

Clinical Experiences in Using Cognitive-Behavior Therapy to Treat Panic Disorder

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Although there is a growing body of research to support the use of psychological treatments for specific disorders, there has been no way for practitioners to provide feedback to researchers on the barriers they encounter in implementing these treatments in their day-to-day clinical work. In order to provide practitioners a means to give researchers information about their clinical experience, the Society of Clinical Psychology and the Division of Psychotherapy of the American Psychological Association collaborated on an initiative to build a two-way bridge between practice and research. A questionnaire was developed on the therapist, patient, and contextual variables that undermine the effective use of CBT in reducing the symptoms of panic disorder, a clinical problem that occurs frequently in clinical practice and has an extensive research base. An Internet-based survey was advertised internationally in listservs and professional newsletters, asking clinicians to indicate all aspects of CBT that they used in treating panic disorder, and to respond to a series of questions with variables that presumably limited successful symptom reduction in clinical work using CBT to treat panic disorder. The final database included responses from 338 participants who varied in experience in applying CBT to the treatment of panic disorders. Participants identified a wide range of patient factors that were barriers to symptom reduction, including symptoms related to panic, motivation, social system, and the psychotherapy relationship, in addition to specific

problems with implementing CBT for the treatment of panic disorder.

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PANIC DISORDER, WHICH CAN BE SERIOUSLY DISABLING by virtue of the distress involved as well as the possibility of agoraphobic avoidance limiting one's functioning, is one of the more frequent anxiety disorders one is likely to encounter clinically. According to findings from the National Comorbidity Survey, panic disorder has a lifetime prevalence of 3.5%, and is twice as likely to occur among women as men (Eaton, Kessler, Wittchen, & Magee, 1994). Panic attacks themselves are readily diagnosable and are characterized by a sudden and intense fear that involves both physiological and subjective symptoms, including increased heart rate, sweating, chest pains, dizziness, palpitations, as well as fears of going crazy, losing control, and dying. This can often result in fear-related behavioral avoidance, such as the fear of crowded places, the use of public transportation, being home alone, and fear of traveling. Because the symptoms often occur "out of the blue," the unexpected and seemingly uncontrollable nature of this severe physical and emotional reaction—as well as the fear that something life-threatening may be occurring—can in and of itself enhance the distress.

Notwithstanding the highly distressing and impairing nature of panic disorder, we have nonetheless been able to develop interventions over the past few decades that have shown to be efficacious (Mitte, 2005; Westen & Morrison, 2001). Much of

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the work on developing treatment procedures began in the early 1980s and was derived from direct clinical experience, which may be thought of as the context of discovery (e.g., [Chambless & Goldstein, 1982](#); [Fishman, 1980](#)). For example, the work of Fishman in 1980 presented the field with a treatment package to deal with agoraphobia, which had been the primary diagnosis at the time, with panic existing as a secondary symptomatology. Based on his years of practice with cognitive-behavior therapy, Fishman developed a multifaceted intervention to deal with the symptoms of agoraphobia, panic, and anxiety, which consisted of applied relaxation, breathing retraining, prolonged imaginal exposure, interoceptive exposure, and in vivo behavioral exposure to deal with the agoraphobic avoidance. Depending on the individual case at hand, other cognitive-behavioral interventions were used as well, such as assertiveness training and encouragement of independent functioning.

Although there are some variations among cognitive-behavior therapists regarding how to intervene with panic, most approaches involve a common set of procedures. It typically begins with a psychoeducational phase, which helps the patient better understand and become less fearful of what they are experiencing physiologically and emotionally. They are then encouraged to self-monitor those situations in which they experience panic attacks, and eventually learn to cope with them, either with or without breathing retraining and relaxation. A good deal of emphasis is placed on cognitive restructuring, whereby catastrophic interpretations of bodily sensations are placed within a normal context of heightened arousal, and not a signal of an impending serious crisis. Some therapists make use of interoceptive exposure, whereby patients are encouraged to create the symptoms they experience during panic attacks during the session by means of exercise or hyperventilation. In addition to viewing interoceptive exposure as a means of desensitizing patients, it may also serve the function of providing them with experiences that can correct their conceptualization of panic as “coming out of the blue” and being uncontrollable. Moreover, with the use of slow, deep breathing and/or applied relaxation, patients can also learn that they can reduce these symptoms. To the extent that there is agoraphobic avoidance, graduated exposure is used as well, the goal being to encourage such avoided behaviors as traveling, the use of public transportation, being away from home, or being alone.

The results of randomized clinical trials (RCTs) in using CBT to treat panic have been very encouraging. For example, meta-analyses have found effect sizes to range from .90 to 1.55 ([Mitte, 2005](#); [Westen & Morrison, 2001](#)). Findings have also revealed that

somewhere between 70% and 80% of individuals undergoing CBT for panic disorder are able to achieve significant symptom reduction ([Craske & Barlow, 2008](#)). Despite these favorable results, there remain several factors that undermine the efficacy of the treatment.

For example, although research findings have indicated meaningful reductions in symptomatology, not all patients are panic free. Indeed, it has been found that roughly 50% remain somewhat symptomatic at the end of treatment ([Arch & Craske, 2011](#)). In treating panic disorder with agoraphobia, the average dropout rate has been found to be 19%, with a range between 0% and 54%. Longitudinal studies have found a relatively high recurrence rate of symptomatology (Arch & Craske). Moreover, the question of the extent to which the findings from RCTs are able to generalize to clinical settings has been questioned. As noted by [Craske and Barlow \(2008\)](#):

Most of the outcome studies to date are conducted in university or research settings, with select samples (although fewer exclusionary criteria are used in more recent studies). Consequently, of major concern is the degree to which these treatment methods and outcomes are transportable to nonresearch settings, with more severe or otherwise different populations and with less experienced or trained clinicians. ([Craske & Barlow, 2008, p. 33](#))

The issue of whether empirically supported treatments derived from RCTs can generalize to actual clinical settings has been much debated (e.g., [Goldfried & Wolfe, 1996, 1998](#)). In an attempt to delineate those treatments having a stronger empirical foundation, the American Psychological Association Division of Clinical Psychology Task Force on Promotion and Dissemination of Psychological Procedures (1995) was formed “to consider methods for educating clinical psychologists, third party payers, and the public about effective psychotherapies” (p. 3). After reviewing the outcome research literature, the task force came up with a list of “empirically validated” treatments, which was later referred to as “empirically supported” treatments.

As a result of the lively controversy over empirically supported treatments in the literature, there has emerged a greater recognition that other forms of evidence can inform clinical practice. In broadening the concept of empirical evidence, the [American Psychological Association Presidential Task Force on Evidence-Based Practice \(2006\)](#) made it clear that RCTs represent only one approach to providing empirical evidence that can inform clinical practice. Findings from other forms of research, such as research on clinical disorders, client characteristics and contextual variables, therapist competence, basic research on psychological processes, as well

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