American Counseling Association Practice Briefs

Panic Disorder

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Description of Panic Disorder

Panic disorder is characterized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychological Association [APA], 2013) by persistent, yet unexpected panic attacks (Criterion A). These episodes of fear and extreme distress are followed by at least one month of worrying about or modifying of daily activities in an attempt to avoid further panic episodes (Criterion B) that cannot be attributed to substance use or medical conditions (Criterion C), and are not better explained by another psychiatric disturbance (Criterion D). A key feature of this disorder is the unexpected emergence of symptoms that tend to peak relatively quickly, within about 10 minutes. During this brief episode, individuals experience at least four somatic and cognitive symptoms including (but not limited to) accelerated heart rate, sweating, trembling, chest pain, shortness of breath, fear of losing control, and fear of dying.

Given the high prevalence of anxiety disorders, it is likely that counselors across settings will encounter clients who meet criteria for treatment of panic disorder. Lifetime prevalence estimates indicate that approximately 3.8% of individuals within the United States will experience panic disorder (APA, 2013; Kessler et al., 2012). Among this subgroup, women tend to report panic disorder symptoms about twice as often as men. Several researchers have cited robust evidence illustrating strong associations between genetic, neuroanatomical, and socio-contextual variables and the emergence of panic disorder. Family studies have indicated that individuals who have a rst-degree family member with a history for panic attacks are between 6-17 times more likely to develop panic disorder than those without a positive family history (Na, Kang, Lee, & Yu, 2011). Structural, metabolic, and functional investigations of the nervous system have implicated the limbic system and prefrontal cortices as mediating the fear and anxiety responses associated with panic disorder (Dresler et al., 2013). In particular, the dysregulation of neurotransmitters and hormones such as dopamine, serotonin, norepinephrine, orexin, and adenosine appears to in uence panic symptoms, and may cause panic disorder (Geiger, Neufang, Stein, & Domschke, 2014).

IDENTIFICATION/ ASSESSMENT STRATEGIES

Panic disorder can resemble several serious medical, psychiatric, or cultural syndromes; therefore, a prudent approach to evaluation will integrate multiple modalities and include reporting from both clients and collaterals. We recommend conducting a clinical interview, referring for a medical evaluation, conducting a behavioral assessment, and reviewing self-report data. A comprehensive clinical interview should include data related to: (a) onset, severity, and frequency of panic attacks; (b) developmental issues that may have in uenced presence of panic attacks; (c) history of abuse, neglect, or maltreatment; (d) history of problematic substance use; (e) family dynamics; (f) cultural factors that may account for interpretation of symptoms; and (g) the degree that symptoms have been associated with endangerment of self or others. Clinical interview data are then integrated with results from a medical examination to rule out etiology related to cardiopulmonary conditions, hyperthn(f)-tosdit8de8dnc22.

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Comprehensive assessment of panic disorder can be facilitated by use of several formal rating scales including the DSM-5 Severity Measure for Panic Disorder (Craske et al., 2013), the Patient Health Questionnaire (Spitzer, Kroenke, & Williams, 1993), the Panic Disorder Self-Report (Apfeldorf, Shear, Leon, & Portera, 1994), and the Anxiety and Related Disorders Interview Schedule for DSM-5 (Brown & Barlow, 2014). Each of these assessments provides users with cutoff scores to designate client symptom severity within clinically relevant ranges such as mild, moderate, and severe. In addition to these formal assessments, several online resources are available to clien through free, web-based platforms such as those provided by Anxiety and Depression Association of America (www.adaa.org) and the Institute of Living (http://www.harthosp.org/Instituteo iving/default.aspx). The self-assessments offered by these groups are intended to support education, prevention, and treatment of anxiety disorders, including panic disorder.

Resources:

Anxiety and Depression Association of America Self-Assessment: http://www.adaa.org/screening-panic-disorder

DSM-5 Severity Measure for Panic Disorder Adult and Children Forms: http://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5/online-assessment-measures#Disorder

Institute of Living Panic Disorder Self-Assessment: http://www.harthosp.org/InstituteOfLiving/AnxietyDisorders Center/PanicDisorder/OnlineAssessment/default.aspx

Patient Health Questionnaire Free Screeners for generalized anxiety disorder, panic disorder, and other psychiatric syndromeshttp://www.phqscreeners.com/

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Pharmacological Interventions

The pathophysiology of panic disorder involves surges of intense fear related to elevated levels of catecholamines such as norepinephrine, epinephrine, and dopamine in the brain. Some individuals may be successfully treated with medications intended to balance levels of these three key neurotransmitters (Oh et al., 2015). Van Apeldoorn et al. (2014) recommend treatment with a selective serotonin reuptake inhibitor (SSRI) in conjunction with CBT as the most optimum, cost-effective modality. An SSRI called paroxetine (brand name Paxil or Pexeva) may positively impact the brain's ability to regulate catecholamines, but additional research is needed to determine its ef cacy (Oh et al., 2015). Sertraline (brand name Zoloft), another SSRI, has been effective in preventing the resurgence of panic disorder symptoms and is considered another rst-line psychopharmacological intervention (Rapaport et al., 2001). In a more recent clinical trial comparing the ef cacy of self-administered CBT (SCBT) and treatment with sertraline, analyses of trends over time con rmed that sertraline and SCBT produced greater declines in symptoms associated with panic disorder than SCBT or pharmacological treatment alone (Koszycki, Taljaard, Segal, & Brnd t/[(T)103./f&iio.tilalaljm12(e)-103.8lomelm19(uc)6.9(Ame)s (e)2.9(n e)1.9(f03.)4.9(up)-2(t46
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American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).