PANIC ATTACKS

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Panic attacks are sudden periods of intense fear that may include palpitations, sweating, shaking, shortness of breath, numbness, and the ominous feeling that something very bad is going to happen. The maximum degree of symptoms occurs within minutes. There may be a fear of losing control and various somatic symptoms, which induce great anxiety.

Treatment of panic attacks is usually successful and often involves a combination of psychotherapy and medication.

Keywords: panic attack, anxiety, psychotherapy, medication, psychiatry

Contents

Introduction

Panic attacks are sudden periods of intense fear that may include palpitations, sweating, shaking, shortness of breath, numbness, and the ominous feeling that something very bad is going to happen. [2] The maximum degree of symptoms occurs within minutes. There may be a fear of losing control or chest pain. [2] The loss of control is usually the cardinal feeling in a panic attack. However, it is the fear of the loss of control which is the problem rather than an actual loss of control.

Panic attacks themselves are usually not dangerous in an otherwise healthy individual. [3] They are distinguished from other forms of anxiety by their intensity and their sudden, episodic nature. [5] They are often experienced in conjunction with anxiety disorders and other psychological conditions, although panic attacks are not generally indicative of a mental disorder.

There are several therapies that work against anxiety with good empirical evidence for their effectiveness such as CBT. Another therapy is communication-focused therapy (CFT), which has been developed by the author to focus directly on the underlying mechanism that many forms of psychotherapy have in common, communication [1].

Often people are not aware of a specific trigger or underlying psychological issues, feelings and emotions that may contribute to a panic attack. An awareness of them usually makes the panic attacks subside and elucidating the underlying dynamics can be an important part of therapy. At the same time, it is important to see the condition in the larger context of how patients engage in communication with themselves and others. Panic attacks and anxiety in general occur because something in the life of the patient is ‘out of sync’. They are an important signal which needs to be taken seriously. Even though panic attacks have a biological component as well, they are more likely to occur if an individual is exposed to a situation which is difficult or conflict rich on the interpersonal level.

Co-Morbidity

Panic attacks can occur as part of several mental health conditions, including panic disorder, social anxiety disorder, post-traumatic stress disorder, drug use, depression, and a number of medical problems. [2][4] It is important to rule them out, also to calm the patient, although some patients become even more anxious if they have to undergo medical tests. The best strategy should be decided on an individual level, while not taking unnecessary risks.

Panic Attacks are common

In Europe about 3% of the population has a panic attack in a given year while in the United States they affect about 11%. They are more common in females than males. They often begin during puberty or early adulthood. Children and older people are less commonly affected. [2] Panic attacks are, as already mentioned, more frequent when there are changes in life, particularly on a relationship level. While in a good number of cases potential triggers or stressors are not obvious, it always helps to identify what could be potential stressors. As life has become faster and more complex, there is also a greater risk for work related stress.

Symptoms

People with panic attacks often report a fear of dying or heart attack, flashing vision, faintness or nausea, numbness throughout the body, heavy breathing and hyperventilation, or loss of bodily control. Some people also suffer from tunnel vision, mostly due to blood flow leaving the head to more critical parts of the body in defense. These feelings may provoke a strong urge to escape or flee the place where the attack began (a consequence of the "fight-or-flight response", in which the hormone causing this response is released in significant amounts). This response floods the body with hormones, particularly epinephrine (adrenaline), which aid it in defending against harm. [5]

Mechanism

A panic attack is a response of the sympathetic nervous system (SNS). The most common symptoms include trembling, dyspnea (shortness of breath), heart palpitations, chest pain (or chest tightness), hot flashes, cold flashes, burning sensations (particularly in the facial or neck area), sweating, nausea, dizziness (or slight vertigo), light-headedness, hyperventilation, paresthesia (tingling sensations), sensations of choking or smothering, difficulty moving, and derealization. These physical symptoms are interpreted with alarm in people prone to panic attacks. This results in increased anxiety and forms a positive feedback loop. [6]

Often, the onset of shortness of breath and chest pain are the predominant symptoms. Shallow and rapid breathing can change the pH level in one's blood, which leads to even more symptoms of a panic attack. To break this vicious cycle is difficult once the panic attack has started.

Common risk factors include smoking and psychological stress. Similar symptoms to panic attacks can be caused hyperthyroidism, hyperparathyroidism, heart disease, lung disease, and drug use. [2]

Treatment

Since the symptoms of a panic attack are similar to symptoms of severe physical illnesses, they should always be investigated for somatic sources.

Psychotherapy

Psychotherapy should always be a part of treatment. As mentioned, there are various therapeutic approaches. The important part is to match the right therapy to the right patient.

While individuals can have a genetic predisposition towards anxiety and panic attacks, there are usually some underlying emotions or worries that induce and maintain a phase of more frequent panic attacks. Identifying and working through such issues is largely the domain of psychodynamic (or psychoanalytic) psychotherapy. On the other hand, panic attacks and anxiety in general can also be related to unhelpful thoughts and behaviors, which may be learned, which is the domain of cognitive behavioral therapy (CBT), which has the largest empirical evidence base among all the different therapies. Interpersonal Psychotherapy (IPT) may also be helpful, while communication-focused therapy (CFT) is a therapy developed by the author to address and work with the mechanism that is common to practically all the psychotherapies, communication.

Psychotherapy usually takes some time to work. There should be a sense that it is helping against the panic attacks within the first two or three sessions. However, for a clear and enduring effect it can take months, or in some cases even longer. This is why medication is a valuable support early on in treatment. It does achieve results quicker and gives patients some breathing space from the panic attacks, which can severely constrain a patient's life, leading to situations where one can become house or even bed bound.

Medication

Medication can be added to prevent the occurrence of panic attacks for a while. This lowers the anxiety of having another panic attack, which in itself lowers the likelihood of having a panic attack.

First line treatment is usually an antidepressant from the group of serotonin reuptake inhibitors (SSRIs) for the long-term in combination with a benzodiazepine, such as alprazolam (Xanax®) or lorazepam (Temesta®), as a one-off when a panic attack might be coming on. The disadvantage of the benzodiazepines is that they take up to an hour to have an effect, work only for up to a couple of hours and, if they are taken regularly, they can be addictive. However, many patients find it useful to carry a tablet of alprazolam or lorazepam with them. This already often lowers the fear of having a panic attack.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Selective serotonin reuptake inhibitors (SSRIs) are in many countries the most widely prescribed antidepressants. However, they do not only help against depression, but also against various forms of anxiety and panic attacks. They do their work by increasing the serotonin levels in certain centers in the brain and also by docking on serotonin receptors, where, depending on the receptor subclass, they can have inhibitory or activating effects. Their effectiveness is in line with observations that serotonin receptors, which are encoded in the genes, and their densities may be altered in patients suffering from depression and anxiety.

An SSRI is taken daily, but it may take a month or even longer to notice an effect. The dose is usually increased gradually to find the minimum dose that achieves the desired effect. Most recommendations specify that a patient should be on them for at least six months, but a year or more is often better to have a more enduring effect once the medication is stopped. SSRIs should in generally not be stopped from one day to the next but tapered off.

SSRIs need to be used with caution with some underlying health problems, including diabetes, epilepsy, kidney disease and others. Some SSRIs can react unpredictably with other medicines, including some over-the-counter painkillers and herbal remedies, such as St John's wort. Some of the more common side effects are:

- feeling agitated, shaky or anxious
- feeling or being sick
- dizziness
- blurred vision
- low sex drive (reduced libido)
- difficulty achieving orgasm during sex or masturbation
- in men, difficulty obtaining or maintaining an erection (erectile dysfunction)

However, the more common side effects, such as queasiness in the stomach, nausea or headache often only occur in the beginning, if at all, and then go away over a couple of days to two weeks. Also, increasing the medication slowly, and in some cases starting with only a quarter tablet, in many cases helps to avoid these side effects. While the sexual side effects and an increase in appetite, if they occur, tend to be more persistent, there are usually ways to mitigate the problem, either by switching the SSRI or in some cases even by adding on another antidepressant, such as bupropion, a dopamine and norepinephrine reuptake inhibitor.

Some of the more common SSRIs include escitalopram (Cipralex®, Lexapro®), sertraline (Zoloft®, Lustral®), citalopram (Cipramil®), paroxetine (Paxil®, Seroxat®), fluoxetine (Prozac®) and fluvoxamine (Faverine®). Since there are differences in the affinity for certain serotonin receptor subclasses and other non-serotonin receptors, their side effect profiles differ, as do the preferences for their use in specific condition, such as depression, OCD, anxiety, eating disorder and others.

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