Research Article

Journal of Novel Physiotherapies Research Reviews

Panic Attacks are Frequent

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Submitted: 29 July 2021; **Accepted**: 14 Sep 2021; **Published**: 24 Sep 2021

Citation: *Siniša Franjić (2021) Panic Attacks are Frequent. J Nov Psy 2(1): 5- 8.*

Abstract

Panic is a state of extreme fear of actual or assumed danger to life. Panic is a behavior that occurs in dangerous and crisis situations, leading to crowds and panic situations. A panic attack is a sudden onset of inconspicuous, brief periods of marked discomfort or fear, accompanied by somatic or cognitive symptoms. Panic disorder is the occurrence of recurrent panic attacks, typically accompanied by fear of future attacks or behavioral changes that can avoid situations that create susceptibility to attacks. The diagnosis is made clinically. Isolated panic attacks do not have to be treated. Panic disorder is treated with pharmacotherapy and psychotherapy or both. Panic attacks are frequent and affect as many as 10% of the population in one year. Most people recover without treatment; some get panic disorder. Panic disorder is rare, affecting 2-3% of the population over a 12-month period. It usually starts late in adolescence or young adulthood and affects women 2 to 3 times more often than men.

Keywords: Panic, Panic Attack, Panic Disorder, Mental State, Health

Introduction

Panic disorder is characterized by recurrent, episodic, severe panic attacks, which are unpredictable and not restricted to any particular situation or circumstance [1]. Recurrent panic attacks that are not consistently associated with a specific situation or object, and often occur spontaneously. The panic attacks are not associated with marked exertion or with exposure to dangerous or life-threatening situations.

Individuals with this disorder experience both recurring panic attacks and anxiety in regard to experiencing future attacks [2]. These attacks may include physical symptoms such as heart palpitations (pounding heart), sweaty palms, shortness of breath, and tingling in the fingers. Individuals experiencing a panic attack may also sense that they are in some way detached from their experience (called derealization). In addition, they may have a sense that they are dying or going crazy.

An important component of panic attack is that there is no realistic, plausible cause of their acute fear. For example, an individual experiencing a panic attack may think that he or she will choke while having no physical obstruction of the airway. It is important to note that this
condition, like other anxiety disorders, is not caused by medication, drugs, or illness. Panic attack is also different from panic in that normal panic results from a realistic concern. Individuals who experience this disorder may also experience agoraphobia.

Mental Disorder

Mental disorders are defined in diagnostic and statistical manuals such as The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and The International Statistical Classification of Diseases and Related Health Problems (ICD-10), and include a broad range of syndromes, which are generally characterized by some combination of abnormal thoughts, emotions, behaviour, and/or cognitive impairments that have an effect on a person's ability to function and may also affect his or her relationships with others [3]. The term 'mental disorder' is often used to refer to:

1. The major mental illnesses (e.g. schizophrenia, bipolar affective disorders, depression, generalized anxiety disorder, phobias, obsessive-compulsive disorders, eating disorders, dementias, and delirium).
2. Conditions of developmental origin (e.g. intellectual/learning disabilities, autism spectrum conditions, and personality disorders).
3. Substance dependency (e.g. alcohol or other mind-altering substances).
4. Symptoms associated with physical illnesses (e.g. affective disorders in Parkinson's and Huntington's diseases).

This broad range of mental disorders is common in primary care, with prevalence rates reported in the range of 30–50%. Many of these very varied disorders can be successfully treated or managed in a way that reduces and minimizes their impact on a person's life. Mental disorders that are serious enough potentially to complicate the management of physical health problems are also common. Accident and emergency (A&E) departments frequently see patients who have self-harmed or have suffered injuries owing to substance abuse. A person dependent on alcohol who is admitted for surgery may develop withdrawal symptoms and delirium tremens some days after admission to hospital because of forced abstinence from alcohol. Other examples are anxiety and depression, both of which may arise on a general medical ward in the context of a diagnosis of a life-limiting physical illness. People may also present with symptoms that are not readily explained in which anxiety and depression may be a significant factor.

Panic Attack

Panic attacks represent a particularly severe form of anxiety, which may lead to avoidance and isolation as the person attempts to thwart another attack by avoiding any situations that he or she may connect with a previous attack [4]. Symptoms such as rapid heart rate and chest pressure or overt pain may be confused with myocardial infarction, leading the person to seek emergency room services. Ringing in the ears, hyperventilation and subsequent dizziness, paresthesias, and sweaty palms may occur. Many panic patients experience intense cognitive distortions during an attack, such as a sense that they are "losing control" or fear that they are going crazy. A sense of "impending doom" is also quite common. Panic symptoms typically peak within 10 minutes and then begin to subside, though some symptoms may persist. Panic attacks may be linked to a particular stimulus but often occur without warning.

Many people experience isolated or occasional panic attacks. Persons who have repeated panic attacks that are associated with persistent worry about having another attack or consequences of the attack, or with maladaptive behavioral changes related to panic attacks (e.g., avoidance of situations in which panic attacks have been experienced), may meet DSM-5 (Diagnostic and Statistical Manual, fifth edition) criteria for PD (panic disorder). Agoraphobia may occur as the person suffering from repeated panic attacks fears having another attack in public.

Panic attacks are very common, but panic disorder is uncommon [5]. The term refers to a chronic disorder whose essential feature is the presence of recurrent, unexpected panic attacks followed by persistent concern about having further panic attacks. Discrete periods of intense fear or discomfort which have a sudden onset and build to a peak rapidly (usually within 10min) and are associated with four or more of the following symptoms:

- Palpitations
- Sweating
- Trembling or shaking
- Shortness of breath
- Feeling of choking
- Chest pain or discomfort
- Nausea
- Dizziness or light-headedness
- Derealization or depersonalization
- Fear of losing control
- Fear of dying
- Numbness or tingling
- Chills or hot flushes

A panic attack, by definition, generally occurs very abruptly and is often unexpected [6]. The patient may fear having a panic attack and avoid certain situations that they know may trigger an attack. DSM-5 criteria for panic attack defines the illness as an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and during which time 4 (or more) specific symptoms occur. In order to diagnose panic disorder, an attack must be followed by 1 month or more of worry about the event, worrying it may recur and the consequences, and/or "maladapative changes" to avoid another event. The presentation of a panic attack can be potentially a difficult situation to handle in a limited in-flight environment, as many of the symptoms listed have significant overlap with life-threatening illness. Respiratory, cardiac, and metabolic abnormalities can all present with tachycardia, shortness of breath, and feeling faint, for example. It is important for the physician in these cases to carefully take the patient's history, medical conditions, medications, and presentation into account to consider the need for further evaluation to rule out other life-threatening conditions.

Gait Disorder

During panic attacks, patients may feel that their legs are weak and they become unsteady [7]. To protect themselves from a perceived risk of falling, they may adopt a gait pattern described as "walking on ice." They crouch forward, abduct their arms, and shorten their stride. Sometimes these patients cling to walls or furniture and may not venture away from the house. A similar gait pattern, described as cautious gait, is very common in patients with organic gait disorders. A major difference is that the cautious gait in patients with anxiety tends to occur episodically, in the context of a panic attack, whereas organic gait disorders are generally more persistent. Other features that differentiate psychogenic from organic gait disorder include dramatic moment-tomoment fluctuations in performance, excessive hesitation, resembling slow motion or walking through a viscous fluid, and buckling of the knees without falling. A psychogenic Romberg test is characterized by buildup of sway, with a consistent tendency to fall toward the observer. It can often be overcome by distraction, for instance, by examining the pupils while the patient quietly stands.

Of the 60 patients with "hysterical gait disorders" described by Keane (Keane J. Hysterical gait disorders. Neurology. 1989;39:586–589.), some manifested a hemiparesis or paraparesis, but the largest group had an assortment of ataxic gaits, characterized by dramatically exaggerated sway but avoiding falls. Some patients exhibited "tightrope balancing," walking on a narrow base while keeping their arms abducted. Others were described as "tremblers," not to be confused with patients with orthostatic tremor, an organic disorder. Overall, a neurologic examination can easily pinpoint the nature of the problem in about three-quarters of patients with psychogenic gait disorders.

Anxiety

Anxiety symptoms are quite prevalent among older people [8].

In contrast to depression, however, treatment of anxiety has received much less systematic attention. Anxiety symptoms can be part of the clinical picture of several disorders. Among older clients, therapists are most likely to encounter generalized anxiety disorders, panic and phobic disorders, and obsessive–compulsive disorder. Although pure cases of these syndromes can be found, the more usual presentation is as part of a mixed pattern of symptoms that includes medical illness and/or depression. Insomnia is a common component as well. In this chapter, we present a general approach to treatment of anxiety symptoms and indicate when special techniques need to be used for a particular diagnostic category. Management of insomnia is also addressed.

Late-life anxiety usually does not involve fears about aging. Aging is a gradual process, and people do not wake up suddenly at age 60 or 70 with fears about what is happening to them. Anxiety about growing older is more likely to be found in younger people, who sometimes go to great lengths to maintain a youthful appearance. Older people as a rule are accepting of the changes that have happened. Apart from the overt physiological changes, they feel a psychological continuity in their lives. They may have regrets over things they have done or not done but no anxiety over being old. They also have come to terms with death, though they may have concerns about avoiding a painful or prolonged death.

Anxiety and fear are both normal human responses to a real or perceived danger, and while they are intimately related and co-occurring phenomena, they are also distinct [9]. Anxiety acts as a warning signal to prompt an individual to anticipate and subsequently cope with or avoid a wide array of real or perceived threats. Whereas anxiety occurs in anticipation of threat, fear occurs as a direct response to a real or perceived danger. Fear is more related to characteristic autonomic symptoms, including but not limited to tachycardia, increased blood pressure, hyperhidrosis, and nausea, while anxiety is characterized by worry, muscle tenseness, vigilance, and cautionary or avoidance behaviors. A malfunctioning "fight or flight" response is thought to be related to the predisposition to panic attacks.

Anxiety disorders are a heterogeneous group of related disorders that are characterized by varying degrees of their core symptoms, excessive anxiety (or worry), and fear. Each disorder varies in terms of the eliciting causes as well as the frequency and intensity of these symptoms. In addition to excessive fear and worry, other important symptomology in anxiety disorders includes sleep disturbance, impaired concentration, irritability, and restlessness. Core symptoms of worry and fear have common underlying neurocircuitry, and the different phenotypes that are represented by each anxiety disorder represent differential malfunctioning of the same neural circuits as opposed to unique circuitry specific to each anxiety disorder. Panic attacks have characteristically briefer but more intense episodes of fear, whereas generalized anxiety disorder is characterized by longer but less intense periods of worried anguish. Panic attacks are not pathognomonic of panic disorder; rather, they can occur in a number of psychiatric disorders but play an especially important defining role in panic disorder. In addition to discrete, spontaneous panic attacks, panic disorder is characterized by anticipatory anxiety and behavior changes to cope with panic.

The DSM-5 does not describe age-specific anxiety disorder phenotypes, despite reports of geriatric-specific anxiety syndromes such as fear of falling [10]. Fear of falling can be viewed as a specific phobia in older adults. Generalized anxiety disorder and specific phobias are among the most commonly occurring anxiety disorders late in life. Almost half the cases of generalized anxiety disorder have a late-life onset, although cases with an early onset tend to have a more severe course characterized by excessive worry and a higher rate of psychiatric comorbidity and psychotropic medication use; physical disability may be a risk factor for late-onset generalized anxiety disorder. Social anxiety disorder typically presents early in life. Older patients with panic disorder, which involves the fear response, have less distress during panic attacks in relation to body sensations and panic-related cognitive symptoms and emotions than the younger adults. Panic disorder has a lower incidence in older adults than in younger peers.

This decrease in incidence may be explained by age-related dampening of physiological autonomic responses. For example, older age is associated with diminished symptomatic and cardiovascular response to the panicogenic agent cholecystokinin tetrapeptide. New onset of panic symptoms in late life should prompt a thorough medical workup to rule out alternative and comorbid conditions particularly systemic medical disorders and medication side effects.

Context

Establishing the context in which panic attacks occur is very important, because "panic attack" is not a psychiatric diagnosis [11]. Panic attacks can be associated with any of the anxiety disorders, and in only a subset of cases is the diagnosis of PD appropriate. Clinicians must establish whether attacks occur unexpectedly across situations or if they occur exclusively in the context of a specific situation. For instance, individuals with social phobia or specific phobia often experience panic attacks, but these attacks are always cued by the presence of the feared stimulus (e.g., air travel, driving, public speaking). On the other hand, individuals who receive a diagnosis of PD experience at least some "out of the blue" panic attacks that are not predictable based on a specific feared situation.

Panic attacks can also occur in the context of GAD (generalized anxiety disorder), and these attacks may be difficult to distinguish from the unexpected attacks that characterize PD. However, upon careful examination it becomes clear that the patient with generalized anxiety experiences attacks as the culmination of intense worry. Patients sometimes describe "working themselves into a panic attack" and emphasize the content of the worry rather than the panic symptoms as the key feature of the experience. Similarly, individuals with OCD (obsessive-compulsive disorder) may experience panic attacks when exposed to the content of their obsessions or when prevented from engaging in compulsive behaviors (e.g., when confronted with a contaminant or when prevented from checking an appliance). Once again, the focus of the patient's distress is likely to be the exposure to the obsessional content rather than the symptoms of anxiety.

It is also very important to determine if panic attacks are occurring in response to internal or external traumatic cues, as in the case

of individuals with posttraumatic stress disorder (PTSD). Patients with a trauma history often experience autonomic arousal and even full-blown panic attacks when confronted with intrusive recollections or external cues that remind them of the traumatic event. Treatment for PD would not be helpful for most of these individuals because the provocative traumatic material would be left unaddressed.

Some individuals with GAD may suffer from panic disorder, which involves brief episodes of extremely elevated physiological arousal and fear [12]. Or panic disorder may exist as a sole syndrome, which may be all the more disconcerting, as the attacks often seem to come out of nowhere. During a panic attack, the individual may experience a racing, pounding heart, profuse sweating, rapid, shallow breathing, numbness and tingling in the face and extremities, and faintness or lightheadedness—all the hallmarks of sheer terror. Many subjects fear they will faint or pass out during an attack, although this is extremely rare. The attacks may occur in response to certain events, or they may happen randomly out of the blue. Panic attacks are also likely to occur in the context of depression, often in response to perceived abandonment or loss of support. Interestingly, a number of crime victims have related that, during the attack, the fear and terror they experienced were actually familiar to them from previous panic episodes they've endured. Still, the frequency and intensity of these attacks may be expected to rise following criminal victimization, and the clinician should try to capitalize on what has previously proven effective in treating past attacks.

Conclusion

Panic attacks are common today, but most people recover without treatment, while fewer people develop panic disorder. A panic attack differs from a panic disorder in that panic attacks are spontaneous and unexpected, at least initially, while panic disorder is characterized by patients anticipating and worrying about the next attack. A panic attack is defined as the sudden onset of at least four of symptoms that must culminate within 10 minutes and usually subside within a few minutes, so the doctor actually most often sees the patient with almost no symptoms.

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