

Chapter 1 *Introductory Information for Therapists*

Development of This Treatment Program and Its Evidence Base

Research on the efficacy of nonpharmacological treatments for the various anxiety disorders has been ongoing for over two decades at our institutions, the Center for Anxiety and Related Disorders at Boston University and the University of California, Los Angeles, Anxiety Disorders Behavioral Research Program. Developments in the conceptualization of panic attacks and Panic Disorder (PD) in the 1990s made possible significant improvements in the psychological treatment of PD and the development of panic control treatment (PCT), a treatment for panic disorder with proven effectiveness. As a result, we received many requests to inform mental health professionals of the ways in which the treatment is conducted. After completing a series of workshops, we recognized the value of a guide outlining the treatment procedures. Hence, the *Mastery of Your Anxiety and Panic, Workbook* and *Mastery of Your Anxiety and Panic, Therapist Guide* were written and have now been revised. Now in its fourth edition, the revised client workbook is written in a style suitable for the client's direct use, under the supervision of a trained professional.

Efficacy of Panic Control Treatment

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The PCT described has undergone many independent evaluations. Specifically, PCT is more effective than general relaxation training (Barlow, Craske, Cerny, & Klosko, 1989) and typically yields panic-free rates in the range of 70–80% and high end-state rates (i.e., within normative ranges of functioning) in the range of 50–70% (e.g., see Barlow, et al., 1989). Also, results generally maintain over follow-up intervals for as long

as two years (Craske, Brown, & Barlow, 1991). This contrasts with the higher relapse rates typically found with medication approaches to the treatment of PD, particularly, high potency benzodiazepines (e.g., Gould, Otto, & Pollack, 1995). One analysis of individual profiles over time suggested a less optimistic picture in that one third of clients who were panic free 24 months after PCT had experienced a panic attack in the preceding year, and 27% had received additional treatment for panic over that same interval of time (Brown & Barlow, 1995). Nevertheless, this approach to analysis did not take into account the general trend toward continuing improvement over time. Thus, rates of eventual therapeutic success may be underestimated when success is defined by continuous panic-free status since the end of active treatment.

The effectiveness extends to patients who experience *nocturnal panic attacks*, panic attacks from out of sleep (Craske, Lang, Aikins, & Mystkowski, 2005). Also, PCT is effective even when there is comorbidity and some studies indicate that comorbidity does not reduce the effectiveness of PCT for PD (e.g., Brown, Antony, & Barlow, 1995; McLean, Woody, Taylor, & Koch, 1998). Furthermore, PCT results in improvements in comorbid conditions (Brown, Antony, & Barlow, 1995; Tsao, Lewin, & Craske, 1998; Tsao, Mystkowski, Zucker, & Craske, 2002, 2005). In other words, co-occurring symptoms of depression and other anxiety disorders tend to improve after PCT for PD. However, one study suggests that the benefits for comorbid conditions may lessen over time when they are assessed two years after PCT (Brown et al., 1995). Nonetheless, the general finding of improvement in comorbidity is significant since it suggests the value of remaining focused on the treatment for PD even when comorbidity is present since the comorbidity will be benefited as well, at least up to one year. In fact, there is preliminary evidence to suggest that attempting to address PD simultaneously along with comorbidity using cognitive-behavioral therapy (CBT) tailored to each disorder may be less effective in general than remaining focused on PD (Craske et al., 2005), although this finding is in need of replication.

Also, applications of PCT have proven very helpful in lowering relapse rates on discontinuation of high-potency benzodiazepines (e.g., Otto, Pollack, Sachs, Reiter, Meltzer-Brody, & Rosenbaum, 1993; Spiegel, Bruce, Gregg, & Nuzzarello, 1994). Procedures for benzodiazepine withdrawal are detailed in *Stopping Anxiety Medication: Panic Control Ther-*

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apy for Benzodiazepine Discontinuation, Therapist Guide and Stopping Anxiety Medication: Panic Control Therapy for Benzodiazepine Discontinuation, Workbook (Otto, Pollack, & Barlow, xxxx), available as part of the Treatments *ThatWork*TM series from Oxford University Press.

The efficacy of psychological treatments for panic has been demonstrated in several other institutions around the world, using the same or similar approaches, by clinicians and researchers such as Beck (1988); Clark, Salkovskis, and Chalkley (1985); Clark, Salkovskis, Hackmann, et al. (1994); and Ost (1988). Although they are derived from somewhat different theoretical perspectives, most of these treatments to some degree involve: (a) re-education about the nature of panic attacks; (b) breathing skills training or relaxation; (c) cognitive therapy directed at negative cognitions associated with panic; and (d) exposure to interoceptive somatic cues. PCT highlights interoceptive exposure to feared bodily sensations by providing a variety of unique methods of provoking these sensations in a mild way in the office. In 1991, the National Institute of Mental Health published the results of a consensus conference recommending that the treatments of choice for PD, based on research to date, are cognitive-behavioral approaches, such as PCT; medications; or both. Empirical studies since then continue to uphold the strong efficacy of PCT for PD, leading to its classification as an empirically validated treatment (Chambless et al., 1996). Two meta-analyses reported very large effect sizes of 1.55 and 0.90 for CBT (including PCT) for PD (Mitte, 2005; Westin & Morrison, 2001).

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Efficacy of Cognitive-Behavioral Treatment for Agoraphobia

The CBT for agoraphobia typically incorporates cognitive restructuring, some form of breathing skills training, and in vivo exposure to feared agoraphobia situations. In this guide, these methods are combined with strategies for deliberately facing feared somatic sensations in agoraphobia situations. Researchers since the 1970s have established the efficacy of this type of CBT, in one form or another, for agoraphobia. Randomized controlled studies that include an index of clinically significant change yield the following average statistics: after an average of 12 treatment sessions and a 17% rate of attrition, 69% of participants show

some level of clinically significant improvement by posttreatment, as do the same percentage by follow-up assessment. High end-state, meaning normative levels of functioning, is attained by 50% by posttreatment and by 59% by follow-up (see Craske, 1999). The trend for continuing improvement over time is noteworthy in this regard. Furthermore, Fava, Zielezny, Savron, and Grandi (1995) found that only 18.5% of their panic-free clients relapsed over a period of five to seven years after exposure-based treatment for agoraphobia. Some research suggests that the trend for improvement after acute treatment is facilitated by the involvement of significant others in every aspect of treatment (e.g., Cerny, Barlow, Craske, & Himadi, 1987). For this reason, our program describes methods for involving significant others in the treatment process. As with PCT, CBT for agoraphobia is considered an empirically validated treatment (Chambless et al., 1996). Recently, an intensive, eight-day treatment, using a sensation-focused PCT approach was developed for individuals with moderate to severe agoraphobia, and initial results are promising (Morissette, Spiegel, & Heinrichs, 2005).

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Dismantling CBT for Panic and Agoraphobia

Attempts have been made to dismantle the different components of PCT and CBT for agoraphobia. The results are somewhat confusing, and they are dependent on the samples used (e.g., mild versus severe levels of agoraphobia) and the exact comparisons made. It appears that the cognitive therapy component may be effective (e.g., Williams & Falbo, 1996), even when conducted in full isolation from exposure and behavioral procedures (e.g., Salkovskis, Clark, & Hackman, 1991), and is more effective than applied relaxation (e.g., Arntz & van den Hout, 1996; Beck et al., 1994; Clark et al., 1994). On the other hand, some studies find that cognitive therapy does not improve outcome when added to in vivo exposure treatment for agoraphobia (e.g., van den Hout, Arntz, & Hoekstra, 1994; Rijiken, Kraaimaat, De Ruiter, & Garssen, 1992). Similarly, one study found that for agoraphobia, breathing skills training and repeated interoceptive exposure to hyperventilation did not improve outcome beyond in vivo exposure alone (de Beurs, Lange, van Dyck, & Koele, 1995), and we found that breathing skills training was slightly less effective than interoceptive exposure when each was added to cognitive

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restructuring (Craske, Rowe, Lewin, Noriego-Dimitri, 1997). Clearly, more dismantling research is needed.

Cost-Effective Treatments for Panic and Agoraphobia

Group formats appear to be as effective as individual-treatment formats for PCT and behavioral treatment for agoraphobia (Neron, Lacroix, & Chaput, 1995; Lidren et al., 1994). One possible exception is that individual, one-on-one formats may be better in the long term with respect to symptoms of generalized anxiety and depression (Neron et al., 1995). However, more direct comparison between group and individual formats is warranted before firm conclusions can be made.

Most of the studies described above averaged around 11–12 treatment sessions. On the one hand, four to six sessions of PCT (Craske, Maidenberg, & Bystritsky, 1995; Roy-Byrne, Craske, Stein, Sherbourne, Bystritsky, Golinelli, Katon, & Sullivan, 2005) seem effective also, although the results were not as effective as those typically seen with 11–12 treatment sessions. On the other hand, another study demonstrated equally effective results when delivering CBT for PD across the standard 12 sessions versus approximately six sessions (Clark, Salkovskis, Hackmann, Wells, et al., 1999), and a pilot study indicated good effectiveness with intensive CBT over two days (Deacon & Abramowitz, 2006).

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Computerized versions of CBT for PD now exist. Computer-assisted and Internet-based versions of CBT are effective for PD (e.g., Richards, Klein, & Carlbring, 2003). In one study, a four-session, computer-assisted CBT for PD was less effective than a 12-session PCT at posttreatment, although they were equally effective at follow-up (Newman, Kenardy, Herman, & Taylor, 1997).

Finally, self-directed treatments, with minimal direct contact with a therapist, are very beneficial to highly motivated and educated clients (e.g., Ghosh & Marks, 1987; Gould & Clum, 1995; Gould, Clum, & Shapiro, 1993). Nevertheless, we generally recommend that a mental health professional conduct and supervise this treatment because not all clients are highly motivated, educated, or able to fully appreciate the nuances of the cognitive and behavioral therapeutic strategies.

However, findings from computerized programs for emotional disorders in general indicate that such treatments are more acceptable and successful when they are combined with therapist involvement (e.g., Carlbring, Ekselius, & Andersson, 2003).

Pharmacological Treatments for Panic and Agoraphobia

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Currently, serotonin-specific reuptake inhibitors (SSRIs) are the medication treatment of choice for PD, based on 19 positive, placebo-controlled, randomized clinical trials (Roy-Byrne & Cowley, 2002). Meta-analyses and reviews have reported medium to large effect sizes compared to placebo (e.g., Mitte, 2005; Bakker, van Balkom, & Spinhoven, 2002). The majority of trials have been short term, although several have examined and confirmed longer-term efficacy up to one year.

Benzodiazepines are effective agents for PD. They work rapidly, within days to one week, and are even better tolerated than the very tolerable SSRI class of agents. However, they are limited by their risk of physiologic dependence and withdrawal and by the risk of abuse (Roy-Byrne & Cowley, 2002)

Numerous studies clearly show that discontinuation of medication results in relapse in a significant proportion of patients, with placebo-controlled discontinuation studies showing rates between 25–50% within six months, depending on each study's design. In addition, SSRIs, serotonin-norepinephrine reuptake inhibitors (SNRIs) and benzodiazepines are associated with a time-limited withdrawal syndrome (considerably worse for the benzodiazepines) which itself may serve as an interoceptive stimulus that promotes or contributes to PD relapse.

In terms of comparison between pharmacological and psychological approaches to the treatment of PD, we compared the antidepressant imipramine, CBT, placebo, a combination of CBT and placebo, and a combination of CBT and imipramine in patients with PD uncomplicated by depression or significant agoraphobia (Barlow et al., 2000). This landmark study showed that all four active treatments were equivalent at the end of the acute (three-month) phase and that the combination of imipramine and CBT was marginally superior to either treatment alone

at six months (consistent with prior reports of the superiority of combined treatment in more complicated panic). Following discontinuation, however, patients receiving the CBT plus imipramine combination fared somewhat worse than those receiving CBT alone, suggesting the possibility that state- or context-dependent learning in the presence of imipramine may have attenuated the new learning that occurs during CBT (Bouton, Mineka, & Barlow, 2001).

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Findings from the combination of fast-acting anxiolytics—and, specifically, the high-potency benzodiazepines with behavioral treatments for agoraphobia—are contradictory (e.g., Marks et al., 1993; Wardle et al., 1994). Nevertheless, several studies reliably show detrimental effects from chronic use of high-potency benzodiazepines on short-term and long-term outcome from PCT and cognitive-behavioral treatments for agoraphobia (e.g., Otto, Pollack, & Sabatino, 1996; van Balkom, de Beurs, Koele, Lange, & Van Dyck, 1996; Wardle et al., 1994). Specifically, there is evidence for more attrition, poorer outcome, and more relapse with chronic use of high-potency benzodiazepines.

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Therapist Variables

Therapist variables have been understudied with respect to cognitive-behavioral treatments. Williams and Chambless (1990) found that patients who rated their therapists as caring or involved and as modeling self-confidence achieved better outcomes on behavioral-approach tests. However, an important confound in this study is that client ratings of therapist qualities may have depended on client responses to treatment. Keijsers, Schaap, Hooghuin, and Lammers (1995) reviewed findings regarding therapist-relationship factors and behavioral outcome. They conclude that empathy, warmth, positive regard, and genuineness assessed early in treatment predict positive outcome. Second, patients who view their therapists as understanding and respectful improve the most. Also, patient perceptions of therapist expertness, self-confidence, and directiveness related positively to outcome, although not consistently. In their own study of junior therapists who provided cognitive-behavioral treatment for PDA, Keijsers, et al. (1995) found that therapists used more empathic statements and more questioning in the first session than

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in later sessions. In the third session, therapists became more active and offered more instructions and explanations. In the tenth session, therapists employed more interpretations and confrontations than previously. In fact, directive statements and explanations in the first session predicted poorer outcome. Empathic listening in the first session related to better behavioral outcome, whereas empathic listening in the third session related to poorer behavioral outcome. Thus, they demonstrated the advantages of different interactional styles at different points in therapy.

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Finally, Huppert, et al. (2001) demonstrated that the experience of therapists positively influenced outcome, seemingly because these therapists were more flexible in administering the treatment and better able to adapt it to the individual being treated (Huppert, Barlow, Gorman, Shear, & Woods, in press).

Outline of This Treatment Program

It is our intention that the *Mastery of Your Anxiety and Panic, Fourth Edition (MAP-IV)*, although written for the client, be carried out under the supervision of a mental health professional. We recommend this practice because many of the concepts and procedures are relatively complex. The most effective implementation requires an understanding of the principles underlying the different procedures. Therefore, the mental health professional should be fully familiar with the therapist guide and client workbook and aware of the conceptual bases for the different techniques.

The following outline presents a recommended pace for working through the chapters in the workbook. It is important to realize that the pace is likely to shift based on the client's own profile of panic, anxiety, and agoraphobia. For example, clients will spend much less time on chapter 7 if they avoid only a limited number of agoraphobia situations.

Week 1 Chapter 2: Learning to Record Panic and Anxiety
 Chapter 3: Negative Cycles of Panic and Agoraphobia
 Chapter 4: Panic Attacks Are Not Harmful
 Chapter 11, Section 1: Medications (Education)

- Week 2 Chapter 5: Establishing Your Hierarchy of Agoraphobia Situations
- Chapter 6, Section 1: Breathing Skills (Diaphragmatic Breathing)
- Chapter 7, Sections 1 and 2: Thinking Skills (Basics; Realistic Odds)
- Week 3 Chapter 6, Section 2: Breathing Skills (Slow Breathing)
- Chapter 7, Section 3: Thinking Skills (Putting Things Into Perspective)
- Week 4 Chapter 6, Section 3: Breathing Skills (Coping Application)
- Chapter 7, Section 4: Thinking Skills (Review; Memories)
- Chapter 8, Section 1: Facing Agoraphobia Situations (Planning)
- Chapter 9: Involving Others
- Week 5 Chapter 6, Section 4: Breathing Skills (Review)
- Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
- Chapter 10, Section 1: Facing Physical Symptoms (Assessment and Practice)
- Week 6 Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
- Chapter 10, Section 2: Facing Physical Symptoms (Review and Practice)
- Week 7 Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
- Chapter 10, Section 2: Facing Physical Symptoms (Review and Practice)
- Week 8 Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)

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- Chapter 10, Section 3: Facing Physical Symptoms (Review and Practice; Activities Planning)
- Week 9 Chapter 8, Section 2: Facing Agoraphobia Situations (Review and Planning)
- Chapter 10, Section 3: Facing Physical Symptoms (Review and Practice; Activities Planning)
- Week 10 Chapter 8, Section 3: Facing Agoraphobia Situations (Symptoms)
- Chapter 10, Section 3: Facing Physical Symptoms (Review and Practice; Activities Planning)
- Week 11 Chapter 8, Section 3: Facing Agoraphobia Situations (Symptoms)
- Chapter 10, Section 3: Facing Physical Symptoms (Review and Practice; Activities Planning)
- Week 12 Chapter 11, Section 2: Medications (Stopping Medications)
- Chapter 12: Accomplishments, Maintenance, and Relapse Prevention

Ideally, clients will meet with their therapist to cover the material in the introductory chapter and to review the principles of chapter 2 (“Learning to Record Panic and Anxiety”) of the workbook. The client is asked to read chapter 2, begin to record panic and anxiety, and read chapters 3 and 4, as well as chapter 11, section 1. At the second visit, the therapist reviews the material in chapters 3 and 4 and chapter 11, Section 1, and then assists clients in establishing a hierarchy of agoraphobia situations and in beginning to use coping skills, and so on. At the end of each visit with the therapist, we suggest that clients read the chapters relevant to the material to be covered in the next visit with the therapist. Thus, suggested readings are provided as homework in the client workbook. If preferred, therapists may suggest that clients only read the relevant chapters after the material is discussed in session.

This therapist guide provides session outlines, the concepts and principles underlying the therapeutic procedures, the relevant therapist behaviors, vignettes depicting typical questions asked by clients, and prob-

lems that may arise in each chapter. Each chapter in this guide is structured as follows: (a) materials needed; (b) session outline; (c) therapist behaviors; (d) main concepts and principles underlying the particular treatment procedures included in the chapter; (e) case vignettes that reflect typical types of questions asked in each chapter and examples of therapist responses; and (f) atypical or problematic client responses. A final chapter in the therapist guide discusses ways in which this treatment is modified for primary care settings. A separate workbook for this six-session program is available from Oxford University Press.

Who Will Benefit From This Program?

The *MAP-IV* workbook is geared toward people who suffer from panic or anxiety attacks and agoraphobia. It is ideal for those who meet the criteria for PD, with or without agoraphobia, according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (1994), fourth edition (*DSM-IV*). However, it will be useful for clients who suffer occasional panic attacks but who do not meet the severity criteria for PD or who show only mild signs of agoraphobia. In addition, it will be useful for people suffering from more discrete phobias such as claustrophobia, fear of heights, or fear of driving. This is because many of these phobias are associated with unexpected panic attacks, although the avoidance behavior that develops is very circumscribed. However, we also have a therapist guide and a workbook especially designed for specific phobias: *Mastery of Your Fears and Phobias, Therapist Guide* (xxxx) and *Mastery of Your Fears and Phobias, Workbook* (xxxx) are available from Oxford University Press.

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What If Other Problems Are Present?

It is not at all uncommon for people with panic attacks and agoraphobia to be depressed, to have other anxiety disorders, or to exhibit features of a variety of personality disorders. None of these problems precludes treatment using *MAP-IV*. However, we have taken the approach that the most severe and disabling problem should be the problem that is targeted first for treatment. For example, if certain clients present with a

major depressive episode that is clearly more severe than their panic attacks, then the depression should be treated first, and they can perhaps return to treating their panic and agoraphobia after the depressed mood has alleviated. This would be our recommendation even if the depression developed secondary to, or as a consequence of, panic and agoraphobia. On the other hand, if clients present with both conditions, but the PD and agoraphobia are clearly equally or more severe than the depression, then it is appropriate to proceed with our workbook. The same is true for other comorbidities. Keep in mind that comorbid conditions tend to improve, at least for some period of time, with successful treatment of PD (see chapter 1). That being said, our assumptions about which constellation of symptoms should be treated first are based on clinical experience and have not been empirically tested.

This program is not appropriate for clients who are generally anxious or depressed without the complication of panic attacks and agoraphobia. Different treatment protocols have been developed and evaluated for people suffering from more generalized anxiety, stress, and associated depression. On occasion, people with a broad pattern of hypochondriacal complaints may think this program is appropriate. However, other approaches exist that are more suited to hypochondriasis. Thus, it is important to distinguish people suffering from PD from those with a more generalized anxiety, stress, depression, or somatoform disorder.

Finally, clients who are undergoing major life stressors, such as marital or financial crises, may not have the time or energy to devote to this type of treatment program and are best advised to postpone beginning such a treatment until their other major problems are resolved.

Assessment

Mental health professionals may wish to screen clients using the *Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV)*, which was designed for this purpose. Specifically, this semistructured interview provides a very detailed analysis of the nature of the anxiety or panic, the ability to determine if one or more anxiety and/or mood disorders is present, as well as the ability to measure the relative severity of each disorder. A par-

ticular strength of this interview is that it helps to differentiate among the different anxiety and somatoform disorders. *ADIS-IV* is available from Oxford University Press.

Furthermore, a medical evaluation is generally recommended because several medical conditions should be ruled out before assigning the diagnosis of PD. These include thyroid conditions, caffeine or amphetamine intoxication, drug withdrawal, or pheochromocytoma (a tumor on the adrenal gland which produces excess adrenaline). Fortunately, most PD clients have had complete medical evaluations already. Furthermore, certain medical conditions can exacerbate Panic Disorder, although PD is likely to continue despite those conditions' medical control. Mitral valve prolapse, asthma, allergies, and hypoglycemia fall into this category. These medical conditions exacerbate PD to the extent that they elicit the types of physical sensations now feared by the individual. For example, mitral valve prolapse can produce heart murmurs; asthma results in shortness of breath; and hypoglycemia causes dizziness and weak feelings.

Several standardized self-report inventories provide useful information for treatment planning, as well as being sensitive markers of therapeutic change. The Mobility Inventory (Chambless et al., 1984) lists common agoraphobia situations that are rated in terms of degree avoidance, both when alone and when accompanied. This instrument is very useful for establishing in vivo exposure hierarchies. The Anxiety Sensitivity Index (Reiss, Peterson, Gursky, & McNally, 1986) has received wide acceptance as a trait measure of threatening beliefs about bodily sensations. It has good psychometric properties and tends to discriminate PD from other types of anxiety disorders. More specific information about which particular bodily sensations are feared the most, and what specific misappraisals occur most often, can be obtained from the "Body Sensations Questionnaire" and the "Agoraphobia Cognitions Questionnaire" (Chambless et al., 1984).

Ongoing assessment throughout treatment is provided by the self-monitoring procedures outlined in chapter 2 of the workbook.

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Medication

Many people suffering from panic attacks and agoraphobia will be referred to mental health professionals while already on psychotropic medication, most often prescribed by primary care physicians. In our experience, almost three quarters of our clients take low doses of benzodiazepines or minor tranquilizers, tricyclic antidepressants, or selective SSRIs. As described in the last chapter, issues surrounding the combination of medications with CBTs are complex and not fully understood. The most effective ways of combining CBTs with an already-existing medication regimen are yet to be empirically tested. Thus, we make no recommendation that already-medicated clients decrease their medication before beginning our workbook. Rather, we suggest that they continue with whatever dosage of medication they are taking until they complete the workbook.

We do discourage clients from increasing dosages of medication, particularly benzodiazepines, during the course of treatment because, as reviewed in the previous chapter, there is some evidence that high dosages of benzodiazepines may interfere with the effects of PCT. It is believed that high doses of these drugs may have a number of negative effects; they may lessen the motivation to practice cognitive-behavioral skills; result in such little fear and anxiety that exposure-based treatments are no longer valuable; generate a strong attribution of therapeutic improvement to the medication in a way that detracts from the development of self-efficacy; cause medications to become safety signals that detract from learning to correct misappraisals of danger; or cause state dependency of learning, so that skills learned under the influence of the drug may not generalize to times when the drug is discontinued.

In our experience, a large proportion of clients successfully completing the workbook stop all medication use on their own, without any encouragement to do so. Nevertheless, issues of medication withdrawal are discussed in chapter 11 of the workbook. We have found it helpful to use the *MAP-IV* program as an aid for discontinuing medication if clients and prescribing physicians so desire. The program assists clients in tolerating the withdrawal effects of certain medications, particularly, the benzodiazepines. A modification of the *MAP-IV* program has been de-

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veloped as a tool for facilitating the discontinuation of high doses of benzodiazepines in clients who have become dependent on them (Otto, Pollack, & Barlow, 1996). *Stopping Anxiety Medication, Therapist Guide*, and *Stopping Anxiety Medication, Patient Workbook*, are available from Oxford University Press.

Who Should Administer the Program?

The *MAP-IV* workbook is presented in sufficient detail, so that most mental health professionals should be able to supervise its implementation. Efforts are underway to evaluate the issue of program leadership in more detail; there are already studies in primary care settings showing that these kinds of treatments can be delivered without years of specialized clinical expertise. However, we do have some recommendations for minimal requirements. Of most importance is familiarity with the nature of anxiety and panic; some basic information on these topics is presented in chapter 3. Familiarity with the basic principles of cognitive and behavioral intervention is another recommended minimal requirement. In addition, we believe it is important that therapists have sufficient knowledge of the principles underlying the specific treatment in this workbook to allow adaptation of the material to best suit each client. Provision of this knowledge is the purpose of this therapist guide. (More in-depth information can be found in the References and Additional Readings sections.)

Should Former Clients Be Cotherapists?

Many programs, particularly those targeting agoraphobia avoidance behavior, utilize ex-clients as cotherapists or team leaders. These therapists often act as supervisors during in vivo exposure exercises. The philosophy behind this approach is that these ex-clients have struggled through similar problems and can therefore act as good role models for clients currently struggling with panic and associated problems. In addition, these individuals tend to be very understanding and supportive during the process. This is the positive side of the picture.

On the other hand, some less positive aspects have been reported. Sometimes, ex-clients, because of their own success, believe that there is only one correct way to accomplish various tasks. They may not understand the reasons why a client does not wish to work in the same way that they did or to work at the same speed. In other words, they may not be as adept at tailoring the program to individual clients as is the fully trained, professional therapist.

Therapists will have to decide whether the positive aspects of using ex-clients outweigh the potential negatives. Obviously, this decision will depend on the individual ex-client. To date, no research has determined the effectiveness of working with ex-clients. What we do know is that our workbook program has been evaluated and shown to be successful when administered by mental health professionals without the help of ex-clients.

Additional Training Opportunities

For more information on training opportunities, please visit the Treatments *That Work*TM website (<http://www.oup.com/us/ttw>).

Group Versus Individual Sessions

We have administered this program in both individual and group formats. As noted in the previous chapter, there are few direct empirical evaluations of individual versus group formats, but those that exist suggest that they are about equally effective. Possible exceptions are that generalized symptoms of anxiety and depression may be helped more by an individual format, and rates of attrition may be higher from group than from individual sessions.

The decision for group versus individual treatments should probably be determined on a site-by-site basis in accord with therapist preferences. Health maintenance organizations (HMOs) typically administer our program in groups of six to eight to take advantage of the economies afforded by this mode of administration. On the other hand, private practitioners who do not wish to make clients wait until a group forms

may find individual administration more convenient. When we deliver group treatments, we limit the number of group members to no more than eight because it is difficult to allocate individual attention to clients during a 90-minute session in larger groups. However, other therapists have reported successful use of this program in groups of 10 or more.

Frequency of Meetings

Usually, therapists meet with clients or groups once per week and assign readings from the workbook and exercises to be conducted during the week before the next meeting. Some therapists speed treatment by offering two sessions per week, thus cutting the length of treatment in half.

Does Every Person Require the Entire Program?

It is strongly recommend that each client complete the entire workbook (aside from the few chapters that may not be directly relevant because they concern medication issues or involvement of significant others), even if he or she feels considerably better after fewer sessions. It has been our experience that people who stop early because they feel better (a not infrequent occurrence) may be subject to higher rates of relapse than those who complete the entire program.

Benefits of Using a Manual

The first “revolution” in the development of effective psychosocial treatments was the manualization of these treatments. Because these are structured programs for specific disorders, they can be written in sufficient detail to allow trained therapists to administer them in roughly the same manner in which they were proven effective. This does not, however, imply that therapeutic skills are no longer required.

The second phase of this revolution is the preparation of the structured program in a manner suitable for direct distribution to clients working under therapeutic supervision. The *MAP-IV* workbook is one of a few

examples of a scientifically sound guide written at the client's level which can be a valuable supplement to programs delivered by professionals from a number of disciplines. There are several advantages to this.

Self-Paced Progress

Clients can move at their own individual pace. As stated previously, some therapists or clients may wish to shorten the program by scheduling more frequent sessions. Other clients may choose to move more slowly, due to conflicting demands such as travel schedules. Having the client workbook available between irregularly scheduled sessions for review and rereading can be quite beneficial.

Ready Reference for Clients

Although concepts may be perfectly clear to the therapist, clients who seem to understand material during the session often become confused after leaving. One of the greatest benefits of the client workbook is the opportunity for clients to review relevant conceptualizations, explanations, and instructions between sessions. The authors have found that during treatment, the *MAP-IV* workbook frequently becomes the client's "bible." Many clients take the client workbook with them wherever they go for handy reference and have found this availability extremely useful. Certainly, research in memory stresses the importance of such repetition and rehearsal for the consolidation of newly acquired information.

Availability to Family Members and Friends

We have demonstrated a significant advantage from having family members, particularly spouses or other partners, be aware of and involved in treatment (e.g., Barlow, O'Brien, & Last, 1984; Carter, Turovsky, & Barlow, 1994; Cerny et al., 1987). For example, clients whose partners were included in treatment did better at a two-year follow-up than did those clients whose partners were not included. Family participation can be beneficial in several ways. First, attempts to sabotage the program, either

purposely or unwittingly, are offset if family members become familiar with the nature of the disorder and the rationale underlying treatment. Second, family members can be helpful in overcoming some of the avoidance behavior that often accompanies panic. Of course, some clients prefer that their partners or family members remain unaware of their problem. In these cases, we attempt to persuade clients of the advantage of sharing the problem with their partners and thereby to allay any concerns. Typically these concerns revolve around worries that family members will think they are insane or will be openly hostile to their efforts. These reactions almost never happen. Nevertheless, occasionally, there may be clear signs that it is inappropriate to involve the significant other (e.g., severe marital discord), in which case we do not encourage the significant other's involvement. When the decision is made to incorporate the significant other, we usually bring the partner into treatment sessions, either initially or throughout the entire treatment.

Clients Can Refer to the Manual After the Program Ends

The *MAP-IV* workbook will help clients deal effectively with occasional recurrences of panic attacks or agoraphobia after treatment is over. This kind of recurrence is most likely under particularly stressful situations. The client workbook can be a source of great comfort during these periods and can often prevent escalation of panic attacks into a full-blown relapse. The final chapter of the workbook, chapter 12, outlines ways of maintaining progress and dealing with occasional recurrences of panic and agoraphobia. In addition to the availability of useful information and prompts to use the skills learned during treatment, having the client workbook available in and of itself seems to be anxiolytic. In fact, the workbook may function as a cue or reminder that simply by its presence increases the recall of information and skills learned during treatment.

Full Workbook Versus Installments

Some therapists who have been using the *MAP-IV* program since its inception in 1989 report that they prefer to distribute the chapters in installments. In this way, they prevent clients from skipping ahead and thus

encourage better concentration on one chapter at a time. These therapists have adopted loose-leaf binders or other mechanisms of putting the client workbook together.

Based on this feedback, we considered supplying the workbook in such formats but ultimately decided against it. The downside of this practice is that individual chapters are more likely to be misplaced, so, when the program ends, clients will have incomplete workbooks. This causes difficulties in later months, when clients wish to refer to specific chapters.

In addition, we are not particularly concerned if clients do a little skipping around. In general, we find that the more time clients spend reviewing the workbooks, the deeper their understanding, and the greater their benefit. During the sessions, if clients mention material that they have read in future chapters, the therapist can simply refocus the clients' attention to the current assignments. Nevertheless, we do not discourage therapists from distributing the client workbooks in installments if they prefer that practice.

Fees for the Workbook

Different therapists and programs will obviously have their own fee structures. The cost of the workbooks is typically incorporated into this fee structure in one of two ways. First, client workbooks can be purchased in bulk by the program or therapist, and these costs are then incorporated into the costs of the therapy session or program. Alternatively, some therapists and programs, particularly those with rather inflexible rate structures, have the clients themselves assume the cost of purchasing the client workbook. In these cases, workbooks may be purchased in bulk for resale at the beginning of treatment, or our address may be supplied to clients so that they may purchase the workbooks before beginning treatment.

Provide a cross-reference to where this is available in the workbook?