PANIC/AGORAPHOBIA

BEHAVIORAL DEFINITIONS

1. Complains of unexpected, sudden, debilitating panic symptoms (e.g., shallow breathing, sweating, heart racing or pounding, dizziness, depersonalization or derealization, trembling, chest tightness, fear of dying or losing control, nausea) that have occurred repeatedly, resulting in persisting concern about having additional attacks.
2. Demonstrates marked avoidance of activities or environments due to fear of triggering intense panic symptoms, resulting in interference with normal routine.
3. Demonstrates marked fear and avoidance of bodily sensations associated with panic attacks, resulting in interference with normal routine.
4. Has to have a "safe person" accompany him/her to be able to do certain activities (e.g., travel, shop).
5. Increasingly isolates self due to fear of traveling or leaving a "safe environment," such as home.
6. Avoids environments from which escape is not readily available (e.g., public transportation, in large groups of people, malls or big stores).
7. Displays no evidence of agoraphobia.

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LONG-TERM GOALS

1. Reduce the frequency, intensity, and duration of panic attacks.
2. Reduce the fear that panic symptoms will recur without the ability to manage them.
3. Reduce the fear of triggering panic and eliminate avoidance of activities and environments thought to trigger panic.
4. Increase comfort in freely leaving home and being in a public environment.
5. Learn to accept occasional panic symptoms and fearful thoughts without it affecting actions.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the history and nature of the panic symptoms. (1, 2)	1. Establish rapport with the client toward building a therapeutic alliance. 2. Assess the client's frequency, intensity, duration, and history of panic symptoms and the type and severity of avoidance (e.g., *The Anxiety Disorders Interview Schedule–Adult Version*).
2. Complete psychological tests designed to assess the depth and breadth of fear and avoidance. (3)	3. Administer surveys to assess the depth and breadth of fears and avoidance (e.g., *The Mobility Inventory for Agoraphobia*; *The Anxiety Sensitivity Index*); discuss results with client; readminister as indicated to assess treatment progress.
3. Disclose any history of substance use that may contribute to and complicate	4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation

the treatment of panic or agoraphobia. (4)

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well

recommends it (see the Substance Use chapter in this *Planner*).

as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with an evaluation by a physician for psychotropic medication. (9)

9. Arrange for an evaluation for a prescription of psychotropic medications to alleviate the client's symptoms (e.g., serotonergic medication).

6. Take prescribed psychotropic medications consistently. (10)

10. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.

7. Complete a daily journal of experiences with panic and agoraphobia. (11)

11. Ask the client to self-monitor panic and avoidance including cues, level of distress, symptoms, thoughts, and behaviors (or assign "Monitoring My Panic Attack Experiences" in the *Adult Psychotherapy Homework Planner* by Jongsma); use data throughout therapy to support therapeutic interventions (e.g., psychoeducation, cognitive restructuring).

8. Verbalize an accurate understanding of panic attacks and agoraphobia and their treatment. (12, 13)

12. Discuss how panic attacks are "false alarms" of danger, not medically dangerous, not a sign of weakness or craziness, common but often lead to unnecessary fear and avoidance; correct myths and misconceptions about panic symptoms (e.g., going crazy, dying, losing control) that contribute to fear and avoidance.

13. Assign the client to read psychoeducational chapters of books or treatment manuals on panic disorders and agoraphobia (e.g., *Mastery of Your Anxiety and*

Panic—Workbook by Barlow and Craske; *Don't Panic: Taking Control of Anxiety Attacks* by Wilson; *Living with Fear* by Marks; *Thoughts and Feelings: Taking Control of Your Moods and Your Life* by McKay, Davis, and Fanning).

9. Verbalize an understanding of the rationale for treatment of panic. (14)

10. Implement calming and coping strategies to reduce overall anxiety and to cope with the experience of panic. (15, 16, 17)

14. Discuss how exposure serves as an arena to desensitize learned fear, build confidence, and feel safer by building a new history of successful experiences.

15. Teach the client progressive muscle relaxation as a daily exercise for general relaxation and train him/her in the use of coping strategies (e.g., staying focused on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, positive self-talk) to manage symptom attacks.

16. Assign capnometry-assisted respiratory training (CART) to teach the client, by providing CO_2 level biofeedback, how to gain control over dysfunctional respiratory patterns and associated panic symptoms (e.g., lightheadedness, shortness of breath) through reducing hyperventilation and breathing more slowly and more shallow (see *Therapeutic Use of Ambulatory Capnography* by Meuret et al.).

17. Teach the client cognitive coping strategies such as encouraging positive self-talk and/or keeping focused on external stimuli and behavioral responsibilities during panic rather than being preoccupied with internal focus on feared physiological changes.

11. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (18, 19)

18. Explore the client's schema and self-talk that mediate his/her fear response, identify and challenge biases; assist him/her in replacing the distorted messages with alternatives that correct for the biases such as overestimating the likelihood of catastrophic outcomes and underestimating one's ability to cope with panic symptoms.

19. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); test fear-based predictions against alternatives using behavioral experiments; review; reinforce success, problem-solve obstacles toward accomplishing objective (see *10 Simple Solutions to Panic* by Antony and McCabe; *Mastery of Your Anxiety and Panic—Workbook* by Barlow and Craske).

12. Participate in gradual exposure to feared physical sensations until they are no longer frightening to experience. (20, 21)

20. Teach the client a sensation exposure technique in which he/she generates feared physical sensations through exercise (e.g., breathes rapidly until slightly lightheaded, spins in chair briefly until slightly dizzy), then records and allows sensations and anxiety associated with them to calm (e.g., using cognitive and/or somatic coping strategies; repeat exercise until anxiety associated with physical sensations wanes (see *10 Simple Solutions to Panic* by Antony and McCabe; *Mastery of*

	Your Anxiety and Panic—Therapist Guide by Craske and Barlow). EBP
	21. Assign the client a homework exercise in which he/she does sensation exposures and records (e.g., *Mastery of Your Anxiety and Panic—Workbook* by Barlow and Craske; *10 Simple Solutions to Panic* by Antony and McCabe); review; reinforce success, problem-solve obstacles toward accomplishing objective. EBP
EBP 13. Undergo gradual repeated exposure to feared or avoided situations. (22, 23, 24)	22. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with agoraphobia in which a symptom attack and its negative consequences are feared. EBP
	23. Select initial exposures that have a high likelihood of being a successful experience for the client; develop a plan for managing the symptoms and rehearse the plan in imagination. EBP
	24. Assign the client a homework exercise in which he/she does situational exposures and records responses (e.g., "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner* by Jongsma; *Mastery of Your Anxiety and Panic—Workbook* by Barlow and Craske; *10 Simple Solutions to Panic* by Antony and McCabe); review; reinforce success, problem-solve obstacles toward accomplishing objective. EBP
EBP 14. Implement relapse prevention strategies for managing possible future anxiety symptoms. (25, 26, 27, 28, 29)	25. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of

symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

26. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

27. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, exposure), building them into his/her life as much as possible.

28. Develop a "coping card" on which coping strategies and other important information (e.g., "Pace your breathing," "Focus on the task at hand," "You can manage it," and "It will go away") are recorded for the client's later use.

29. Schedule a "booster session" for the client for 1 to 3 months after therapy ends to track progress, reinforce gains, and problem-solve barriers.

15. Participate in Acceptance and Commitment Therapy (ACT) for panic disorder. (30, 31, 32, 33)

30. Use an ACT approach to help the client accept and openly experience anxious thoughts and feelings without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).

31. Teach mindfulness meditation to help the client recognize the negative thought processes associated with panic and change his/her relationship with these thoughts by accepting thoughts,

	images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
	32. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.
	33. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).
16. Work through developmental conflicts that may be influencing current struggles with fear and avoidance and take appropriate actions. (34)	34. Use an insight-oriented approach to explore how psychodynamic conflicts (e.g., separation/autonomy; anger recognition, management, and coping) may be manifesting as fear and avoidance; address transference; work through separation and anger themes during therapy and upon termination toward developing a new ability to manage separations and autonomy.
17. Identify and discuss unresolved life conflicts. (35)	35. Explore the client's life circumstances to help identify key unresolved conflicts that may underlie panic disorder.
18. Verbalize and clarify feelings connected to key life conflicts. (36, 37)	36. Encourage, support, and assist the client in identifying and expressing feelings related to key unresolved life issues.
	37. Assess for secondary gains the client may be receiving by remaining disordered with panic and/or agoraphobia (e.g., attention, care-receiving, avoidance of activity); directly address gains, if evident.

19. Accept or work to resolve identified life conflicts. (38)
20. Implement the Ericksonian task designed to face fear. (39)
21. Commit self to not allowing the threat of panic symptoms to control decisions in life; take actions based on personal goals rather than fear and avoidance. (40)

38. Explore the resolution of identified interpersonal or other identified life conflicts; assist the client with acceptance of those that cannot be changed or use a conflict-resolution approach to address those that can.
39. Develop and assign an Ericksonian task (see *Ericksonian Approaches* by Battino and South) that is consistent with the theme of the client's fears (e.g., the client fears traveling past a certain boundary, so ask him/her to go to it, walk a certain number of steps past it, stop, allow anxiety to come and go, and repeat); process the results with the client
40. Support the client in following through with work, family, and social activities rather than escaping or avoiding them to focus on panic symptoms.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.01	Panic Disorder Without Agoraphobia
	300.21	Panic Disorder With Agoraphobia
	300.22	Agoraphobia Without History of Panic Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.01	F41.0	Panic Disorder
300.22	F40.00	Agoraphobia
300.02	F41.1	Generalized Anxiety Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.