

When panic is overwhelming



Malcolm Falconer

This is the last article of four I have written over the past year on cognitive behavioural therapy (CBT). This article deals with the cognitive model which causes panic attacks.

But, first, here are the main points of my three previous articles, which are most relevant:

- As a therapy, CBT focuses on changing negative spirals of response to overwhelming emotions. It does so by addressing the unhelpful behaviours that are linked to inaccurate thinking about, or appraisal of, a situation that causes this emotional reaction, which often manifests as a physiological response.
- Behavioural activation is a lever for change for most mood disorders – that is arousing a person in a depressed state and causing that person to shift from being “a-motivated” to take productive action instead.
- For anxiety states, the focus is not on behavioural activation but on de-arousing the person who is exhibiting elevated behaviour and physiological responses. The aim is to bring about baseline relaxation. Breathing and mindfulness of internal states is vital to this process.

With panic disorder, as with all CBT conceptualisation and formulation, there are a number of considerations.

First, there are the predisposing factors. These include genetics, trauma, abuse, aetiology, onset etc. All these need to be assessed.

Becoming aware of how full the “bucket”

of stress and anxiety...is will reduce

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Then there are the perpetuating factors, ie, what has worked and hasn't worked in the past when the person has had a panic attack. How much reactivity, such as avoidance, maintenance and overcompensatory behaviours, in panic states needs to be considered.

Next there are the precipitating factors. These are what brought the person to seek help now. These can include sleep problems, disabling avoidance, distress, substance abuse, suicidal thoughts etc.

Finally, the protective factors need to be reinforced. These are the things that keep the person going: their family, their friends, their work, helpful coping skills, for example, exercise, breathing, yoga etc.

When fear takes over

It is estimated that up to 30 per cent of the so-called “normal” population will have occasional and unexpected panic attacks. The state of panic is a physiological response that is explained in biological theory as the reptilian brain's amygdala fear-response. This is triggered by hyperventilation, which, in turn, triggers heart palpitations and stress-hormone boost.

The biological theory is reinforced by studies that have demonstrated how it's possible to produce anxiety in normal patients, and increase panic in patients with panic disorder, by using chemicals to stimulate noradrenergic responses. However, the lack of commonality in chemically produced panic, and the broad range of medications, with differing effects on panic disorder, lends weight to the view that it is the intrapsychic, or internal, catastrophic misinterpretations of physiological responses that results in panic states.

Research has been conducted into the comparative hypersensitivity of the amygdala in panic disorder patients and, correspondingly, the comparatively less functional more recently developed brain structures, ie, the frontal lobes and emotional regulation limbic areas. Whether this anatomical difference is an adaptive response to trauma or is innate is a topic of hot debate between the “naturists and nurturists”. It is probably not this or that, but this and that.

Cognitive theory suggests, whatever the anatomical and brain-chemical issues involved, it is the catastrophic misinterpretation of the physiological responses of anxiety, ie, hyperventilation, palpitations and dizziness, which causes panic. Those who go on to develop panic disorder are those who perceive the consequences of a panic attack to be catastrophic. The outcome is a phobic “fear of

Key points

- With panic states, the aim is to de-arouse the person.
- The underlying level of stress is what predicts panic attack onset.
- If the person can identify the panic symptoms, he or she can act to alleviate them.
- Relaxation or just sitting down for 20 minutes until this neural activity subsides is a good strategy.
- If sensations become overwhelming, distraction is the best tactic.

the fear” of panic states. This may be linked to a pre-existing anxiety condition, learned experiences and coping prior to a panic attack, or the ways in which such attacks were regarded by others and responded to, or reinforced.

Panic disorder: easily treated

Despite the wide range of treatment options, panic disorder is one of the most successfully treated mental health conditions, with about half of patients gaining benefit and many being “cured” of their attacks. But, paradoxically, about half of those with the disorder drop out of treatment and continue to experience disabling symptoms. There are a number of explanations for this: panic-disorder patients seem to experience more side effects from medication; they misinterpret these side effects, and they have phobic tendencies concerning dependency, toxicity etc. Their overcompensatory control issues also reduce their level of trust in the therapist and in the interventions.

David Clark outlines his cognitive model for managing panic attacks in the figure: The Clark Model. There are intervention points at each stage of the process. This model works well for those patients who can apply it.

Triggers, bad thoughts and learning to relax

The triggering event can be identified for some people. It could be a shopping mall, driving over the Harbour Bridge, crowds etc. For others it comes “out of the blue”. However, the underlying level of stress seems to predict the onset. So, becoming aware of how full the “bucket” of stress and anxiety a person is currently carrying is will reduce the risk of “overflow” panic symptom onset.

The “trigger” at intervention point 1 may be “out of the blue” or it may be a specific event. If the person is aware of this stage in the process, “fear of the fear” becomes less phobic. If the person can identify heart-racing or rapid breathing, he or she can take action to get back into balance, for example, exercise, yoga, mindful breathing etc. These all help to reduce hyperventilation.

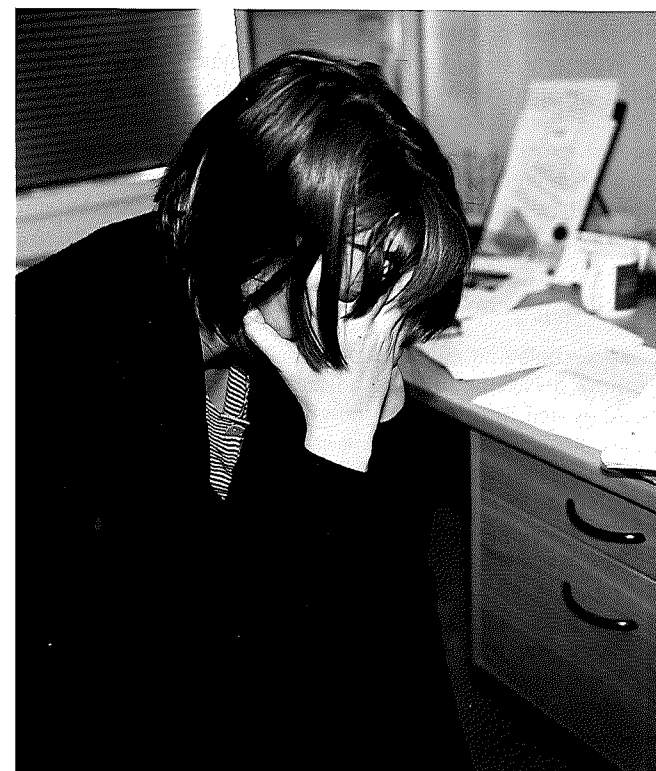
Intervention point 2 is the “automatic thoughts” stage, eg, my heart is pounding; I am losing it etc. These thoughts can be replaced by alternative thoughts. For example, “I just got overwhelmed by something and my body is responding; that's what is happening right now, so I will try and get this under control.”

However, if intervention points 1 and 2 are not identified, the emotion of fear is quickly registered by the body, which accesses memory of the fear of similar experiences, so exacerbating the emotion.

Point 3 occurs when these bodily experiences have not been checked at the “upper pathway”, ie, amygdala-to-frontal lobe and deflected, but have proceeded on the “lower pathway”. The result is stress hormones are released into the body and thought-blocking is experienced. This is because the neural activity of the amygdala reduces the effectiveness of the frontal lobes to think about how the person feels and how to problem-solve. Relaxation or just sitting down for 20 minutes until this neural activity stabilises is the best intervention at this point.

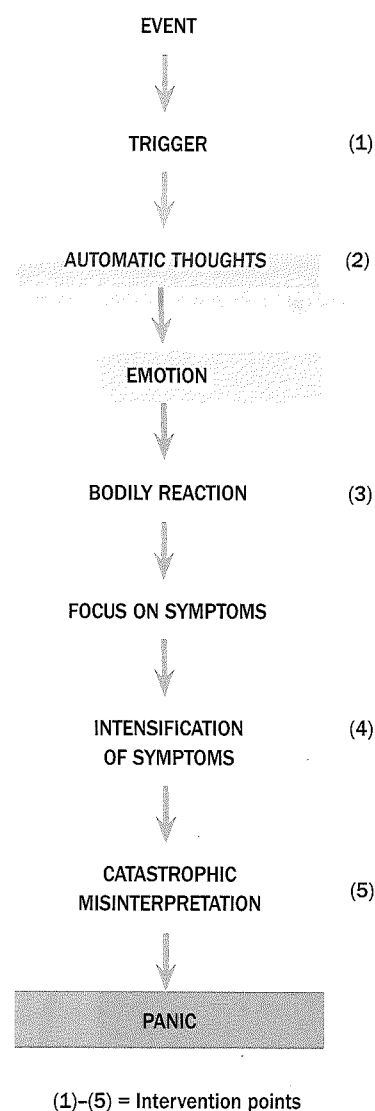
Point 4 involves focusing on sensations. Breathing difficulties, numbness, dizziness, blurred vision and nausea are caused by brain chemicals and hormones released into the body. And the more the person focuses on a sensation the more intense that sensation becomes. Distraction is the best intervention at this point.

If not stopped at intervention points 1-4, feelings intensify



It is the high level of underlying stress that causes a person to tip over and experience a panic attack – not the individual provoking incident

The Clark Model (with intervention points)



Adapted from Clark D. (1986) In Padesky CA and Mooney KA. (1997). Manual: Winter workshop in cognitive therapy, p37. Unpublished

and the person goes on to catastrophic misinterpretations. For example, I'm having a heart attack; I'm going to faint; I'm losing my mind etc. At this point the person needs to tell him or herself: “This is a panic attack; it will pass. I'm not going to die. This will pass in 20 minutes or so, so I'm just going to sit down and let it run its course.”

Malcolm Falconer is a clinical psychologist and leader of a primary mental healthcare team for ProCare Psychology Services

Further reading

Clark, DM. A Cognitive Model of Panic Attacks. In Rachman S. and Maser JD. (eds); 71-89. *Panic - Psychological Perspectives*. Lawrence Erlbaum Assoc Inc: Hillsdale NJ; 1988.