Overcoming Panic

THE TALKING THERAPIES UK SELF-HELP SERIES



Overcoming Panic

An eight-module CBT-based programme for adults with panic attacks and panic disorder, with or without agoraphobic avoidance

A self-help workbook · 8 modules · about 8 weeks

TALKING THERAPIES UK

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First edition, 2026.

This workbook accompanies the Overcoming Panic programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 3. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

Contents

How to use this workbook 1

Part 1 Understanding Panic 5

1. Welcome to the programme 6
2. What a panic attack is, physiologically 7

How to use this workbook

Panic is among the most frightening experiences a person can have. The first time a panic attack arrives most people who experience one believe they are having a heart attack, a stroke, or losing their mind. The chest tightens or pounds, breathing becomes shallow and difficult, the hands and face go numb or tingling, the head feels light or disconnected, the legs feel unable to hold the body, and a wave of dread sweeps through everything. People in the middle of a panic attack often phone an ambulance, present at A&E, or sit very still convinced that any movement will make whatever is happening worse. When the attack passes ten or fifteen minutes later, and the medical investigations come back clear, the person is left with the recognition that the body did all of that with no apparent cause, and the question of whether and when it will happen again. What this programme treats. Panic disorder is the clinical name for the pattern in which panic attacks have started to recur, and the person has begun to fear and anticipate them, and has often started to organise their life around avoiding the situations in which previous attacks have occurred. The pattern is common, treatable, and has one of the most well-evidenced cognitive-behavioural treatment protocols in the whole of clinical psychology. This programme is the self-paced version of that protocol, designed for adults whose panic is interfering with daily life but who can engage with structured material without therapist support. What the model says. The cognitive model of panic, developed by the British clinical psychologist David Clark and published in 1986, holds that panic attacks are not caused by the body suddenly malfunctioning. They are caused by the catastrophic misinterpretation of normal bodily sensations as evidence of an imminent physical or mental catastrophe. The thumping heart that someone with no panic disorder would barely notice becomes, to someone vulnerable to panic, the felt evidence of a heart attack about to happen. The shallow breathing that follows a startle or a difficult conversation becomes the felt evidence of suffocation. The dizziness that follows standing up too fast becomes the felt evidence of a stroke or a faint. The fear produced by these interpretations amplifies the underlying bodily activation, which produces stronger sensations, which produce stronger catastrophic interpretations, and within minutes the person is in a full panic attack. The catastrophe that was feared never actually arrives, the body returns to baseline, the person is left exhausted and shaken, and the loop is now primed to fire again on the next physical sensation. The treatment. The CBT protocol for panic disorder works directly on the catastrophic misinterpretation. Three components do most of the work. The first is psychoeducation: understanding what panic is, what the sensations actually are, and why they do not mean what they seem to mean. The second is interoceptive exposure: deliberately inducing the feared body sensations in a graded way, repeatedly, so the brain learns experientially that the sensations are not dangerous and do not lead to the predicted catastrophe. The third is in-vivo exposure for those whose panic has spread into agoraphobic avoidance: a graded return to the situations and places that the person has been avoiding because they associated them with previous attacks. Across these three components most adults with panic disorder see substantial improvement within eight to twelve weeks of consistent work, with the great majority no longer meeting diagnostic criteria for panic disorder at the end of treatment. What this programme is. It is a self-directed step-2 programme aligned with NICE clinical guideline CG113, which recommends self-help based on CBT principles as the first-line step-2 intervention for panic disorder in adults. The eight modules cover the full CBT-for-panic protocol:

understanding what panic is, mapping the cognitive model onto your own experience, identifying your particular triggers and safety behaviours, learning the cognitive techniques for handling catastrophic thoughts, working through interoceptive exposure systematically, addressing any agoraphobic avoidance with in-vivo exposure, reducing the safety behaviours that have been maintaining the cycle, and building a personal maintenance plan for the months and years ahead. What this programme is not. It is not a substitute for individual therapy where panic is bound up with significant other clinical material that needs therapist-led work. Panic that occurs alongside severe depression, suicidal ideation, ongoing substance use, severe agoraphobia that has confined the person to home for months, post-traumatic symptoms, or a complex psychiatric history is typically better treated at step 3 by a therapist trained in CBT for anxiety disorders, or at higher levels where the comorbid presentations warrant it. Module eight covers in detail when stepping up to individual therapy through the practice or through NHS Talking Therapies is the right move. Important safety note. The interoceptive exposure exercises in modules five and seven deliberately induce body sensations including increased heart rate, brief hyperventilation, and head movements that produce dizziness. These exercises are safe for most adults but should not be attempted without first clearing them with your GP if you have any of the following: a known heart condition, including arrhythmias, recent cardiac events, or a cardiac pacemaker; an active respiratory condition including poorly-controlled asthma, COPD, or recent pneumonia; current pregnancy, in which the exercises should be modified or postponed; epilepsy or any seizure disorder, in which hyperventilation in particular can be a trigger; severe neck or spinal conditions, in which head-rolling exercises can be aggravating; or any other condition that your GP advises against vigorous brief exertion. The exercises are not the treatment in themselves; the treatment is the cognitive learning that the sensations are not dangerous. That learning can still happen for people who need to modify or skip specific physical exercises, and module five covers how to adapt the protocol if needed. If at any point in the programme you experience thoughts of harming yourself, please contact Samaritans on 116 123, text SHOUT to 85258, or your GP without delay. The practice’s therapists are available to discuss whether self-paced work is the right approach for your particular presentation, and to support you if at any point the work becomes harder than it should reasonably be.

This workbook is the written form of the Overcoming Panic programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module’s teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 8 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you reach it, note the date and your total, and compare it with the last.

When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

What this workbook will help you to do

- By the end of this module you will:
- Understand panic as a misfiring of the normal fight-or-flight system, not as a sign of physical or mental breakdown
- Recognise the standard physical symptoms of panic and what each one is doing physiologically
- Know the difference between an isolated panic attack and panic disorder
- Have set three concrete goals for what you want this programme to change
- Understand Clark's cognitive model of panic and how it explains the recurrence of attacks
- Recognise the role of catastrophic misinterpretation as the central mechanism
- Know why hypervigilance to body sensations maintains the cycle
- Have mapped a recent panic attack onto the cycle in your own experience
- Have identified the specific situational and internal triggers that most reliably set off your panic cycle

PART 1

Understanding Panic

What a panic attack actually is, why the body produces one, and the difference between panic and ordinary anxiety

CHAPTER 1

Welcome to the programme

You are reading this because something is happening in your body that you do not want to be happening. Out of nowhere, or in response to a particular situation, your heart suddenly pounds, your chest tightens, your breathing becomes shallow and difficult, your hands and lips go numb or tingling, the world feels strangely unreal, and a wave of dread sweeps through you that says, with absolute conviction, that something terrible is about to happen. The attack lasts maybe ten minutes, maybe twenty, and then it passes, and you are left exhausted and shaken and wondering when the next one is coming. You may have been to A&E or to your GP, you may have had an ECG that came back clear and blood tests that came back clear, and you may now have a piece of paper telling you that this is panic, and you are reading this because the piece of paper has not been quite enough.

A first thing to say plainly. Panic attacks are not dangerous. They are profoundly unpleasant, they are frightening in a particular way that is hard to describe to anyone who has not had one, and they cost real time and energy and they erode confidence. They are not, however, evidence that something is medically wrong with you, and they do not cause heart attacks, strokes, fainting, suffocation, or loss of sanity, even though they feel as though they might. The job of this programme is to give you a working understanding of what panic actually is, a set of techniques for handling the attacks when they arrive, and a structured plan for gradually reducing both their frequency and the influence they have over your daily life.

The programme is eight modules. The first three build a foundation: what panic is in physiological terms, the cognitive model that explains why it keeps happening, and a detailed map of your own particular panic pattern. Module four introduces the cognitive techniques for handling the catastrophic thoughts that drive panic. Module five is interoceptive exposure, which is the core of the behavioural work and where most people see the biggest changes. Module six is in-vivo exposure for those whose panic has spread into avoidance of particular places or situations. Module seven handles the safety behaviours that have been quietly maintaining the cycle. Module eight is a personal maintenance plan for the longer term, including when stepping up to individual therapy is the right move.

A practical note before going further. There is no right pace for this work. Some people move through one module per week, fitting the exercises around ordinary life. Others need to sit with a single module for two or three weeks, especially the exposure modules where the work itself is demanding. The access window is generous because the protocol benefits from steady, patient application rather than a sprint. The exercises only work if they are done, and they only need to be done at a pace you can actually sustain.

CHAPTER 2

What a panic attack is, physiologically

A panic attack is the human fight-or-flight system firing at full strength, in a context where there is no actual external threat to fight or flee from. The system is biologically ancient, exquisitely tuned, and entirely involuntary. When a part of the brain called the amygdala detects what it interprets as a serious threat to survival, it fires a cascade of signals that within seconds floods the body with adrenaline, redirects blood from the digestive system to the large muscles, accelerates the heart, deepens and quickens the breathing, dilates the pupils, sharpens the focus of attention, and switches off everything that is not immediately needed for short-term survival. This system saved your ancestors from predators, hostile humans, and falls from height. It is the same system that fires when a car suddenly swerves into your lane on the motorway, and the rapid response it produces is exactly why you are still here to be reading this.

The system does not have an off-switch for situations where no actual threat is present. In a panic attack, the system has been triggered, often by a physical sensation that the brain has misread as a threat, and it produces the full physical response anyway. Within seconds you have the following: heart rate elevated to around 120 to 160 beats per minute, breathing accelerated to two or three times resting rate, blood pressure raised, blood concentrated in the muscles of the arms and legs leaving the periphery (hands, feet, face) feeling cold or numb or tingling, pupils dilated giving a sense of visual unreality or excessive light, digestion suspended often producing nausea, and the entire body in a state of high alarm.

Each of these physical responses, taken on its own, has a perfectly ordinary explanation. The pounding heart is the body trying to get oxygen-rich blood to your muscles quickly. The shallow breathing is the body trying to take in more oxygen for the same effort. The numb hands and tingling lips are because your blood has gone to your arms and legs and there is less in the surface tissues, which is exactly what your body would want if you were about to run or fight. The dizziness or unreality is because you have changed the carbon dioxide level in your blood by breathing differently, which momentarily shifts brain blood flow. The nausea is because digestion has stopped. The feeling that you cannot quite see properly is the dilated pupils. None of this is your body malfunctioning. Every single one of these symptoms is your body doing exactly what evolution designed it to do in response to a perceived emergency.

The problem is not the response. The problem is that the response was triggered by something that was not actually an emergency. Modules two and three look at why the brain keeps making that mistake, and at what specifically is triggering it in your particular case.

A NOTE

A panic attack is not dangerous. It is the fight-or-flight system firing at full strength in a context where there is no actual threat. The system is biologically ancient and entirely involuntary. The physical sensations are real but they do not mean what they seem to mean, and they will pass on their own within ten to twenty minutes whether you do anything about them or not.

Sarah, a thirty-four-year-old primary school teacher, was driving to work on the M62 on a Monday morning in November. The traffic was slow. She noticed her heart beating a little faster than usual, which she initially attributed to the third coffee she had drunk that morning. Within thirty seconds her heart was pounding hard enough that she could feel it in her throat. Her hands began to feel numb on the steering wheel. The road ahead began to look strangely flat and unreal. The thought arrived, fully formed: I am having a heart attack on the motorway. She pulled onto the hard shoulder, hands shaking, certain that she was about to die. An ambulance was called. By the time the paramedics arrived, the worst of the sensations had eased. Her ECG was normal. Her blood pressure was elevated but settling. The paramedic, kindly, told her it sounded like panic, and that she should see her GP.

What had actually happened: a small, ordinary increase in heart rate from the caffeine had been registered by her brain as a possible danger signal. Her amygdala had fired the fight-or-flight cascade. The cascade had produced the pounding heart, the numb hands, the visual unreality. Sarah, having no framework for understanding what was happening, had reached for the most obvious explanation given the chest sensations and concluded heart attack. The catastrophic interpretation had massively amplified the activation. The whole episode lasted about twelve minutes. The body did exactly what evolution designed it to do; the misreading of the situation as a cardiac emergency is what made it the experience she still remembers two years later.