Mastering Panic Anxiety

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Epidemiologic studies place the lifetime prevalence of panic disorder between 3% and 5%. Ninety percent of those diagnosed with panic disorder have at least 1 other psychiatric diagnosis. The etiology of this disorder is most likely a combination of biological, psychological, and social factors, and the treatment options include medications, therapy, and counseling. The symptoms of a panic attack often lead patients to seek initial evaluation at a medical clinic, making it very likely that a primary care or emergency physician will be the first to see a patient suffering from this disorder.

CASE PRESENTATION

The patient is a 29-year-old single white woman who was referred to the clinic by her primary care physician for further evaluation and treatment of panic attacks. She had been started on treatment with venlafaxine extended release (XR), with the dose titrated to 225 mg/day, and experienced some improvement in her symptoms of generalized anxiety disorder, but no change in the frequency or intensity of her panic attacks. She had no other medical conditions and was taking no other medications, although she had recently been tried on clonazepam therapy with no improvement in her symptoms.

During our first meeting, she described ongoing episodes of the sudden onset of intense physical sensations and feelings of dread and fear. The episodes would start suddenly and last about 10 to 15 minutes, during which she would experience palpitations, chest tightness, sweating, shortness of breath, light-headedness, and a feeling that she was becoming very sick or dying. These episodes met DSM-IV criteria for panic attacks, and they were occurring almost every day. Her concern about the panic attacks and their consequences, and the impact that they had on her daily life, fulfilled the rest of the criteria for panic disorder without agoraphobia. She reported that her generalized anxiety and related difficulty with sleep, concentration, irritability, and muscle tension had improved markedly with psychopharmacologic intervention, and she voiced frustration with the fact that her panic attacks had continued despite her use of medications.

After working for several years at a local television network, the patient now found herself unemployed and living with her parents. She had had several panic attacks at work and became increasingly fearful of recurring attacks, to the point that her job performance suffered. On 2 separate occasions she had been taken to the emergency room directly from work after having a panic attack. She eventually quit her job despite her long-held dream of working in television. She found herself abusing alcohol for the first time in her life, and she began to use marijuana several times a week. She held a series of low-paying manual labor jobs and had been fired on multiple occasions for being consistently late for work. She believed that she was fired from one job because her boss had witnessed her having a panic attack. She could not point to any specific triggers for her panic attacks and did not avoid specific situations or places, but reported feeling like she could "lose control at any time" and that the panic attacks were actually starting to last longer and become more intense. She was very upset with her new living arrangements and seeming inability to find a "good" job and keep the ones she had found. Her recent alcohol and drug use were out of character for her, and her once-vibrant social life was described as "nonexistent."

The patient initially appeared somewhat nervous, was dressed casually, and was very polite and cooperative. She exhibited no abnormalities in her speech pattern or motor movements. She made good eye contact and described her mood as "getting upset about these panic attacks." There was no evidence of delusions, paranoia, disordered thought processes, or other psychotic symptoms. She appeared to be intelligent and did not appear intoxicated. We discussed her ongoing symptoms and the impact that her continued panic attacks were having on her daily life and overall functioning. She related feelings of despair, stating that she felt that she would never "live a normal life again" because of her disorder. We first contracted for her to cut down on her alcohol and marijuana use, with the understanding that therapy would not be

helpful to her if she continued to use alcohol and marijuana regularly.

PSYCHOTHERAPY

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She began the second session by telling me about the circumstances in which her panic attacks had occurred over the past week. I asked her to describe in detail her most recent panic attack in terms of her physical symptoms, which she was readily able to do. We then examined the thoughts that she had both during the attack and after the physical symptoms had resolved. She found this difficult at first, stating that she "did not think at all when I feel that way." I offered to "graph" her panic attack on paper with her help. With time on one axis and intensity of physical symptoms on the other, we were able to construct a curve that shot upward over the course of 1 to 2 minutes and then slowly returned to baseline after another 5 to 10 minutes. We looked at the initial upward curve, and I asked her what was going through her mind at the time the curve began to go up. She quickly said, "I think, 'Oh no, here we go again.'" Further up the curve, she stated that she began to think, "Why is this happening again; what is wrong with me?" At the peak of the curve, she reported thinking, "Am I really sick this time? Am I going to die or end up disabled?" She seemed somewhat surprised by her own thoughts as we wrote them down on the appropriate places on the graph, but was excited about the concept of "seeing" her panic attack on paper.

We examined the thoughts that we had written down, and I explained to her the concept of "automatic thoughts." We looked at the possible errors in thinking that led to her automatic thoughts related to the panic attacks, and I educated her about the nature of panic attacks in that they are self-limited and not life threatening. We worked on generating alternative thoughts by looking at the errors in her thinking and the probability that she would meet with death or disability due to one of her attacks. Since she had not sought emergency treatment for her attacks for several months despite worsening symptoms, we explored the reasons for this and found that she had already started generating her own alternative thoughts. Specifically, she was able to tell herself that there was nothing that the emergency physicians could do for her. Taking it a step further, she told me that she had been told before that she could not die from these attacks, but that it was "hard to believe that when I can't even breathe."

We then discussed the concept of the "feedback loop," and I asked her if she thought there was any relationship between her thoughts and the symptoms that she was having. I specifically asked her if she thought that her concern about the symptoms made them more intense. We talked about "short circuiting" a feedback loop by taking away one of the driving forces, and we wondered together what would happen if she were able to change the initial automatic thoughts that occurred during the onset of her physical symptoms. We were able to generate specific alternative thoughts, and she felt confident that she could "short circuit" her panic attacks.

She returned for our third session looking dejected and stating that "those things that we talked about didn't work." She described having continued panic attacks and felt that it was becoming more and more difficult to stay away from alcohol and marijuana. We reviewed her most recent panic attacks and her thoughts as they occurred. She stated that she was able to identify the onset of the symptoms and thought, "I know what this is, and I am not going to die; everything is going to be alright." As the symptoms continued, she found herself unable to keep these thoughts in her mind. Eventually, she returned to her thinking that she indeed might die, and even thought about returning to the emergency room. We reviewed the possible errors and challenged her thought that "this attack is different from the rest; this is the one that is going to kill me." She generated the alternative thought that "this attack is no different from the rest, and I know in 10 minutes I am going to be fine and will be able to get back to work."

She greeted me with a smile during our fourth session and reported that she had had only 1 panic attack over the course of 2 weeks. She then clarified this by saying that she thought she might have had several "mini" panic attacks, but they did not last very long or even feel like her usual panic attacks. We reviewed several of the "mini" attacks in terms of a "short circuited" feedback loop and examined in detail her new automatic thoughts. During our fifth session, she happily reported that she had experienced no panic attacks during the past 2 weeks and asked if it would be possible to make our next appointment for 3 weeks later. She returned stating that she had not had any panic attacks in the intervening 3 weeks. She reported that she was dating for the first time in a year and had recently moved out of her parents' house. She had become more aggressive in her job search, confiding that she had been "scared" to get a job

due to her panic attacks. We agreed to meet a month later, at which time she continued to do well. Overall, we met for 7 sessions over the course of 3 months.

Panic disorder is a potentially disabling illness that is often refractory to initial treatment. Medications are often used in the initial treatment of this disorder and can diminish the frequency and intensity of the panic attacks in some cases. Brief cognitive therapy offers another treatment option in place of or in addition to the use of medications in patients suffering from this disorder. Cognitive therapy offers patients a treatment that is effective and free of side effects and provides them with the tools to continue their treatment long after they have stopped coming to the clinic.

Editor's note: Dr. Cluver is in his third year of psychiatry residency training at the Medical University of South Carolina in Charleston. Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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