Tools for Treating Panic Disorder Among Latinos

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Prevalence of Panic Disorder in the Latino Population

The Hispanic/Latino population is the largest and fastest-growing ethnic minority population in the United States currently comprising 17.6% of the United States (US) population (United States Census Bureau, Population Division 2016). While panic disorder is less prevalent than other anxiety disorders among Latinos, panic disorder within this population is substantial. A recent epidemiological study indicates lifetime prevalence rates of panic disorder among Latinos to be 4.1% which is slightly lower than the lifetime prevalence rate among non-Hispanic White Americans (5.1%) but higher than the lifetime prevalence rate for both African Americans (3.8%) and Asian Americans (2.1%; Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010). Despite that a substantial number of Latinos are impacted by panic disorder, there is a dearth of research on epidemiological, phenomenological, and outcome-based treatment research with Latinos. This is problematic as symptomatology can differ across and within this population (Carter, Mitchell, & Sbrocco, 2012; Hollifield, Finley, & Skipper, 2003; Katerndahl & Realini, 1998).

Mental Health Service Use

Despite the high prevalence of panic disorder among Hispanic/Latinos, many Hispanic/Latinos do not seek professional services. In fact, Katerndahl and Realini (1998) found that 46.3% of Hispanics who experience panic attacks did not seek medical care. While it is important to note that not all people who experience panic attacks go on to develop panic disorder, these statistics suggest that a large proportion of Hispanic/Latinos do not seek needed services for panic disorder. Such disparities in healthcare utilization can result from barriers to access including economic barriers and lack of health insurance (Andersen, 1995; Cabassa, Zayas, & Hansen, 2006; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Keyes et al., 2012). In addition to structural barriers, cultural factors also play a role in treatment-seeking behaviors.

Indeed, cultural factors and language have been found to greatly influence whether or not Hispanic/Latinos will seek services when barriers to access (e.g., limited income, insurance, financial resources) were controlled for (Keyes et al., 2012). Specifically, the shortage of Spanish-speaking mental health professionals

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L.T. Benuto (ed.), *Toolkit for Counseling Spanish-Speaking Clients*,
DOI 10.1007/978-3-319-64880-4_6

(Institute of Medicine, 2004) and an overall distrust of the medical system as a result of unsuccessful or discriminatory historical transgressions may act as additional barriers in establishing rapport, accurate assessment, diagnosis, and treatment of mental health problems within Hispanic/Latino population (Armstrong, Ravenell, McMurphy, & Putt, 2007; Corbie-Smith, Thomas, & St. George, 2002; Finch, Kolody, & Vega, 2000; Keyes et al., 2012). Additionally, Hispanic/Latinos are more likely to seek help from informal sources (e.g., religious leaders or family), prior to or in lieu of, seeking professional or medical care (Cabassa, & Zayas, 2007; Pescosolido, Wright, Alegría, & Vera, 1998). Thus, community outreach and education that promote a positive relationship with the healthcare system may be a necessary step to increasing mental health service utilization among this underserved population. Additionally interventions that are more aligned with the cultural values of this group may also help to increase treatment engagement.

Cultural Conceptualizations and Presentations of Panic Disorder

Cultural Concepts

While the characteristics of panic disorder appear to be consistent across cultures (i.e., the vast majority include sudden onset of physical sensations such as dizziness or heart palpitations subsequently followed by a private misinterpretation of symptomatology), the phenomenology of these experiences may greatly differ. Such differences in phenomenology should be considered including the use of cultural idioms of distress among Hispanic/Latinos. These are discussed below:

Ataque de nervios *Ataque de nervios* ("attack of nerves") is a cultural concept of distress that is used among Hispanic/Latino populations (Guarnaccia, Canino, Rubio-Stipec, & Bravo 1993). Guarnaccia et al. (2010) found that 7–15% of Hispanic/Latino sample in the National Latino and Asian American Study had experienced *ataques de nervios.* This experience is characterized by symptoms of intense emotional upset that include episodes of anxiety, anger, or grief; this may include screaming and shouting uncontrollably, being physically or verbally aggressive, and/or experiencing dissociative episodes (Guarnaccia, Rivera, Ranco, & Neighbors, 1996). This experience can be conceptualized as an anxiety-induced panic attack that is influenced by specific cultural expectations (Mendoza, Williams, Chapman, & Powers, 2012). While these attacks are usually triggered by a significant stressful event (Lopez & Guarnaccia, 2000), they also may occur as a result of accumulated suffering (Guarnaccia et al., 1996; Lewis-Fernández et al. 2010).

Although much symptom overlap exists, it is unclear whether *ataques de nervios* should be considered panic attacks (LaBruzza & Méndez-Villarrubia, 1994; Liebowitz, Salmán, Jusino, & Garfinkel, 1994). Though this subject has been heavily debated, evidence has shown that they are similar, but not the same, as *ataques de nervios* consists mostly of panic symptoms (Barrera, Wilson, & Norton, 2010; Guarnaccia et al., 1996; LaBruzza & Méndez-Villarrubia, 1994; Liebowitz et al., 1994) and lacks the avoidance aspect that is present in panic disorder (Cintron, Carter, & Sbrocco, 2005). Despite these experiences being different, it is necessary that practitioners are aware of and sensitive to these differences when making diagnostic and treatment decisions.

Somatic Symptom Presentation Research is mixed on whether Hispanic/Latinos experience panic symptoms differently. While some researchers found that Hispanic/Latinos endorse more somatic symptoms than Caucasian Americans (Canino, 2004; Hollifield et al., 2003), others found no difference (Barrera, Wilson, & Norton, 2010). Per the body of literature that suggests that Hispanic/Latinos may endorse more somatic symptoms, this may be due to greater cultural acceptance of physical ailments as compared to psychological ones among Hispanic/Latinos (Varela et al., 2004). Barrera et al. (2010) hypothesized that acculturation may further influence symptom endorsement, as the familiarity of panic disorder within Caucasian culture may be viewed as a culturally

apposite expression of grief (Asnaani, Gutner, Hinton, & Hofmann, 2009). For this reason individuals who are more acculturated may not experience anxiety or panic through traditional expressions (Barrera, Wilson, Norton, 2010). While current research on the direct effects of acculturation is limited, practitioners should assess individuals' levels of acculturation in order to efficiently provide effective services on an ideographic basis. This is not to say that therapists should solely focus on a client's race, ethnicity, or culture as main guiding factors in their treatment selection but instead focus on building a therapeutic relationship with the client that is both unique and specific to the client.

Research on the Treatment of Panic Disorder

Treatment Outcomes for Anxiety Disorders and Panic Disorder

While several studies have examined the outcomes of interventions directed at depression with Hispanic/Latino populations (Cummings & Druss, 2011; Foster, 2007; Hahn, Kim, & Chiriboga, 2011), little research has been conducted on treatment of anxiety within this group (Carter et al., 2012). This lack of treatment outcome studies for anxiety disorders is further magnified in the study of panic disorder as we only identified one study on the outcomes of therapy for the treatment of panic disorder with Hispanic/Latinos. In this single case study, Alfonso and Dziegielewski (2001) found that a 9-week self-directed cognitive behavioral therapy (CBT)-based treatment and weekly panic-based support group significantly reduced the participant's anxiety levels which were maintained through a brief 1-week follow-up. Despite this study's limitations, the results from this study suggest that CBT may produce positive outcomes with Hispanic/Latinos who have panic disorder. This is consistent with research findings from other studies that have examined treatment outcomes for anxiety with this group (Benuto, O'Donohue, & Bennett, Under Review) and also with a systemic review that noted that CBT can produce positive treatment outcomes for Latinos (Benuto & O'Donohue, 2015).

Cognitive Behavioral Therapy

While there is evidence that both CBT and medication have been independently found to be effective in the treatment of panic disorder (Hicks, Leitenberg, Barlow, & Gorman, 2005), given the focus of this book, this chapter is focused on behavioral interventions. CBT is considered an empirically supported treatment for anxiety disorders. Indeed, the Society of Clinical Psychology has classified the empirically supported treatment (EST) status of CBT for anxiety as having strong research support (Hajcak 2016). Meta-analyses have also concluded that CBT is an efficacious treatment for anxiety disorders including panic disorder (Cuijpers, Cristea, Weitz, Gentili, & Berking, 2016). CBT for panic disorder includes the use of cognitive restructuring, mindfulness, and exposure:

Cognitive Restructuring Cognitive restructuring involves helping people replace catastrophic cognitions with more reasonable ones (Vickers & McNally 2006). When people experience the fight or flight response, it is common that they believe they are in danger even if they are actually safe. These beliefs can act to further intensify the fight or flight response (Fight or Flight Response n.d), which leads to increased fear, catastrophic thoughts and predictions, avoidance, and escape behaviors (Vickers & McNally 2006). By replacing these negative thoughts with more adaptive ones, people learn how to accept feelings of panic without mislabeling them as catastrophic (Vickers & McNally 2006).

Mindfulness The process of mindfulness acts by having people accept the sensations and feelings that accompany them in the present (e.g., the fight or flight response) without judging or negatively labeling them (Brown & Ryan, 2003). In taking a mindful approach, people are able to pay attention to themselves (thoughts, feelings,

emotions, and sensations) and their experiences in the present moment and accept them nonjudgmentally so that they can respond to them more effectively and efficiently, as opposed to engaging in negative behaviors of avoidance or escape (Bishop, et al., 2004; Kabat-Zinn, 1994).

Exposure Our primal response to fear is to engage in avoiding or escaping from danger (Craske & Barlow, 2014). However, these responses are paradoxical as the more a person tries to avoid or escape from a situation the stronger the fight or flight response becomes (Craske & Barlow, 2014). This occurs because every time that a person engages in avoiding a feared situation, they do not learn that the experience of anxiety or fight or flight is not dangerous and will decrease on their own over time (Craske & Barlow, 2014). Exposure involves having people be in these situations of heightened arousal until their anxiety naturally returns to normal (Craske & Barlow, 2014). This process allows the person to learn that these feelings are not permanent nor dangerous. Repeatedly engaging in this behavior helps people diminish their panic response (Craske & Barlow, 2014).

The above treatment principals are part of a manualized treatment for panic disorder (Craske & Barlow, 2014). As discussed above, this treatment protocol is a CBT treatment protocol, and CBT is considered an efficacious treatment for panic disorder. Also as discussed above, Hispanic/Latinos may present with culturally specific presentations of anxiety. Thus, our first recommendation is that clinicians carefully assess for anxiety with working with this population (see Benuto, (2013a, 2013b) for a general overview of assessment with Latinos and Snipes (2013) for a discussion of the assessment of anxiety with Latinos). Our second recommendation is that clinicians consider the clinical utility of any intervention that is to be used with any client. This includes a consideration of available research evidence and clinical consensus about the generalizability, feasibility, and client acceptability of the intervention (APA Presidential Taskforce, 2006). This may include a consideration of the client's ethnic background, cultural level, attitudes toward therapy, personal conceptualization of anxiety (i.e., while some Hispanic/Latino clients may use cultural idioms of distress, others may not), etc. The client's mental health literacy, general literacy, and level of education should also be considered. Many of the tools and worksheets included utilize language and terms that the average person may not understand. Thus, all worksheets and tools should be reviewed in session with the client to ensure that she/he understands the concepts and content therein. Worksheet 0 lists several terms or concepts and associated definitions, and there is space on the worksheet to add additional ones depending on the client's level of mental health literacy.

Our final recommendation is that clinicians use evidence-based interventions with Hispanic/Latino clients. There is research support to suggest that Hispanic/Latinos can benefit from evidence-based interventions. The final section of this chapter includes a sample session plan and corresponding tools and worksheets. While these are based on evidence-based principles (discussed above) and were trans-adapted (several clinicians who specialize in working with Latinos reviewed the session plan and tools and worksheets and provided feedback, and revisions were made based on that feedback), it is important to note that they have not been empirically tested in their current form. Nonetheless, the research supports that empirically supported treatments and evidence-based treatment principals can be used with Hispanic/Latino clients (Benuto & O'Donohue, 2015).

Sample Session Plan

(Based on Craske & Barlow, 2014)

Session 1

The goal of this session is to establish rapport with the client, provide psychoeducation regarding patterns of anxiety, and gather information relating to the client-specific patterns and presentations of anxiety and panic:

- In session one the goal is to build rapport with the client in order to create a beneficial

therapeutic relationship that will further guide treatment. This can include but is not limited to speaking to the client about their career or personal life, explaining the therapeutic process with the client, reviewing limits of confidentiality (especially if immigration status is a concern for the client), and addressing any of the client's questions. Specific to Latinos this may include an assessment and/or consideration of cultural idioms of distress, attitudes toward mental illness therapy, and conceptualization of anxiety.

- Describe anxiety and gather information about when the client first experienced panic attacks. Identify when the client first began experiencing anxiety, and examine patterns in which it is presenting (people, places, situations, etc.). This may also include an assessment of the client's own personal descriptors of what she/he is experiencing and psychoeducation about what the term "anxiety" (i.e., *ansiedad*) means (Worksheet 0/PD0).
- Once this information has been gathered, the therapist should provide the client with a rational and description of treatment (if this was not done during the building rapport aspect of the treatment).
- Introduce the client to several tools that they will use throughout their treatment. These tools include:
  What is anxiety? (Worksheet 0)
  Daily Mood Log (Worksheet 1 PD1):
  This tool is used to log the client's daily levels of anxiety, depression, and worry specifically related to having panic attacks.
  The Panic Self-Monitoring Record (Worksheet PD2):
  The client will carry this tool with them at all times. The therapist should instruct the client to complete the worksheet as soon as they are able following any experienced panic attack.
- These tools will be used throughout the majority of the therapy, so it is very important that the therapist takes their time explaining how each of these work and then answering any questions that the client has regarding these tools. A good strategy to ensure that the client understands these methods is to ask them to explain how to use each of the tools a few minutes after you have explained it to them.
- *Homework*:
  – The therapist will assign the client the homework of using and completing each of the tools (listed above) during the following week prior to the next session.

Session 2

The goal of this session is to provide the client with psychoeducation regarding the role and relationship between physiology and anxiety/panic symptoms:

- This session (and each subsequent session) begins by having the therapist review the client's homework and gather information about the client's past week. The clinician should gather information about whether the client had any difficulties using the tools that were assigned to them as homework. This is important as verifying that clients are using the tools correctly early on will benefit overall treatment efficacy and efficiency by allowing the therapist to focus on current treatment goals rather than reteaching tool use during later sessions.
- Describe the evolutionary role of anxiety and panic in the fight or flight process (Worksheets PD3 and PD4). Worksheets PD3 and PD4 offer an overview of panic and the flight or fight response. The clinician should be mindful of the client's level of general and mental health literacy. Depending on these levels, the clinician may need to spend a time going through these worksheets with the client and explaining what the various concepts mean. During this time the therapist will relate how the physiological changes of anxiety and panic relate to the bodily sensations that the client experienced during their panic attack.
- Describe to the client how specific thoughts and thought patterns relating to stressors or fears can lead to panic attacks. For instance, emphasizing that while panic attacks may appear to

come out of nowhere, a pattern or trigger likely exists. If the therapist has determined a common pattern of thoughts, actions, or situations that lead to a panic attack, this is a good example to present to the client. Otherwise if this has not yet occurred, the therapist can create an example of this to present. The benefit of providing this information is twofold. First it is to reduce anxiety related to the uncertainty of the onset of panic attacks and second to provide more credibility and support for CBT.

- *Homework*:
  - Instruct the client to read and reread the Biology and Psychology of Anxiety and Panic Handouts (Worksheets PD5 and PD6) (Biology & Psychology of Panic 2006).
  - Last of all the therapist should reemphasize that their panic will gradually decrease as they read the assigned material and engage in homework activities.

Session 3

The goal of this session is to educate the client on breathing, simulate ineffective breathing and symptoms of panic, and begin practicing breathing control:

- This session begins by having the therapist review the client's homework and gather information about the client's past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will educate the client on breathing and the role that it plays in their experience of anxiety and panic. During this time the therapist will address any misconceptions (e.g., fear of overbreathing) or questions the client has regarding breathing and the physiological effects associated with it.
- The therapist will provide the client with information relating to the benefits of deep slow diaphragmatic (breathing from their diaphragm) breathing and have the client practice this by engaging in three continuous sets of the breathing pattern:
  - Slowly inhale through their nose for 3 s, hold this breath in for 3 s, and then slowly exhale this breath for 4 s before repeating the cycle:
    - Note: It can be beneficial for the therapist to count while the client is practicing this routine so that they can establish the tempo without having to internally monitor time.
- Following breathing education, answering questions, and practicing, the therapist will instruct the client to engage in simulated hyperventilation by asking them to breathe quickly and shallowly for 1 min (or enough time to facilitate panic symptoms).
- Immediately following this the therapist will ask the client to breathe slowly while sitting with their eyes closed until the panic symptoms have decreased.
- Once their panic symptoms have decreased, the therapist then asks the client about their experience and how it compares to other prior panic experiences. A majority of the time, the client will report that while the exercise produced symptoms that were the same or similar to those experienced during a panic attack, it was not as anxiety provoking as they felt safe in the environment:
  - If this occurs the therapist should emphasize the experience of perceived safety and relate this back to their prior learning about how the environment, events, or situation relates to their anxiety.
  - If the client does not report this, the therapist may emphasize how this situation was different in that even if the client was unaware they noticed it, they felt safer in the current environment than during their real-life experiences with anxiety and panic. Following this the therapist emphasizes the effects that perceived safety has on prior learning specifically how the environment, events, or situations relates to their anxiety.
- *Homework:*
  - Assign the client to practice deep diaphragmatic breathing at least two times a day for nine to ten cycles each, and complete the Breathing Practice Record (PD7). Make sure to emphasize that at this time clients

should only engage in this breathing while they are in safe environments and not situations of panic or anxiety.
  - Remind the client to continue to engage in completing the Daily Mood Log and Panic Self-Monitoring Record (Worksheets PD1 and PD2).

Session 4

The goal of this session is to begin active cognitive restructuring with the client:

- This session begins by having the therapist review the client's homework and gather information about the client's past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will restate that there is no actual threat related to experiencing panic attacks (Fictional Fears Worksheet PD8), emphasizing that the client's thoughts may not be facts but rather guesses about the future. Additionally, the therapist will help the client in completing the downward thinking section of this worksheet emphasizing that the arrows do not necessarily go in order and that a lot of other consequences can occur rather than only the negative ones (e.g., panic-> faint-> embarrassment ->feeling of overwhelming shame).
- The therapist will ask the client about automatic thoughts and teach them to observe these thoughts from an objective and descriptive perspective:
  - An example of a not useful thought: I feel bad so something bad will happen now.
  - I am afraid if I get too anxious around tall flights of stairs that I will jump off or fall down them and die.
- *Homework:*
  - Complete the Thought Occurrence Likelihood Worksheet (Worksheet PD9).
  - Assign the client to continue to practice and log their deep diaphragmatic breathing twice a day for nine to ten cycles (Worksheet PD7). Make sure to emphasize that at this time the client should only engage in this breathing practice while they are in safe environments and not situations of panic or anxiety.
  - Have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).

Session 5

The goal of this session is to educate and challenge client around catastrophizing:

- This session begins by having the therapist review the client's homework and gather information about the client's past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will educate the client on the common cognitive error of catastrophizing (viewing a situation as treacherous, intolerable, insufferable, or disastrous) and the two parts which compose it:
  1. Predicting a negative outcome.
  2. Concluding that if the negative outcome occurs, it will be disastrous.
- This should be used to both make the client aware of both their thought patterns of catastrophizing and help them realize that other things can occur (and often are more likely to occur) other than their predictions.
- The therapist should emphasize that people are very bad at predicting, that situations are often not as bad as originally thought, and that catastrophizing situations or physiological experiences increases the severity of the situation or experience.
- *Homework:*
  - Have the client continue to practice their breathing on a daily basis but also engage in the breathing exercise outside of safe settings.
  - Have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).

Session 6

The goal of this session is to begin interoceptive exposure (IE):

!!!!!!!!!!STOP!!!!!!!!!!

*** Prior to engaging in any interoceptive exposure exercises the therapist needs to ask ** ***the client that if she/he has any health problems of any kind they should consult with *** ****their doctor to see if these exercises are acceptable before they attempt them. *****

- This session begins with the therapist reviewing the client's homework and gathering information about their past week.
- The therapist will then provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist should educate the client on the purpose of IE. The purpose of IE is to create and repeatedly create feelings and sensations the client fears so that the fear response associated with these feelings and sensations weakens. The therapist should educate the client that often people are not aware that they avoid or escape from specific stimuli (people, places, situations, or interactions) because of the physical sensations that come along with them, for example, not running or working out because you are afraid of experiencing an elevated heart rate. Additionally, the therapist should reemphasize that while the client may experience feelings that are unpleasant, they are not dangerous and that they will eventually dissipate.
- Following providing the client with psychoeducation, the therapist should educate and establish a scale of sensation intensity with the client that can be used while they are engaging in IE. The client will use this metric to rate the intensity of their experience during IE from 0 to 100 or 0 to 10 with 0 being the most relaxed they could feel and 100 or 10 being the worst feelings they can ever experience. It is important that in establishing this metric with the client, the therapist asks them for examples of the endpoints 0 and 100 so that they have personalized context to reference during their statements.
- Once this metric has been established, the therapist should ask the client their current score on their sensation scale and then instruct the client to engage in one of the following activities:
  - Shaking their head back and forth for 30 s
  - Holding their breath for as long as they are able
  - Placing their head between their legs while they are sitting in a chair for 30 s to 1 min and then lifting it quickly up
  - Exercising as hard as they can for 1 min (e.g., push-ups, jumping up and down, sit-ups, clenching all of their muscles as tight as they can, or running)
  - Holding a push-up position with their arms bent for as long as they are able
  - Spinning in a swivel chair for 1 min
  - Breathing through a straw while having their nose plugged for a few minutes (either plugged by them holding it shut or with nose plugs)
  - Breathing as slow as possible for 2 min
  - Looking at a mirror for 2 min:
    - Note: The therapist should match the intensity of the activity to the client's ability. For example, if the client is in very good physical shape, the therapist increases the amount of strenuous activity that they engage in.
    - Also, in instances in which the client may be engaging in exercise to, the therapist will want to inform them to bring appropriate clothes so that they are able to engage in the activities without damaging their clothes.
- These activities are meant to simulate feelings and sensations that are feared, so it is important that the therapist asks the client immediately following the activity what their current score is on their sensation scale. If the score has increased from their prior score (before they engaged in the activity), then this is an indication that the activity worked in elevating their feared sensations. The therapist should

then instruct the client to notice their discomfort and not distract themselves from it but remind themselves that their discomfort is only temporary and will soon pass.
- During this time the therapist can ask the client about what they are thinking and experiencing and record this on the Interoceptive Exposure Worksheet (Worksheet PD10).
- Once the client's scores have diminished from their reported post-activity score, the therapist should praise the client for engaging in the task and then inquire about the client's experience and what thoughts they had during their elevated feared sensations.
- The therapist should discuss with the client what misassumptions can make naturally occurring panic symptoms frightening and difficult to engage.
- *Homework:*
  - The therapist will assign the client to continue to practice their breathing in response to experiencing symptoms of anxiety.
  - Have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).

Sessions 7 and 8

The goals of these sessions are to engage in IE and hypothesis testing:

- This session begins by having the therapist review the client's homework and gather information about the client's past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will ask the client their current sensation score and then instruct them that they can apply breathing control strategies during times of anxiety (e.g., once they have completed the IE activity).
- Next the therapist will instruct the client to engage in the same or another interoceptive exposure activity (a list of potential activities is provided in session 8. The therapist is also free to use other strategies in order to evoke feared sensation as long as they are safe for the client).
- Following completion of IE (and reported elevated score), the therapist engages in hypothesis testing with the client. The purpose of hypothesis testing is to continue with cognitive restructuring of disconfirming the client's incorrect hypotheses.
- For example:
  - Will a person fall if they do not lean on a wall while they are feeling dizzy?
  - If someone feels uncomfortable at the grocery store, can they still get groceries and take their time at the store?
    - Note: During this hypothesis testing, you want to ensure that the client is safe (e.g., the client has the ability to catch themselves or lean on a wall to prevent them from falling), but simultaneously the therapist wants to challenge them from engaging in avoiding activities.
- After engaging in hypothesis testing, the therapist should emphasize how the client is already making progress (even if they are only able to stand while dizzy without touching a wall for a few seconds).
- The therapist should end the session by again asking the client about their thoughts during the exercise and analyzing any misconceptions they may have had during this time, making sure to emphasize how well the client is currently doing after the feared thoughts and sensations have passed.
- *Homework:*
  - The therapist will have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).
  - Have the client complete the Avoidance Hierarchy Worksheet (Worksheet PD11) Avoidance Hierarchy/Fear Hierarchy (n.d). Create a panic level scale in which 0 is no fear at all and 100 is the most afraid that you can possibly imagine. Help the client identify situations which cause them anxiety or panic, and then assign a panic rating to each.

Session 9

The goals of this session are to extend IE to daily tasks that the client has avoided or dreaded experiencing:

- This session begins by having the therapist review the client's homework and gather information about their past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will inform the client that they are going to engage in an activity that the client has indicated is very difficult for them to engage in (the client finds this very horrible or they completely avoid this activity all together):
  - These activities can be selected from the Avoidance Ladder Hierarchy Worksheet (Worksheet PD11) which the client completed as homework during sessions 7 and 8.
- Prior to engaging in these activities, the client is instructed to identify any maladaptive cognitions they have surrounding the activity and then restructure them (by themselves or with the therapist's help) prior to engaging in the activity:
  - Note: The therapist should remove safety signals or trinkets (lucky charms, cell phone, and or any ritualistic or superstitious activities) that the client may attribute the success of the activity to (e.g., I was able to ride in the taxi because I wore my lucky wristband) or allow the client to escape from engaging in the activity (e.g., I was able to ride in the taxi because I was distracting myself on my phone by texting the entire time).
- Some examples of activities may include:
  - Going to crowded areas (e.g., the mall, the grocery store)
  - Sitting in a waiting room
  - Sitting in a steamy room
  - Exercising
  - Eating foods that have been avoided but are liked (e.g., filling or spicy foods)
  - Being in a taxi
  - Walking on a cracked sidewalk
  - Watching the news
- Following IE the therapist should inquire about the client's experience and again reiterate any progress that the client made no matter how small (e.g., I was able to sit in a taxi even though it did not take me anywhere).
- *Homework:*
  - The therapist will have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).
  - Assign the client to engage in two IE activities on their own in their home. These can include any of the IE activities from session 6.

Session 10–15

The goals of these sessions are to continue to engage in in vivo exposure:

- During each session continue to work with the client on in vivo exposure moving up their personalized avoidance hierarchy as they meet each goal.
- *Homework:*
  - Have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).

Concluding/Final Session

The goal of this session is to review how much progress the client has made and praise them for this progress:

- Throughout this session the therapist will review the client's progress by referencing prior difficulties and how they have overcome them.
- The therapist will use the client's self-monitoring logs as data to support the client's progress.
- The therapist will indicate to the client that if they need any additional services or maintenance sessions, they are more than welcome to contact the therapist.

Worksheet PD 0

Que es ansiedad?

A lo largo de nuestro trabajo juntos, vamos a usar un varios palabras y frases que son psicológicas.

Ansiedad
Esto se refiere a los nervios, el estrés, la preocupación, etc. ¿Qué significa esto para usted? (Discuta con el cliente).

Animo-Registro diario
Este es un lugar donde usted va registrar sus sentimientos y síntomas.

Sensaciones corporales
Estos son sentimientos que usted tiene en su cuerpo. Por ejemplo, esto podría ser tener palmas sudorosas o el latido del corazón muy rapido.

Interpretación errónea
Esto significa que lo que usted cree que está sucediendo, no es correcto. Por ejemplo, usted podría creer que está teniendo un ataque de corazón cuando realmente está teniendo un ataque de pánico.

Consecuencia de su actuación
Esto se refiere a lo que sucede después de algo. Por ejemplo, si usted comienza a tener un ataque de pánico en la tienda y se va de la tienda, ¿qué sucede después de que se va de la tienda?

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Worksheet PD 1

Estado de Animo-Registro diario

0----------1----------2----------3----------4----------5----------6----------7----------8

Ninguno Leve Moderado Fuerte Extremo

Califique su ansiedad, depresión y preocupación diaria en las siguientes casillas de acuerdo con la escala anterior.

	Mañana			Mediodia			Noche		
	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio
Lunes									
Martes									
Miercoles									
Jueves									
Viernes									
Sabado									
Domingo									

Semana #___ Fecha de comienzo_____ Fecha de Termino_____

Worksheet PD 1

Estado de Animo-Registro diario

0----------1----------2----------3----------4----------5----------6----------7----------8

Ninguno Leve Moderado Fuerte Extremo

Califique su ansiedad, depresión y preocupación diaria en las siguientes casillas de acuerdo con la escala anterior.

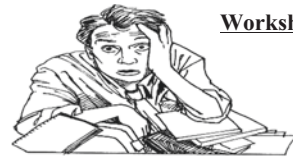
	Mañana			Mediodia			Noche		
	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio
Lunes									
Martes									
Miercoles									
Jueves									
Viernes									
Sabado									
Domingo									

Semana #___ Fecha de comienzo_____ Fecha de Termino_____

Registroauto de pánico - autosupervisado **Worksheet PD 2**

Fecha & Tiempo	**Situación** ¿Que pasó? ¿Quien estuvo ahí? ¿Dónde ocurrió?	**Sensaciones corporales ¿Cómo te sentiste?** Por ejemplo: mareado y tembloroso, doloe de cabeza leve, debilidad, dolor en el pecho, etc.	**Pensamiento Negativo** Interpretación errónea de la(s) sensación(es) corporal(es). Por ejemplo: "Me voy a desmayar", "Estoy teniendo un ataque de corazón", "Voy a vomitar".	**Acción tomada** ¿Cómo respondió al pensamiento negativo? ¿Qué acción tomaste?	**Resultado (s)** La consecuencia de su actuación	**Otra Opción de Pensamiento** (s)¿Qué te podrias haber dicho a ti mismo que te hubiera ayudado?	**¿Cuántos minutos duró el pánico?**

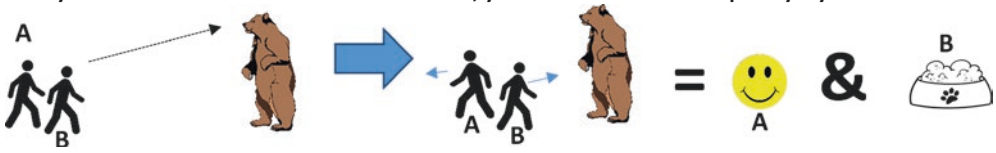
Worksheet PD 3



Entendiendo el Pánico

¿Qué es?

Los ataques de pánico se describen como una experiencia en la que una persona esta envuelta en una gran ola de miedo. Experimentar miedo es a menudo una experiencia muy desagradable, pero es importante recordar que la razón por la que experimentamos el miedo es para prepararnos para el peligro. El miedo es un sentimiento que es inducido por la percepción de peligro o amenaza que nos ayuda a sobrevivir. Cuando experimentamos el miedo, nuestros cuerpos se preparan para huir de la situación (hombre A abajo) o se prepararse para luchar por nuestras vidas. Por ejemplo, si nuestros grandes antepasados no hubiesen experimentaron miedo al ver a un oso hambriento (hombre B abajo) mientras caminaban por el bosque, tal vez hayan terminado siendo la comida de ese oso, y tal vez no estaríamos aquí hoy leyendo este folleto.



Si bien experimentar miedo puede ser de gran beneficio, también puede llegar a ser perjudicial cuando percibimos las cosas y situaciones mal, es decir, como peligrosas cuando en realidad no lo son. Estas experiencias son similares a un detector de humo que se prende cuando en realidad no hay ningun fuego. Esencialmente esto es lo que es un ataque de pánico. Es una falsa alarma. Los síntomas comunes de un ataque de pánico incluyen: (por favor marque todo aquellos sintomas que ha experimentado)

Sintomas de Ataques de Pánico

- o Corazon acelerado/ palpitaciones
- o Dolor de pecho
- o Siente asfixia
- o Dificultad para respirar
- o Sudor
- o Miedo de Morir
- o Siente que pierde el control
- o Mareos
- o Adormeciemiento
- o Nauseas
- o Siente que se sale de su cuerpo
- o Siente que pierde la razon

Los ataques de pánico pueden ser muy angustiosos y se puede sentir como si estuviera en una situación de verdadero peligro. Los síntomas pueden hacerle sentir como si se tuviera una condición médica, y es por eso, que muchas personas van a los cuartos de emergencia; pero luego descubren que no estaban enfermos. Un ataque de pánico pudiese ocurrir sola una vez o puede experimentar episodios repetidos. Los ataques recurrentes a menudo son provocados por una situación específica, como cruzar un puente o hablar en público, esto es más probable si esa situación ha causado un ataque de pánico antes. Por lo general, la situación que conduce al pánico es aquella en la que uno se siente inseguro e incapaz de escapar y le pueden llevar a retirarse de las actividades normales. Si no se tratan, pueden conducir al "Trastorno de pánico" y otros problemas. Los ataques de pánico pueden ser curados, lo mas pronto que lo haga lo mejor que será su resultado. El tratamiento le puede ayudar a reducir, manejar o eliminar los síntomas de pánico y le ayuda a parar de excluirse y asi poder disfrutar su vida.

Fisiología de Luchar o Huir

Worksheet PD 4

La mayoría de los síntomas angustiantes que experimenta una persona durante un ataque de pánico son los cambios físicos que se producen como resultado de la respuesta de lucha o huida. Esta respuesta se produce como resultado de nuestro cuerpo preparándose para luchar o huir de una amenaza. Estos cambios fisiológicos son útiles si nos encontramos con una amenaza (como un oso) con la que debemos luchar o huir, sin embargo no son útiles y nos sentimos incómodos cuando no existe amenaza.

A continuación se presentan ejemplos de aspectos positivos y negativos que resultan de la respuesta de lucha o huida. Por favor circule cada experiencia que se aplica a usted.

Pensamientos continuos y rapidos

+ Un pensamiento más rápido nos ayuda a evaluar el peligro y tomar decisiones más rápidas
- Puede ser difícil enfocarse en cosas que no sean el peligro

Cambios en la visión

+ La visión puede ser aguda para poder prestar más atención al peligro
- Puede experimentar la visión de túnel

Cambios en la respiración

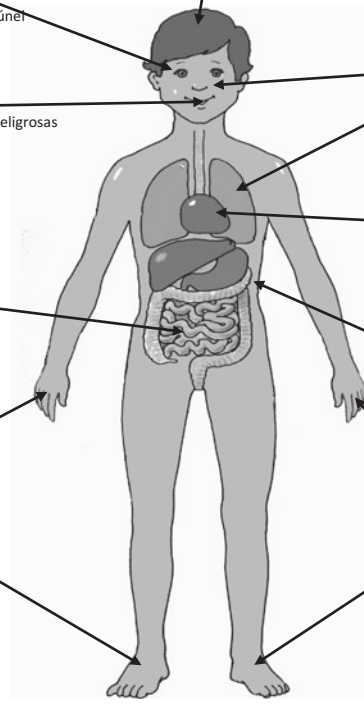
+ La respiración se hace más rápida y superficial para absorber más oxígeno a nuestros músculos
- Si este oxígeno no se usa, podemos sentirnos mareados o aturdidos

Boca seca

+ La digestión se cierra durantesituaciones peligrosas
- La boca se seca y comer se hace difícil

Aumento de la frecuencia cardíaca

+ Frecuencia cardiaca más rápida aumenta el suministro de nutrientes a los músculos para prepararse para participar o escapar a la amenaza
- La frecuencia cardíaca rápida puede conducir a un aumento de la presión arterialconducir a un aumento de la presión arterial



Siente náuseas

+ La sangre es desviada del sistema digestivo para prepararse para luchar o hui
- Esto puede conducir a náuseas, malestar estomacal o trastornos gastrointestinales

Incremento de Adrenalina

+/- La adrenalina aumenta la intensidad de los cambios fisiológicos

Manos y pies sudorosos

+El cuerpo suda para mantener los músculos frescos
- Las manos y los pies sudorosos pueden resultar incómodos

Enfriamiento de manos y pies

+ Los vasos sanguíneos se contraen para aumentar el flujo sanguíneo a los músculos principales
- Las manos y los pies pueden enfriarse

Aumento general de la tensión muscular

+ Músculos en todo el cuerpo se tensan para prepararse para confrontar o escapar de la situación
- Los músculos pueden temblar para poder usar el exceso de energía

Por favor liste cualquier otro síntoma de ansiedad que experimente:

_____
_____
_____
_____

Worksheet PD 5

La Biología de la Ansiedad y el Pánico

Una característica clave del "Trastorno de pánico" son los ataques de pánico. Los ataques de pánico pueden verse como una combinación de síntomas biológicos y psicológicos. Cuando nuestros cuerpos creen que estamos en peligro pasan por cambios fisiológicos que nos preparan para responder físicamente a una amenaza y nos preparan para pelear o huir de la situación.

Las reacciones biológicas de la respuesta "luchar o huir" pueden incluir pero no están limitadas a:

- Aumento en la fuerza y el numero de latidos cardíacos.
    - Estos cambios aumentan la cantidad de flujo sanguíneo y el transporte de productos químicos esenciales como el oxígeno en todo el cuerpo
- Aumento de la frecuencia y profundidad de la respiración.
    - Más oxígeno se introduce en el cuerpo para prepararlo para la actividad de supervivencia.
- Sudoración.
    - Un aumento de la cantidad de sudor ayuda a bajar la temperatura de la piel, lo que ayuda a enfriar el cuerpo preparando para las actividades que se necesitan para la supervivencia.
- La tensión muscular aumenta en todo el cuerpo
    - Aumento de la tensión muscular avisa a los grupos de musculos principales el prepararse para las actividades que se necesitan para la supervivencia.

Reacciones Biológicas de la Respiración Ansiosa y la Hiperventilación

Con cada respiración inhalamos oxígeno y exhalamos dióxido de carbono. Si bien es bien sabido que nuestros cuerpos necesitan oxígeno para funcionar, es menos conocido que necesitamos un equilibrio de oxígeno y dióxido de carbono para que nuestros cuerpos sean más eficientes. Cuando nos ponemos ansiosos, aceleramos la respiracion, lo que crea un desequilibrio entre estos dos gases esenciales. Para ayudar a regular este desequilibrio, nuestros cuerpos liberan una variedad de químicos que producen síntomas tales como sentirse mareado, confundido, sin aliento, con un aumento de la frecuencia cardíaca, visión borrosa o experimentando entumecimiento en las extremidades del cuerpo. Estos síntomas pueden ser angustiosos para cualquiera, pero para las personas con pánico estos sensaciones pueden ser especialmente angustiosos, ya que pueden ser vistos como un ataque venidero. Es importante recordar que estos síntomas están en gran parte relacionados con el exceso de respiración, y no con un problema fisiológico.

Worksheet PD 6

Psicología de la Ansiedad y el Pánico

En la hoja de trabajo PD5 "Biología de la ansiedad y el pánico", describimos los síntomas físicos que están asociados con el pánico (lea la hoja de trabajo PD5 antes de leer esta hoja de trabajo). Las personas que experimentan pánico son muy buenos observando y notando los síntomas físicos. Ellos continuamente se dedican a escanear y re-escanear sus cuerpos para identificar estas sensaciones físicas. Estas exploraciones se hacen continuamente, y se convierten en un hábito automático, en el que una vez que se perciben estas sensaciones se interpretan como un signo de peligro inminente. Esta manera de pensar puede dar lugar a interpretaciones equivocadas en las que se cree que hay algo que está mal con ellos, que están perdiendo el control, o que se están volviendo locos.

Tipos de pensamientos equivocados. Pueden incluir estos ejemplos pero no están limitados a:

- Sobreestimar la probabilidad de que ocurra un ataque de pánico.
    - Creyendo que si algo sucede o no sucede la probabilidad de un ataque de pánico aumenta drásticamente
        - "Voy a tener un ataque de pánico si hay un montón de tráfico en mi camino al trabajo".
- Sobreestimar el costo de tener un ataque de pánico.
    - Creer que el resultado de tener un ataque de pánico será extremadamente severo tive.
        - "Si tengo un ataque de pánico, mi fin de semana se arruinará".
- Tener pensamientos catastróficos sobre sensaciones físicas normales.
- Believing that the experience of anxious physical sensations are indications of nega health outcomes
  O Creyendo que la experiencia de las sensaciones físicas ansiosas son indicaciones de resultados negativos para la salud
    -
        - "Mi corazón esta acelerado, estoy teniendo un ataque al corazón"

Reacciones psicológicas que permiten que el pánico continue

Cuando las personas experimentan síntomas de ansiedad o pánico a menudo tratan de encontrar una manera de reducirlo o controlarlo. Una forma en que la gente hace esto es evitando cosas que les hacen experimentar las sensasiones de ansiedad o pánico. Esto puede incluir evitar situaciones donde una persona ha experimentado un ataque de pánico anterior, situaciones que provocan sensaciones similares de pánico (por ejemplo, tener relaciones sexuales, enfadarse, beber cafeína, actividad física) o situaciones en las que es difícil escapar o obtener ayuda Por ejemplo, conducir durante horas de tráfico pesado, usar el transporte público, áreas congestionadas). Esta acción se llama "Evadiendo" y si bien puede ser una estrategia exitosa en el corto plazo, los efectos a largo plazo puede ser muy perjudicial para el bienestar de una persona y la calidad de vida. Además de esto ultimo, estas personas, con frecuencia, se involucran en el uso de comportamientos que les permitan asegurarse que son capaces de hacer frente o escapar de una situación. Estos comportamientos,por ejemplo, pueden tomar la forma de estar de pie cerca de una pared para apoyarse en caso de que comienzan a sentirse débil o mareado, permaneciendo cerca de una salida por si surge un peligro, o distraerse de su ansiedad leyendo algo, escuchando música, cantando / tarareando, repitiendo un mantra, o tratando de asegurarse de que todo estará bien. Mientras que éstos comportamientos no parecer ser dañinos en el nivel superficial, pueden perjudiciales si la gente llega a ser dependiente de el uso de estos mismos. Ademas, la persona puede sentirse aún más angustiado si se encuentra en una situación en la que no puede utilizar estas estrategias.

Worksheet PD 7

Práctica de Respiración-Registro

0----------1----------2----------3----------4----------5----------6----------7----------

Ninguno Leve Moderado Fuerte Extremo

Después de cada práctica (dos por día) por favor evalue su concentración con respecto a su respiración, contando internamente durante el ejercicio, y su éxito con la respiración profunda diafragmática. Utilice el sistema de evaluacion anterior para evaluar su puntuaje.

Fecha	Hora en que realize su session	Sesión de práctica respiratoria #	Concentración en Respirar y contar	Exito con su Práctica de Respiración
		1		
		2		
		1		
		2		
		1		
		2		
		1		
		2		
		1		
		2		
		1		
		2		
		1		
		2		

Worksheet PD 8

Miedos ficticios

Este folleto le proporcionará una visión general de algunos malentendidos y malas interpretaciones que son comunes entre las personas que sufren de ansiedad y pánico. Las personas con trastorno de pánico a menudo malinterpretan las sensaciones físicas como algo que está seriamente mal con ellos. Dado que la mayoría de las personas no tienen una explicación clara de las sensaciones que están experimentando a menudo creen que están teniendo graves problemas mentales o físicos. Dado que estas sensaciones son interpretadas como algo peligroso, pueden desencadenar más ansiedad y respuestas de pánico. Con el fin de comprender mejor el "pánico" le explicaremos cuatro malentendidos que son comunes con respecto de los síntomas de ansiedad.

Desmayos, Caídas y Colapsos

Es común que algunas personas con pánico crean que en cualquier momento que experimenten mareos o aturdimiento, crean que se caerán, se desmayarán o se derrumbarán. Sin embargo, esta respuesta de ansiedad implica directamente un aumento en la presión sanguínea global que disminuye la probabilidad de que la persona se desmaye. Esto se debe a que el desmayo realmente implica una disminución o caída de la presión arterial. Esto tiene sentido ya que la respuesta de lucha o huida aumenta el estado de alerta de la persona, y no los hace más propensos a desmayarse ante el peligro.

Sentir como si se estuviera volviendo loco

Algunas personas creen que cuando experimentan pánico es una señal de que se están volviendo locos o fuera de su mente. Esto puede ser muy aterrador si estos síntomas se producen a menudo, ya que pueden aumentar el nivel de angustia general de una persona y aumentar la fuerza de su creencia. Mientras que los síntomas de la respuesta "luchar o huir" pueden ser aterradores y angustiantes, son muy diferentes de los síntomas de enfermedades mentales severas (por ejemplo Schizophrenia, desorden bipolar, depresión crónica)

Teniendo un ataque al corazón

Las personas que experimentan pánico pueden creer que sus sensaciones de pánico y sus experiencias son signos de un ataque al corazón. Esto se deriva de la creencia de que experimentar la falta de aire y tener dolor en el pecho es idéntico a la experiencia de tener un ataque al corazón. Dado que la mayoría de las personas no han experimentado un ataque al corazón no entienden las diferencias entre tener un ataque al corazón y tener un ataque de pánico. Experimentar dolor agudo en el centro del pecho que se extiende hasta el hombro o el brazo izquierdo es un signo clásico de experimentar un ataque al corazón. Además, el dolor que se asocia con un ataque al corazón no aumenta como resultado de la respiración excesiva. Además, una diferencia adicional es que las sensaciones de enfermedad cardíaca se correlacionan con el esfuerzo y disminuyen al descansar, mientras que los ataques de pánico pueden ocurrir durante los períodos de descanso o esfuerzo.

Es fácil ver cómo estas creencias pueden mantener y exacerbar los síntomas. Al aprender a desafiar estos conceptos erróneos y creencias falsas, las personas son más capaces de entender sus experiencias. Esto es de gran beneficio, ya que pueden empezar a vivir experiencias en lugar de evitarlas.

Worksheet PD 9

Frecuencia de Pensamientos

Registre su pensamiento negativo inicial y cheque el pensamiento equivocado que corresponde. Entonces,use la escala debajo de 0 a 100 indicando la probabilidad de que este pensamiento ocurrirá. Esto significaque una puntuación de 0 indica que el pensamiento imaginario negativo no ocurrirá, donde una puntuación de 100 indica que definitivamente ocurrirá. Después de esto, registre un nuevo pensamiento o pensamientos tomando en cuenta la evidencia real y las maneras de hacerle frente.

0----------25----------50----------75----------100

NO ES PROBABLE **Moderadamente Probable** **Definitivamente Probable**

Fecha	Hora	Situación	Primer Pensamiento Negativo	Pensamiento Equivocado		Probabilidad Realistica	Pensamiento Nuevo
				Conclusiones Automaticas	Actuando fuera de proporción		

Worksheet PD 10

Registro de exposición interoceptiva

Si tiene algún problema de salud o problemas de salud física, consulte a su médico para ver si estos ejercicios son aceptables antes de intentarlo.

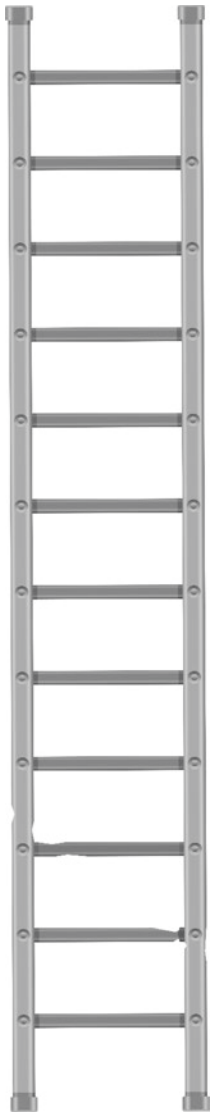
FECHA	Actividad	Sintomas	Pensamientos	Anxiedad (0-100)		
				Antes	Punto mas alto	Despues
Ejemplo: 1/1/2017 Lunes	**Respirando Rapido** (Respiré rápidamente y superficialmente durante 1,5 minutos)	Casi no puedo respirar y mi corazon esta acelerado	Espero no tener un ataque al corazón, No, solo estaba hiperventilando	**65**	**87**	**59**

Worksheet PD 11

Evadiendo - Escalera de Jerarquías

Ahorra usted va construye una escalera de las cosas que le provoca panico y que usted evita. A cada situación que usted pone en su escalera usted va indicar que nivel de panico le causa.

0----------50----------100



Una vez que haz construido la escalera, trabajaras en enfrentar estas situaciónes empezando de la parte de abajo hacia la parte de arriba durante tus sesiones de terapia.

Situatión	**Nivel de panico % (0-100)**

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