A class of ANXIETY DISORDERS characterized by recurrent PANIC ATTACKS. The term is not used when a known organic factor is responsible. A panic disorder is typically classified as with or without AGORAPHOBIA.

Summary Article: Panic Disorders
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A panic attack is the sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. In addition, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of "going crazy" or losing control are present. Panic disorder involves the presence of recurrent and unexpected panic attacks, followed by at least a month of persistent concern about another panic attack, or worry about the possible effects of having another panic attack.

The combination of unexpected attacks and persistent anxiety about recurrent episodes of physiological dysregulation, termed fear of fear or anxiety sensitivity, distinguishes panic disorder from other anxiety disorders in which panic episodes occasionally occur. Anxiety sensitivity is defined as fear of anxiety symptoms, which arises out of the belief that those symptoms are harmful. For instance, individuals with high anxiety sensitivity may believe chest pains signify an impending heart attack, whereas individuals with low anxiety sensitivity will regard such pains as merely unpleasant. To meet the criteria for panic disorder, the symptoms cannot be due to the direct physiological effects of a substance, a medical condition, or another mental disorder.

There are three types of panic attacks. An unexpected panic attack is a sudden, surprising, spontaneous, quick increase of panic symptoms and sensations that seem to arise without an obvious situational trigger or external stimuli. A situationally bound attack is one in which a sudden surge of fear of terror is triggered by exposure to a situational trigger. Situational triggers can either be external, (i.e., a phobic object or situation) or internal (i.e., physiological arousal or sensations). These attacks are characteristics of specific phobias and occur whenever the situational trigger is present.

The third type of panic attack, a situationally predisposed attack, differs from a situationally bound attack in that exposure to a situational trigger increases the likelihood of panic but does not invariably precipitate it. Concerns about having another attack, or the impact of such, are often linked to the avoidance of specific situations or places. When the avoidance behavior meets the criteria for agoraphobia (i.e., avoidance of open spaces), panic disorder with agoraphobia is diagnosed.

Panic Versus Anxiety

Although panic disorder is classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM–IV–TR) as a type of anxiety disorder, the preponderance of research suggests that panic is qualitatively distinct from anxiety; that is, panic is not just a severe form of anxiety. Panic consists solely of fear, while anxiety comprises other dysphoric states in addition to fear. Sudden onset of symptoms also distinguishes panic from anxiety. Episodes of severe anxiety with gradual onset generally do not involve fears of dying or going crazy, and they do not involve as
many symptoms as episodes of severe anxiety with a rapid onset. Panic arouses a flight-or-fight response to a perceived immediate threat, whereas anxiety functions as vigilance for anticipating and coping with future threats. The cognitive content of panic involves imminent danger, whereas the cognitive content of anxiety is composed of worry about a variety of concerns.

**Anxiety Sensitivity Index**

The Anxiety Sensitivity Index (ASI) has received considerable support as a valid self-report measure of the fear of anxiety symptoms. It consists of 16 5-point Likert scale items that express concerns or worries about the possible consequences of anxiety. It has a high degree of internal consistency and satisfactory test-retest reliability over 3 years. It has a single factor structure, with a low level of shared variance with general trait anxiety. Clients experiencing panic score about two standard deviations above the normative mean on the ASI and significantly higher than clients diagnosed with generalized anxiety disorder (GAD).

**How Panic Arises**

Research on the causes of panic is still in its early stages, but in general the evidence suggests that panic can occur for a variety of reasons. Cognitive theory hypothesizes that catastrophic misinterpretation of certain bodily sensations (e.g., interpreting palpitations as signs of impending heart attack, dizziness as imminent collapse, or derealization as going crazy) causes panic attacks. Catastrophic misinterpretations escalate anxiety and intensify bodily sensations until they culminate in panic.

Support for this theory is available from retrospective studies in which patients who experienced panic reported that thoughts of imminent threat or danger tended to precede their attacks. Catastrophic thoughts occurred after the detection of a specific bodily sensation but before the emergence of panic. If the cognitive hypothesis of panic is correct, interventions that reduce the likelihood of a catastrophic misinterpretation should reduce the likelihood of panic. This hypothesis has been validated by numerous research studies.

Catastrophic misinterpretation is not the only cause of panic attacks. Some patients recalled having catastrophic thoughts only after they experienced panic symptoms. In another study, 27% of those who experienced panic attacks reported that fearful thoughts did not precede the attacks.

**Psychological Treatments for Panic Disorder With Agoraphobia**

Psychological treatments that do not include in vivo exposure to feared situations are ineffective in treating phobic fear. Patients told to avoid contact with phobic situations generally experience no improvement or even a worsening of their symptoms. Exposure to feared situations, delivered in a variety of ways, can be effective. For example, between-session exposure to feared situations, assigned by the therapist as self-exposure homework, typically increases treatment effectiveness. Scheduling frequent exposure sessions and spacing exposure sessions do not differentially affect dropout or relapse rates. Furthermore, minimizing or maximizing the patient’s level of anxiety during exposure sessions does not seem to affect outcome.

Behavioral psychologists hypothesize that escape from anxiety-provoking situations reduces anxiety and strengthens agoraphobic avoidance behavior. However, the research evidence suggests that it is not “escape” per se that reduces anxiety. It appears that the sense of control experienced by those who believe they have the option of escaping the fear-inducing situation that fosters fear reduction.
The demonstrated effectiveness of exposure therapy has prompted research to investigate adjunctive techniques that might enhance outcome. Overall, relaxation and cognitive procedures add little to exposure in vivo unless they specifically target panic. Cognitive therapy for panic disorder with agoraphobia is helpful only when it incorporates exposure to feared situations in addition to altering persistent tendencies to catastrophically misinterpret bodily sensations. This requires eliciting the client’s misinterpretations and assessing the evidence for and against their validity. For example, a cognitive therapist would inquire whether the last episode of chest pains turned out to precede a heart attack. Alternately, the client could engage in shallow breathing for a few minutes to induce bodily sensations similar to the last episode of panic attack, while taking care to ensure that the bodily sensations do not escalate into a panic attack.

Research shows that individuals with panic disorder with agoraphobia experience a significant decrease in panic, anxiety, and agoraphobia avoidance when treated with graduated exposure in vivo, graduated exposure plus relaxation training, and graduated exposure plus cognitive therapy. Both adjunct treatments increase the effectiveness of exposure in vivo; the cognitive therapy adjunct seems to increase the effectiveness of exposure more than the relaxation training adjunct.

There is a preponderance of evidence supporting the effectiveness of cognitive-behavioral treatment for both agoraphobic avoidance and spontaneous panic. Another non-cognitive-behavioral approach, 3 sessions of psychoeducation and 12 sessions of nondirective psychotherapy, also has demonstrated some effectiveness in reducing panic. These findings should be replicated and the therapeutic factor identified to enhance understanding of what made that particular treatment modality a potential option for treating panic.

See also

Cognitive-Behavioral Therapy and Techniques; Cognitive Therapy; Diagnostic and Statistical Manual of Mental Disorders (DSM); Homework Assignments

Further Readings


Macy M. Lai

APA

Chicago

Harvard

https://search.credoreference.com/content/topic/panic_disorders