



**Cognitive Therapy for Panic Disorder: Guidance for conducting treatment remotely (version 2)**

Cognitive Therapy is recommended by the National Institute for Health and Care Excellence (NICE) as a first line treatment for Panic Disorder (NICE, 2011). This guidance is for therapists who are familiar with delivering the treatment in face-to face sessions with clients in England’s Improving Access to Psychological Therapies (IAPT) services at Step 3 or in other settings, but would like some guidance in how to deliver it remotely. The people being treated may have already engaged with a Step 2 guided self-help treatment, but without sufficient improvement.

When working remotely using video conferencing or the phone, the standard treatment components can be used in the usual order and the treatment should be kept as similar as possible to in-person treatment. The CT for Panic Therapist Manual can be downloaded from the OxCADAT therapist resources website (<https://oxcadatresources.com/> )

It is better to use video conferencing than a phone call as video allows better identification of emotions and behaviours. This is particularly important when conducting panic symptom induction exercises. Video calls also allow therapists to model dropping safety behaviours and other key therapeutic manoeuvres.

**Basic principles**

Before starting cognitive therapy for panic disorder (CT-Panic)

- Be clear the person is experiencing panic attacks.
  - People use the term colloquially. A panic attack is a sudden rush of physical symptoms such as palpitations, chest pain, dizziness and breathlessness. It usually reaches a peak within a few minutes.
- Be clear it is panic disorder.
  - Occasional panic attacks are common across anxiety disorders. Panic Disorder describes the experience of the smaller number of people who have had repeated panic attacks (some of which come on unexpectedly or out of the blue) and who are very worried about having more panic attacks.
- The key to panic disorder is the catastrophic misinterpretation of physical sensations (e.g. heart racing means ‘I’m having a heart attack’). The fears are of imminent catastrophe rather than at a later time point as seen in health anxiety.

Some people with panic disorder find that the frequency of their panic attacks increases at times when they are generally stressed, due to work issues, interpersonal issues or times of societal stress such as the current Coronavirus Pandemic.

**Possible adaptations**

| Treatment component | Possible adaptations for remote treatment  |
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| Identify goals      | Share by email or use share screen facilities in video conference facility (Zoom/Skype/Microsoft |

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|  | Teams etc.). If using phone, goals can be written down by therapist or client and shared by email later.  |
| Use of self-report questionnaires  | In face-to-face CT-Panic therapists are encouraged to give patients a measure of the severity of panic disorder and measures of some process variables (belief in negative thoughts, safety behaviours) regularly throughout treatment. The same measures should be used to guide remotely delivered therapy. Word versions of the process measures can be downloaded from the OxCADAT resources website ( <a href="https://oxcadatresources.com/">https://oxcadatresources.com/</a> ) and emailed to patients for completion before sessions. Patients can return the completed questionnaires by email so the therapist can review them with the patient in session, perhaps via share screen. In IAPT the relevant measure of panic severity is the Panic Disorder Severity Scale (PDSS, see IAPT Manual Appendices at <a href="https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/">https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/</a> ) |
| Keeping a Panic Diary  | Have the person email the completed diary in advance of a session or view with share screen if it has not been emailed in advance.  |
| Personalised formulation (the vicious circle model)  | This can be developed in session using the screen share facility in Zoom/Skype/Teams etc. Email completed model to the person after the session or encourage them to take a screen shot.  |
| Establishing the role of safety behaviours in generating feared sensations and in preventing disconfirmation of catastrophic beliefs about the sensations. | Discussions as usual (see CT for Panic Disorder Therapist Manual). When relevant, encourage people to demonstrate their safety behaviours in the video call and observe the effects of performing the safety behaviours (e.g. breathing as in a panic attack, leading to many of the feared sensations or checking that things look real, leading to them appearing unreal). The therapist can also model dropping safety behaviours to clarify what might be required in behavioural experiments.<br><br>In phone sessions it is not possible to observe whether patients do safety behaviours (e.g. holding on to something to prevent feared collapse) during behavioural experiments so the therapist should specifically probe for them.   |
| Discussion of evidence for and against catastrophic beliefs  | This can progress in the usual manner (see Therapist Manual). Therapists can type up the evidence as the discussion progresses and either use share screen in the session or email to the person afterwards.  |
| Prediction testing behavioural experiments   | This is the heart of treatment. Numerous examples of possible experiments for testing different fearful   |

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|                                    | <p>beliefs are provided in pages 72-77 of the CT for Panic Disorder Treatment Manual. Most can be done remotely by the patient at home during a video or phone call with the therapist. The following points will help maximize the effectiveness of the behavioural experiments.</p> <ul style="list-style-type: none"> <li>• Use the behavioural experiment sheet (downloadable from Panic Disorder section of OxCADAT Resources website) to plan and record the outcome of behavioural experiments. View together with person in session using screen share or share by email before/after sessions.</li> <li>• Therapists should model the relevant behaviour before the patient is asked to do it or to do it along with the patient. This can create confidence and ensure the patient is able to do the relevant experiment.</li> <li>• It is useful to set further experiments as homework, following discussion and mutual agreement with the patient.</li> <li>• For some experiments it may be preferable for both therapist and patient to video conference on a smart phone, rather than laptop, to allow greater mobility.</li> </ul> |
| Overcoming avoidance - agoraphobia | The social restrictions that are in place to reduce the spread of COVID-19 mean that during the pandemic the main focus of therapy will be on interoceptive exposure, rather than exposure to feared external situations (such as travelling on public transport, being in crowds, etc). Research shows that reducing patients' fearful concerns about panic symptoms in this way often leads to a reduction in situational anxiety and avoidance. If this is less than complete, additional experiments in agoraphobic situations can be planned for the time when COVID-19 restrictions are lifted.   |
| Homework tasks                     | Plan and review as usual.   |
| Imagery techniques                 | Implement as usual in video sessions.   |
| Developing the therapy blueprint   | Send person a blank of the blueprint to start completing before the relevant therapy session. Complete together in session, perhaps using screen share.   |

### Managing a panic attack remotely

- Same principles apply as if in person.
- If it happens at assessment or before the formulation and vicious circle model has been developed, allow person to use whatever strategies they usually use to help (breathe deeply, open window etc). Subsequently, use as an opportunity to help the person learn more about what triggers panic attacks (for example talking about feared sensations or catastrophes, see pages 43-44 in the Manual), and how the feared catastrophes don't happen, even when they don't use their safety behaviours.

- If it happens once the formulation and treatment direction are clear then try to support the person in riding out the attack, discovering that panic attacks feel horrible but aren't actually dangerous.
- The main difference working remotely is that you may not have all the same observable cues as with in person treatment so you need to ask more frequently what sensations are being experienced in the moment, and whether they are using any safety behaviours mentally or that you can't see.
- Remember, ultimately you want the person to experience a panic attack in treatment and to discover that the worst fears / catastrophes don't occur.

### **Health status**

As with in person treatment some interventions may be contraindicated for some people. For example, strenuous hyperventilation should not be done if the person is severely asthmatic, has COPD, a cardiovascular disease, or is pregnant. Agreement from the person's family doctor (GP) or other relevant health professional should occur before such strategies are used (see Therapist Manual).

### **Breathlessness and COVID-19**

Feeling short of breath is one of the most common symptoms of a panic attack. As COVID-19 can cause difficulty breathing, it is likely that some patients with long-standing panic attacks may worry that the shortness of breath they experience in panic attacks is a sign that they have contracted the virus. One of the most helpful ways of dealing with this concern is to discuss the similarities and differences between shortness of breath in the person's panic attacks and as typically reported in COVID-19. For example, shortness of breathe in COVID-19 tends to be a later symptom, preceded by a fever and a dry cough. It is also not short-lived in the way that panic attacks are. A similar process would be used for asthma, COPD and other health concerns.

### **Support from others**

A partner or other supporters could join the video / phone sessions in order to help the person with their homework tasks – initially with them, and then encouraging them to do by themselves.

### **Further Resources**

The Therapist Manual for face-to-face Cognitive Therapy for Panic Disorder and other useful materials can be downloaded from the OxCADAT Therapist Resources website (<https://oxcadatresources.com/>. ) You will need to register as a clinician to access these materials. There is no charge. The Manual is written for therapists who already have a core training in cognitive behaviour therapy and, as a consequence, it does not cover the foundation CBT skills that the treatment builds on. The Panic Disorder NICE guideline, is available at [www.nice.org.uk/guidance/cg113](http://www.nice.org.uk/guidance/cg113).

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