# PANIC DISORDER
## by Fred Penzel, Ph.D.

Panic disorder would best be described as sudden episodes of intense fear accompanied by strong physical discomfort which might include such sensations as rapid heartbeat, nausea, dizziness, shortness of breath, feelings of unreality or distance from one's surroundings, etc. (see Self-Screen For Panic Disorder elsewhere on this site). Panic attacks may occur either when awake or asleep. The disorder tends to begin during the teenage or early adult years, and is believed to affect one out of every seventy-five people. About one third of those with panic disorder also suffer from what is known as Agoraphobia. A Greek word, it literally means "fear of the marketplace" and has been interpreted to mean fear of open spaces, however, this is not correct. In actuality, it could be characterized as a fear of having a panic attack when venturing away from home, either when alone or accompanied. Thus, Agoraphobia sufferers tend to have a very restricted ability to travel, and may sometimes become housebound. Traveling on trains or buses may be a problem, too, as sufferers fear they will not be able to get off, if and when they start to feel anxious. Most difficult situations for Panic sufferers would seem to have, as their main element, a feeling of being physically "trapped" somewhere, where flight is not possible. When traveling by car, they often may prefer to be the driver, so that they can be in control of the car and either pull off the road or turn back if anxiety should set in. When driving on highways, they may also tend to drive exclusively in the right-hand lane for the same reasons. Driving via back roads rather than main streets is frequently seen. Driving over bridges or through tunnels can be extremely difficult or impossible for Agoraphobia sufferers. It would almost seem that their whole lives are dedicated to avoiding the experience of a panic attack. Other activities which seem to be difficult for Panic sufferers would include standing on long lines, in stores, sifting up front or in the middle of a row in a theatre (away from the aisle), or sitting far from the entrance in a restaurant.

There are a number of theories about the genesis of panic attacks. Several competing biological theories suggest that there is some type of brain dysfunction that makes sufferers prone to panic attacks. One theory hypothesizes that there is a "suffocation alarm" in the brain that is being inappropriately tripped off. Another theory suggests that some individuals possess an "anxiety sensitivity" which makes them more prone to overreact to their own feelings of anxiety. These possibilities are still in the process of being researched. There does exist some evidence that the tendency to develop Panic Disorder may run in families.

Although they might have difficulty believing it at first, panic sufferers actually cause their own panic attacks. From the cognitive viewpoint, panic disorder (with or without Agoraphobia) would appear to be based upon a misinterpretation of the bodily experiences that normally accompany anxiety. Sufferers may actually believe that their rapid heartbeat means that they are having a heart attack; that their shortness of breath means that they are suffocating or choking to death;

that their feelings of dizziness mean that they will faint or pass out; or that their feelings of unreality or distance from their surroundings mean that they are losing control or will go crazy. They seem to not be able to recognize that what is happening to them is the normal "fight or flight" response, in which blood pressure drops, and adrenaline is pumping into their bloodstream, causing rapid heartbeat. Sufferers also engage in a certain amount of superstitious thinking if they have experienced a panic attack in a particular place, or during a particular activity, they may come to believe that these places or activities actually cause panic attacks. Because of this, they avoid these things, and their lives become more and more restricted. This sets up a vicious circle, which tends to generate more and more panic attacks as time goes on. Thus, a sufferer will become apprehensive when approaching a particular situation, or when experiencing a particular sensation, which will then generate bodily sensations of anxiety. They may also breathe abnormally hyperventilating or holding their breath, which only worsens things. They become increasingly fearful of these sensations, which only generates more apprehension and physical sensations. This turns into a downward spiral that culminates in a full-blown panic attack.

Treatment generally requires a multi-pronged approach. First, would be behavioral therapy (BT). In BT, patients are taught anxiety management skills, which would include breathing retraining (to fight the tendency to hyperventilate or hold one's breath when anxious), and progressive muscle relaxation to damp down the "fight or flight" reaction and accompanying sensations. A further technique known as "interoceptive exposure" is also used. Using this, patients are taught how to gradually bring on and expose themselves to greater and greater doses of the physical sensations they fear, in order to build a tolerance to them, and to learn they really are not harmful. This amounts to conducting behavioral experiments to see if dreaded predictions will actually come true.

Second, is cognitive therapy. This is employed to teach sufferers how to challenge their misinterpretations of their own physical sensations, and correctly identify what is really happening to them. It aims to correct this unhelpful self-talk. Beliefs such as "A racing heart means I am having a heart attack, "or "Feeling of unreality mean that I will go crazy" are examined for their logical content, and then corrected. This is done at first, in practice exercises, and then later in real-life situations on a systematic basis. Cognitive therapy may also be useful in another way. I have frequently observed that Panic Disorder may begin or worsen in individuals who find themselves "trapped" by life circumstances such as relationships, jobs, family problems, etc.. These are obvious sources of stress, which is known to worsen all types of psychological problems. Cognitive therapy can help them to cope and to sort things out so they can find solutions to these situations, thus relieving the stress caused by them.

Third, may be the use of medications, although whether or not these are required may depend upon the individual and the intensity of their symptoms. While the biological basis of panic

disorder has not yet been established, it is clear that in severe cases, medication will be necessary and helpful. It is probably best to look upon medication as a tool to help you to do cognitive/behavioral therapy. Although antianxiety medications such as Xanax and Klonopin are widely used to treat panic, they are habit-forming, and are short acting. Many individuals do better using SSRI-type antidepressants, which only have to be taken once per day, and will not cause withdrawal if discontinued. Medication can lower the panic threshold, and many sufferers who take it observe that while they may experience some pre-panic sensations, the attacks don't seem to occur. This gives them more confidence to then pursue behavioral assignments and to restore their mobility.

One further suggestion which I have frequently recommended to my Panic patients, and which many have found helpful is that they become involved in some type of activity which helps to reduce their physical tension. This may include some form of regular exercise or stretching regimen. I have actually found yoga to be extremely helpful, and have sent quite a number of my patients to classes to study it. It teaches stretching, breathing skills, and meditation - all extremely useful to panic sufferers.