Overcoming Panic: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Overcoming Panic: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

Copyright © 2026 Talking Therapies UK. All rights reserved.

The moral right of the author has been asserted. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the publisher, except for brief quotations in a review, and except that the contact plans and checklists may be copied by the licensee for their own use.

First edition, 2026.

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

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 4. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

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

Contents

How to use this guide 1

Part 1 The approach and the evidence 2

1. The model behind the programme 2
2. What the research shows 7

How to use this guide

This guide is for qualified practitioners who support clients through the Overcoming Panic programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: Clark's cognitive model of panic, why the fear of panic becomes the problem, and how the eight modules are built
- Chapter 2, What the research shows: the evidence for CBT in panic disorder, for its components, and for guided self-help, with its limits

CHAPTER 1

The model behind the programme

Panic as a misfiring alarm

The programme starts where most clients with panic disorder need to start: with what a panic attack actually is. A panic attack is the fight-or-flight response firing at full strength when there is nothing to fight or flee from. Within seconds adrenaline is released, the heart speeds and pounds, breathing quickens, blood is redirected to the large muscles, and attention narrows onto the threat. Each of these changes is protective in real danger, and each produces a sensation that, out of context, feels alarming: a pounding heart, breathlessness, dizziness, tingling in the hands and lips, and a strange sense that the world or oneself is unreal. Module 1 takes the client through the symptoms one by one and gives each its physiological explanation, which for many clients is the first time anyone has explained them rather than simply ruled out a heart attack.

The module also makes a distinction that is central to the rest of the programme. Panic attacks are common: in a large survey of adults in the United States, more than a quarter reported at least one panic attack in their lives, while about one in twenty had met the criteria for panic disorder (Kessler et al., 2006). What turns occasional attacks into a disorder is not the attacks themselves but the response to them: the fear of the next attack, the watching of the body for signs of it, and the arrangements made to prevent it.



FIGURE 1.1 From a panic attack to panic disorder
Most people who have a panic attack never develop panic disorder. What turns attacks into a disorder is the response to them: fear of the next attack, constant watching of the body, and the safety behaviours and avoidance that keep the fear untested. Module 1 teaches this distinction, and it explains why the programme treats the fear of panic rather than the attacks alone.

Clark’s cognitive model

The programme is built on the cognitive model of panic that David Clark published in 1986. Clark (1986) proposed that panic attacks result from the catastrophic misinterpretation of bodily sensations. A sensation, such as a skipped beat, a moment of breathlessness or a wave of dizziness, is taken as a sign of immediate disaster: a heart attack, suffocation, collapse or madness. The interpretation produces fear, the fear produces more of the same sensations, and the stronger sensations seem to confirm the interpretation, so that the cycle can run from a flicker of sensation to a full attack in under a minute. Attacks that seem to come “out of the blue” usually begin with a sensation the person did not consciously register before the cycle was already running.

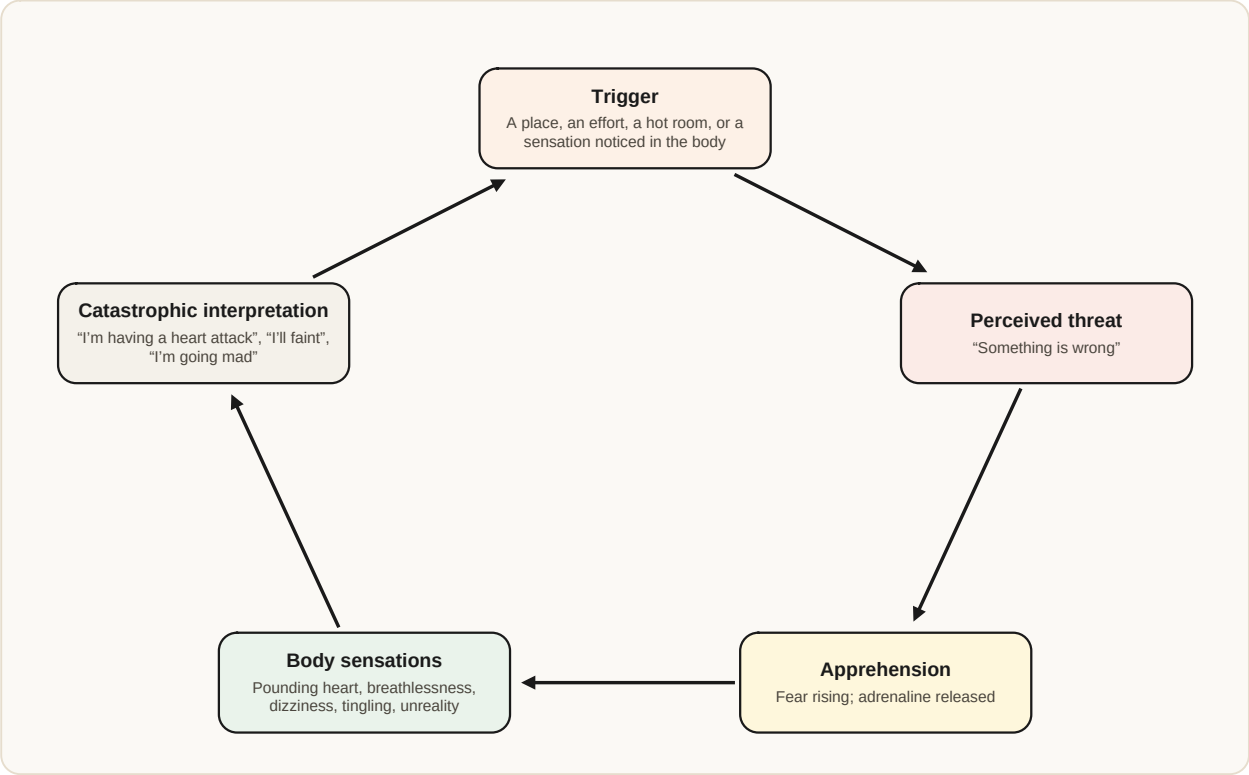


FIGURE 1.2 Clark's cognitive model of panic
A trigger, often a bodily sensation, is perceived as a threat and brings apprehension; apprehension produces more sensations; the sensations are interpreted as signs of immediate catastrophe; and the interpretation increases the sense of threat, so the cycle tightens within seconds. The programme breaks it at the interpretation and at the behaviours that keep the interpretation alive.

The model has strong support. People with panic disorder are more likely than people with other anxiety disorders, or none, to interpret ambiguous bodily sensations catastrophically (Clark et al., 1997). And treatment built on the model works: in a trial comparing cognitive therapy with applied relaxation and with imipramine, an antidepressant then widely used for panic, cognitive therapy produced the best results at three months, and at fifteen months, after the medication had been withdrawn, it remained more effective than both (Clark et al., 1994).

Why the fear does not go away by itself

A natural question, and one module 2 answers for the client, is why the catastrophic interpretation survives when the catastrophe never happens. Salkovskis (1991) gave the answer that the programme relies on: the things a person does to prevent the catastrophe stop them discovering that it was never going to happen. Someone who sits down "in case I faint" and does not faint concludes that sitting down saved them. Someone who leaves the supermarket at the first flutter of the heart concludes that leaving prevented a heart attack. Each attack that ends without disaster is credited to the safety behaviour rather than counted as evidence against the prediction, so the prediction is as strong after the fiftieth attack as after the first.

Two further processes keep the cycle primed. The first is hypervigilance: once panic is established, the brain watches the body continuously for the first sign of an attack, which means ordinary sensations are noticed sooner and more often and give the cycle more to start from. The second is avoidance, which is the most complete safety behaviour of all: a situation never entered can never show that the prediction was wrong.

How the programme breaks the cycle

The programme's order follows the model. Modules 1 to 3 explain panic, show the client the cycle in their own attacks, and build a four-part map of their triggers, sensations, interpretations and safety behaviours, which becomes the working document for everything that follows. Module 4 works directly on the interpretations, weighing each against the evidence of the client's own history and preparing an alternative. Modules 5, 6 and 7 are the behavioural centre of the programme: interoceptive exposure, which brings on the feared sensations deliberately so the brain can learn that they pass without harm; exposure to avoided situations in a graded way; and dropping safety behaviours one at a time as behavioural experiments. Module 8 is about keeping the gains.

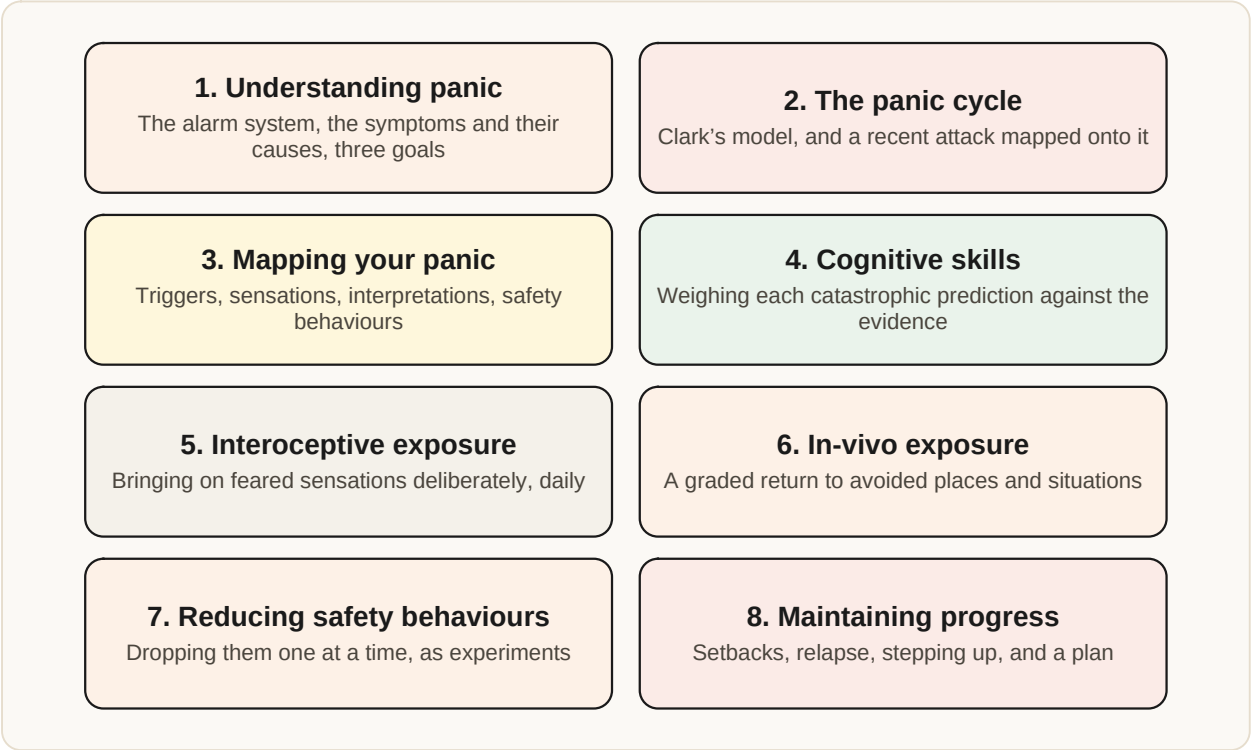


FIGURE 1.3 The eight modules and what each works on

Modules 1 to 3 explain panic and build the client's own map of it. Module 4 works on the catastrophic interpretations. Modules 5 to 7 are the behavioural centre of the programme: exposure to feared sensations, to avoided situations and without safety behaviours. Module 8 keeps the gains. Modules 5, 6 and 7 each need weeks of practice, not days.

Pacing

The modules are not of equal weight, and the practitioner needs to plan for this from the start. Modules 1 to 4 can each be read and worked through in a week. Module 5 asks for at least two weeks of daily practice before module 6 begins, and modules 6 and 7 describe work that continues for four to six weeks alongside the interoceptive practice. A client who reads one module a week and treats each as finished will have read about exposure without doing it. A workable pattern is weekly contacts for modules 1 to 5, then contacts every one to two weeks for modules 6 to 8, so that the programme runs for twelve to sixteen weeks in all. Agree this with the client at the first contact, so that a slower second half is understood as the design rather than a delay.

How the modules are built

Each module has the same shape: an introduction, three or four teaching sections, a sorting exercise, a practical worksheet, a summary and a closing reflection, “Taking this forward”, which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do then. Several modules include a worked example slowed down; module 5’s follows Ben, 29, through a single session of running on the spot. The check-ins come in modules 1, 4 and 8: the PHQ-9 and the Work and Social Adjustment Scale in module 1, and the PHQ-9, GAD-7 and WSAS in modules 4 and 8. There is no anxiety measure in module 1, so take the GAD-7 at assessment, and where your service uses it, the Panic Disorder Severity Scale (Shear et al., 1997), which measures the frequency of attacks, the distress they cause, anticipatory anxiety and avoidance. The worked examples in this guide follow one composite client, Shona, through all eight contacts.

What the practitioner adds

The programme carries the teaching. The practitioner’s part in panic work is narrower and more demanding than in many programmes. It is to help the client apply the model to their own attacks rather than to panic in general; to calibrate the exposure work so that it is hard enough to teach something and not so hard that the client escapes; to find the safety behaviours that the client cannot see because they look like common sense; and above all not to become a safety behaviour oneself. Clients with panic seek reassurance, often skilfully, and a practitioner who answers “Could it be my heart?” with “No, it’s definitely anxiety” has provided the same relief, and the same maintenance, as the client’s partner taking their pulse. Chapter 5 shows how a thirty-minute contact keeps its attention on what the client has done and learned.

CHAPTER 2

What the research shows

Psychological treatment of panic disorder

Cognitive behavioural therapy is the best-established psychological treatment for panic disorder. A Cochrane network meta-analysis of psychological therapies for panic disorder, with or without agoraphobia, found the most consistent evidence for CBT, which was often superior to other therapies in the short term, while judging the quality of the evidence low and the advantages over other active therapies small (Pompoli et al., 2016). The trials behind it go back to the 1980s and 1990s, including Clark's trial of cognitive therapy (Clark et al., 1994), described in the previous chapter, and early trials of treatment combining exposure to bodily sensations with cognitive restructuring, in which most participants were free of panic attacks by the end of treatment (Barlow et al., 1989).

The National Institute for Health and Care Excellence (2011) sets out stepped care for panic disorder. It recommends self-help based on CBT principles, with or without the support of a practitioner, for mild to moderate panic disorder, and identifies psychological therapy, CBT delivered by a trained practitioner, as the intervention whose effects last longest. It advises that benzodiazepines should not be prescribed for panic disorder, because they are associated with a less good outcome in the long term, which is relevant to clients who carry a rarely taken tablet "just in case".

The components

The programme's components each have their own evidence. For interoceptive exposure, Antony and colleagues (2006) tested a range of symptom induction exercises with people with panic disorder and found that breathing through a thin straw, over-breathing and spinning produced the most intense and panic-like sensations, which is why the programme uses them. For safety behaviours, Salkovskis and colleagues (1999) gave people with panic disorder and agoraphobia brief exposure either with their usual safety behaviours or with instructions to drop them, and found greater reductions in catastrophic beliefs and anxiety when the safety behaviours were dropped.

For exposure to situations, modules 5 and 6 tell the client to stay until distress has peaked and fallen, by about half in module 6, which matches most clients' experience and is a useful rule of thumb. Practitioners should know that research has moved beyond the idea that exposure works because fear falls during it. Craske and colleagues (2014) reviewed evidence that the fall in fear during a session does not reliably predict how well the gains last; what matters more is that the exposure violates the person's expectation, above all that the feared outcome does not happen, and that this new learning is strong enough to compete with the old fear when it is next triggered. They describe ways of strengthening it: framing each exposure as a test of a stated prediction, varying the situations and conditions in which it is practised, dropping safety behaviours, and on occasion combining exposure to sensations with exposure to situations. The contact notes for modules 5 and 6 show how to use the programme's guidance while keeping the emphasis on

prediction and outcome, so that waiting for the drop does not become a new rule.

Guided self-help

Studies comparing guided self-help directly with face-to-face psychotherapy for anxiety and depression have found similar effects (Cuijpers et al., 2010), and NICE recommends self-help as a first step for mild to moderate panic disorder. Two features of panic work make the guidance particularly important. Interoceptive and situational exposure are unpleasant by design, and without someone to plan them with, many clients either do not start or stop at the first spike of fear. And safety behaviours are hard to see from the inside, so the practitioner's questions are often how they come to light.

What the research does not show

No trial has tested this programme in its present form. The evidence above comes mainly from therapist-delivered CBT for panic disorder, from experimental studies of its components, and from guided self-help in other formats. The programme applies that evidence with care, and the stepping-up guidance in Part 2 and in module 8 is the safeguard for clients for whom it is not enough: those whose panic does not shift after weeks of consistent practice, those whose avoidance is too severe to start self-paced exposure, and those for whom panic is bound up with depression, trauma or the use of alcohol or drugs.