FORM 3.4. Information for Patients about Panic Disorder and Agoraphobia

What Are Panic Disorder and Agoraphobia?

Almost everyone feels anxious at times. But a panic attack involves such a high level of that it can feel as if you are having a heart attack, going insane, or losing control of yourself. During a panic attack, you may have physical symptoms such as shortness of breath, tingling sensations, ringing in your ears, a sense of impending doom, trembling, a feeling of choking, chest pain, sweating, and heart pounding. You should see your physician in order to rule out medical causes for these symptoms, such as hyperthyroidism, caffeine addiction, mitral valve prolapse, or other causes. A panic attack, however, can produce the same physical symptoms as these medical conditions. When a person has recurring, unexpected panic attacks, is afraid of having more or worried about their meaning, and makes changes in his or her behavior as a result, the person is said to have “panic disorder.”

Many patients who have panic disorder also experience “agoraphobia.” Agoraphobia is fear of places or situations where a panic attack may occur or from which escape might be difficult. For example, people with agoraphobia avoid being out alone, going to supermarkets, traveling in trains or airplanes, crossing bridges, being at heights, going through tunnels, crossing open fields, and riding in elevators. Many patients even experience panic when they are asleep, possibly because the large decrease in pulse rate during sleep elicits a compensating increase in pulse rate, resulting in feeling jolted out of sleep.

Some patients with agoraphobia experience anxiety in sunlight; others become anxious in dimming light. Heat is a major factor in panic disorder—there is a dramatic increase in panic disorder and agoraphobia during the summer, primarily because heat increases pulse rate, dizziness, and dehydration, and there are more opportunities to be outside (where an individual feels more vulnerable). The individual fears that in these situations, he or she will have a panic attack.

What Are the Causes of Panic Disorder and Agoraphobia?

According to some theories, many situations that can trigger panic attacks were truly dangerous earlier in human evolution. For example, being trapped in a tunnel could lead to suffocation or collapse; heights might be dangerous; in open fields, an individual was more susceptible to predators (such as lions or wolves); public places might have brought our ancestors into contact with hostile strangers. Many of the fears involved in panic disorder and agoraphobia are reminiscent of these earlier instinctive and adaptive fears. However, these situations are not dangerous today.

Research does demonstrate that panic disorder and agoraphobia have some genetic links, but they are not entirely inherited. In any given year, 30% to 40% of the general population will have a panic attack. However, most of these people will not interpret their panic as a signal of catastrophic danger, and thus will not go on to develop panic disorder or agoraphobia.

Initially, a panic attack is usually activated by a stressful situation, such as leaving home, marital/couple conflict, surgery, new responsibilities, or physical illness. These sensations of physical arousal (heavy breathing, sweating, dizziness, pounding heart, and so on) may be misinterpreted as signals of catastrophic danger—for example, a person may focus on the increase in heart rate and jump to the conclusion that he or she is about to have a heart attack. As a result, the person may develop “hypervigilance” (that is, an excessive focus on physical sensations), which can result in increased arousal (increased physical sensations and worry). This arousal triggers further catastrophic misinter-
pretations, which we call “false alarms” because they signal that danger is imminent when it really is not. A full-blown panic attack can result from such arousal and misinterpretations. Consequently, the person develops “anticipatory anxiety” (fear that panic attacks will continue to occur) and begins to avoid situations that give rise to such anxiety—especially if escape from these situations may be difficult or embarrassing, or if help may not be readily available. In fact, when avoidance and escape become the major coping mechanisms used to handle anxiety, the person has developed agoraphobia.

An individual with agoraphobia who does not avoid feared situations altogether usually enlists the aid of a “safety person”—that is, a person who accompanies the individual into these situations in case the anxiety becomes too great and the individual needs to escape. Even though reliance on the “safety person,” avoidance, and other “safety behaviors” may mean that the individual has had no panic attacks in months, he or she often lives in fear of the next attack. The world becomes smaller and smaller as a result of the individual’s fear and avoidance. Partly because of this constriction in their lives, and partly because they feel out of control and are unsure how to handle their problem, many people with panic disorder and agoraphobia also develop depression. Some of these people become so anxious and depressed that they self-medicate with alcohol, Valium, or Xanax.

What Are Some Common Misconceptions about Panic Disorder and Agoraphobia?

Some people incorrectly believe that panic disorder is a result of deep-seated psychological problems. Of course, anyone with or without panic may have deeper problems, but panic disorder and agoraphobia are not necessarily related to deeper psychological problems. You may become depressed, dependent, and self-critical because you have panic disorder—but panic, in itself, can be treated effectively without long-term therapy exploring your childhood experiences. People with panic disorder and agoraphobia often have unrealistic beliefs about anxiety, such as “All anxiety is bad” and “I have to get rid of my anxiety immediately.” Some of these people misinterpret their anxiety as a sign of a dangerous medical condition. Others believe that because they have had panic attacks and agoraphobia for many years—and because traditional therapy has not been helpful for these problems—they can never improve. Cognitive-behavioral therapy, with or without medication, is often quite effective in the treatment of panic disorder and agoraphobia.

How Effective Is Cognitive-Behavioral Therapy for Panic Disorder and Agoraphobia?

Fortunately, there have been a number of studies examining the effects of cognitive-behavioral therapy for panic disorder and agoraphobia. These studies have been done at Oxford University in England, the University of Pennsylvania, the State University of New York at Albany, and other universities and medical schools. Over a course of 20 to 25 sessions, the efficacy rates ranges from 85% to 90%. Furthermore, once treatment is terminated, most patients who are tested 1 year later have maintained their improvement.

Medications for Panic Disorder and Agoraphobia

A number of medications have been found to be useful in the treatment of panic disorder and agoraphobia. These include antidepressants (such as Tofranil, Prozac, Zoloft, and monoamine oxidase inhibitors); Xanax and other medications for anxiety; and beta-blockers. These medications may help reduce
your arousal, but once you terminate the medication, your panic symptoms may return. Consequently, we recommend that even if you use medication for panic disorder and agoraphobia, you should also consider cognitive-behavioral therapy.

What Are Some of the Steps in Cognitive-Behavioral Treatment?

The cognitive-behavioral treatment of panic disorder and agoraphobia is organized around several goals: first, helping you to understand the nature of anxiety, panic, and agoraphobia; second, determining the range of situations that you avoid or fear; third, evaluating the nature of your particular symptoms, their severity and frequency, and the situations that elicit your panic; and, fourth, determining whether any other problems coexist with your panic—for example, depression, other anxieties, substance abuse, overeating, loneliness, or marital/couple problems.

Your therapy may include some or all of the following treatments: muscle relaxation training; breathing relaxation training and rebreathing training (especially if you hyperventilate); gradual exposure to situations that elicit panic; stress reduction; identification of your interpretation of physical stress symptoms; training in general cognitive therapy principles (that is, understanding how thoughts can lead to feelings such as fear, and learning how examining your thoughts and beliefs can help you feel better); assertion training (when needed); and training in the ability to recognize and reduce your panic symptoms when they occur. In addition, other problems that you may have (such as depression) may be addressed in the therapy.

What Is Expected of You as a Patient?

Cognitive-behavioral therapy is not a passive experience for patients. It requires your active involvement to work. You are expected to come to sessions weekly (sometimes more than once per week), to fill out forms that evaluate your problems, and to do self-help homework that you and your therapist plan and assign. As indicated earlier, most patients who participate in this treatment experience improvement in their panic disorder and agoraphobia—some experience rapid improvement. *Even if you experience rapid improvement, however, you should complete the full treatment package. Premature dropout from treatment increases the likelihood that you will have relapses.*

The course of treatment is planned for 12 sessions. The first few sessions are used for evaluation and explanation of the treatment. The last few sessions of the treatment are mainly for follow-up—these are scheduled twice a week and then once per month.

The treatment package that we use combines the excellent treatment techniques developed at Oxford University, the University of Pennsylvania, and the State University of New York at Albany. We view the treatment as a way in which you can learn how to help yourself. That is why doing homework in therapy is so important.