

Avoidance behavior in panic disorder: The moderating influence of perceived control [☆]

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Abstract

The relations among anxiety sensitivity, perceived control, and agoraphobia were examined in 239 patients diagnosed with panic disorder (PD). Most patients exhibited agoraphobia accompanying their PD (98% situational avoidance; 90% experiential avoidance; and 80% endorsed interoceptive fear and avoidance). Anxiety sensitivity and perceived emotional control were associated with agoraphobia, and perceived threat control was found to moderate the relationship between anxiety sensitivity and agoraphobia. Lower levels of perceived control were associated with a stronger relationship between anxiety sensitivity and agoraphobia. Results were consistent for self-reported and clinician-rated agoraphobia. Implications for the role of perceived control in agoraphobia development and treatment are discussed.

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Introduction

Agoraphobia is a separate but common complication of panic disorder (PD). Agoraphobia generally refers to an individual's avoidance or endurance with distress of situations that are difficult to escape in the event of a panic attack. The diagnosis of agoraphobia does not require avoidance to be an essential feature (American Psychiatric Association, 1994), but can be made from any one of three criteria: (1) avoidance behavior, (2) experiencing and enduring anxiety or distress in the phobic situation, or (3) requiring a companion for exposure to the phobic situation. It is conceivable that an individual could have no or few avoidance behaviors but may have considerable fear, anxiety, and distress in situations. In short, the anxiety associated with agoraphobia is aimed at the onset of distressing symptoms in situations, not the situation itself. Because of this

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“fear of fear” (Goldstein & Chambless, 1978), a continuum of restrictions may develop that range from subtle to more obvious avoidance.

Avoidance tactics often arise in PD because individuals believe these will “protect” them in the event of a panic attack (White & Barlow, 2002). These strategies may include situational, interoceptive, and experiential avoidance. The most obvious behavioral marker of avoidance is situational avoidance, which entails refusal of entering phobic locations (e.g., driving, theaters). This type of avoidance is commonly regarded as the most palpable and impairing aspect of PD. Less understood and less overt forms of avoidance are interoceptive and experiential avoidance. *Interoceptive avoidance* involves refusal of substances (e.g., caffeine) or activities (e.g., exercise) that produce sensations that resemble the symptoms of panic, and *experiential avoidance* involves withdrawing from and minimizing contact with the phobic stimulus through the use of avoidance tactics including use of safety signals (e.g., cell phones, bottled water) or use of thought strategies (e.g., distraction, counting, reading). Research has consistently demonstrated an attentional bias for threat information in anxious individuals (Broadbent & Broadbent, 1988), and experiential avoidance encompasses an effortful attempt to minimize attention to and contact with a feared stimulus to avert panic or other associated negative consequences (i.e., embarrassment, humiliation). Experiential avoidance is thought to occur when an individual is “unwilling to remain in contact” with certain experiences, including emotions, bodily sensations, and thoughts (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). In application to PD, an anxious individual may exhibit no or few overt, situational avoidance behaviors (e.g., they may be willing to cross a bridge) but may be engaging in considerable subtle interoceptive avoidance (e.g., walking at a slow pace) or experiential avoidance (e.g., listening to music or counting footsteps) that serve to lessen contact with the phobic stimulus. In sum, avoidance behaviors range from overt to more subtle efforts to evade or lessen contact with the phobic stimulus and serve to help the individual feel more secure or less anxious in the event of a panic attack.

Improving the understanding of agoraphobia and the factors that contribute to phobic avoidance has far-reaching implications for individuals with PD. It is well documented that degree of situational avoidance is associated with a more severe syndrome of PD (Buller, Maier, & Benkert, 1986). Prospective studies have consistently demonstrated that agoraphobia has a negative impact on the course of PD including reduced remission rates (Keller et al., 1994), higher role impairment (Magee et al., 1996), higher disability (Buller, Maier, Goldenberg, & Lavori, 1991), and poorer long-term impairment in general (Faravelli & Albanesi, 1987). Agoraphobia is also associated with a less favorable response to treatment (Ehlers, 1995) and increased relapse following treatment (Katschnig & Amering, 1998). Moreover, agoraphobia is related to maintenance of PD in treated samples, recurrence of panic attacks in remitted patients, and continuance of spontaneous attacks in infrequent panic (Ehlers, 1995). Collectively, these studies and many others highlight the wide-ranging negative impact of phobic avoidance on PD.

Contemporary theories of agoraphobia have stemmed from comprehensive models of PD (Barlow, 2002; Beck, 1988; Clark & Ehlers, 1993). Barlow’s model of PD posits that some individuals possess biological and psychological vulnerabilities to develop panic attacks in the absence of a real threat (“false alarms”; White & Barlow, 2002). These false alarms (or panic attacks) occur as a function of stressful life events and are facilitated by negative affect. Through classical conditioning, interoceptive cues may become associated with the initial panic attack and result in subsequent panic attacks (“learned alarms”), and PD is thought to be the result of contiguous stimuli being conditioned to elicit the anxiety (Wolpe & Rowan, 1988). It is this association of an initial false alarm with interoceptive or somatic cues that may be particularly crucial in the development of agoraphobia. At this point, some individuals experience a panic attack, and subsequently become anxious in anticipation of having another attack. The vulnerability for developing anxious apprehension may lay dormant unless activated by certain psychological vulnerabilities and experiences. One *generalized psychological vulnerability* factor consists of the perception that emotions and situations in general are uncontrollable and unpredictable (i.e., a lack of perceived control). As a result of the false alarm and the individual’s low perceptions of control, they may begin to experience anxious apprehension about having future panic attacks. Individuals without this vulnerability would not experience anxiety focused on the next panic attack (i.e., considered a non-clinical panic attack). Indeed, experimental studies in non-clinical samples have shown that perceived control may buffer the panicogenic response to biological challenge (Zvolensky, Eifert, & Lejuez, 2001). Consequently, phobic avoidance behaviors in anxious individuals are thought to be

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