

PANIC DISORDER

Authored by
mohammad looti

November 1, 2025

RECOMMENDED CITATION

mohammad looti (2025). *PANIC DISORDER*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=63050>

PANIC DISORDER

Primary Disciplinary Field(s): Clinical Psychology, Psychiatry, Abnormal Psychology

1. Core Definition

Panic Disorder (PD) is an anxiety disorder characterized by the presence of recurrent, unexpected panic attacks (PAs) followed by at least one month of persistent worry about having additional attacks or their consequences, or by significant maladaptive changes in behavior related to the attacks. The defining feature of PD is not merely the occurrence of panic attacks--which can be situational or expected in the context of other anxiety disorders--but the subsequent chronic apprehension and the fundamental alteration of daily life dictated by the fear of future attacks. These attacks are abrupt surges of intense fear or intense discomfort that reach a peak within minutes, during which time four or more specific physical and cognitive symptoms occur, such as palpitations, sweating, trembling, sensations of shortness of breath, chest pain, nausea, dizziness, chills or heat sensations, paresthesias (numbness or tingling sensations), derealization (feelings of unreality) or depersonalization (being detached from oneself), fear of losing control or 'going crazy,' and the paramount fear of dying.

The diagnosis of Panic Disorder hinges on the persistent inter-attack worry, often termed 'anticipatory anxiety.' This worry transforms the panic attack from a temporary, acute event into a chronic psychological burden. Individuals with PD frequently misinterpret benign physiological sensations (e.g., a rapid heartbeat after exercise) as immediate signs of impending catastrophe (e.g., a heart attack or collapse), a process known as catastrophic misinterpretation. This cognitive distortion is central to the maintenance of the disorder and the perpetuation of the fear-avoidance cycle. Furthermore, the severity of the disorder is often increased by the association with avoidance behaviors; when PD is correlated with substantial avoidance of situations where escape might be difficult or help unavailable, such as being in crowds, standing in line, or traveling in a car, the condition is categorized as being accompanied by Agoraphobia, a distinction crucial for treatment planning.

It is essential to differentiate Panic Disorder from generalized anxiety or specific phobias. While General Anxiety Disorder (GAD) involves chronic, pervasive worry across multiple domains, PD focuses worry specifically on the physical and psychological consequences of the panic attacks themselves. Similarly, while specific phobias involve intense fear tied to a specific object or situation, the panic attacks in PD are, by definition, initially unexpected and uncued, although they may later become conditioned to specific contexts. The high co-morbidity of PD with other mood and anxiety disorders, particularly Major Depressive Disorder, complicates both diagnosis and clinical management, necessitating a thorough differential assessment.

2. Etymology and Historical Development

The recognition of symptoms characteristic of Panic Disorder precedes its formal classification. In the 19th century, phenomena closely resembling panic attacks were often described under medical or neurological rubrics. For instance, Jacob Mendes Da Costa detailed a condition among Civil War soldiers characterized by cardiac symptoms, breathlessness, and anxiety, which he termed Da Costa's syndrome or neurocirculatory asthenia. Later, early psychoanalytic thinkers, notably Sigmund Freud, introduced the concept of Anxiety Neurosis in the late 19th century, which encompassed both generalized worry and acute anxiety episodes characterized by physical symptoms. However, these formulations blended what are now recognized as distinct clinical entities.

The modern conceptualization of Panic Disorder as a distinct, primary anxiety diagnosis emerged definitively with the publication of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) in 1980. The DSM-III revolutionized psychiatric diagnosis by adopting operational criteria and separating specific anxiety conditions. Crucially, it established the diagnostic independence of Panic Disorder, distinguishing it sharply from Generalized Anxiety Disorder and other neurotic conditions, marking a significant milestone in clinical psychiatry. The criteria emphasized the unexpected nature of the attacks and the resulting change in behavior or persistent worry.

Subsequent revisions refined the criteria. The DSM-IV-TR (referenced in the source material) maintained the core structure, defining PD based on the repetitive, sudden nature of the attacks and the four resulting sequelae: worry about subsequent attacks, concern about consequences, substantial alteration in actions, or a mixture thereof. A major shift occurred with the transition to the DSM-5 (2013). While the core diagnostic features of the panic attack remained the same, the DSM-5 criteria slightly altered the relationship between Panic Disorder and Agoraphobia. In previous editions, Agoraphobia was considered a subtype of PD (Panic Disorder with Agoraphobia). The DSM-5 separated them into two distinct diagnoses that can be diagnosed concurrently, recognizing that Agoraphobia can occur without a history of Panic Disorder, although they most frequently co-occur. This revision aimed for greater clinical specificity and clarity regarding the distinct motivational factors underlying each condition.

3. Key Diagnostic Components

The diagnostic standard for Panic Disorder requires the fulfillment of several interlinked components, primarily focusing on the frequency and nature of the panic attacks themselves, and the subsequent psychological and behavioral responses they elicit. The attacks must not be attributable to the physiological effects of a substance (e.g., drug abuse, medication) or another medical condition (e.g., hyperthyroidism). Furthermore, they must not be better explained by

another mental disorder, such as the panic attacks that occur exclusively in response to a phobic object in Specific Phobia.

The core components mandated by current diagnostic systems, refined from the DSM-IV-TR perspective, include:

Recurrent Unexpected Panic Attacks: The individual must experience multiple episodes of panic attacks that occur "out of the blue," meaning they are not triggered by a specific situation or context. This differentiates PD from expected attacks, which are common in Specific Phobia or Social Anxiety Disorder.

Persistent Worry about Subsequent Attacks: Following at least one unexpected panic attack, the individual must experience one month or more of persistent concern or worry about having additional panic attacks or about their consequences. This includes fearing serious medical outcomes (e.g., heart attack, stroke) or social consequences (e.g., public embarrassment or loss of control).

Maladaptive Behavioral Change: A critical characteristic is the presence of a significant, maladaptive change in behavior related to the attacks. This often manifests as intense avoidance behavior (e.g., avoiding exercise, avoiding places where previous attacks occurred, or carrying around extensive emergency supplies) designed to prevent future attacks. This behavioral alteration often leads to substantial functional impairment in occupational and social settings.

Symptomatic Criteria: Each panic attack must meet the full symptomatic criteria, involving a rapid onset and peak of four or more characteristic symptoms (cardiac, respiratory, gastrointestinal, neurological, and cognitive) from the standardized list. These symptoms reflect the acute activation of the sympathetic nervous system and the associated catastrophic cognitive appraisal.

4. Pathophysiology and Cognitive Models

Research into Panic Disorder has identified complex interactions between biological vulnerabilities and cognitive processes. Biologically, PD is associated with dysregulation in the noradrenergic and serotonergic systems. Specific brain structures, notably the amygdala (involved in fear conditioning) and the locus coeruleus (a primary source of norepinephrine), are hypothesized to play roles in triggering the acute physical symptoms that constitute a panic attack. Studies suggest that individuals with PD may have an overly sensitive "suffocation monitor" or alarm system, possibly triggered by minor changes in carbon dioxide or lactate levels, leading to a perceived threat of suffocation and subsequent panic.

However, the most influential psychological model remains the **Cognitive Model of Panic** proposed by David Clark. This model posits that panic attacks are primarily triggered and maintained not by internal biological anomalies, but by the catastrophic misinterpretation of bodily sensations. According to Clark, an individual with PD perceives harmless physical symptoms (e.g.,

a palpitation, slight dizziness) as signs of imminent physical or psychological disaster (e.g., "I am having a heart attack," or "I am going to faint and lose control"). This misinterpretation rapidly escalates anxiety, which, in turn, intensifies the physical symptoms, creating a vicious cycle that culminates in a full-blown panic attack.

Furthermore, behavioral mechanisms, specifically the development of safety behaviors and avoidance, are crucial in maintaining the disorder. Safety behaviors (e.g., sitting near an exit, always carrying water, checking one's pulse) are actions taken to prevent a catastrophe during perceived danger. While these behaviors reduce acute anxiety, they prevent the individual from disconfirming their catastrophic beliefs. By relying on the safety behavior, the individual falsely attributes the lack of catastrophe to the behavior itself, rather than recognizing that the initial symptom was benign. This reinforces the core fear and maintains the disorder over time.

5. Therapeutic Interventions and Prognosis

Panic Disorder is highly treatable, with established efficacy for both pharmacological and psychological interventions. The primary goals of treatment are to eliminate panic attacks, reduce anticipatory anxiety, and eliminate avoidance behaviors.

Psychological Treatment: Cognitive Behavioral Therapy (CBT), particularly exposure-based treatments, is widely regarded as the first-line psychological intervention for PD. Key CBT techniques include:

Psychoeducation: Providing an understanding of the fight-or-flight response and the role of hyperventilation in generating panic symptoms.

Cognitive Restructuring: Directly challenging the catastrophic misinterpretations of bodily sensations, helping the patient generate more realistic, non-catastrophic interpretations.

Interoceptive Exposure: Deliberately inducing the physical sensations associated with panic (e.g., rapid breathing to induce dizziness, spinning in a chair) in a controlled setting. This allows the patient to habituate to the sensations and disconfirm the belief that these sensations lead to catastrophe.

In Vivo Exposure: If agoraphobia is present, systematic exposure to feared external situations is necessary to reduce avoidance.

Pharmacological Treatment: Medication is frequently used, often in conjunction with CBT. Selective Serotonin Reuptake Inhibitors (SSRIs) are the first-line pharmacological agents due to their efficacy in reducing panic frequency and severity, and their favorable side-effect profile compared to older drugs. Benzodiazepines, while fast-acting and highly effective in blocking acute panic attacks, are often reserved for short-term use due to the risk of dependence and withdrawal symptoms, which can mimic anxiety. Long-term management typically favors SSRIs or Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs).

6. Comorbidity and Functional Impact

The presence of Panic Disorder often leads to significant functional impairment and high rates of psychiatric comorbidity. The constant fear of attacks often leads individuals to withdraw from social and occupational activities, severely limiting their life choices and opportunities. The quality of life for individuals with untreated PD is comparable to that of people suffering from chronic medical conditions like asthma or hypertension.

Comorbidity is the rule rather than the exception. Common co-occurring disorders include:

Agoraphobia: A fear of places or situations from which escape might be difficult or embarrassing, or where help might not be available, which develops in response to repeated panic attacks.

Major Depressive Disorder (MDD): The chronic stress, frustration, and limitations imposed by PD often lead to secondary depressive episodes.

Substance Use Disorders: Individuals sometimes attempt to self-medicate their anxiety or panic symptoms using alcohol or other sedatives, leading to the development of substance use problems.

Other Anxiety Disorders: Including Generalized Anxiety Disorder and Social Anxiety Disorder.

The interplay between these conditions necessitates integrated treatment approaches. For example, treating underlying depression or co-occurring substance abuse must often be accomplished concurrently with addressing the core mechanisms of the panic attacks themselves. Successful treatment not only reduces the frequency of PAs but dramatically improves the individual's overall social, relational, and occupational functioning, demonstrating the profound impact of this treatable condition.

Further Reading

[Panic disorder - Wikipedia](#)

[National Institute of Mental Health \(NIMH\) - Panic Disorder](#)

[Cognitive Model of Panic - Wikipedia](#)