Panic Disorder and Attentional Bias: A Cognitive Approach

Sarah Penny

University of Calgary

Panic Disorder and Attentional Bias: A Cognitive Approach

Panic disorder can significantly impact one’s life, and can be extremely impairing to live with (Wiener, Perloe, Whitton & Pincus, 2011). It has been theorized that a major component to this disorder is an increased focus (also referred to as an attentional bias) on bodily sensations related to anxiety and panic (Schmidt, Lerew & Trakowski, 1997). The purpose of this paper is to explore the role that attention plays in panic disorder. To begin, panic disorder will be described, the role that attentional bias has on panic disorder is explored, and implications for counsellors treating clients with this disorder will be discussed.

Panic disorder (PD) is defined by the DSM-IV as the presence of recurrent, unexpected panic attacks and the presence of one or more of the following symptoms for a month or longer: a) persistent concern about having additional attacks; b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy") and; c) a significant change in behavior related to the attacks (American Psychiatric Association, 2000). PD is important for counsellors to be knowledgeable about, as it is one of the most common psychological disorders for which individuals seek treatment (Weiner et al., 2011). It has also been reported that between 1 and 3.5% of the population experience panic disorder at some point in their lives (DiFilippo & Overholser, 1999;Wiener et al., 2011).

Attention has been found to play a key role in cognitive theories of panic disorder (De Cort, Hermans, Spruyt, Griez and Schruers, 2008). It is theorized that individuals with PD mistake certain somatic sensations as evidence “of an impending disaster” (De Cort et al., 2008, p. 951). An example of this could be mistaking the quickening of the pulse and corresponding light-headedness for the feeling that one is about to faint. The focused attention on these bodily sensations can make them seem more severe than they actually are, contributing to further anxiety. This increased conscious attention is also known as ‘body vigilance’ (Schmidt et al., 1997). Although normal bodily awareness is important for crucial survival behaviours, such as the avoidance of serious danger, it can become problematic when the awareness takes on an increased importance, and creates psychological conceptualizations of panic sensations (Schmidt et al., 1997). According to cognitive theories of body vigilance in panic disorder, the individual experiences false alarms of panic to a perceived threat, and this creates the anticipation of a panic attack. Once the attentional focus is shifted to bodily sensations, any minute somatic responses

may lead to further panic sensations (Barlow, 1988). For example, the individual may become aware of a quickening of the pulse, and believe that a full-blown panic attack is about to follow. DiFilippo and Overholser (1999) found that increased attention on bodily sensations enhances the likelihood of the perception of physiological changes. When there is an increased perception of threat, as often occurs in panic disorder, it can lead to greater autonomic arousal, and creates a cycle of panic reactions. Therefore, attention plays a major role in panic disorder, because the more attention is focused on panic related symptoms, the more emphasized these symptoms become, and the more likely a panic attack will occur (Schmidt et al. 1997).

A commonly used approach to treat PD is cognitive-behavioural therapy (CBT) (DiFilippo & Overholser, 1999; Wiener et al., 2011). A directive approach such as CBT has been found to be effective when treating panic disorder, as opposed to non-directive approaches such as client-centered therapy (Beck, Sokol, Clark, Berchick & Wright, 1992). Furthermore, learning techniques to cope with panic attacks, such as those used in CBT, rather than relying on medication to quell the symptoms has proven to be more effective long-term (Wiener et al., 2011). There are six components that are central to cognitive behavioral treatment of PD (DiFilippo & Overholser, 1999), which will be briefly described; the first is a *therapeutic relationship*, which is the foundation for treatment. This is the supportive and collaborative partnership between client and therapist. The second component is *education*, where the client learns about the cyclic nature of attention to somatic symptoms and the resulting anxiety leading to panic. Thirdly, *passive relaxation training* encourages the client to create peaceful feelings and discourage anxious thoughts using deep breathing, muscle relaxation and positive imagery. The fourth component is *cognitive restructuring*, which involves identifying problematic thinking that is related to panic, as well as challenging dysfunctional thinking, and generating new, more positive ways of thinking. The fifth component is *behavioral exposure* which includes exposure techniques such as behavioural rehearsal to confront anxiety. Finally, *relapse prevention* focuses on reviewing coping strategies and identifying future areas of concern. CBT uses these six components to help clients effectively handle their panic disorder, and redirect their attention away from their anxiety-provoking bodily sensations.

In conclusion, attention plays an important role in panic disorder, as attention to somatic sensations associated with panic can cause further anxious reactions. It is important for people with panic disorder to re-direct their attention so their anxious thoughts and sensations do not develop into full-blown panic. Cognitive behavioural therapy is a useful approach to helping clients with PD, because it teaches clients techniques to redirect their attention away from the anxiety, and on to more peaceful and positive thoughts.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). doi:10.1176/appi.books.9780890423349.

Barlow, D. H. (1988). *Anxiety and its disorders*. New York, NY: Guilford Press.

Beck, A. T, Sokol, L., Clark, D. A., Berchick, R., & Wright, F. (1992). A crossover study of focused cognitive therapy for panic disorder. *American Journal of Psychiatry, 149*(6), 778 -783. Retrieved online from: <http://psychiatryonline.org/article.aspx?articleid=168682>.

De Cort, K., Hermans, D., Spruyt, A., Griez, E. & Schruers, K. (2008). A specific attentional bias in panic disorder. *Depression and Anxiety, 25*(11),951-955.

doi: http://dx.doi.org/10.1002/da.20376

DiFilippo, J.M. & Overholser, J.C. (1999). Cognitive-behavioural treatment of panic disorder: Confronting situational precipitants. *Journal of Contemporary Psychotherapy, 29*(2), 99-113. doi: 10.1023/A:1021952614479.

Schmidt, N.B., Lerew, D.R. & Trakowski, J.H. (1997). Body vigilance in panic disorder: Evaluating attention to bodily perturbations. *Journal of Consulting and Clinical Psychology, 65*(2), 214-220. doi:10.1037//0022-006X.65.2.214.

Wiener, C., Perloe, A., Whitton, S. & Pincus, D. (2011). Attentional bias in adolescents with panic disorder: Changes over an 8-day intensive treatment program. *Behavioural and Cognitive Psychotherapy, 40*(2)*,* 193-204. doi:10.1017/S1352465811000580.