



Panic Disorder* Clinical Guidelines

Developed In Collaboration with FBH Partners' Providers, MHCBBC and JCMH
DSM-IV-TR Diagnostic Code: 300.1

Screening/Diagnosing Guidelines:

- 1. Assess current physical and emotional symptoms.** Panic disorder is diagnosed when an individual experiences recurrent panic attacks and persistent concern about having another attack and/or worries about the implications and consequences of the attacks. Panic attacks are discrete periods of intense fear or discomfort, accompanied by somatic or cognitive symptoms. They are characterized by sudden attacks of terror, usually accompanied by a pounding heart, shortness of breath, sweatiness, weakness, faintness, or dizziness. Panic attacks usually produce a sense of unreality, a fear of impending doom, or a fear of losing control. An attack has an abrupt onset and reaches a peak usually within 10 minutes.
- 2. Assess for co-occurring mental health problems.** Panic disorder is often accompanied by other mental health concerns such as depression, specific phobias, posttraumatic stress disorder, separation anxiety disorder, and substance abuse. Among individuals with panic disorder, the lifetime prevalence of major depression is 50%-60%. One third to one half of individuals with panic disorder will develop agoraphobia. Approximately 36% of individuals with panic disorder have a co-occurring substance use disorder.
- 3. Clarify the age of onset.** The onset for panic disorder is usually during a person's twenties. Females are at higher risk for developing panic disorder. While the syndrome is usually not evident until adulthood, symptoms of anxiety may often occur in childhood.
- 4. Consider and assess risk factors.** Symptoms for developing panic disorder include situational panic attacks, a history of anxiety related symptoms, and a family history of anxiety disorders.
- 5. Differentiate between panic attacks versus panic disorder.** There is a difference between a panic attack and panic disorder. A panic disorder features recurrent, unexpected panic attacks followed by at least one month of persistent concern about having another panic attack.

Treatment Guidelines:

- The following should be **assessed regularly**: suicidal risk, depressive symptoms, substance use/abuse, and psychosocial impairment.
- It is helpful for individuals 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 panic can start as a natural response and evolve into a disorder.
- Intervene as early as possible, early intervention** is a key element of client care. If a person can learn how to interpret that a panic attack is not dangerous, they may not develop the fear or preoccupation with their own panic. This knowledge may prevent a panic attack from becoming a panic disorder. Additionally, early treatment of panic disorder 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 their 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.

5. **Panic Control Therapy**, developed by David Barlow, is a specific CBT program for panic disorder. It involves three components which are divided into 15 lessons or sessions. 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.

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.

7. The attached **medication algorithm** is recommended in prescribing for individuals with panic disorder. Rationale for deviations from this algorithm should be documented in the clinical record.

8. **Self-help or support groups** provide persons with panic disorder the opportunity to share their problems and achievements with others. Talking with a trusted friend or member of the clergy can also provide support, but it is not a substitute for care from a mental health professional.

9. **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.

10. Family and friends are very important in the recovery of a person with a panic disorder. Therefore **education for family and friends** about how to be supportive without helping to perpetuate the symptoms should be included in the treatment program. 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.

**Adapted from: National Institute for Mental Health nimhinfo@nih.gov. Diagnostic Statistical Manual- IV TR, American Psychiatric Association www.psych.org, Practice Guidelines for the Treatment of Psychiatric Disorders.*

**Adapted from: Current Opinion in Psychiatry 16(3): 261-270, 2003. www.medscape.com. Review of Comorbidity of Affective, Anxiety, and Substance Use.*