Panic Disorder

Code: 300.01 (F41.0)

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A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:
Note: The abrupt surge can occur from a calm state or an anxious state.
1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.
Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.
B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).
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C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).
D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).

Diagnostic Features

Panic disorder refers to recurrent unexpected panic attacks (Criterion A). A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four or more of a list of 13 physical and cognitive symptoms occur. The term recurrent literally means more than one unexpected panic attack. The term unexpected refers to a panic attack for which there is no obvious cue or trigger at the time of occurrence—that is, the attack appears to occur from out of the blue, such as when the individual is relaxing or emerging from sleep (nocturnal panic attack). In contrast, expected panic attacks are attacks for which there is an obvious cue or trigger, such as a situation in which panic attacks typically occur. The determination of whether panic attacks are expected or unexpected is made by the clinician, who makes this judgment based on a combination of careful questioning as to the sequence of events preceding or leading up to the attack and the individual's own judgment of whether or not the attack seemed to occur for no apparent reason. Cultural interpretations may influence the assignment of panic attacks as expected or unexpected (see section "Culture-Related Diagnostic Issues" for this disorder). In the United States and Europe, approximately one-half of individuals with panic disorder have expected panic attacks as well as unexpected panic attacks. Thus, the presence of expected panic attacks does not rule out the diagnosis of panic disorder. For more details regarding expected versus unexpected panic attacks, see the text accompanying panic attacks (pp. 214–217).
The frequency and severity of panic attacks vary widely. In terms of frequency, there may be moderately frequent attacks (e.g., one per week) for months at a time, or short bursts of more frequent attacks (e.g., daily) separated by weeks or months without any attacks or with less frequent attacks (e.g., two per month) over many years. Persons who have infrequent panic attacks resemble persons with more frequent panic attacks in terms of panic attack symptoms, demographic characteristics, comorbidity with other disorders, family history, and biological data. In terms of severity, individuals with panic disorder may have both full-symptom (four or more symptoms) and limited-symptom (fewer than four symptoms) attacks, and the number and type of panic attack symptoms frequently differ from one panic attack to the next. However, more than one unexpected full-symptom panic attack is required for the diagnosis of panic disorder.
The worries about panic attacks or their consequences usually pertain to physical concerns, such as worry that panic attacks reflect the presence of life-threatening illnesses (e.g., cardiac disease, seizure disorder); social concerns, such as embarrassment or fear of being judged negatively by others because of visible panic symptoms; and concerns about mental functioning, such as "going crazy" or losing control (Criterion B). The maladaptive changes in behavior represent attempts to minimize or avoid panic attacks or their consequences. Examples include avoiding physical exertion, reorganizing daily life to ensure that help is available in the event of a panic attack, restricting usual daily activities, and avoiding agoraphobia-type situations, such as leaving home, using public transportation, or shopping. If agoraphobia is present, a separate diagnosis of agoraphobia is given.
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Associated Features Supporting Diagnosis

One type of unexpected panic attack is a nocturnal panic attack (i.e., waking from sleep in a state of panic, which differs from panicking after fully waking from sleep). In the United States, this type of panic attack has been estimated to occur at least one time in roughly one-quarter to one-third of individuals with panic disorder, of whom the majority also have daytime panic attacks. In addition to worry about panic attacks and their consequences, many individuals with panic disorder report constant or intermittent feelings of anxiety that are more broadly related to health and mental health concerns. For example, individuals with panic disorder often anticipate a catastrophic outcome from a mild physical symptom or medication side effect (e.g., thinking that they may have heart disease or that a headache means presence of a brain tumor). Such individuals often are relatively intolerant of medication side effects. In addition, there may be pervasive concerns about abilities to complete daily tasks or withstand daily stressors, excessive use of drugs (e.g., alcohol, prescribed medications or illicit drugs) to control panic attacks, or extreme behaviors aimed at controlling panic attacks (e.g., severe restrictions on food intake or avoidance of specific foods or medications because of concerns about physical symptoms that provoke panic attacks).

Prevalence

In the general population, the 12-month prevalence estimate for panic disorder across the United States and several European countries is about 2%–3% in adults and adolescents. In the United States, significantly lower rates of panic disorder are reported among Latinos, African Americans, Caribbean blacks, and Asian Americans, compared with non-Latino whites; American Indians, by contrast, have significantly higher rates. Lower estimates have been reported for Asian, African, and Latin American countries, ranging from 0.1% to 0.8%. Females are more frequently affected than males, at a rate of approximately 2:1. The gender differentiation occurs in adolescence and is already observable before age 14 years. Although panic attacks occur in children, the overall prevalence of panic disorder is low before age 14 years (<0.4%). The rates of panic disorder show a gradual increase during adolescence, particularly in females, and possibly following the onset of puberty, and peak during adulthood. The prevalence rates decline in older individuals (i.e., 0.7% in adults over the age of 64), possibly reflecting diminishing severity to subclinical levels.

Development and Course

The median age at onset for panic disorder in the United States is 20–24 years. A small number of cases begin in childhood, and onset after age 45 years is unusual but can occur. The usual course, if the disorder is untreated, is chronic but waxing and waning. Some individuals may have episodic outbreaks with years of remission in between, and others may have continuous severe symptomatology. Only a minority of individuals have full remission without subsequent relapse within a few years. The course of panic disorder typically is complicated by a range of other disorders, in particular other anxiety disorders, depressive disorders, and substance use disorders (see section "Comorbidity" for this disorder).
Although panic disorder is very rare in childhood, first occurrence of "fearful spells" is often dated retrospectively back to childhood. As in adults, panic disorder in adolescents tends to have a chronic course and is frequently comorbid with other anxiety, depressive, and bipolar disorders. To date, no differences in the clinical presentation between adolescents and adults have been found. However, adolescents may be less worried about additional panic attacks than are young adults. Lower prevalence of panic disorder in older adults appears to be attributable to age-related "dampening" of the autonomic nervous system response. Many older individuals with "panicky feelings" are observed to have a "hybrid" of limited-symptom panic attacks and generalized anxiety. Also, older adults
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tend to attribute their panic attacks to certain stressful situations, such as a medical procedure or social setting. Older individuals may retrospectively endorse explanations for the panic attack (which would preclude the diagnosis of panic disorder), even if an attack might actually have been unexpected in the moment (and thus qualify as the basis for a panic disorder diagnosis). This may result in under-endorsement of unexpected panic attacks in older individuals. Thus, careful questioning of older adults is required to assess whether panic attacks were expected before entering the situation, so that unexpected panic attacks and the diagnosis of panic disorder are not overlooked.
While the low rate of panic disorder in children could relate to difficulties in symptom reporting, this seems unlikely given that children are capable of reporting intense fear or panic in relation to separation and to phobic objects or phobic situations. Adolescents might be less willing than adults to openly discuss panic attacks. Therefore, clinicians should be aware that unexpected panic attacks do occur in adolescents, much as they do in adults, and be attuned to this possibility when encountering adolescents presenting with episodes of intense fear or distress.

Risk and Prognostic Factors

Temperamental. Negative affectivity (neuroticism) (i.e., proneness to experiencing negative emotions) and anxiety sensitivity (i.e., the disposition to believe that symptoms of anxiety are harmful) are risk factors for the onset of panic attacks and, separately, for worry about panic, although their risk status for the diagnosis of panic disorder is unknown. History of "fearful spells" (i.e., limited-symptom attacks that do not meet full criteria for a panic attack) may be a risk factor for later panic attacks and panic disorder. Although separation anxiety in childhood, especially when severe, may precede the later development of panic disorder, it is not a consistent risk factor.
Environmental. Reports of childhood experiences of sexual and physical abuse are more common in panic disorder than in certain other anxiety disorders. Smoking is a risk factor for panic attacks and panic disorder. Most individuals report identifiable stressors in the months before their first panic attack (e.g., interpersonal stressors and stressors related to physical well-being, such as negative experiences with illicit or prescription drugs, disease, or death in the family).
Genetic and physiological. It is believed that multiple genes confer vulnerability to panic disorder. However, the exact genes, gene products, or functions related to the genetic regions implicated remain unknown. Current neural systems models for panic disorder emphasize the amygdala and related structures, much as in other anxiety disorders. There is an increased risk for panic disorder among offspring of parents with anxiety, depressive, and bipolar disorders. Respiratory disturbance, such as asthma, is associated with panic disorder, in terms of past history, comorbidity, and family history.

Culture-Related Diagnostic Issues

The rate of fears about mental and somatic symptoms of anxiety appears to vary across cultures and may influence the rate of panic attacks and panic disorder. Also, cultural expectations may influence the classification of panic attacks as expected or unexpected. For example, a Vietnamese individual who has a panic attack after walking out into a windy environment (trúng gió; "hit by the wind") may attribute the panic attack to exposure to wind as a result of the cultural syndrome that links these two experiences, resulting in classification of the panic attack as expected. Various other cultural syndromes are associated with panic disorder, including ataque de nervios ("attack of nerves") among Latin Americans and khyâl attacks and "soul loss" among Cambodians. Ataque de nervios may involve trembling, uncontrollable screaming or crying, aggressive or suicidal behavior, and depersonalization or derealization, which may be experienced longer than the few minutes typical
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of panic attacks. Some clinical presentations of ataque de nervios fulfill criteria for conditions other than panic attack (e.g., other specified dissociative disorder). These syndromes impact the symptoms and frequency of panic disorder, including the individual's attribution of unexpectedness, as cultural syndromes may create fear of certain situations, ranging from interpersonal arguments (associated with ataque de nervios), to types of exertion (associated with khyâl attacks), to atmospheric wind (associated with trúng gió attacks). Clarification of the details of cultural attributions may aid in distinguishing expected and unexpected panic attacks. For more information regarding cultural syndromes, refer to the "Glossary of Cultural Concepts of Distress" in the Appendix.
The specific worries about panic attacks or their consequences are likely to vary from one culture to another (and across different age groups and gender). For panic disorder, U.S. community samples of non-Latino whites have significantly less functional impairment than African Americans. There are also higher rates of objectively-defined severity in non-Latino Caribbean blacks with panic disorder, and lower rates of panic disorder overall in both African American and Afro-Caribbean groups, suggesting that among individuals of African descent, the criteria for panic disorder may be met only when there is substantial severity and impairment.

Gender-Related Diagnostic Issues

The clinical features of panic disorder do not appear to differ between males and females. There is some evidence for sexual dimorphism, with an association between panic disorder and the catechol-O-methyltransferase (COMT) gene in females only.

Diagnostic Markers

Agents with disparate mechanisms of action, such as sodium lactate, caffeine, isoproterenol, yohimbine, carbon dioxide, and cholecystokinin, provoke panic attacks in individuals with panic disorder to a much greater extent than in healthy control subjects (and in some cases, than in individuals with other anxiety, depressive, or bipolar disorders without panic attacks). Also, for a proportion of individuals with panic disorder, panic attacks are related to hypersensitive medullary carbon dioxide detectors, resulting in hypocapnia and other respiratory irregularities. However, none of these laboratory findings are considered diagnostic of panic disorder.

Suicide Risk

Panic attacks and a diagnosis of panic disorder in the past 12 months are related to a higher rate of suicide attempts and suicidal ideation in the past 12 months even when comorbidity and a history of childhood abuse and other suicide risk factors are taken into account.

Functional Consequences of Panic Disorder

Panic disorder is associated with high levels of social, occupational, and physical disability; considerable economic costs; and the highest number of medical visits among the anxiety disorders, although the effects are strongest with the presence of agoraphobia. Individuals with panic disorder may be frequently absent from work or school for doctor and emergency room visits, which can lead to unemployment or dropping out of school. In older adults, impairment may be seen in caregiving duties or volunteer activities. Full-symptom panic attacks typically are associated with greater morbidity (e.g., greater health care utilization, more disability, poorer quality of life) than limited-symptom attacks.

Differential Diagnosis

Other specified anxiety disorder or unspecified anxiety disorder. Panic disorder should not be diagnosed if full-symptom (unexpected) panic attacks have never been experienced. In
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the case of only limited-symptom unexpected panic attacks, an other specified anxiety disorder or unspecified anxiety disorder diagnosis should be considered.
Anxiety disorder due to another medical condition. Panic disorder is not diagnosed if the panic attacks are judged to be a direct physiological consequence of another medical condition. Examples of medical conditions that can cause panic attacks include hyperthyroidism, hyperparathyroidism, pheochromocytoma, vestibular dysfunctions, seizure dis-