

COMMENTARY

More “C” Please: Commentary on Arch and Craske's (2011) “Addressing Relapse in Cognitive Behavioral Therapy for Panic Disorder”

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Comments are offered to clarify the learning model proposed by Arch and Craske (2011) based on extensive clinical experience with the CBT model for treating panic disorder developed by Barlow and Craske (1990). Suggestions are made regarding treatment targets and several cases are offered as examples of how choice of treatment target can make a significant difference when panic appears refractory.

STUDY of actual clinical cases where a treatment modality does not prove successful is courageous and potentially of significant value in the development of theory and therapist skills. In a special issue of this journal (Dimidjian & Hollon, 2011), Arch and Craske (2011) presented a case study of John, a man whose panic and agoraphobia apparently improved to a significant extent only to reemerge powerfully when the most feared situation of flying was faced in an in-vivo trial. Their analysis of the treatment failure highlights shortcomings of emotional processing theory to the effect that habituation within sessions and even between sessions to elements of conditioned fear stimuli is not necessarily an indication of learning when faced with the full array of stimuli presented by the most feared situation. In fact, exposure can be used by the patient as a form of a ritualized fear-avoidance strategy, and this was evident in the case of John, who prayed not to experience anxiety.

Arch and Craske (2011) discussed the importance of inhibitory learning as an element of treatment that would assist patients such as John to face and habituate to the experience of anxiety and fear. They described panic attacks as an unconditioned stimuli and focused on assisting patients in mismatching expectancies, using a variety of contexts in which the conditioned stimuli (interoceptive sensations) are presented without the occurrence of the “unconditioned stimulus.” This formulation is arguably incorrect and, if so, an alteration of thinking leads to different treatment targets.

A panic attack is an unconditioned response (UR) to the perception of immediate danger, where the danger is a catastrophic belief, usually the misinterpretation of benign somatic sensations (Barlow, 1988; Clark, 1986, 1996). This belief could be considered the unconditioned stimulus (US) in the language of classical learning theory, which appears to be the language used by Arch and Craske (2011).

Given that panic disorder is unlike other fears, in that the fear is self-reflective—that is, the patient becomes terrified of having a response of terror—the UR of panic transforms into a conditioned stimuli (CS) capable of eliciting all the physical and mental manifestations of itself, a panic attack. Barlow noted this early on and it is part of his model of panic that forms the basis of the first treatment manuals for panic disorder (Barlow, 1988; Barlow, Craske, Cerny & Klosko, 1989). He referred to this transformed panic as a *learned alarm*. He and Clark converge on this transformation as crucial in the development and maintenance of panic disorder. The physical sensations, thoughts, situations, and people associated with these learned alarms act like CSs to elicit conditioned responses (elements of panic).

Arch and Craske (2011) focused their efforts to enhance CBT through more effective exposure, especially interoceptive, and in the brief discussion of enhancing cognitive restructuring, the focus is on surviving anxiety, even panic, with almost no mention of the catastrophic misinterpretation that underlies the panic system. As a clinician who utilized the Barlow and Craske manuals from 1989 to 2004 running groups for patients suffering from panic disorder in a hospital setting, I would suggest respectfully that addressing the power of catastrophic cognitions is very important, especially when dealing with refractory cases.

Keywords: panic disorder; CBT; catastrophic cognitions

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Brief Case Studies

As a demonstration of the importance of addressing the underlying catastrophic cognitions, two case studies are offered. In the first case, a 30-year-old female patient found she could barely continue teaching due to her fear of sensations of passing out or losing control associated with panic attacks. She went through a 12-week group using the Mastery of Your Anxiety and Panic program (MAP; Barlow & Craske, 1990) and made some improvements but then felt she was going to pass out during a school assembly and also felt she was in danger of losing control of her car while traveling over a high-level bridge. She had done interoceptive exposure with diligence during the group program and found that deliberate hyperventilating created sensations most similar to those of a panic attack. She found she could hyperventilate for several minutes with minimal anxiety and could do this at work, at the gym, and in her car. Discussion during an individual session led to the sense that she believed that she was possibly in danger and would lose control if the strength of the sensations escalated beyond some subjectively experienced limit. We devised a test for her wherein she would stand in my office and hyperventilate until she lost control (prolonged exposure to the US). It took 35 minutes of hyperventilating until she was convinced that the US was not going to happen. She reported that she no longer believed that these sensations would lead to fainting or loss of control. She was free of panic and somatic hypervigilance at 1-week, 1-month, 1-year, and 3-year follow-ups. After 5 years I ran into her in public and she said that she had experienced a heart attack due to hyperlipidemia but had not relapsed into panic.

A second patient made progressive improvements with the MAP program. She had initially presented with a pervasive and at times debilitating fear of suffocating, which was provoked by sensations of hyperventilation and a pronounced heaviness on her chest. She performed all the exercises in the MAP, including diaphragmatic breathing and interoceptive exposure, and reported significant relief along with a change in thinking (i.e., that she feared predictable sensations of hyperventilation). However, she relapsed suddenly after attending the funeral of a relative. While waiting in the receiving line, in sight of the casket, she felt that she could not breathe and left the funeral home in tears.

When seen in an individual session, we explored the situation at length. She reported only that she had a sense of imminent suffocation and felt the room collapsing in on her. We discussed and then proceeded to engage in prolonged exposure to her feelings of imminent suffocation within the context of the funeral home, which she held in imagination. The feeling of breathlessness became very intense but she persisted in staying with

the image due to her great desire to be free of what was troubling her. Panic swept over her but she stayed present and then there was a sudden shift and she reported feeling a deep sense of calm. This went on for some while and I left her to experience whatever was there for her. I then asked her what had precipitated this shift from fear to calm. She reported that she realized there was no danger of not being able to breathe, and she reported that a memory of her eldest brother's funeral came to her while doing the exposure. She was aged 17 and remembered standing at the graveside and experiencing a panic attack while thinking, "They can't bury him, he won't be able to breathe." Calm now, she was able to process the irrationality of her thinking then and formed the belief that sensations of breathlessness brought her close to this underlying terrifying possibility of being buried alive. This was, in my opinion, the catastrophic belief or US underlying panic. Over the next few years the patient reported feeling free of anxiety for long periods with occasional moments of anxiety when she thought, "What if it comes back?" These thoughts were fortunately dispelled quickly. I encountered her over the next decade as she worked at a local store and she indicated that she was doing well.

Conclusions

The CBT model developed by Barlow (1988) and then elaborated by Craske (1999) is powerful and ultimately very effective overall for patients suffering from panic disorder (cf. Barlow, 2004; Brown & Barlow, 1995; Gould, Otto, & Pollack, 1995). Along the way, though, the cognitive component seems have become more of an afterthought and this weakens the treatment model. The cognitive changes that occur with full exposure to the catastrophic belief (US) appear to be crucial in leading to change in some patients. As another example, simply upon learning that the physical symptoms of difficulty breathing, dizziness, numbness, and tingling could be produced by hyperventilation, a male patient in his 30s literally stopped panicking after searching for answers for 4 years. He had believed that he was going to die from a heart attack and that all of the specialists he saw were somehow wrong in concluding that his cardiac functioning was healthy. Interoceptive exposure to hyperventilation led to a shift in his beliefs as to the meaning of the sensations. He was still free of panic problems when I met him in public 10 years later.

References

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