Panic Disorder At A Glance*

Panic disorder is characterized by sudden attacks of terror, frequently accompanied by a pounding heart, sweating, weakness, faintness, or dizziness. Panic attacks usually produce fear of impending doom, or a fear of losing control. Panic attacks can occur at any time, even during sleep. An attack usually peaks within 10 minutes, but some symptoms may persist.

In the U.S., panic disorder affects about 6 million adults and is twice as common in women as men. Panic attacks often begin in late adolescence or early adulthood, but not everyone who experiences panic attacks will develop panic disorder. Many people have just one attack and never have another. The tendency to develop panic attacks appears to be heritable.

People who have full-blown, repeated panic attacks can become disabled by the condition; they avoid normal activities of daily living such as shopping . About one-third become housebound or are able to confront a feared situation only when accompanied.

Panic disorder is one of the most treatable of all the anxiety disorders, responding in most cases to pharmacological and psychosocial interventions. Panic disorder is often co-morbid with other serious problems, such as depression and substance use. These conditions should also be identified and treated.

Assessment

Patients should receive a thorough diagnostic evaluation both to establish the diagnosis of panic disorder and to identify other psychiatric or general medical conditions.

Delineating the specific features of panic disorder that characterize a given patient is an essential element of assessment and treatment planning. It is crucial to determine if agoraphobia is present and to establish the extent of situational fear and avoidance. It must be determined that panic attacks do not occur solely as a result of a general medical condition or substance use and that they are not better conceptualized as a feature of another diagnosis.

The presence of medical disorders, substance use, and other psychiatric disorders does not preclude a concomitant diagnosis of panic disorder. If the symptoms of panic disorder are not deemed solely attributable to these factors, then diagnosing (and treating) both panic disorder and another condition may be warranted.

A careful assessment of suicide risk is necessary for all patients with panic disorder. Panic disorder has been shown to be associated with an elevated risk of suicidal ideation and behavior, even absent co-occurring conditions such as major depression.

Treatment

Tailoring the treatment plan to match the needs of the patient requires careful assessment

of the frequency and nature of the patient's symptoms. It may be helpful, in some circumstances, for individuals to monitor their panic symptoms by keeping a daily diary. Such monitoring can aid in identification of triggers for panic symptoms, which may become a focus of subsequent intervention.

Continuing evaluation and management of co-occurring psychiatric and/or medical conditions is also essential to developing a treatment plan for an individual patient. Co-occurring conditions may influence both selection and implementation of pharmacological and psychosocial treatments for panic disorder.

A variety of specific psychosocial and pharmacological interventions have proven benefits in treating panic disorder. The use of a selective serotonin reuptake inhibitor (SSRI), serotonin-norepinephrine reuptake inhibitor (SNRI), tricyclic antidepressant (TCA), benzodiazepine (appropriate as monotherapy only in the absence of a co-occurring mood disorder), or cognitive-behavioral therapy (CBT) as the initial treatment for panic disorder is strongly supported by demonstrated efficacy in numerous randomized controlled trials. Panic-focused psychodynamic psychotherapy (PFPP), was effective in one randomized controlled trial and could be offered as an initial treatment under certain circumstances.

CBT is the psychosocial treatment that would be indicated most often for patients presenting with panic disorder. CBT is a time-limited treatment (generally 10–15 weekly sessions) with durable effects. It is successfully administered individually or in a group format. Self-directed forms of CBT may be useful for patients who do not have ready access to a trained therapist. CBT for panic disorder generally includes psychoeducation, self-monitoring, countering anxious beliefs, exposure to fear cues, modification of anxiety-maintaining behaviors, and relapse prevention. Exposure therapy, which focuses almost exclusively on systematic exposure to fear cues, is also effective.

Treatment Goals

Treatment duration varies depending on the extent to which symptoms resolve and the presence of comorbidities. The relevant literature suggests from 12 to 20 weeks of psychotherapy; medication may be prescribed for a year or more.

Because panic disorder is often a chronic disorder, there should be realistic expectations of treatment, i.e., symptoms may be relieved but will not necessarily be completely eliminated. Persons with GAD often experience exacerbation of symptoms with stress. For this reason, it is important to encourage affected individuals to develop effective strategies for managing stress and to apprise them of the potential need for additional treatment during periods of extraordinary stress

*Adapted from American Psychiatric Association (APA). Practice guideline for the treatment of patients with panic disorder. 2nd ed. Washington (DC): American Psychiatric Association (APA); 2009.