious during the past month (finals of the spring term at school), and was concerned that she was “going to die”
because of her racing heart. She reported that she also experienced dizziness, mild nausea, and fear that she was “going crazy.” She disclosed that she first noticed these feelings two years ago, and that they had become progressively worse since then. Although she had had only one attack prior to this year, she reported experiencing symptoms of panic attacks “once or twice a week” during the past month. Ms. Anthony commented that only in the past two months had her attacks been debilitating, causing her to take longer lunch breaks in order to avoid staying in her office, where most of her attacks occurred (suggesting that the attacks were situationally predisposed to some extent). She commented that she was well liked in her place of business, and that she liked her coworkers as well. She had experienced panic attacks lasting up to “about fifteen minutes—but that doesn’t count the hour and a half it takes to wind down from the experience.” The duration of these attacks had increased by about five minutes, and they had become more frequent in the month prior to our first session. Ms. Anthony did not think they were related to the time of the school year, as they had continued after her finals were over. Although she was concerned that her coworkers would discover her problem, she was most concerned that her professors would find out about it and use it as a reason to avoid recommending her for possible teaching jobs in the future.

During the first session I obtained information pertinent to her problem. Although she initially appeared quite nervous, she quickly relaxed and was able to fully answer all of my questions. I showed her the DSM-IV classification for panic disorders, and we reviewed the criteria for this disorder. We also looked at the classification for agoraphobia. While Ms. Anthony admitted that she didn’t like being in situations where she would look foolish if she had an attack, she indicated that she had not needed to actually avoid going anywhere. (In fact, she indicated that one aspect of her attacks that was particularly troublesome was that she typically wanted to run away from wherever she was in order to “get out of the situation,” causing her heart to race, but that “where” she was physically wasn’t the problem—and thus, physically running away didn’t help!) She commented that she was relieved to know what her problem was. She was comforted by the knowledge that her problem is highly treatable, even though she would likely experience less severe relapses on occasion.

I emphasized the idea that panic attacks are often only exaggerated reactions to fearful situations. Because of this, learning to control our responses can bring tremendous relief. As an example of a way she could alter her response, I taught her a breathing exercise in which I had her concentrate on breathing diaphragmatically, with deep breaths. I asked her to do this exercise at least twice a day (and more if it was beneficial in stressful situations).

Our second session was later in the same week as the first. During the second session we identified the specific sequence of thoughts she went through when she was experiencing a panic attack. As noted by Barlow and Brown (1998), it is important to help the client become sufficiently specific so that these thoughts accurately and fully describe the thoughts most responsible for producing the panic attack. We listed these on paper, and went through them item-by-item to confront their logic. Although she was aware that these thoughts were not rational, I thought it was important to review them step-by-step in order to introduce a new thought process and begin to dispel her old, routinized thought process. Ms. Anthony reported that her panic attacks often began with her noting that her heart was beating fast or hard, and this realization initiated a sequence of thoughts about being anxious that grew into a full panic attack. Barlow has commented on the phenomena of persons suffering from panic disorder becoming hyper-
sensitive to their own bodily sensations, to the point where they attempt to avoid these sensations (Barlow, 1988). In this manner these people are agoraphobic not of places or situations, but of sensations. While I was concerned that this might be the case with Ms. Anthony, she did not report behaviors attempting to avoid these body sensations before they presented.

During our third session we reviewed the list of the thoughts she had during panic attacks. I also had her elaborate on the worst consequences she could imagine if she were to really lose control of herself. Other than others using this information against her, she was most concerned that she would be unable to continue with her normal daily activities—that she would be paralyzed in some fashion. She commented that she had experienced an attack during the previous week, but that it didn’t seem as powerful as previous attacks since it didn’t last as long. I asked her why she thought this was so, and she answered that she had concentrated on her breathing.

Because her description of the circumstances surrounding her panic attacks suggested that they were not situationally predisposed, I had decided to use interoceptive exposure with Ms. Anthony. Because she had indicated that tightness in her chest and a racing heart were principal symptoms during her attacks, I had her do a hyperventilation exercise to produce facsimiles of these symptoms. She was unable to complete the exercise because she became so anxious. She began to perspire and blink rapidly. She was breathing rapidly and became flushed. Still, she was able to perform physical tasks when directed to do so. I asked her to bring me a particular book from the shelf behind her, for instance. I was able to show her that she was fully functional despite her discomfort. She was somewhat surprised by this realization.

The hyperventilation exercise and its follow-up took approximately 20 min to complete. After Ms. Anthony had relaxed, I commented that she hadn’t taken very long at all to recover from her “attack.” She agreed, and suggested that having someone there who knew what she was experiencing—and focusing on her panicky feelings, even—probably helped her. I asked if her husband could provide this service, and she agreed that this would likely help. She agreed to bring him with her for the next session.

Ms. Anthony came for her fourth session with her husband. He indicated that his wife had been “filling him in” on our sessions, and that she seemed very pleased with the way things were going. I asked him if he had an idea of what it felt like for his wife when she experienced a panic attack. When he indicated that he didn’t, I had him do a hyperventilation exercise in which he panted as quickly as he could without stopping until I told him to quit. Although I only had him pant for thirty seconds, he reported feeling light-headed and scared. When I told him, “That’s a little bit what it feels like for your wife, but she doesn’t know when it’s going to start or how long it might last. And she tells me that these feelings last for over fifteen minutes at a time,” he quietly took her hand.

I explored with Ms. Anthony how her physical sensations led to exaggerated thoughts about her situation. For instance, her racing heart caused her to think that she was “out of control.” Her tight chest would cause her to be unable to walk around to get help if she needed it. I suggested that these physical sensations (although they might be caused by totally unrelated events) are protective if they aren’t exaggerated. Consequently, she might take the opportunity when she first noticed one of her sensations to explore if she was in a dangerous situation. She laughed as she commented that she wasn’t ever in a “real dangerous situation,” but acknowledged that she must have been scared of something when she had attacks.

I commented that at that time, at that moment,
she seemed to be safe. She agreed, and I had her repeat the phrase, “Right here, right now, I’m O.K.” I mentioned that most of us worry about things in the future and forget to pay attention to the fact that “right here, right now” we’re O.K. She agreed that she did this a lot. I had her describe a few of the things she worried about. They were all situations or events at least a month away. I noticed that as she mentioned them her heartbeat increased and she began to blink more rapidly. I grabbed her hands in mine and made sure she was looking right into my eyes as I quietly said, “Right here, right now, I’m O.K. Repeat it.” She did, four times. I made sure she was looking into my eyes as she did so, and that she noticed my exaggerated slow, full breaths as she said the phrase. Following this I asked her how she felt. She said, “I’m O.K. I’m glad I didn’t go in the other direction, because I really thought I was for a minute.” I remarked to Mr. Anthony that helping his wife continue to take full breaths when she became anxious would be an important coaching task. I suggested that she review her list of “irrational thoughts” at least twice in the next week, and that she continue to concentrate on her breathing, perhaps using her “new mantra.”

Ms. Anthony came in for her next session reporting only one “minor” panic attack during the previous week. She stated that she was able to use her “I’m O.K., right here, right now” phrase to calm herself, and that she had intentionally walked the halls of her office in the middle of the attack to show herself that she really was O.K. After offering my congratulations I asked if we could try to provoke another pseudo-attack so that I could see if additional tools would be helpful. I had Ms. Anthony breathe through a couple of straws for three minutes in order to provoke shallow breathing or a sense that her breathing was not normal. Her breathing became shallow, and she became a bit flushed. However, she didn’t report feeling anxious, only silly.

I asked her to review things that she thought were worrying her. However, she did not become anxious in doing so. We then did a short role-play in which I assumed the role of her boss. I repeatedly accused her of not being prepared with a business report I had supposedly asked her to prepare. I raised my voice and spoke harshly. Finally, I noted that she was breathing quickly and she blinked her eyes rapidly (as she had on a previous occasion when she felt panicky). I continued to keep my voice raised for about ten minutes, even keeping it raised as I asked her if she felt out of control. She stated that she didn’t like feeling that she had let someone down, but that she knew if she just kept taking “as big a breath as I can” she would be O.K. When we completed the exercise she commented that seeing her husband struggle with his breath in my office had been a big help for her; seeing that anyone might feel “scared” when they aren’t breathing normally had given her reassurance that her own response wasn’t really crazy after all.

I saw Ms. Anthony two more times. Although I tried to provoke feelings of panic, I was unsuccessful. At each session she reported less concern about her feelings of panic. Although I cautioned her that her feelings of panic might reappear in moments of stress, she felt confident that her coping tools would help her overcome these attacks. I indicated that she should not be embarrassed if she needed to see me again because her feelings of panic became unmanageable; this is a common occurrence for those who have experienced panic attacks. I asked how much she was drinking, and if she continued to drink to help her deal with her attacks. She said she hadn’t had a drink in almost a month, and that drinking hadn’t really helped at all anyway.

I phoned Ms. Anthony four months later to find out how she was doing. She stated that she had only had one attack of any consequence,
and that focusing on her breathing and “staying right here, right now” had gotten her through it without problems.

Conclusion and Future Directions

In this case illustration, a combination of client education, cognitive restructuring, and interoceptive exposure was employed. Had Ms. Anthony indicated that she was avoiding any situation or place I may have introduced in-vivo exposure to transfer her skills to those “real world” places that were problematic. I also sometimes use self-anchored rating scales in order to provide concrete feedback to clients who do not think they are making progress. These scales allow for the quick assessment by both the client and the social worker about the progress and attainment of session expectations.

It is important to also note limitations. Although the model presented here is entirely appropriate in the current managed care environment, not every client will benefit from it. Approximately 30% of clients do not experience relief from panic attacks with this kind of intervention package. Treatment efficacy is reduced for those with comorbid conditions, and it is sadly the case that approximately 70% of clients with panic disorder have Axis I comorbidity and 50% have Axis II comorbidity (Steketee, Van Noppen, Cohen, & Clary, 1998).

Certainly not every client will make the quick gains Ms. Anthony did. Some will progress at a much slower pace, perhaps prompting questions about whether the treatment is working at all. It is important in these instances to be honest about the progress (or lack of progress) that is occurring, and to insure that the client does not reintroduce negative cognitions previously employed. Finally, perhaps we should remember that our goal need not be absolute elimination of panic attacks, but rather increased functioning despite these attacks. Clients typically seek our help because their lives are impaired. Our task in helping them is to assist them in improving the quality of their lives. The treatment package offered here is one way to accomplish this task with clients suffering from panic disorders.

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