

# Panic Disorder Clinical Guidelines

Developed in collaboration with the mental health centers associated with NBHP and FBHP  
DSM-5 Diagnostic Code: 300.01

## Diagnostic Considerations:

- 1. Review diagnostic criteria** and assess current physical and emotional symptoms. Differentiate between panic attacks versus panic disorder. While panic attacks occur across a variety of conditions, such as anxiety and mood disorders and in non-clinical situations, this is different from panic disorder.
  - Panic attacks are characterized by:
    - Discrete periods of intense fear or discomfort, accompanied by somatic or cognitive symptoms;
    - sudden attacks of terror, usually accompanied by a pounding heart, shortness of breath, sweatiness, weakness, faintness, or dizziness;
    - a sense of unreality, a fear of impending doom, or a fear of losing control;
    - and an abrupt onset that usually reaches a peak within 10 minutes.
  - Panic disorder is diagnosed when an individual:
    - experiences recurrent panic attacks;
    - has persistent concern, for one month or longer, about having another attack and/or worries about the implications and consequences of the attacks.
- 2. Assess for co-occurring problems.** Panic disorder is often accompanied by other mental health concerns such as generalized anxiety disorder, depression, specific phobias, posttraumatic stress disorder, separation anxiety, and substance abuse. Co-occurring agoraphobia is especially common. Suicide risk should be thoroughly assessed, as risk increases in individuals with a panic disorder diagnosis within the past year.
- 3. Assess the presence of nocturnal panic attacks** that occur when a person suddenly wakes in a state of panic, with no obvious trigger like a nightmare or a noise. Thirty to 45% of people with panic disorder report repeated nocturnal panics. These individuals often attempt to delay sleep onset as they are afraid of the attacks. This may result in sleep deprivation, which precipitates more nocturnal panics.
- 4. The prevalence** of panic disorder is 2-3% in the United States, with females at higher risk. Symptoms usually develop during a person's twenties, and onset after age 45 is rare. While the syndrome is usually not evident until adulthood, symptoms of anxiety often occur in childhood. While anxiety can occur under the age of 14, panic disorder is uncommon in childhood.
- 5. Thoroughly assess personal and family history.** Personal risk factors for developing panic disorder include situational panic attacks, a history of anxiety related symptoms (proneness to negative emotions or anxiety sensitivity), history of childhood abuse, smoking, or identifiable stressors prior to their first attack. Family history is important to consider as there is an increased risk of panic disorder for individuals whose parents have anxiety, depressive or bipolar disorders. Having a personal or family history of respiratory illness, such as asthma or chronic obstructive pulmonary disease (COPD,) is correlated more highly with patients with panic disorder than patients with other anxiety disorders.
- 6. Assess severity and functional impairment.** Consider the impact of panic disorder on daily functioning in major areas, such as relationships, work, and leisure. Minimizing the degree to

which panic disorder impacts functioning should be a primary goal of treatment. Assessment of severity can be aided by the use of APA online assessment measures, “Severity Measure for Panic Disorder-Adult” and “Severity Measure for Panic Disorder- Child Age 11-17.”

- 7. Review medical history** and health status, as a number of medical conditions may mimic panic symptoms or can co-occur with panic disorder and exacerbate symptoms. Ensure recent medical exam has ruled out conditions such as asthma, hyperthyroidism, COPD, cardiac conditions, hypoglycemia, or substance use, particularly caffeine or amphetamine drug use. If a medical condition is present and distinct from panic disorder, consider this in your treatment planning.

### **Treatment Guidelines:**

- 1. Assess regularly** for factors that increase suicidal risk, including suicidal ideation, an increase in depressive symptoms, changes in substance use, and new environmental stressors. Also assess the use of substances as an avoidance strategy, as this may decrease treatment effectiveness by prohibiting necessary exposure to and tolerance of anxiety.
- 2. Encourage clients to monitor their panic attacks** using techniques such as keeping a daily diary in order to link panic symptoms with their own internal stimuli and external triggers. It is important to note that physiological arousal, related to the feeling of panic, can start as a natural response and evolve into a disorder.
- 3. Intervene as early as possible.** If people can learn to interpret that a panic attack is not dangerous, they may not develop the fear or preoccupation with their own panic. This knowledge can prevent a panic attack from becoming panic disorder. Additionally, early treatment can often prevent agoraphobia. People with panic disorder may sometimes go from one clinician to the next for years and/or visit the emergency room repeatedly before someone correctly diagnoses the condition. This is unfortunate, because panic disorder is one of the most treatable of all the anxiety disorders, responding in most cases to certain kinds of medication or psychotherapy.
- 4. Cognitive Behavioral Therapy** has been empirically validated for the treatment of panic disorder. Specifically, CBT implements panic monitoring, breathing retraining, cognitive restructuring of misinterpretations of bodily sensations, and exposure to fear cues and exposure to physiological effects of anxiety. Recent research on exposure trials demonstrates that having the experience of tolerating fear and anxiety appears to be more critical than experiencing a natural reduction of fear and anxiety. The length of a given exposure trial is based not on fear reduction but on staying in the situation until the client learns that he/she is able to tolerate fear.
- 5. Panic Control Therapy**, developed by David Barlow, is a specific CBT program for panic disorder (Craske & Barlow, 2006.) It involves three components, emphasized to varying degrees based on clinical presentation. The first component includes educating the client and helping re-label somatic experiences. In the second component, the client learns to intervene in the maladaptive cycle that maintains panic by retraining breathing and practicing relaxation. In the final component, interoceptive/in-vivo exposure to the feared stimuli increases fear tolerance. Research shows that 80% to 100% of clients who undergo this treatment are panic free at the end of treatment and maintain gains for a number of years.
- 6. Pharmacologic treatment** can be helpful in conjunction with CBT therapies. PET scans have demonstrated central nervous system changes in individuals who report chronic anxiety symptoms. Pharmacological interventions have been shown to address these neurological changes and treat anxiety related symptoms effectively. However, medication should be used as an adjunct to therapy or until the person is ready to participate in an exposure based therapy.

Consider referral for medication evaluation if there has been no response or only partial response to therapy alone within 6-8 weeks (see medication algorithm).

7. **Stress management techniques** can help people with panic disorders calm themselves and may enhance the effects of therapy. There is preliminary evidence that aerobic exercise may have a calming effect. Since caffeine, certain illicit drugs, and even some over-the-counter cold medications can aggravate the symptoms of panic disorders, they should be avoided.
8. **Social support** is important in recovery. Through education, family and friends can learn supportive techniques such as helping the client face feared situations instead of avoiding them, helping the client to implement newly acquired skills and reinforcing the client's mastery of feared situations. Family members should know that this is a very real and treatable condition. Self-help or support groups provide persons with panic disorder the opportunity to share their problems and achievements with others.
9. **Cultural considerations** are important in treatment planning and determining an appropriate therapeutic approach. Culture undoubtedly influences what is viewed as anxiety-provoking and also can influence what level of anxiety is considered problematic. Anxiety may be expressed in specific cultural idioms. Likewise, the standards for display of emotion may vary by gender. The clinician should inquire about cultural expectations or beliefs about the experience of panic symptoms and its etiology within the individual's cultural perspective.

Adapted from American Psychiatric Association, Practice guidelines for the treatment of patients with panic disorder, second edition (2010). Available at <http://psychiatryonline.org/guidelines.aspx>; Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition

### **Additional References and Resources for Clinicians**

American Psychiatric Association: Online Assessment Measures <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Disorder>

Craske, M. G. & Barlow, D. H. (2006). *Mastery of Your Anxiety and Panic: Therapist Guide* (Fourth Edition)

National Institute for Mental Health <http://www.nimh.nih.gov/health/topics/panic-disorder/index.shtml>