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COGNITIVE THERAPY AND EXERCISE FOR PANIC AND AGORAPHOBIA IN PRIMARY CARE: PILOT STUDY AND SERVICE DEVELOPMENT

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Abstract. Exercise is generally accepted as means of improving mental health yet few studies have examined its use in specific disorders. This study examines delivery and efficacy of cognitive behaviour therapy (CBT) for panic and agoraphobia combined with a gym-based exercise programme in a Healthy Living Centre. Preliminary evidence for this novel service has shown Group CBT followed by exercise targeting safety behaviours to be clinically successful and acceptable to clients. Details of the pilot service and some of the clinical issues are discussed

*Keywords: G*roup CBT, panic, agoraphobia, gym, exercise.

Introduction

There is increasing evidence of the relationship between regular exercise and improved mental health, yet there has been a limited number of attempts to target specific disorders through exercise. The only controlled randomized study examining exercise in panic and agoraphobia (Broocks et al., 1998) suggested that regular exercise (running outside), compared with placebo, was associated with significant improvement. This could be viewed as containing exposure or behavioural experimentation used in CBT and not purely exercise. A recent national consensus statement reports a clear beneficial effect of exercise on anxiety, but cautions, "certain subgroups may not become less anxious as a result of physical activity (e.g. people with panic disorder, with agoraphobia)" (Grant, 2000). The present study uses a model of CBT (Clark, 1986) that recognizes the potential of exercise in challenging "safety behaviours" that maintain the problem. The aim was to provide preliminary evidence that combined CBT and exercise would be effective for subjects meeting DSM-IV criteria for Panic Disorder, with or without agoraphobia. Unlike previous studies, exercise was part of a CBT package, not a separately prescribed treatment. The service was developed between a specialist CBT service and a Health Resource Centre.

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Method

Procedure

Participants received a CBT assessment, a health and exercise assessment, and completed measures pre and post treatment and at 3-month follow-up. The program was run over 6 weeks followed by two further group sessions at 1 and 3 months follow-up. A cognitive behaviour therapist and a health and fitness instructor jointly facilitated the groups and gym. Sessions involved an hour of group CBT followed immediately by an hour in the gym. All measures were self-rated. These included the Agoraphobic Cognitions Questionnaire (Chambless, Caputo, Bright, & Gallagher, 1984), the Beck Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988), the Body Sensations Questionnaire (Chambless et al., 1984), the Work and Social Adjustment Scale (Marks, 1986) and the Rosenberg Self Esteem Scale (Rosenberg, 1965).

Participants

Systematic data are available for only 16 of the 30 participants in the first three groups, and out of these 16 the mean number of sessions attended was 6. All were diagnosed with panic or panic with agoraphobia. Eleven were female and five were male, aged from 19 to 76 with a mean age of 47. Over two-thirds were receiving psychotropic medication. Of the remaining 14 cases, 6 dropped out (before session 3) and the remainder either did not attend the final session or attended but did not complete all measures. All 30 were residents of a socially disadvantaged area where accessibility and uptake of specialist psychotherapy services tends to be low. This covers three inner city wards currently rated as 36th, 131st and 183rd out of 8414 on Indices of Multiple Deprivation in England and Wales.

Treatment

Group CBT focused on Clark's 1986 model covering the two broad principles: 1) normalizing body sensations in panic, and 2) stopping safety behaviours. This included examining the panic cycle to guide individuals in identifying their catastrophic misinterpretations and safety behaviours, and then experiments to test them in the gym. Progress with this was reported in the following group. The two follow-up sessions continued this but introduced plans for maintenance and a final review of goals.

Preliminary results and discussion

Sufficient data were obtained on a subset ($n = 16$) of the initial cohort to provide changes in means, standard deviations and preliminary estimates of effect size (Cohen's d) for the standardized measures. The data show moderate effects on anxiety, agoraphobic cognitions and work and social adjustment, and larger effect sizes on fear related to specific sensations and self-esteem. Changes in the means were modest but overall results were positive, with improvement in participants' pre- and post-therapy scores equating to clinically significant change. Brief CBT in groups with exercise appears to improve self-esteem, functioning and panic symptoms as it does on a one-to-one basis. Despite initial positive results further evaluation of the package is required. In addition to evidence of clinical change, feedback from service users was very positive, in particular with reference to meeting other sufferers,

Table 1. Means and standard deviations and effect sizes for the treated group ($N = 16$)

	Pre		Post		
Measure	Mean	*SD*	Mean	*SD*	Effect size
Agoraphobic Cognitions Questionnaire	35.25	10.60	30.25	9.39	0.47
Body Sensations Questionnaire	56.60	14.84	45.90	10.30	0.72
Beck Anxiety Inventory	33.60	12.02	27.73	12.33	0.49
Work and Social Adjustment Questionnaire	18.00	10.60	13.70	6.30	0.41
Rosenberg Self Esteem	19.80	5.90	25.40	4.90	0.95

access to services in their immediate locality, and removal of stigma through being located in a community setting. Three users came off sickness benefit, one of whom returned to full-time work, one gained employment for the first time, and the other began college immediately after attending the service.

Improvement via activating body sensations in the gym was not restricted to individuals with physiologically related fears such as heart attack or chest pains. This occurred across presentations including agoraphobic fears triggered by specific public situations and non-physiological feared consequences such as losing control of the mind. This suggests the whole range of catastrophic cognitions in panic and agoraphobia are activated via increased body sensations. The health and fitness instructor's approach proved compatible with CBT. Their knowledge of body sensations and normalizing of symptoms following exertion added more credibility to the cognitive model. For example, people were told to consider their heart as a muscle and that avoiding exertion was less healthy than regularly exercising the muscle.

This pilot indicates exercise can be successfully incorporated into the cognitive model for panic. This novel delivery of CBT in non-mental health settings has proved acceptable to consumers, primary health and leisure services staff. Initial data support the efficacy of the treatment. More importantly, the package provides a service in the community, to a group of people who otherwise may have little access to specialized resources.

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