Red Whale
Lifelong Learning for Primary Care

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Panic disorder

> "My heart was beating so hard, it felt like it was about to jump right out of my chest. Suddenly, the lights seemed too bright, the world went out of focus and I felt sick. It hurt to breathe and I was sure I was dying. I felt dizzy and I collapsed on the ground. Later, I discovered I was slumped on the floor of the work toilet. Afterwards, I felt embarrassed and humiliated, feeling sure that all my colleagues must think I'm completely crazy."

Panic attacks are highly distressing experiences which can often present in primary care. The symptoms of panic disorder can mimic or be comorbid with many other physical and mental health problems, which can cause challenges for making the diagnosis. During a panic attack, exaggerated fears about possible catastrophic medical outcomes may also rapidly worsen the patient's anxiety as a vicious cycle.

In the following article, we look at the recognition and management of panic attacks and panic disorder in primary care. It is based on: NICE (2011) CG113; BAP anxiety guidelines; Lancet 2021;397: 914–27, ICD-11 (WHO,

2019), and BMJ 2022;376:e066084.

This article was updated in December 2024.

1. Diagnostic criteria

Panic attacks

- Panic attacks involve discrete episodes of intense fear. They arise rapidly and usually peak within 10 mins, typically lasting 20–40 mins.
- They are often accompanied by intense physical symptoms such as palpitations, sweating, trembling, shortness of breath, chest pain, dizziness or lightheadedness.
- Panic attacks can appear out of the blue or can be triggered by particular situations.

Panic disorder

- In panic disorder, panic attacks have become recurrent but typically arise unpredictably ('out of the blue'), without specific stimuli or situations. Panic attacks occurring in specific or predictable situations are usually phobias (social phobia, agoraphobia) rather than panic disorder.
- The frequency and severity of panic attacks in panic disorder varies widely from many times a day to one or two per month. Nocturnal panic attacks may occur, which arise at night and wake the person from sleep.
- Panic disorder is often associated with a persistent fear of having a

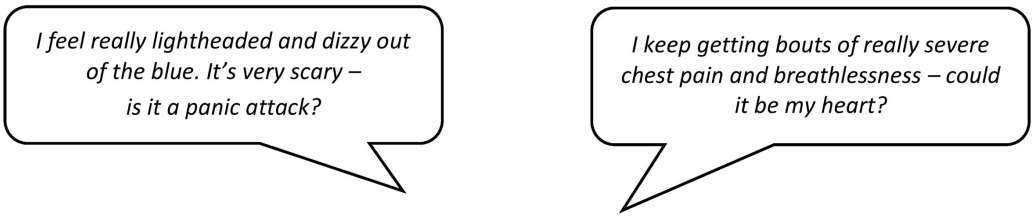
further panic attack, which often causes anticipatory anxiety between panic attacks. This also leads to marked avoidance behaviour, which can cause significant impairment of social, work and family functioning.

- The age of onset of panic disorder is typically during the early 20s, and it is 2–3 times more common in women.

2. Comorbidity and risk factors

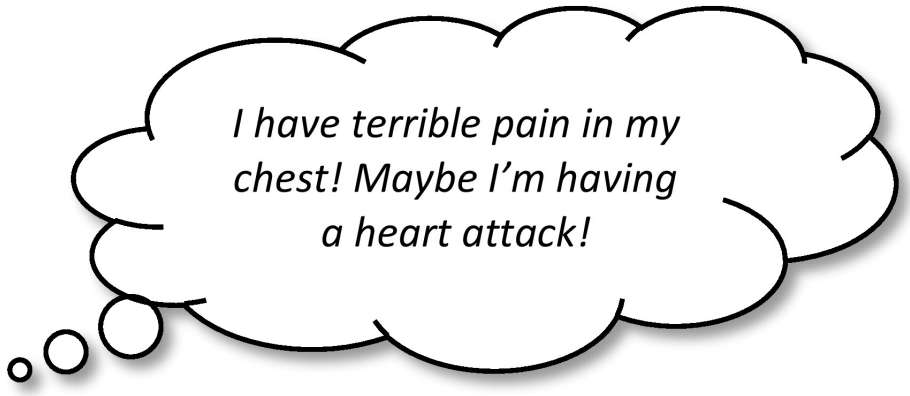
- Two-thirds of people with panic disorder also develop agoraphobia, which involves fear and avoidance of places or situations for fear of panic or being unable to escape (see our associated article on *Agoraphobia*).
- Panic disorder is often classified into panic disorder with, or without, agoraphobia. High levels of agoraphobic avoidance are associated with increased severity of panic attacks and a chronic relapsing course.
- Panic disorder is also associated with a variety of comorbid mental health conditions, including other anxiety disorders, depression and substance misuse, including nicotine dependence. When comorbidity is present, the long-term outcomes are typically poorer.
- Panic disorder is also more common in patients presenting with gastrointestinal symptoms and in those with a history of cardiovascular disease, including mitral valve prolapse, cardiomyopathy and hypertension.

3. Tips for spotting panic disorder



- Consider panic disorder in patients with high use of medical services who present frequently to primary care or emergency services with somatic symptoms that can be severe and mimic those of serious physical illness.

4. Catastrophic misinterpretations of symptoms in panic attacks



- A cognitive-behavioural model of panic attacks views them as spiralling levels of anxiety associated with catastrophic misinterpretations of harmless, often anxiety-related, physical symptoms.
- The patient incorrectly interprets these symptoms as indicating imminent disaster such as a heart attack, suffocation or going mad.

- This triggers the fight or flight sympathetic response, consequently leading to further anxiety symptoms as a rapidly-escalating vicious cycle.

Physiological response to anxiety	**What the patient might notice**	**Catastrophic thoughts**
Rapid heart rate Muscle tension in chest wall	Palpitations and muscular chest pain	*I'm having a heart attack!* *I'm going to collapse and die!*
Hyperventilation	Chest tightness, feeling short of breath Tingling around mouth and in hands Lightheaded and dizzy	*I can't breathe!* *I'm going to suffocate!* *Maybe I'm having a stroke!*
Reduced saliva production	Dry mouth, difficulty swallowing	*I've got a lump in my throat* *I'm choking!*
Impaired concentration	Racing thoughts, forgetfulness	*I'm losing control* *I'm going crazy*

- Unhelpful behaviour that contributes to the cycle of anxiety and panic includes escape from feared situations. 'Safety behaviours' are designed to minimise perceived risk (e.g. get to hospital, sit near exits, open window to get 'more air'), but these also reinforce the negative beliefs and worsen anxiety over time.
- In the long term, behaviour such as avoidance and restriction of activities can have a major impact on quality of life and mood.

5. Sharing an explanation of panic disorder

*In panic attacks, you experience intense bouts of anxiety that often come on very quickly. They usually involve intense **physical symptoms** as your body prepares to cope with physical danger by activating the 'fight or flight' response. You breathe faster and deeper to get more oxygen. Your heart races to pump more blood around the body to help your muscles prepare to fight or run. The chest wall muscles tense and work harder, causing discomfort or pain in the chest.*

*The physical symptoms are unpleasant and extremely frightening, causing **feelings** of fear, anxiety and panic. You might have catastrophic **thoughts** and fears about being in extreme danger ('I'm having a heart attack'), which rapidly increase your anxiety in a vicious cycle.*

*Your b**ehaviour** changes in response to panic attacks. You might try to escape or avoid risky situations, but you might lose confidence and the anxiety comes on quicker and feels even worse next time. Avoiding important activities can also have a negative impact on your work, education and family life.*

Although it can feel very unpleasant, remember that symptoms of anxiety are not harmful or dangerous. Try to accept what is happening and do not run away from the situation. If you wait, the fear will pass.

6. Initial assessment

- **GAD-2 can be used for screening**, and has 82% sensitivity and 75% specificity for panic disorder (BMJ Evidence-Based Medicine 2007;12:149).

GAD-2 involves asking two questions:

- Over the past two weeks, how often have you been bothered by the following problems?:
    - Feeling nervous, anxious or on edge.
    - Not being able to stop or control worrying.
- For each question, score from 0–3 (not at all: 0, several days: 1, more than half the days: 2, nearly every day: 3).
- A score of 3 or more suggests further investigation is warranted.
- Asking a third question may help to identify people with marked functional impairment ('Do you find yourself avoiding places or activities, and does this cause you problems?').

- **Rule out physical causes if appropriate**, e.g. consider thyroid/anaemia/cardiorespiratory investigation. However, it is not necessary to investigate routinely or with a typical history of panic disorder.
- **Remember to ask about drug use or withdrawal**, including illegal or prescription drugs that may trigger panic.
- **Consider using a timeline** in patients with complex comorbid conditions to clarify the sequence of when various problems developed, which can help to prioritise choice of treatments.
- **Ask about any catastrophic fears** which might be triggering a panic attack. Try asking questions such as:
    - *Which is the most severe symptom? What is the worst thing that a symptom might mean?*
    - *What goes through your mind at the time of the panic attack?*
    - *Is there anything you are doing or avoiding to prevent panic attacks?*

- **Carry out a suicide risk assessment**, particularly in patients with low mood or hopelessness.

7. Initial management

- **Experiencing a single panic attack does not constitute panic disorder,** and how clinicians respond and explain this may influence the patient's future course. Giving clear, credible explanations for how panic attacks arise may reduce catastrophisation and make the individual less likely to go on to develop recurrent panic attacks.
    - In this group, 'watch and wait' with regular review may be appropriate.
- **Physical exercise is a useful adjunct to treatment** for many patients. There is some evidence of a reduction in anxiety symptoms following exercise, although the effect is less than using antidepressants (Br J Sports Med. 2014 Feb;48(3):187). Other lifestyle advice such as regular meals, sleep hygiene and limiting drug and alcohol intake may also be important.
- **Advise all patients to avoid or cut down substances that trigger or worsen anxiety,** including legal drugs such as caffeine, nicotine, complementary remedies or OTC preparations such as decongestants.
- If alcohol or drug misuse is present, it is usually necessary to treat this first. Reassessment after successful treatment will indicate whether panic persists or was a symptom of this primary problem.

8. Stepped management of panic disorder

NICE (2011) recommends the following approach to management:

- **Mild to moderate panic disorder**: offer facilitated or non-facilitated self-help.
- **Moderate to severe panic disorder** (with or without agoraphobia): offer CBT first line. Consider an antidepressant if the disorder is longstanding or the person has not benefitted from or has declined psychological intervention.

9. Psychological therapies for panic

- CBT is the most effective treatment for panic disorder and is the first-line choice (usually 7–14 sessions).
- This involves learning to recognise factors that trigger panic, cognitive restructuring and behavioural strategies to cope with the symptoms and reduce avoidance and safety behaviours.
- Therapy should be provided by trained and supervised CBT therapists working to empirically-grounded protocols.
- Outcomes from CBT are usually worse if the patient is highly avoidant or has high levels of social dysfunction.
- Self-help based on CBT principles may be beneficial for panic disorder (Br J Psychiatry, 2012 Jan;200(1):15-21), but the evidence for efficacy or long-term benefits is less strong.
- Relaxation techniques (e.g. progressive muscle relaxation) may actually worsen outcomes of CBT as they detract from the patient's ability to tolerate anxiety, and reinforce the idea that anxiety is dangerous.

10. Drug therapies

- **SSRIs have the greatest benefit and the lowest risk of adverse events**, and are the first-line choice when medication is indicated. A recent systematic review suggests that sertraline and escitalopram may be the most effective agents (BMJ 2022;376:e066084).
- NICE (2011) highlights that escitalopram, sertraline, citalopram, paroxetine and venlafaxine are licensed for the treatment of panic disorder.
- When initiating therapy, warn patients about transient increase in anxiety and slow onset of action. Consider initiating therapy at low doses to minimise the risk of side-effects. Review every 2–4w, particularly in younger adults who are at greater risk of increased suicidal thoughts when initiating treatment.
- If there has been a response to treatment, continue for 6–12 months after reaching optimal dose. Warn about discontinuation symptoms before stopping (mild and self-limiting in most).
- If unable to use SSRIs or treatment remains ineffective after 12w, other treatment choices with evidence of benefit include SNRIs or TCAs such as imipramine or clomipramine (off-label).
- When making decisions about choice of treatment, always consider the likelihood of deliberate self-harm by overdose or otherwise (TCAs are the medication with greatest risk if taken in overdose).
- The British Association of Psychopharmacology (but not NICE) also suggests gabapentin or sodium valproate as options.

Which drugs to avoid

- **Beta-blockers are not recommended by NICE as a treatment for panic disorder.** Prescriptions in the UK have been steadily increasing since 2003, but propranolol can be highly toxic in overdose, and can lead to QRS widening, hypotension, bradycardia and other arrhythmias, bronchospasm, convulsions and coma. It can cause death with doses as low as 2000mg. There is also a lack of evidence for the efficacy of propranolol as a treatment for panic disorder. While there is some evidence that propranolol may provide symptomatic relief from the somatic symptoms of anxiety, its use may also reinforce catastrophic beliefs about the meaning of anxiety symptoms, and lead to a worsening of anxiety and panic over time (BJGP 2024; 74:516).
- **NICE says that benzodiazepines should NOT be prescribed for the treatment of panic disorder** because they are associated with poorer outcomes in the long term. Benzodiazepines can also have significant other adverse effects, including sedation, impaired memory and cognitive function, and increased risk of falls in the elderly. In line with NICE's recommendation, overallrates of benzodiazepine prescriptions for anxiety decreased between 2003 and 2018, although 44% were issued for longer than the recommended 4w maximum. However, prescribing in young adults has increased since 2008. A qualitative study found that GPs continue to view benzodiazepines as having a role in managing acute anxiety symptoms, e.g. following a bereavement, when starting SSRI treatment or in a crisis when the individual is struggling to cope with anxiety. Longer-term treatment may sometimes be offered because of long waiting lists for talking therapies, a lack of other options in primary or secondary care, or because of patient pressure and the discomfort that can arise when refusing requests for a prescription (BJGP 2024; 74:e742).
- **Do NOT use sedating antihistamines or antipsychotics**.
- **Where possible, avoid PRN medication** because this can worsen anxiety by reinforcing fears about the dangers of panic attacks.

Managing patients with panic disorder can be a major challenge, especially when resources are limited and there may be long waiting lists for talking therapies. Beta-blockers are often considered a 'low-risk' option for panic, but their risk of toxicity and lack of evidence of efficacy should move us away from them as a treatment option. It is also important to minimise the use of benzodiazepines, even in young adults, because this may trigger risk of lifelong dependence.

11. When to refer

- Refer if significant symptoms persist after treatment with two interventions (any combination of psychological intervention, medication or self-help).

12. Microskills

- **Identify specific fears and provide credible explanations**: identifying the patient's fears will enable you to ensure that your explanations of key symptoms are clear and make sense to the individual. This can be extremely important to help give perspective to the person's catastrophic beliefs about what the symptoms mean.
- **Offer brief 'psycho-education'**: this might involve explaining panic using a CBT framework and the fight or flight response to illustrate vicious cycles of anxiety, or emphasising that anxiety is highly unpleasant but is not dangerous and will pass with time.
- **Graded exposure**: encourage patients to reduce avoidance of feared situations in small realistic steps. See our linked article *Graded exposure* for more information about this.
- **Helpful behaviour during episodes of panic**: skills such as 'square

breathing' and lengthening the exhale can help to reduce symptoms arising from hyperventilation. Distraction (focus on surroundings, puzzles, physical activity) or attention training may also help take the focus away from catastrophic negative thoughts during episodes of panic, enabling the person to then continue with important activities of daily life.



Panic disorder

- Panic attacks = discrete episodes of intense fear with often intense fight or flight physical symptoms.
- Panic disorder = recurrent panic attacks that come unpredictably and out of the blue, with no particular trigger.
- In panic disorder, the fear of further panic attacks leads to marked avoidance behaviours and significant functional impairment.
- Agoraphobia co-exists in 2/3 cases.
- Patients with panic disorder often have high use of primary care and even emergency services.
- CBT is the most effective treatment.
- Graded exposure, breathing exercises and distraction are useful skills we can teach in primary care.
- Do not use benzodiazepines or sedating antihistamines, or recommend relaxation techniques.



Can you think of a patient in whom you might have missed this diagnosis? Consider reviewing them and using this framework to support a new kind of consultation. Reflect on the outcome.



Useful resources:

Websites (all resources are hyperlinked for ease of use in

	Red Whale Knowledge) • MOODJUICE – panic self-help guide • NHS – self-help leaflets • CCI – panic resources for clinicians *Books* • *Overcoming panic: a self-help guide using CBT techniques*, Manicavasagar V, Silove D (Robinson, 2017)

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