

## Brief Clinical Reports

### BRIEF PSYCHOLOGICAL TREATMENT FOR THE RELIEF OF PANIC DISORDER

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**Abstract.** This study compared complaints management training and cognitive therapy (retribution) in treating panic disorder. Both treatment groups received three sessions with initial psychoeducation. Thirty patients with panic disorder took part in the study. Assessments were carried out before and after treatment and again at a 4-week follow-up. Both groups showed similarly significant improvements and maintenance of the clinical change over the follow-up period. It is concluded that the initial psychoeducation, which conveyed to patients the cognitive-behavioural model of panic disorder, contributed to the treatment outcome.

*Keywords:* Panic disorder, complaints management training, cognitive therapy, psychoeducation, brief treatment.

#### Introduction

Brief treatment of cognitive therapy has been shown to lead to marked improvement of panic disorder (Salkovskis, Clark, & Hackmann, 1991; Arntz & van den Hout, 1996), as has an approach that conveys coping strategies for somatic symptoms thought to be triggers of attacks (Salkovskis, Jones, & Clark, 1986; Sartory & Olajide, 1988). This ‘‘complaints management training’’ (CMT) has since been extended and successfully applied in patients withdrawing from long-term use of benzodiazepines (Elsesser, Sartory, & Maurer, 1996) who are also suffering from increased sensitivity to bodily sensations. The aim of the present study was to compare CMT with cognitive treatment and, in particular, to investigate whether CMT would initially have a specific impact on fear of bodily symptoms of panics whereas cognitive therapy would have an initial effect upon thoughts relating to the dangers associated with panics. If at all, the two approaches were likely to be specific at the beginning of treatment as either anxiety reducing effect is apt to generalize. Only three treatment sessions were therefore administered.

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## Method

### *Subjects*

Thirty patients (18 w, 12 m) who met DSM-III-R criteria for panic disorder took part in the study. Their mean age was 38.2 years ( $SD = 9.0$ ) ranging from 25 to 58 years. The mean duration of the panic disorder was 4.1 years ( $SD = 7.5$ ; range = 0.8 – 39 years). Patients were referred to the outpatient treatment centre of the Psychology Department or responded to newspaper advertisements. Eighteen of the patients had previous psychiatric treatments. Among the comorbid disorders were agoraphobia ( $N = 19$ ), depression ( $N = 5$ ), social phobia ( $N = 4$ ), hypochondriasis ( $N = 2$ ) and post traumatic stress disorder ( $N = 1$ ). Patients were admitted to the study if they agreed to refrain from taking medication throughout, starting two weeks before the trial. All patients gave their informed consent to the study conditions and were medication-free at the start of treatment.

### *Design and measures*

There were two treatment groups who received either complaints management training (CMT) or cognitive therapy (CT). Treatment was administered within three weekly, individual sessions with assessments before and after treatment and again after a follow-up phase of 4 weeks. All patients kept a panic diary starting 3 weeks before treatment (baseline phase) and continuing until the end of the follow-up period. Panic attacks noted in the diary were subdivided into full (at least 4 symptoms) and minor attacks (less than four symptoms) and mean weekly frequency calculated. A number of questionnaires were completed at each of the three assessment occasions (Table 1).

### *Treatments*

To assure accurate and uniform application, treatments proceeded according to a manual with a detailed description of each session. The initial part of treatment was the same for both groups. Extensive psychoeducation was given as to anxiety and panic disorder including written materials and graphs for patients to take home.

*Complaints management training (CMT):* Patients were introduced to slow diaphragmatic breathing and – using a heart rate monitor – to the Valsalva manoeuvre (Sartory & Olajide, 1988) to effect an instantaneous decrease in heart rate. In session 2, patients were instructed to hyperventilate (breathing with 60 cycles per minute) and counter the resulting bodily symptoms with slow diaphragmatic breathing. Progressive relaxation and cued relaxation were demonstrated by the therapist. Patients were asked to continue practising all exercises at home. In session 3, the most frequently noted panic symptoms in the diary were discussed and patients were instructed in strategies designed to bring them under control (Elsesser et al., 1996). Patients were instructed to use the techniques whenever they noticed the first symptoms of attacks.

*Cognitive therapy:* The cognitive treatment was based on the re-attribution method suggested by Salkovskis et al. (1991). The most frequently noted panic symptoms in the diary were explored and a hierarchy established according to their fear-inducing properties. Sessions 2 and 3 were devoted to the re-attribution of the causes and consequences of these symptoms.

**Table 1.** Group means and standard deviations of questionnaires before and after treatment and at the follow-up assessment after one month

Variable		Complaints management training ( <i>N</i> = 15)		Cognitive training ( <i>N</i> = 15)	
		M	( <i>SD</i> )	M	( <i>SD</i> )
Trait-Anxiety	pre	54.27	(9.20)	52.67	(10.96)
	post	50.33	(9.91)	48.87	(10.20)
	follow-up	49.14	(10.56)	46.73	(10.65)
Depression (EDS)	pre	14.47	(5.74)	12.60	(6.71)
	post	10.80	(7.20)	10.87	(7.10)
	follow-up	10.14	(5.83)	10.80	(6.95)
Mobility alone (MI-A)	pre	2.47	(.96)	2.53	(1.01)
	post	2.20	(.83)	2.22	(1.08)
	follow-up	2.22	(.91)	2.17	(1.09)
Agoraphobic cognitions (ACQ) total score	pre	2.36	(.59)	2.38	(.63)
	post	1.98	(.49)	1.94	(.71)
	follow-up	2.01	(.45)	1.87	(.62)
Body sensations (BSQ)	pre	2.68	(.44)	2.92	(.72)
	post	2.28	(.36)	2.45	(.87)
	follow-up	2.45	(.56)	2.34	(.85)
Anxiety Sensitivity Index (ASI)	pre	1.82	(.58)	1.79	(.68)
	post	1.40	(.62)	1.27	(.65)
	follow-up	1.35	(.52)	1.23	(.78)

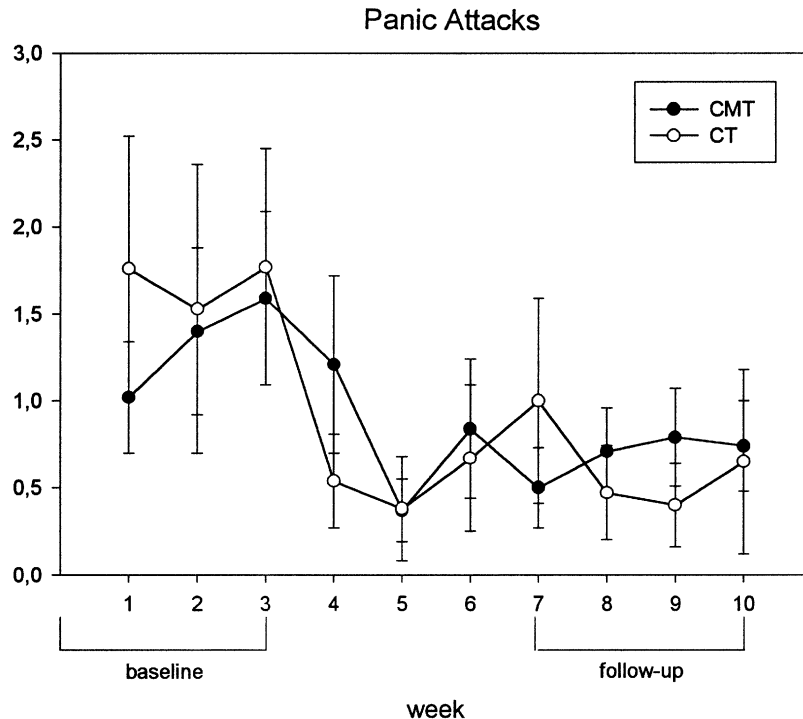
## Results

There were no significant group differences with regard to age, sex ratio, duration of the disorder, frequency of comorbid disorders and number of panic attacks during the baseline phase. Figure 1 shows the group means of the number of panic attacks as recorded in the panic diary. Groups did not differ with regard to number of panic attacks at any of the three measurement occasions. Both showed a highly significant decrease in panic attack frequency ( $\chi^2 = 15.44$ ,  $p \leq .001$ ). The same results emerged with regard to minor panic attacks.

Groups did not differ significantly with regard to per cent improvement. After the removal of an outlier, the CT group showed 59.6% ( $SD = 63.1$ ) reduction in attacks and the CMT group 54.9% ( $SD = 50.2$ ). Only three patients required further treatment at the end of the follow-up phase. There were also no significant group differences with regard to any of the questionnaire measures (Table 1), with all of them showing a significant decrease over assessment periods.

## Discussion

Complaints management training and cognitive therapy were similarly effective in improving panic frequency over the three treatment sessions. The improvement rate was considerably higher than that for placebo or a wait list control condition (Clark et al., 1994). Panic frequency started to improve with the first treatment session and not during the baseline



**Figure 1.** Group means of weekly panic attacks during the baseline, the treatment and follow-up phase (CMT: Complaints management training; CT: Cognitive therapy)

period as can be seen in Figure 1. The improvement remained stable during the follow-up period.

Contrary to our prediction, the two treatments failed to show a differential effect on either fear of bodily symptoms or cognitive aspects of anxiety. No differences were found in any of the measures after brief administration of the treatments. It is conceivable that learning to control anxiety-inducing symptoms or learning that they have no dangerous consequences will ultimately reduce their threat potential and therefore lead to fewer anxious thoughts and diminished bodily symptoms. It is, however, also conceivable that psychoeducation has a greater effect on the occurrence of panic attacks than has hitherto been acknowledged. It was given to both treatment groups and it could be argued that providing information about the symptoms of anxiety and panic attacks constitutes a form of reattribution of the panic inducing sensations. A similar pattern of results was reported by Shear, Pilkonis, Cloitre and Leon (1994) who compared cognitive treatment with a nonprescriptive treatment focusing on life problems. Initially, both groups of patients received information and a hand-out of the cognitive-behavioural model of anxiety and panic disorder. Both groups showed a similar extent of improvement after treatment. Arntz and van den Hout (1996) also noted that the initial psychoeducation may have had a major impact. The present data corroborate this view as there is an immediate reduction in panic frequency after the first treatment session, during which psychoeducation was administered.

### References

- ARNTZ, A., & VAN DEN HOUT, M. (1996). Psychological treatments of panic disorder without agoraphobia: Cognitive therapy versus applied relaxation. *Behaviour Research and Therapy*, *34*, 113–121.
- CLARK, D. M., SALKOWSKIS, M., HACKMANN, A., MIDDLETON, H., ANASTASIADIS, P., & GELDER, M. (1994). A comparison of cognitive therapy, applied relaxation and imipramine in the treatment of panic disorder. *British Journal of Psychiatry*, *164*, 759–769.
- ELSESSER, K., SARTORY, G., & MAURER, J. (1996). The efficacy of complaints management training in facilitating benzodiazepine withdrawal. *Behaviour Research and Therapy*, *34*, 149–156.
- SALKOWSKIS, P. M., CLARK, D., & HACKMANN, A. (1991). Treatment of panic attacks using cognitive therapy without exposure or breathing retraining. *Behaviour Research and Therapy*, *29*, 91–94.
- SALKOWSKIS, P. M., JONES, D. R. O., & CLARK, D. M. (1986). Respiratory control in the treatment of panic attacks: Replication and extension with concurrent measurement of behaviour and pCO<sub>2</sub>. *British Journal of Psychiatry*, *148*, 526–534.
- SARTORY, G., & OLAJIDE, D. (1988). Vagal innervation techniques in the treatment of panic disorder. *Behaviour Research and Therapy*, *26*, 431–434.
- SHEAR, M. K., PILKONIS, P. A., CLOITRE, M., & LEON, A. C. (1994). Cognitive behavioral treatment compared with nonprescriptive treatment of panic disorder. *Archives of General Psychiatry*, *51*, 395–401.