Chapter 4: Panic Disorder: A Comprehensive Nursing Update

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Learning objectives

Upon completion of this course the learner should be able to:

- Describe clinical presentation, etiology, differentiation for diagnosis, and potential complications.
- Identify and describe the multiple treatment modalities and complementary therapies.
- Understand supportive care during a panic attack and collateral impact on families.

PANIC DISORDER: WHAT IS IT?

Definition of panic disorder

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) panic disorder is defined as occurrence of panic attacks associated with more than one month of subsequent persistent worry about having another attack, consequences of the attack, or significant behavioral changes related to the attack.

Panic disorder may be with or without agoraphobia. Agoraphobia, which literally means fear of open spaces, is fear and avoidance of places and situations where escape or help in the event of panic is not readily available.

So what is a panic attack? The DSM-IV-TR states that a panic attack has four of the following potential symptom manifestations:

- Palpitations, pounding heart, or increased pulse.
- Sweating.
- Trembling or shaking.
- Sense of smothering or shortness of breath.
- Chest pain or discomfort.
- Feeling of choking.
- Nausea, abdominal distress.
- Feeling dizzy, lightheaded, unsteady, faint.
- Derealization or depersonalization.
- Fear of going crazy or losing control.
- Fear of dying.
- Numbness, tingling.
- Chills or hot flashes.

In panic disorder, the panic is spontaneous and unexpected. Panic attacks can occur with other anxiety disorders, but for the diagnosis of panic disorder to be made, the panic must occur without a specific, predictable precipitant. For example, a person who has a fear of heights goes in a tall building and has a panic attack while looking out the window. That is not panic disorder.

For a diagnosis of panic disorder to be made, let’s look at another example: A person is washing dishes. She has a panic attack. That attack occurred without a clearly precipitating event. The attack is spontaneous and unexpected as in the case of panic disorder.

When people are having a panic attack, they feel like they “have to get out of here” and may feel like they are suffocating or dying. Additional symptoms may include diarrhea, headache, cold extremities, fatigue, insomnia or persistent thoughts that “won’t go away.” Panic attacks may occur sporadically or many times daily. Most peak within 10 minutes and resolve within 30 minutes.

Panic disorder with agoraphobia

Having a panic attack is terrifying. The memory of it is etched deeply by a process that is primitive and without rational thought. Avoidance behaviors may begin after just one panic attack. Early treatment is critical because with each panic, the likelihood of avoidance increases. Intensity may increase as well because the victim fears reoccurrence more and more.

Signs of agoraphobia include:

- Traveling shorter and shorter distances; this can increase to where people may only feel safe in a small portion of one room of their home.
- Needing a “safe” person with them.
- Inability to be employed.
- No longer driving.
- Avoiding situations where “escape” is difficult, such as shopping malls, social events, narrow hallways, and public transportation.
- Avoiding exercise because of fear that shortness of breath or increased heart rate will trigger a panic attack.
- Avoiding foods that might trigger symptoms, such as coffee.

Statistics

Sixty million Americans, approximately 20 percent of the population of the United States, will suffer a panic attack at some time during their lives. Of those, 1.7-5 percent of American adults have panic disorder. The National Comorbidity Survey Replication (NCS-R) records that the lifetime prevalence rate of panic disorder is 4.7 percent.

According to the National Institute of Mental Health, panic disorder affects about 6 million Americans. Australian and British rates are slightly lower. Approximately 0.7 percent of children are believed to suffer from panic disorder or generalized anxiety disorder. Numbers, especially for children, may be higher because panic disorder is under diagnosed and undertreated in children.
Peak onset of panic is generally considered to be ages 15-19. While it can develop at any age, panic disorder usually develops before age 40. Panic disorder is diagnosed twice as often in women as in men, and is more common in women who have never been pregnant. Panic attacks may be less frequent during pregnancy but more common in the postpartum period.

**Physiology/etiology**

While environment has a role in the occurrence of stress and stress management, most theorists focus on a physiological origin of panic disorder. Many researchers conclude that both physiology and stress are a factor to varying degrees.

When there is a threat to a mammal, humans included, a minimum of two neurological pathways are activated within the brain. The frontal lobe of the cerebral cortex becomes activated to facilitate decision-making. Prior to that, the more primitive, unconscious brain activates the fight-or-flight response. Much of that response involves the amygdala, responsible for regulating blood pressure, increasing heart rate, and alertness.

The amygdala is a critical part of the emotional, limbic system. It consists of two small portions of tissue deep within each side of the brain. The amygdala rapidly freezes memories using a different mechanism than that which is used by the frontal cortex when learning and creating memories result from a non-threatened state. The amygdala stimulates impulses that send the person into a fight-or-flight response before conscious, rational thinking occurs. Several studies refer to processes within the amygdala, hypothalamus, and brainstem centers.

Studies indicate that panic disorder is related to various biochemical imbalances. Chemicals involved include GABA, serotonin, cortisol, dopamine, norepinephrine, cholecystokinin, and interleukin. Others indicate carbon dioxide receptor hypersensitivity and lactate-producing symptoms. The HPPA (hypothalamic-pituitary-adrenal axis) has been implicated. Catecholamines may be involved.

Hyperventilation is involved in panic attacks. Some theorists believe people with panic disorders may chronically hyperventilate, precipitating panic attacks. Many studies allude to hypersensitivity within the nervous system.

Children 2 to 3 years old who tend to be very shy and withdrawn in new social environments appear to be more at risk of developing anxiety disorders. However, the vast majority do not develop any disorders. Studies do not specify what anxiety disorders that the children are at risk of developing, but panic disorder does seem to be a possible outcome.

The amygdala of older children with anxiety disorders reacts similarly to children at risk for developing anxiety and depression. This response is different from children who do not have an anxiety disorder.

There is no clear-cut genetic pattern identified yet in the development of panic disorder.

Panic may be exacerbated during changes of hormonal balance, such as onset of menses or menopause.

Some theorists believe that people with panic attacks are more cognizant of internal clues to “danger,” such as increased awareness of muscles tightening or increased heart rate. They may unknowingly overreact to normal variances within the body, producing thoughts of danger where none exists.

Positron emission tomography (PET) scanning indicates increased flow around the right hippocampal area and decreased serotonin binding. MRI (magnetic resonance imaging) shows normal volume of the hippocampus, with reduced temporal lobe volume in patients with panic disorder.

**Differential diagnosis**

Panic is a medical disorder. While no specific lab or imaging tests confirm the diagnosis of panic disorder, a medical exam is indicated to rule out other health conditions. Often people who are experiencing a panic attack present in an emergency department thinking they are having a heart attack. Most patients first seek help for panic disorder from their primary caregiver.

Whether the person appears first in an emergency department, psychiatrist’s office or general practitioner’s office, an EKG, blood chemistry panel, thyroid level, and a CBC should be obtained.

Panic symptoms may mimic mitral valve prolapse, hyperthyroidism, hyperparathyroidism, or hypoglycemia. Pheochromocytoma, cardiac arrhythmias, temporal lobe epilepsy, and audiovestibular system dysfunctions may resemble panic.

A medication review is needed. Legal and illegal substances may produce panic-like symptoms. The use of stimulants, including caffeine and hallucinogens, may provoke or mimic panic. Withdrawal from medications may precipitate panic as well. People who are discontinuing SSRIs (selective serotonin reuptake inhibitors) may present with the SSRI discontinuation syndrome, which has symptoms similar to panic.

Panic disorder is one of six major types of anxiety disorders. Anxiety disorders are among the most common disorders of our time. The six major types of anxiety disorders are:

- Generalized anxiety disorder.
- Obsessive-compulsive disorder.
- Phobias.
- Post-traumatic stress disorder (PTSD).
- Social anxiety disorder.
- Panic disorder.

While each of the anxiety disorders has specific symptoms, they often overlap. People with panic often suffer from one or more of the other anxiety disorders as well.

As noted above, panic disorder may occur with or without agoraphobia. Approximately one-third of people with panic disorder become agoraphobic, unable to leave their homes or to do normal activities of daily living, such as grocery shopping, without being accompanied by a trusted, “safe” person.

A diagnosis of panic disorder may be made by obtaining a detailed history and physical exam. Screening tools may be useful to provide more detailed information and to rule out other anxiety disorders.

Psychological screening assessment tools that may be useful in the diagnosis and subsequent evaluation of treatment include:

- Composite International Diagnostic Interview.
- Anxiety Sensitivity Index – ASI.
- Fear Questionnaire.
- The Mobility Inventory for Agoraphobia – MI.
- Agoraphobic Cognitions Questionnaire – ACQ.
Body Sensations Questionnaire – BSQ.
Sheehan Disability Scale – SDS.
Panic Disorder Severity Scale – PDSS.

Hospital Anxiety and Depression Scale – HADS.
Becks Anxiety Inventory – BAI.
Hamilton Anxiety Rating Scale – HAM-A.

Co-morbidities

Panic disorder affects one in 10 patients in primary care settings. Patients with panic disorder often suffer from one or more of the other anxiety disorders. Some researchers consider the boundaries defining panic and other forms of anxiety to be gray areas. The presence of co-morbidities significantly impacts the effects of treatment and degree of recovery from panic disorder.

People with depression or personality disorders who present with panic have poorer outcomes than people without those co-morbidities. Studies indicate that patients who have generalized anxiety disorder, social phobia, or PTSD in combination with panic disorder do not recover as well as those without those concurrent diagnoses.

Prevalence of major depression accompanied by panic disorder may be as high as 50 to 60 percent. This is not surprising because of the effects each disease has upon individuals. In addition, many of the same chemicals within the brain are associated with depression and panic disorder.

Panic disorder is found among 7 to 28 percent of drug and alcohol abusers. Most indicators show that people with panic disorder self-medicate to control their anxiety. The flip side is that the substances can trigger panic attacks. Eight to 15 percent of individuals in alcohol treatment programs have panic disorder.

Prognosis

Panic disorder is not considered curable, yet it is often a highly treatable condition, with 65 percent of patients obtaining remission within six months or less. The use of medication and Cognitive-behavioral therapies are beneficial in 85 percent of patients. They may be used individually or in conjunction with each other. However, the outlook is less promising if co-morbidities are present. People who develop panic later in life tend to do better than those who develop it while very young.

Studies relating to race are inconsistent. Some studies indicate that Caucasians have better remission rates than nonwhites; others do not support that. Some researchers find that people with a higher socioeconomic status have better outcomes. These studies are sometimes linked to the improved outcomes for Caucasians. Socioeconomic studies are also linked to whether the person is employed and to what degree as well. In addition:

- Panic disorder with the presence of agoraphobia has a poorer prognosis than panic disorder without agoraphobia.
- Early treatment is key to improved outcomes in many cases.
- People living with elevated stress do not fare as well as those who do not have added stress.

One of the most reliable predictors of treatment response is the overall severity of the panic disorder. This is measured by frequency and intensity of panic attacks as well as the presence or absence of agoraphobia and avoidance behaviors. The degree of avoidance behaviors is considered by some to be the key indicator of success or failure of treatment.

In studies addressing anxiety disorders as a whole and not specifically panic disorder, smokers, separated or divorced individuals, people living alone, and those with social problems were at higher risk of developing anxiety, with poorer outcomes resulting. Survivors of abuse and single parents were also at risk. Of note, 35 percent of elderly depressed patients had at least one anxiety disorder.

Treatment options

Treatment of panic disorder frequently consists of two primary modalities: medication and cognitive-behavioral therapies. Exposure therapies, breath work, nutrition, herbs, and additional complementary modalities are useful as well. People with panic disorder frequently employ several treatment modalities.

Because panic is a multifaceted disorder, improving quality of life and stress reduction techniques are important to include in an effective treatment plan for panic disorder. Family therapy may be beneficial as well to reduce stress and to provide education and support for family members.

Pharmaceuticals

Medications are very helpful in managing panic disorder. They can help to prevent panic attacks, relieve common comorbidities such as depression, and reduce the intensity of panic attacks. There are three main types of medications commonly used: antidepressants, benzodiazepines, and beta blockers.

Sometimes medications are prescribed for short-term use until other types of therapies are deemed effective. Success rates improve when medications are used in combination with cognitive-behavioral therapies. Medications and therapy do not cure panic disorder but have major impacts on a patient’s quality of life.
Some people recommend trying cognitive-behavioral therapies before prescribing medication. The degree that the patient's life is being affected by panic disorder must be considered. The advantage of using medications early in treatment is that it prevents the occurrence of panic attacks and reduces the severity of those that occur. With approximately one-third of people developing agoraphobia in the presence of panic disorder, early treatment with medication may outweigh the risks of the medications.

When treating with pharmaceuticals is considered, it must be kept in mind that people with panic have an increased frequency of self-medicating with alcohol and other legal and illegal substances. Potentially dangerous or life-threatening interactions may occur.

**Antidepressants**

Antidepressants can be very useful in the treatment of panic disorder. However, they have been associated with a higher risk of suicide.

Selective serotonin reuptake inhibitors (SSRIs) are the most frequently prescribed medications. Examples include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa) and Lexapro (citalopram). SSRIs relieve anxiety and the depression that is often present in the face of panic disorder. These medications take about two to six weeks to reach their maximum effectiveness. They work by regulating serotonin levels. SSRIs must be taken consistently. They are not effective for treating acute panic attacks.

Common side effects include gastrointestinal distress, sexual dysfunction, weight gain, and changes in sleep patterns. Other side effects are nervousness and drowsiness. If discontinued, SSRIs need to be tapered off gradually. If reduced too quickly, marked depression, irritability, and increased anxiety may occur.

Older tricyclic antidepressants are still employed to treat panic disorder. Imipramine, (Tofranil), clomipramine (Anafranil), desipramine (Norpramin), nortriptyline (Pamelor), and amitriptyline (Elavil) have all been used to treat panic disorder. The medications are effective, but they can be sedating and may cause dry mouth, dizziness, and weight gain.

Tricyclic antidepressants take three to six weeks to become effective. They are not physically addictive and they are inexpensive. Particularly while titration initially occurs, patients may report feeling dull and have difficulty with concentration and memory. A benefit of the tricyclics is that they can help to relieve insomnia and panic attacks that occur during sleep.

Monoamine oxidase inhibitors (MAOIs) are less frequently used except when there are co-morbidities that indicate their use is needed or if other treatments for panic disorder have failed. Phenelzine (Nardil) is the most widely used MAO inhibitor used to relieve panic disorder.

MAOIs have several serious side effects. A low tyramine diet must be followed. MAOIs may interact with SSRIs, causing serotonin syndrome, a dangerous condition that can be life-threatening. Symptoms include confusion, hallucinations, muscle stiffness, seizures, blood pressure changes and arrhythmias. Development of serotonin syndrome is a medical emergency, and immediate help must be sought.

**Benzodiazepines and anti-anxiety medications**

Benzodiazepines are tranquilizers. They provide rapid reduction of anxiety and are useful when a panic attack occurs or during periods of high stress. Taken orally, they act within 30 minutes or less and are sometimes administered intravenously if patients are hospitalized. Common benzodiazepines used include alprazolam (Xanax), lorazepam (Ativan), diazepam (Valium), and clonazepam (Klonopin).

These medications may be habit-forming and are sedating. Tolerance may develop, requiring larger doses to be effective. Panic can be worse when these medications are discontinued. These drugs have the potential for abuse and can be hazardous when alcohol is consumed. Care must be taken when driving or operating machinery until the effect on the individual is known.

Patients may feel dull, lethargic, or have difficulty concentrating with these medications, especially during initial treatment. Some patients report feeling “hung over” the next day after using benzodiazepines. Side effects increase with higher doses, but some people report that when they are having very intense panic attacks, they can tolerate higher doses – yet the same doses when they are less panicked give them side effects.

Lack of coordination, clumsiness, slow reflexes, depression, dizziness, and lightheadedness can result from benzodiazepine administration. Thinking and judgment may be impaired, and memory may be impacted. Visual changes have been reported.

Benzodiazepines can decrease panic, but also numb other emotions. They may cause or increase depression. Some people, usually the very young or elderly, experience a paradoxical effect when benzodiazepines are administered; hypermania, rage, hallucination, and aggression may occur.

Buspirone, trade name Buspar, is an azaziprine that can be helpful in the treatment of panic disorder. Side effects may include dizziness, headaches and nausea. Buspirone requires administration for about two weeks to reach its peak therapeutic effect. It is calming, but not fast-acting like the benzodiazepines for acute panic situations.

**Beta blockers**

Propranolol, trade name Inderal, is believed to block the effect of epinephrine and stress hormones. Studies reveal threat receptor sites in the brain are blocked when Inderal is administered. It appears to decrease the extent that a terrifying experience, such as a panic attack, is etched into the brain’s memory.

Propranolol also modulates the pulse rate, so the victim does not experience and associate a racing heart rate with panic, which heightens anxiety. Beta blockers may be administered before a patient enters a high-stress situation to reduce the physical symptoms of anxiety. This can be useful when people are attempting to “push their limits” or if they are in new situations. The beta blockers reduce the sense of panic without the sedation and cognitive impairment that may accompany benzodiazepines.
The use of beta blockers for the relief of panic disorder is controversial among some therapists. They believe beta blockers are not effective for panic disorder and that panic that responds to treatment with beta blockers is actually mitral valve prolapse misdiagnosed as panic disorder.

Other pharmaceuticals

A small study tested an antibiotic, D-cycloserine. The theory is that D-cycloserine may facilitate unlearning of fearful memories. Further research is needed.

COUNSELING

Cognitive-behavioral therapy (CBT)

Cognitive-behavioral therapy is an effective treatment of panic disorder with or without agoraphobia. It may be used in conjunction with medication or independently. Cognitive-behavioral therapy empowers the patient with techniques to manage stress, decrease anxiety and correct thinking patterns that potentiate panic. It is the most widely used psychological therapy for treatment of panic disorder.

Cognitive-behavioral therapies focus on thinking and making conscious changes in thoughts that are not helpful as well as making behavioral changes. These therapies focus on the here-and-now; they do not attempt to resolve underlying psychological conflict or trauma. Often programs are short-term, ranging from one to three months. There are self-help and distance support programs available via the Internet. Group and individual sessions are available.

CBT programs require a high degree of patient motivation and commitment, and the work can be rewarding and exhausting simultaneously. But benefits can reach beyond reducing the panic disorder; therapy can change a patient’s way of relating to him- or herself and others. It may prompt significant lifestyle changes.

CBT addresses thought and belief patterns that cause anxiety and disempower the patient, who learns ways to challenge negative thoughts and replace them with constructive ones.

People who suffer from panic may engage in catastrophic thinking, which means believing that the worst possible outcome for an event may happen, even if the likelihood is minute. Participants in CBT programs learn to recognize and refute catastrophic thoughts. They then learn to replace them with more realistic thoughts.

CBT programs use a systematic approach. The participants receive homework to practice skills. Workbooks often are used. Initially, it is very hard work that feels unnatural. In time, confidence grows. Automatic negative thinking is replaced with more realistic, manageable thoughts that reduce baseline anxiety levels.

Cognitive-behavioral therapies can be helpful for people newly diagnosed with panic as well as for people who have had panic disorder for decades. It works with mild panic and even with patients who suffer from agoraphobia.

The tools are helpful for agoraphobics when trying to decrease avoidance behaviors. They learn to break down barriers into smaller components, which increase the likelihood of success.

Panic disorders may be persistent or they may vanish for years then suddenly reappear. People who have successfully learned CBT strategies in the past may reach back to use the techniques if panic reappears or if new situations are causing anxiety.

Cognitive-behavioral therapies help patients to reduce anxiety by teaching healthier thinking patterns. Participants learn behavioral strategies to change their responses to stressful situations, including panic attacks. They learn that a panic attack can be interrupted at any stage of panic, but that it is most effective to recognize early stages of panic and stop the panic before it becomes intense.

Here are ways development of healthier thinking patterns may be facilitated:

- Participants in a cognitive-behavioral therapy session are provided education that explains panic attacks are not fatal, nor does having a panic attack indicate insanity.
- People in the midst of a panic attack often think that they are dying of a heart attack or “going crazy.” With education about the nature of panic attacks, anxiety that would normally exacerbate fear and heighten the terror of the panic attack is reduced. Baseline anxiety is lessened.
- The participant learns to self-assure him- or herself, and realizes “I know what this is. It is a panic attack. I feel horrible, but I know what it happening. Panic attacks are self-limiting. I am not losing my mind. I am not having a heart attack. I am not going to die from this. It will pass.”

Basic instructions like these offer enormous relief for patients. Knowing that they are essentially OK and not going insane or facing death reduces panic levels monumentally.

Cognitive-behavioral therapy may also be beneficial because having a panic attack feels like being completely out of control. This terrifying thought compounds the panicky feelings. Reframing, recognizing self-defeating thoughts, and feeling “more in control,” can reduce panic. Perceiving a higher level of control instead of feeling at the mercy of panic attacks that arise uninvited from anywhere at anyplace or time helps patients feel empowered and less anxious.

The less underlying anxiety present, the less frequent and less intense panic attacks may become. As frequency and intensity are reduced, patients can think clearer, sleep better, and be more realistic. They become optimistic about gaining some power over preventing panic attacks.

Skills practiced during cognitive-behavioral therapy sessions include recognizing overestimation of the power that panic possesses as well as ways to manage anxiety and panic. Resources are discussed. Realizing that others will provide assistance if panic attacks occur reduces feelings of isolation that dominate during panic attacks.

While these strategies may seem obvious to a person who does not suffer from panic disorder, to a person with it, these acts sometimes seem about as likely for them to achieve as is flying to the moon.

A study done in Australia measured the effectiveness of an Internet-based cognitive-behavioral therapy program led by a therapist. It had promising results. While the Internet is not a substitute for direct face-to-face contact, this offers an affordable, accessible option for people who are far from services, too embarrassed to obtain services, or agoraphobic. For some, it may be sufficient help; for others, it may be a much-needed lifeline when other options are not available.

Some cognitive-behavioral therapy programs include instruction about progressive muscle relaxation techniques. To do progressive muscle relaxation, clients sit or lie in a comfortable position with their...
eyes closed. Starting at the toes, the person contracts then release the muscles in the toes, then feet, followed by the ankles and so forth until his or her entire body is relaxed. The exercise provides immediate relaxation and body awareness skills.

Numbness and not being able to feel grounded is terrifying during panic. Being able to feel, concentrating on an activity that can be performed anywhere, and having to think about something other than the panicky feelings can be useful during a panic attack. Participants are encouraged to use this strategy on a regular basis as a healthy exercise as well.

Many of the frightening symptoms of panic are caused by hyperventilation. Often, people with panic disorder hyperventilate under stress so frequently that they are not even aware of it until it becomes extreme. Learning breath awareness and practicing breathing techniques for 10 minutes twice daily can be beneficial. It is relaxing and helps people realize they can control their breathing.

During a panic attack, people commonly say that they feel like they are suffocating and can’t breathe. By practicing breathing techniques, the likelihood of hyperventilation precipitating a panic is reduced. If a panic does occur, the person has another tool to calm him- or herself. Of all the behavioral skills, breath awareness is probably the most powerful.

Another component of cognitive-behavioral therapy is education about the disorder. As participants learn the physiology, it may help to reduce feelings of shame that are common. People with panic disorder often feel embarrassed by their limitations and “odd” behaviors. To know that panic is a physical disorder and not a weakness goes a long way in stress reduction. By learning about the condition, participants feel more in control. This is critical with people who suffer from panic disorder because they feel extremely vulnerable and out of control when panic attacks occur. In addition, the more information that sufferers have, the more choices they can make to minimize panic.

Participants in cognitive-behavioral therapy programs learn to identify what makes them feel anxious. Learning to avoid caffeine and nicotine, being aware that panic may increase at certain times of a menstrual cycle, or finding that exercise may help prevent panic are just some of the topics that may be addressed. Participants learn to make lifestyle choices that reduce stress and panic and frequency of panic attacks.

A great deal of time in cognitive-behavioral therapy is spent examining thought patterns. Automatic thoughts can trigger and intensify panic attacks. Participants learn to recognize their negative thoughts and refute them. They learn to distinguish between thoughts and feelings.

There are several common, automatic thought patterns that panic sufferers have that increase their distress. These include:

- Viewing situations as black and white; perfectionism; feeling “I am weak.”
- Catastrophic thinking: “If I have a panic attack, I might die from a heart attack.”
- Exaggerating risk: “If I have a panic attack, no one will want to go out with me ever again.”
- Giving up: “I will have a panic attack and get fired, so I am not even going to apply for a job.”
- Thinking that they are weak: “There is something wrong with me, I am too sensitive; it’s just the way I am, and that won’t change.”
- Thinking too many “shoulds”: “I should be able to drive on the interstate, everyone else does.”
- Confusing body feelings with facts that imply danger: “When I run, my heart beats fast” or “That will give me a panic attack.”

Recognizing, examining, refuting, and replacing unhelpful thinking patterns is very hard work. People who have panic disorder may have thousands of these kinds of thoughts each day. Fortunately, most people have a few patterns that tend to repeat themselves over and over, so a process does not have to be developed for every one. Participants are instructed to write down their thought patterns and substitute new, realistic ones instead.

Here is an example of how to challenge an automatic negative thought pattern:

Jane suffers from panic disorder. Her biggest fear is that she will not be able to breathe during a panic. She believes that she will die a horrible, suffocating death and no one will care for her children. The children will end up in foster care and lead terrible lives because she is unable to “get a grip.”

In this example, it is clear that Jane is not being kind to herself and sees herself as defective. She is using catastrophic thinking, assuming she will be dead and her children’s lives will be ruined. She is exaggerating the risk associated with panic. People do not die from panic attacks. People do not stop breathing with panic, even if it feels that they are not getting air. She is associating the feeling of suffocation with death, when in reality, it is the panic that makes her feel unable to breathe. She is actually hyperventilating and causing the feeling.

So how can Jane help herself?

She needs to learn the physiology of panic so she can separate feelings from thoughts. Jane would initially be asked to write down the following procedure, shown below in bold type. Several workbooks are available to guide clients through this process, but a simple notebook may be used as well.

First, Jane needs to (1) identify the feelings that make her feel like she is going to die. She believes that when she feels short of breath, it means she is dying. Thus, in this case, the feelings of shortness of breath are the trigger for the panic.

Jane then must (2) identify the automatic thought she gets in this situation: “I am suffocating to death.”

She then must learn to (3) challenge that thought. She should ask herself what the likelihood of her dying during a panic attack realistically is. Because she has received information about the physiology of panic, even though Jane feels like it’s 100 percent likely when in the throes of panic, her rational thought might tell her that it is a 40 percent probability (which is still an exaggeration, but also is markedly less than 100 percent.) She then must (4) write down the change in her feelings, in this case the percentage she now estimates is her likelihood of dying from suffocation during a panic attack.

Then Jane needs to (5) write down her revised rationale for believing the new estimate that there is a 40 percent chance of dying.

She might write something like this: “It gets so hard to breathe when I am having a panic attack. I try really hard to take a deep breath, but I just can’t. My throat feels so tight. It will just block off my airway completely one day.” Then she needs to write down why that is not what is really happening and (6) state what actually is occurring: “I know that I am breathing. Throats do not just close up during panic. I feel short of breath because I am hyperventilating.”

Jane then should be asked to (7) consider other ways of thinking about the feeling of suffocating and (8) rate the probability that the new thoughts are true:

“People do not just suffocate to death. Most people who have trouble breathing suffer from emphysema or have bad hearts or something like that. I had a physical. I have a healthy heart and lungs. The likelihood of this being a fact is 75 percent,” Jane might write.

She also should consider another explanation for her symptom:
“My throat feels terrible because my neck muscles are tense because of the anxiety. The likelihood of this being true is 50 percent.”

Finally, Jane should (9) write down what she now thinks is the likelihood of that original automatic thought, that she is going to suffocate to death during a panic. When she faces facts, Jan should realize that the true likelihood of suffocating to death in a panic is much less than she thought. So she might at this point rate the likelihood of dying from suffocation during a panic at a much-reduced level of 2 percent. She might write that it is less likely because if she were going to die during a panic because of suffocation, “I would have already died because I’ve had that feeling many times and I am still alive.”

**Exposure therapy**

Exposure therapy is used to treat panic disorder. It may be used alone or in conjunction with cognitive-behavioral therapy. Participants learn calming skills to prepare them for confronting anxiety-producing situations. The theory behind exposure therapy is that with repetitive successful exposures to an anxiety-producing activity, anxiety and panic will lessen. The person will build on prior successes, familiarity, and improved coping skills to broaden his or her horizons.

Exposure therapy is scary for people with panic. Anxiety may increase temporarily. If using medications, temporary adjustments may need to be made to control feelings of panic while the person works on facing a fearful situation. Sometimes a coach is utilized, but if so, the coach’s involvement should be reduced as quickly as possible.

Exposure therapy uses many of the same strategies as cognitive-behavioral therapy. Participants learn facts about the disease. They learn to separate feelings from thoughts. Participants concentrate on facts about symptoms and their perceptions of danger. Exposure therapy is a planned, step-by-step process. It is used to confront specific anxiety-producing situations.

Here is an example:

Henry does not drive because he is afraid that he will crash the car during a panic and die. He has learned the facts about his fear and how to challenge his automatic thoughts and look realistically at his symptoms of panic. He wants to drive to his daughter’s house, which is about three miles away.

During therapy, Henry and the therapist will determine the steps required to meet Henry’s goal of driving to his daughter’s house.

Depending upon Henry’s level of anxiety, they will begin at a step that is uncomfortable for Henry. For example, Henry may need to just sit in a parked car in the driver’s seat with a coach if he is very uncomfortable, or he may start by just driving out of the driveway or to a location on his street.

Henry will learn to rate the intensity of his discomfort using a simple number scale, similar to a pain scale. He then will develop a plan that breaks down obtaining his goal into small steps. He must take the first step and repeat it until that step is tolerable. He then will move to the next step.

Henry must plan strategies for managing his anxiety ahead of time. He may select two or three techniques that reduce his anxiety the best. For example, his “tool kit” may consist of deep breathing exercises or visualizing himself enjoying a meal at his daughter’s house.

As Henry learned in cognitive-behavioral therapy, he should keep a record of his driving attempts and realize he will have good days, but also more challenging ones. He must commit to keeping going and realize it may take a few weeks or many months to reach his goal.

Initially, he may drive with a coach. The coach may then follow Henry in a car directly behind him. Next the coach will put several car lengths behind his car and Henry’s. Ultimately, Henry will drive alone.

Success depends upon being consistent and breaking each fearful activity into tiny steps. When Henry achieves his goal to drive, he may choose another activity to work on. But it is best to pursue only one goal at a time.

**EMDR – Eye movement desensitization and reprocessing**

EMDR can help to release deep-rooted fears that resulted from trauma or from earlier panic attacks. It can be provided by a therapist who teaches patients to do the technique themselves.

EMDR practitioners believe that traumatic memories are etched into the brain differently than other memories. They find that tracking back and forth with the eyes while reliving a traumatic memory removes the emotion associated with the memory. It is highly effective, quick to do, and easy for most people to learn. It is currently being used in the treatment of post-traumatic stress disorder as well as panic disorder.

To conduct this therapy, the therapist sits closely in front of the patient, facing him or her, and they discuss what memory will be addressed. The therapist encourages the patient to recall the event as if she or he is watching it on a movie screen or as if watching a train passing by.

As the patient recalls the event, the therapist asks for clear details of what the person experienced. While the patient is recounting the event, the therapist asks the patient to follow her or his finger as he or she waves it horizontally in front of the patient’s face. The patient is told to keep his or her eyes focused on the moving finger and to move only the eyes, not the head.

Emotions may be intense, but the therapist reminds the patient that it is just a memory, like a movie on a screen or a passing train. EMDR can be highly effective treatment despite its somewhat strange approach. Patients can learn to do the technique at home simply by looking at an object, for example, the molding between the ceiling and walls of a room. The person then should follow the line of the molding back and forth with his or her eyes while recalling the trauma.

**Complementary therapies**
Many people who suffer from panic and other disorders turn to alternative therapies as adjuncts to conventional health care. Prior to adding any alternative therapies, instruct patients to notify their health care provider. Some therapies have been researched extensively, while other are ideas that people who suffer from panic disorder have reported using. Use caution as herbal preparations and other complementary therapies, such as herbs or homeopathic preparations. Sometimes they may interact with conventional treatments or cause undesirable side effects. Occasionally, medication doses may need to be adjusted. Herbs may compete with SSRIs, rendering treatments or cause undesirable side effects. Occasionally, medication doses may need to be adjusted. Herbs may compete with SSRIs, rendering the SSRIs less effective.

**Nutrition**

Healthy nutritional choices support brain health and reduce anxiety. Stimulants, such as products that contain caffeine, may increase panic and promote a sensation of heart palpitations. Chocolate, green and black teas, coffee, and colas all contain caffeine. Caffeine is also found in over-the-counter headache, diet, and cold remedies. The herbs guarana and yerba mate contain caffeine as well. Caffeine should be avoided.

Alcohol is a depressant. It may temporarily reduce anxiety, but in the long run, it can make it worse. Alcohol may interact with medications commonly prescribed for anxiety.

Carbohydrates should be consumed as fresh fruits and vegetables and whole grains. Simple sugars may cause spikes in blood sugar levels, which can make a person feel “wired” or jittery. Fruits and vegetables are rich in vitamin C, which is depleted during stress, and whole grains provide B complex vitamins that are needed for nerve function. They can help to reduce stress. Oats produce calming substances and contain calcium and B vitamins that nourish and calm the nervous system. Figs and avocados contain nerve-soothing components as well.

Foods rich in calcium, magnesium, and potassium should be eaten because these nutrients may be depleted with anxiety. Cold, deep-water fish, green leafy vegetables, nuts and legumes are good sources. These also provide essential fatty acids that are critical for neurotransmitters and general wellness. They can be calming for some individuals.

Keeping a diet diary may be beneficial for some patients with panic disorder to help them learn to identify foods that make them “feel good” and those that increase feelings of anxiety.

**Herbal medicine**

Herbal medicine can help relieve panic disorder via a multitude of mechanisms. There are herbs that reduce panic as well as relieve symptoms that people with panic frequently suffer from.

Herbs may be used in several ways. Some herbs need to be used consistently for maximum effectiveness. Other herbal remedies work quickly to relieve symptoms.

Lemon balm is often thought of as an antidepressant herb. Antidepressant herbs have relaxant effects, which is why they are beneficial for the relief of anxiety. Lemon balm has been employed for centuries for good mental health. It calms “nervous stomachs” and helps to relieve migraines that are triggered by stress.

St. John’s wort is an herb that has been shown to relieve mild to moderated depression. It needs to be administered consistently for several weeks to reach maximum effectiveness. It is calming. St. John’s wort should not be taken at the same time as pharmaceutical antidepressants because the herb and the drug will compete for receptor sites in the brain.

Passionflower relieves tension and has sedative, antispasmodic effects. It can relieve tension headaches, including migraines that are triggered by stress. Passionflower contains inodols, which are components of serotonin and tryptophan.

Kava is a well-researched herb that is useful as a substitute for benzodiazepines. It is sedating, and caution must be exercised when initially implemented. Alcohol potentiates its sedating effects.

Chamomile is calming and can relieve stomach upsets. Sometimes it is used to relieve tension headaches.

Evening primrose oil, black current seed oil and borage seed oil are also useful in the treatment of anxiety. They contain substances that nourish and soothe the nervous system. They are rich sources of essential fatty acids.

Herbs are generally well tolerated. People utilizing herbs experience fewer side effects than those using pharmaceuticals. The herbs are gentle but effective when used consistently.

**Aromatherapy**

The sense of smell is closely tied into the limbic system. Aromatherapy uses concentrated essential oils of plants for healing. Some people believe that essential oil treatment can be very useful and grounding to patients with panic disorder.

There are a multitude of oils that provide multiple benefits. Some are uplifting, others grounding. Rosemary and peppermint essential oils can aid concentration. Many tree oils, such as sandalwood and cypress, promote a feeling of grounding. Floral oils are uplifting and reduce anxiety. Rose and jasmine are very effective. Some oils, such as marjoram, aid sleep.

Lavender is oil that has been used for centuries and is the most researched essential oil. Lavender can be added to a soothing bath to promote relaxation. Add it to a massage for double benefits – relaxation from the massage and from the essential oil. People might carry a few drops of oil on a tissue when facing anxiety-provoking situations. Inhaling the odor will work because of the relaxant principles of the lavender as well as by encouraging a deep breath. Essential oils are very concentrated. They are used externally and are diluted in most cases. They need to be kept out of the reach of children because they are poisonous.

**Flower essences**

Flower remedies reportedly work on a vibrational level. They are harmless and very dilute, yet they work. They are similar to homeopathic remedies in that there is no measurable amount of the actual plant substance in the remedy. A few drops are taken under the tongue or diluted in a small amount of water. They do contain alcohol. Specific remedies are chosen based upon the quality of the fear and anxiety that the person has.

Several essences can be blended together to create a custom blend. There is a product that contains five remedies that has many devoted users. Remedies may be used consistently or on an as-needed basis and can be effective options during panic attacks. No known side effects are recognized.

**Exercise**

Fresh air and exercise have been used to relieve anxiety for a very long time. Exercise has multiple benefits, including reducing stress, and it aids with neurotransmitter function. Some people with panic are fearful of exercise, thinking it will provoke panic. Usually, these fears are tied into awareness of the increased respiratory and heart rate that occurs with vigorous exercise. If this is a concern, gentle exercises should be initiated until the person becomes more confident. Yoga and Tai Chi provide excellent workout options that focus on integration of the body, mind and spirit. This is especially beneficial for people with panic disorder.
Several studies have been done that link wellness to exposure in the natural world. Blood pressure and pulse rates as well as self-assessments of participants exposed to nature indicate a clear reduction in stress levels when people are exposed to a natural environment.

Taking a walk outside provides exercise, and gives the added benefits that nature provides. For people with panic disorder, the change in scenery helps to reduce ruminating unhealthy thoughts. Breathing deeply is more likely when walking in fresh air as well.

Living with panic disorder

Living with panic disorder can be challenging. If panic attacks are new, there is the fear of not knowing what is happening. If panic has persisted, it can be discouraging. Panic attacks sometimes disappear and then resurface, sometimes even years later. That is frustrating. It is not a curable illness but may become chronic.

If agoraphobia exists, stress intensifies. Some people are unable to work. Financial challenges may arise. If employed, a person with panic may require support if she or he faces increased stress in the workplace.

Family members will benefit from learning about the disorder. They may feel angry until they realize that panic disorder is a physical drive, clingy and scared the following week. Resentment may occur when a loved one who was fully appreciated, the person suffering from panic may feel pressured to please others or may resent that loved ones do not understand.

Emotional support during panic attacks

People having panic attacks feel terrified and vulnerable during the attacks. They feel totally out of control, embarrassed, and certain that something horrible is happening. They feel they cannot survive the attack.

How to support a person during a panic attack depends on the person's needs. If it is a new diagnosis or undiagnosed panic, the fear is likely of death or of going insane. People who have more knowledge about panic may realize what is happening but fear that this time is different or that they just can't keep suffering through the attacks.

The patient's perspective

Patients suffering from panic disorder often feel isolated. They may not want others to know about the panic disorder. If agoraphobic, they may feel like a burden to their families. They just want to be able to do what everyone else does without it having to be so hard.

Learning that close friends and family want to help is a relief, but may increase anxiety. People who have not experienced a panic attack may not understand how terrifying it is. The person with the panic is given lots of advice about how to get over it. While the concern is appreciated, the person suffering from panic may feel pressured to please others or may resent that loved ones do not understand.

People who have panic may have setbacks from time to time. It is frustrating and scary to experience panic again and repeat the steps that they previously did just to be able to do ordinary activities. Long-term sufferers may reach what they consider to be a reasonable level of comfort and quality of life. They may not want to attempt to broaden their horizons.

People who have been agoraphobic may live in constant dread of signs that their world is shrinking. They may feel that they can't climb out of the fear again and again. On the other hand, the joy that they feel from simple things such as being able to go in a grocery store may be limitless.

With each success, more successes become possible. Growth spurts may occur. Panic disorder is like any other condition. It is different for each person, depending upon support and where they are at various stages of life.

When a loved one suffers from panic

Watching a loved one experience a panic attack can be frightening. Family members will benefit from learning about the disorder. They may feel angry until they realize that panic disorder is a physical disorder. It is overwhelming to watch a loved one who was fully employed, independent, and assertive one week become afraid to drive, clingy and scared the following week. Resentment may occur if the family member who has panic disorder doesn't “push” her- or himself enough in the eyes of the rest of the family.

Other family members may need to take on additional responsibilities. Children may be frightened or resentful if the parent is agoraphobic and cannot take them to activities like other parents do.

It is important to teach family members about boundaries and how to prevent enabling behaviors. Family members have an important role in stress management and need to find a balance between being supportive, letting go, and living their own lives. Family members may need counseling to deal with the stress of panic disorder.

Summary

Panic disorder is a common condition. The degree of disruption that it causes in a person's life is highly variable. Several theories exist that try to explain the origin of panic disorder. It seems to be primarily biological but heavily impacted by stress in the environment.
Anyone, any age, can be diagnosed with panic disorder. The most serious form of panic disorder is panic disorder with agoraphobia. Agoraphobia may develop quickly. It may occur after just one panic attack.

Panic disorder needs to be diagnosed early for treatment to be most effective. With each subsequent panic attack, the fear of recurrence and likelihood of avoidance behaviors developing increases. Children may suffer from panic disorder. It is likely that panic is underdiagnosed and undertreated in children.

Several treatment options are available. The most effective programs utilize medication and cognitive-behavioral therapy. Complementary medicine offers support for panic disorder as well.

People with panic often suffer from depression. They may self-medicate to relieve their symptoms.

Living with panic disorder as the sufferer or as a family member can be challenging. All family members must learn strategies for self care.

Panic disorder is a treatable condition. Options are available to relieve panic attacks, improve coping skills, and optimize quality of life for the person with panic and the entire family.

References