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Anxiety and Panic: When Does Normal Stress Cross the Line into a Disorder?

Narrative Literature Review

Abstract—Anxiety, stress, fear, and panic are overlapping but non-equivalent terms. Their ordinary forms prepare action and protect safety; their clinical forms can narrow life, amplify bodily threat, and persist after the relevant challenge has passed. Because no single symptom or questionnaire score marks a boundary between normality and disorder, recognition depends on proportionality, persistence, recurrence, controllability, functional cost, avoidance, and differential diagnosis. This narrative review integrates diagnostic guidance, affective neuroscience, cognitive-behavioral evidence, and a communication-oriented formulation. Panic attacks are treated as episodes that can occur within several disorders, medical states, and substance effects, rather than as automatic proof of panic disorder. The review explains the reinforcing roles of catastrophic interpretation, interoceptive vigilance, anticipatory anxiety, avoidance, and safety behavior. It also outlines medical and psychiatric alternatives, staged assessment, urgent warning signs, and evidence-based treatment principles. A central conclusion is that the clinically important question is not whether distress feels intense, but whether the response remains flexible, informative, proportionate, and compatible with valued functioning. Assessment should validate suffering without pathologizing every alarm response and should identify when anxiety has become a self-maintaining constraint requiring professional care.

Index Terms—anxiety, panic attack, panic disorder, stress, avoidance, differential diagnosis, impairment, psychotherapy

I. INTRODUCTION

A pounding heart before a difficult conversation, restless sleep during financial uncertainty, or a surge of fear after a near accident can all be understandable. The same sensations may also appear in panic disorder, generalized anxiety disorder, trauma-related conditions, depression, substance effects, or a medical illness. The boundary is therefore not a single bodily sensation and not a moral judgment about whether someone is coping well

enough. It is a clinical inference about pattern, context, consequences, and plausible alternatives.

Earlier JPPC discussions described severe anxiety as a multilevel experience and emphasized that communication, meaning, and treatment context influence how symptoms are understood (Haverkamp, 2012; Haverkamp, 2017a). This review retains that concern while grounding threshold decisions in established diagnostic and treatment evidence. The goal is recognition, not self-diagnosis: a reader should be able to ask better questions about ordinary stress, panic episodes, and when a structured assessment is warranted.

II. SCOPE AND REVIEW METHOD

This article is a narrative literature review with a literature-search cutoff of 28 February 2022, one month before the nominal issue date of 2022 Mar 31. Searches covered anxiety disorders, panic attacks, panic disorder, stress physiology, threat anticipation, screening, differential diagnosis, cognitive-behavioral therapy, and relevant local JPPC work. Priority was given to professional guidance available by 28 February 2022, systematic or umbrella reviews, meta-analyses, longitudinal studies, diagnostic research, and clinically informative original studies. Bibliographic details were checked against PubMed records, the Crossref DOI registry, or the issuing organization's page. Relevant JPPC articles were read in the local archive and used where they materially informed the present question.

The review is not a systematic review and does not estimate a pooled effect. It is intended to support recognition, formulation, and shared clinical reasoning. Absence of a citation does not imply absence of evidence, and the applicability of group findings to one person depends on setting, development, culture, medical status, exposure, and the quality of the assessment. Guidance cited here should be checked for later updates before clinical use.

Core propositions (author-developed summary; nonvalidated)

- Intensity alone does not separate adaptive alarm from disorder.
- Panic attack is an episode and specifier; panic disorder requires a characteristic recurrent pattern and consequences.
- Time course, proportionality, avoidance, and functional cost matter more than one symptom in isolation.
- New or atypical bodily symptoms require an appropriate medical differential, not automatic psychologizing.
- Validated scales support inquiry and monitoring but do not make a diagnosis.

III. FEAR, ANXIETY, STRESS, AND PANIC

Fear usually names a response to danger perceived as present; anxiety is more often prospective, organized around a possible future threat. Stress refers more broadly to demands and the processes by which the organism adapts to them. These distinctions are useful rather than absolute. Conscious apprehension, defensive behavior, autonomic arousal, attention, and action tendency interact, but they are not one indivisible system. LeDoux and Pine (2016) cautioned against treating defensive circuits as if they directly and completely explain conscious fear and anxiety.

A panic attack is a rapid surge of intense fear or discomfort accompanied by symptoms such as palpitations, breathlessness, dizziness, trembling, chest discomfort, derealization, or fear of losing control or dying. The event can be expected or unexpected and can occur in several diagnoses. Panic disorder is a longer pattern in which recurrent unexpected attacks are followed by persistent concern, maladaptive behavior change, or both. This distinction prevents the common error of converting one frightening episode into a chronic diagnosis.

Stress responses can be adaptive over minutes or days yet costly when activation is prolonged, recovery is incomplete, and sleep, immune, metabolic, or cognitive processes are repeatedly disrupted. McEwen (2007) described the cumulative burden of adaptation as allostatic load. This model does not supply a psychiatric diagnosis, but it clarifies why a realistic external demand can still produce clinically important consequences when exposure is sustained and resources are insufficient. The stress and uncertainty literature further shows why intensity alone is not a diagnostic boundary: perceived stress is an appraisal construct, while uncertain anticipation can amplify threat processing without by itself establishing a disorder (Cohen et al., 1983; Grupe & Nitschke, 2013).

Threshold questions: from expected alarm to clinical concern (author-developed narrative synthesis; nonvalidated)

Dimension	More consistent with an adaptive response	More consistent with clinical concern
Trigger	Recognizable challenge or danger	Absent, remote, repeatedly overestimated, or generalized

Dimension	More consistent with an adaptive response	More consistent with clinical concern
Time course	Rises and settles with the situation	Persists, recurs unexpectedly, or recovery is prolonged
Flexibility	Attention can return to other tasks	Threat monitoring dominates despite new information
Behavior	Preparation followed by action	Avoidance, repeated checking, reassurance, or escape
Function	Temporary, limited disruption	Work, study, relationships, sleep, health care, or travel constrict
Meaning	Alarm is interpreted in context	Sensations are treated as catastrophe or proof of incapacity

IV. NO SINGLE LINE: A MULTIDIMENSIONAL THRESHOLD

Clinical thresholds combine several dimensions. Disproportionality asks whether the response fits the likelihood and magnitude of danger, while acknowledging that information may be incomplete. Persistence asks whether alarm remains after the challenge or returns without a useful signal. Controllability concerns whether attention can shift and whether worry can end in a decision. Functional impairment concerns lost roles, not merely visible productivity. Distress matters, but a person can be severely constrained while describing little distress because avoidance has removed most feared situations.

Context is indispensable. A vigilant response in an unsafe environment should not be relabeled irrational simply because it resembles an anxiety symptom. Conversely, understandable origins do not make a disabling pattern benign. The task is to recognize both external conditions and learned self-maintaining processes. Anxiety disorders are common, heterogeneous, and frequently comorbid; Craske et al. (2017) emphasize developmental, genetic, environmental, cognitive, and neural contributions rather than a single cause.

Duration criteria improve reliability but are not a rule to withhold help until a calendar threshold expires. Acute symptoms may require assessment because of severity, medical uncertainty, or risk. Subthreshold problems can also merit early intervention when avoidance is spreading. The practical threshold for seeking help is therefore lower than the formal threshold for assigning a disorder: consultation is appropriate whenever the pattern is confusing, recurrent, escalating, or costly.

V. HOW PANIC BECOMES SELF-MAINTAINING

Panic often develops through an interaction between bodily sensation and catastrophic meaning. A normal fluctuation—rapid heartbeat after caffeine, light-headedness after standing, breathlessness during exertion—can be interpreted as imminent collapse, suffocation, insanity, or loss of control. Attention then turns inward, arousal rises, sensations intensify, and the threatening interpretation appears confirmed. The cycle is real even when the predicted catastrophe is not occurring; the sensations are not imagined.

Anticipatory anxiety extends an episode into a way of organizing life. The person scans for early sensations, rehearses escape routes, checks pulse or breathing, avoids exertion, travels only with a companion, or remains near an exit. These safety behaviors reduce fear in the short term but make it hard to learn that sensations can peak and pass without the feared outcome. Avoidance can generalize from one location to crowds, public transport, distance from home, and eventually being alone.

A communication-oriented formulation asks what information is being treated as decisive. Does bodily activation mean danger, weakness, humiliation, or abandonment? Which reassurance can be received only briefly? Which feared message cannot be tested because escape occurs first? Earlier JPPC work on treatment-resistant anxiety similarly argues for reassessing patterns that keep symptoms credible despite repeated care (Haverkamp, 2017b). These questions supplement, rather than replace, exposure-based and cognitive-behavioral models.

A functional sequence for a panic episode (author-developed narrative synthesis; nonvalidated)

Step	Example	Assessment target
Cue	Heat, dizziness, crowded train, intrusive thought	Internal and external antecedents
Appraisal	'I will faint' or 'I cannot escape'	Predicted event and confidence
Response	Arousal, narrowed attention, urge to flee	Bodily, cognitive, and behavioral components
Safety action	Sit by exit, check pulse, call someone	Immediate relief and hidden cost
Short outcome	Anxiety falls after escape	What appears to have prevented disaster
Long outcome	More vigilance and a smaller safe zone	Lost corrective learning and impairment

VI. SCREENING, SEVERITY, AND FUNCTION

The GAD-7 is a brief measure developed to identify probable generalized anxiety and grade symptom severity in clinical settings (Spitzer et al., 2006). It is useful for opening discussion and tracking change, yet it samples one recent time

window and cannot distinguish among anxiety disorders, trauma, depression, medication effects, or medical causes. A low score can miss episodic panic or highly circumscribed avoidance; a high score can reflect severe but time-limited stress.

Function should be described concretely. How much time is consumed by worry, checking, recovery, or route planning? Which activities are no longer attempted? Is work maintained only through exhaustion or concealed rituals? Are relationships organized around reassurance or accommodation? What happens to sleep, eating, exercise, and health care? These questions capture cost that may be invisible in a symptom total and identify outcomes that matter to the person.

Repeated measurement is most informative when paired with a formulation. Improvement may mean fewer attacks, but it may also mean taking a train while anxious, reducing checking, tolerating uncertainty, or recovering more quickly. A temporary rise in anxiety during an exposure task can coexist with meaningful functional progress. Outcome interpretation should therefore examine both distress and renewed participation.

VII. DIFFERENTIAL DIAGNOSIS AND MEDICAL REVIEW

Anxiety-like symptoms can arise from arrhythmia, respiratory disease, anemia, endocrine disturbance, vestibular conditions, infection, pain, sleep loss, pregnancy-related changes, medication effects, and substance intoxication or withdrawal. Caffeine, stimulants, decongestants, cannabis, alcohol withdrawal, and changes in prescribed medication deserve specific inquiry. Investigation should be guided by history, examination, age, risk, and the presentation; a universal test battery is neither necessary nor sufficient.

Psychiatric alternatives and comorbidities include depression with agitation, bipolar activation, obsessive-compulsive phenomena, trauma-related hyperarousal, social anxiety, illness anxiety, eating disorders, substance-use disorders, psychosis, and neurodevelopmental conditions. The sequence matters. A person avoiding shops may fear panic sensations, scrutiny, contamination, assault, or inability to concentrate. The visible behavior is not the diagnosis.

Red flags for medical assessment include a first severe episode with atypical features, syncope, exertional chest pain, persistent hypoxia, focal neurological change, fever, delirium, pregnancy complications, or a temporal relationship with a new drug or withdrawal. Clinical validation does not require premature certainty: it is possible to say that an episode was terrifying while continuing to assess what produced it. Depressive syndromes can also present with agitation, apprehension, sleep disruption, and impaired concentration, so

assessment must test the full mood pattern and course rather than infer anxiety from arousal alone (Malhi et al., 2018).

VIII. WHAT HELPS AND WHAT CAN MAINTAIN THE PROBLEM

Treatment should match the diagnosis, severity, preference, comorbidity, and risk. NICE guidance for generalized anxiety and panic disorder describes stepped care, including education, monitoring, cognitive-behavioral approaches, and medication options (National Institute for Health and Care Excellence, 2011). A meta-analysis of placebo-controlled trials found CBT effective across anxiety and related disorders, while also showing variation across conditions and studies (Carpenter et al., 2018). Panic-focused work commonly includes psychoeducation, cognitive testing, interoceptive and situational exposure, and reduction of safety behavior.

Advice to ‘calm down’ or repeated reassurance can inadvertently imply that sensations are intolerable. Breathing strategies may be useful when they reduce overbreathing or support approach, but they can become a ritual if the person believes safety depends on perfect control. Exposure is not flooding or coercion; it is collaborative, graded learning with consent, a clear hypothesis, and attention to medical and contextual safety.

Medication decisions require individual assessment of benefits, adverse effects, interactions, previous response, discontinuation risk, pregnancy, and preference. Sleep, stimulant intake, alcohol use, activity, and regular meals should be assessed for their effects on arousal and functioning, but this review does not establish diet, exercise, or sleep treatment as therapies for an anxiety disorder. The cited studies concern depression, insomnia, or mixed populations and should be treated as indirect contextual evidence rather than efficacy evidence for anxiety-disorder care (Firth et al., 2019; Freeman et al., 2017; Gordon et al., 2018; Schuch et al., 2018; Trauer et al., 2015). Mindfulness-based interventions may offer additional symptom relief for some patients, although pooled evidence spans mixed anxiety and depression samples and does not replace diagnosis-specific treatment (Hofmann et al., 2010). Self-compassion research may inform work with shame and self-attack, but association is not evidence of a stand-alone anxiety treatment (Neff, 2003; MacBeth & Gumley, 2012).

Common responses: useful function and possible trap (author-developed narrative synthesis; nonvalidated)

Response	Potentially useful when...	Potentially maintaining when...
Planning	It defines a problem and ends in action	It becomes endless hypothetical rehearsal
Reassurance	It supplies new, credible information	It must be repeated to neutralize uncertainty

Response	Potentially useful when...	Potentially maintaining when...
Breathing	It addresses overbreathing and supports staying	It is treated as the only protection from catastrophe
Avoidance	It leaves genuine danger	It expands despite safety and blocks learning
Monitoring	It tracks a known medical risk	It repeatedly scans normal fluctuations
Exposure	It is collaborative and hypothesis-led	It is coercive, unsafe, or used without formulation

IX. CONTEXT, EQUITY, AND ACCESS

Clinical thresholds are not culturally or socially weightless. Opportunity, exposure, power, language, disability, service design, and prior treatment affect both symptoms and the evidence available to an assessor. Equity does not mean applying less rigorous criteria; it means collecting better contextual evidence and avoiding an interpretation that mistakes structural constraint for individual pathology.

Real danger. People exposed to violence, discrimination, insecure housing, or precarious work may be responding to genuine threat; proportionality must include their environment. Assessment should distinguish protective vigilance from alarm that has generalized beyond current danger, while identifying which conditions require practical protection rather than reinterpretation.

Access. Waiting lists and cost can convert a treatable pattern into chronic avoidance, and early low-intensity support should not become indefinite under-treatment. The plan should record which recommended options are genuinely available, who can alter the barriers, and what interim support is realistic, so failure to receive unavailable care is not misread as treatment resistance.

Culture and language. Bodily or spiritual descriptions should be explored in their own terms before they are translated into psychiatric categories. The clinician should ask what the account means within the person's community, what support is acceptable, and whether apparently impractical advice reflects cost, language, or service barriers rather than lack of motivation.

X. MEASUREMENT, INTEGRATED ASSESSMENT, AND FOLLOW-UP

Follow-up should begin before intervention by defining what will be observed, at what interval, and by whom. Symptom measures can be useful, but they should be paired with function, safety, adverse effects, and the person's priorities. The aim is not to accumulate data; it is to notice whether the working formulation predicts the course and whether the chosen action produces a benefit worth its cost.

A balanced outcome dashboard

Start with one recent episode and reconstruct it in ordinary language: what happened first, how quickly the sensations rose, what the patient feared, what they did, and what followed. Then ask what changed between episodes—monitoring, reassurance, escape, work, travel, sleep, or relationships. Medical symptoms, substances, medication changes, mood, trauma, obsessions, and risk widen the differential. A partner or relative may add useful observations with consent, but the account should remain the patient's, and disagreement should become a question to investigate rather than evidence of unreliability.

Prediction. Clarify what the person believed would happen in the next minute or hour: collapse, suffocation, loss of control, humiliation, abandonment, or another feared outcome in their own account. Ask how certain the prediction felt, what information supported it, and whether it changed after the episode. Distinguish the predicted catastrophe from the sensations themselves, which were real even if the feared outcome did not occur. If language, shame, or limited recall makes the prediction difficult to state, return to the sequence without treating silence as absence. Interpret the answer alongside medical findings, context, and behavior rather than using it alone to assign a diagnosis.

Between attacks. Determine what changed after the episode: anticipatory anxiety, monitoring of pulse or breathing, repeated reassurance, route planning, avoidance, or reliance on another person. Establish frequency, duration, and the situations in which these changes recede. Ask what each response is intended to prevent, how long relief lasts, and what the person believes would happen without it. This identifies whether a single attack has become a self-maintaining pattern and whether the safe zone is shrinking. It also distinguishes reasonable preparation from behavior that blocks new learning. When accounts differ, document the discrepancy and decide whether clarification, observation, or consented collateral history is most useful.

Function. Describe which roles, places, and relationships have become restricted and what effort is required to maintain those that remain. Ask about work, study, travel, sleep, eating, exercise, health care, caregiving, and dependence on reassurance or accompaniment. Visible productivity should not be treated as intact function when it is sustained by exhaustion, concealed rituals, or extensive accommodation. Compare present participation with the person's earlier life and identify one activity that would return if confidence increased. Concrete examples help separate distress from impairment and provide outcomes that matter to the patient. They also show whether fewer attacks reflect recovery or simply more complete avoidance.

Differential diagnosis. Review medical symptoms,

substances, medication changes, mood, trauma, obsessions, psychosis, and neurodevelopmental history in relation to the episode timeline. A first or atypical event, exertional symptoms, syncope, focal neurological change, pregnancy, fever, intoxication, or withdrawal changes the order and urgency of assessment. Ask what preceded the symptoms and what conditions make them better or worse; do not let a familiar anxiety label suppress contradictory evidence. More than one process may be present. If the psychological formulation and bodily course do not align, specify whether the next step is examination, targeted investigation, prescriber review, or observation over time rather than offering reflex reassurance.

Risk. Ask directly and proportionately about self-harm, severe hopelessness, intoxication or withdrawal, domestic danger, violence, safeguarding, and inability to meet basic needs. Urgency depends on the whole presentation, not on whether panic is usually medically benign. Clarify current intent, access to means, recent deterioration, supports, and the person's ability to use a safety plan. Severe chest pain, collapse, marked breathing difficulty, new neurological signs, delirium, or a rapidly changing mental state require appropriate urgent assessment. Risk questions should be explained and paced, but consent to a routine interview does not remove the clinician's safeguarding responsibilities. Record the information source, confidence, and action taken.

Resources. Identify who helps, what remains possible, and which earlier coping responses were useful without becoming safety rituals. Ask about trusted people, practical supports, treatment preferences, financial and transport constraints, and activities the person still approaches despite anxiety. With consent, a partner or relative may clarify the episode or its consequences, but collateral information should have a stated purpose and should not displace the patient's account. Disagreement is information to investigate, not proof that either source is unreliable. The resulting plan should name the smallest workable next step, who is responsible for it, and the observation that would show whether the current formulation is useful.

Consent and follow-up. The interview need not be completed in one sitting, and the purpose of collateral contact should be discussed before information is sought. A supporter may clarify timing, avoidance, or function, but should not become the arbiter of the patient's experience or a permanent source of reassurance. Agree which outcomes will be reviewed, when review will occur, and who will respond if attacks, medical warning signs, or risk escalate. This makes uncertainty explicit while ensuring that provisional formulation does not become passive delay.

Interpret the domains together rather than scoring them in isolation. Onset, recurrence, proportionality, controllability, avoidance, function, medical safety, and available resources jointly determine the threshold for care. One answer may

support several hypotheses, while silence may reflect absence, memory, shame, language, fear, or how the question was asked. State the confidence attached to the working formulation and the evidence that would weaken it. When findings conflict, choose a clear next step—clarification, collateral history, targeted medical review, or longitudinal observation—and revise the immediate plan if risk or function changes before diagnostic certainty is reached.

A. EVIDENCE TRANSFER AND REVISION

Evidence transfer depends on design and measurement. Guidance combines evidence and expert judgment for a defined population and date; systematic reviews inherit the definitions and biases of included studies; and original studies retain sampling, measurement, confounding, and chance limitations. Diagnoses, interviews, questionnaire scores, behavioral records, and administrative outcomes are not interchangeable. Cross-sectional association cannot establish temporal order, while randomization supports causal inference only for the tested intervention and conditions. Mechanistic accounts in this review therefore organize testable observations rather than establish an individual's hidden cause.

Average effects can conceal nonresponse, deterioration, exclusion, and unequal access. Before applying an estimate, compare the study population, treatment competence, dose, outcome, setting, and burden with the present decision. Monitoring should include unwanted effects, reasons for discontinuation, and opportunity cost; lack of benefit should prompt a review of fit rather than blame.

The manuscript's nominal publication date is 31 March 2022, and sources were limited to material available through 28 February 2022. Later safety warnings, diagnostic revisions, retractions, and updated recommendations must therefore be checked before clinical use. Local JPPC articles are treated as prior clinical or theoretical work, not substitutes for external evidence; their communication-oriented propositions are used as questions at the level their methods support.

B. CLINICAL ILLUSTRATIONS OF THRESHOLD REASONING

The following contrasts illustrate application of the review; they are not validated decision rules. A racing heart before a deadline can be intense yet remain proportionate when it settles with the demand, does not generate persistent anticipatory fear, and does not narrow the person's activities. The same sensation carries different clinical weight when it recurs unexpectedly, is interpreted as imminent catastrophe, and changes travel, exercise, work, or reliance on another person. The conclusion follows the pattern across time and function, not the intensity of one bodily event (McEwen, 2007; Craske et al., 2017; Penninx et al., 2021).

A first unexpected surge requires two decisions that should not be collapsed. The immediate decision is whether onset,

exertional features, syncope, focal neurological change, pregnancy, intoxication or withdrawal, medication change, or another atypical feature warrants medical assessment. Once urgent alternatives have been addressed, the episode can be reconstructed without presuming a durable diagnosis: what preceded it, how rapidly symptoms rose, which catastrophe was predicted, what action followed, and whether concern or behavioral change persisted. An episode can be real, frightening, and clinically important without yet establishing panic disorder.

Attack frequency can also mislead. Fewer attacks may represent recovery, but they may result from staying home, avoiding exertion, sitting near exits, or requiring accompaniment. Review should therefore compare the person's life space, safety behaviors, recovery time, and chosen activities before and after intervention. When a person travels farther while still experiencing brief fear, functional improvement may precede symptom remission. This distinction makes the treatment target and the meaning of outcome data explicit without minimizing distress or ignoring genuine environmental danger.

C. AVOIDANCE AND SAFETY BEHAVIORS

The clearest evidence that anxiety has crossed a clinically important threshold may be found outside the attack itself. People stop taking trains, sit near exits, carry multiple rescue objects, repeatedly check pulse or oxygen readings, avoid exercise, or require another person to accompany them. Each maneuver can reduce fear immediately while preventing disconfirmation of catastrophe. An assessment should map the person's life space before and after onset, distinguish reasonable precaution from fear-driven restriction, and ask what activity would return first if confidence increased. This functional map is often more informative than a single symptom count.

Safety behavior is defined by function rather than appearance. Carrying water may be ordinary preparation on a hot day, medically necessary for one person, and a condition for leaving home for another. Reassurance also varies in function: a credible explanation after assessment can resolve uncertainty, whereas repeated requests for the same answer may strengthen the belief that danger can be managed only through checking. The clinician should ask what prediction the behavior is meant to prevent, how long relief lasts, and what happens when the behavior is unavailable. That conversation creates a testable maintenance model without shaming self-protection.

When panic disorder or another anxiety disorder is established, cognitive-behavioral treatment has substantial controlled-trial support (Carpenter et al., 2018). Exposure is not forced confrontation or proof that symptoms are imaginary. It is planned learning in which feared predictions,

safety conditions, dose, consent, and review are explicit. Interoceptive work may be relevant when benign bodily sensations have become feared; situational exposure may matter when places or activities are avoided. The sequence must be adapted for medical conditions, trauma, substance use, and genuine environmental danger, and progress should be measured by restored choice as well as reduced fear.

D. COMMUNICATING AND REVIEWING THE THRESHOLD

A threshold conversation should validate distress while avoiding two unhelpful extremes: 'nothing is wrong because stress is normal' and 'severe symptoms must mean a disorder.' A more accurate explanation separates observations from conclusions. The clinician can summarize the bodily episode, the pattern across time, the degree of avoidance, the effect on sleep and roles, and the alternatives still being considered. The person should then hear why the current evidence supports self-management, scheduled follow-up, focused psychotherapy, medical assessment, or urgent care. The reasoning matters because a label without its evidential basis is difficult to revise.

Screening scales can organize discussion but cannot make that threshold decision. The GAD-7 was developed as a brief severity measure (Spitzer et al., 2006); its score is influenced by the time window, comorbidity, context, and the person's interpretation of items. Panic-specific assessment also requires episode structure, unexpectedness, behavioral change, and differential diagnosis. A low score should not erase focal panic attacks or marked avoidance, and a high score should not suppress inquiry into grief, stimulants, sleep deprivation, illness, or realistic threat. Measures work best when paired with concrete examples and repeated under comparable conditions.

Earlier JPPC discussions of severe anxiety, panic-focused CFT, and treatment resistance emphasize meaning and communication alongside symptom change (Haverkamp, 2012; Haverkamp, 2017a; Haverkamp, 2017b). In the present review, those ideas function as clinical questions rather than claims that a particular mechanism has been proven. What did the sensation communicate to the person? Which response communicated safety, and which communicated fragility? External anxiety research must remain the evidential anchor, while the communication lens can help identify how fear, reassurance, avoidance, and relationships interact in this individual's pattern.

Follow-up should specify a small set of outcomes before intervention: attack frequency and recovery time, anticipatory worry, the size of the avoided zone, use of safety behaviors, sleep and stimulant exposure, and return to valued activity. Frequency alone can mislead. Fewer attacks may reflect effective treatment, but they may also reflect near-total

avoidance; temporary anxiety may rise while exposure restores mobility. A balanced review therefore pairs symptom measures with behavior and function. The person should know how much change would count as meaningful and when non-improvement will trigger reassessment rather than indefinite repetition.

The formulation should be reopened when the course is atypical. Progressive exertional symptoms, loss of consciousness, persistent arrhythmia, new neurological signs, substance change, marked mood elevation, psychotic symptoms, or attacks confined to a new medication window require renewed differential assessment. So does a pattern that remains unchanged despite a well-delivered intervention at an adequate dose. Nonresponse does not by itself prove 'treatment resistance'; it can indicate that the target, diagnosis, exposure conditions, adherence barriers, or outcome measure was wrong. Documenting the original predictions makes this revision possible.

Recovery is broader than the disappearance of alarm. A durable improvement includes confidence that sensations can be tolerated, capacity to distinguish discomfort from danger, less dependence on checking, restored movement through ordinary environments, and willingness to act without certainty. Relapse planning should identify the person's early pattern and the smallest response likely to prevent renewed contraction, while avoiding continuous self-surveillance. The central question at review is whether the person has more workable choices. That question keeps symptom reduction connected to autonomy, relationships, and participation rather than making calmness the only acceptable outcome.

E. DOCUMENTING AND REVISING THE DECISION

A useful record separates observation from inference. It describes the episode and course, identifies the leading medical and psychiatric alternatives, states the evidence for the current threshold judgment, and records the confidence attached to it. It then names the action chosen now and the finding that would change that action. This author-developed documentation sequence is an implementation suggestion, not a validated diagnostic instrument.

Questionnaire results should be recorded with their time frame and purpose. A score can support monitoring while leaving focal panic, concealed avoidance, language effects, comorbidity, and realistic threat unresolved. Consented collateral information can clarify timing or function, but its source and limits should be stated, and disagreement should prompt further inquiry rather than an automatic judgment that one account is unreliable.

The patient should hear the same distinctions that appear in the record: what is known, what is inferred, what remains uncertain, and why the present plan is proportionate. Inviting correction may reveal a missed symptom, feared consequence,

or practical barrier. Follow-up then tests whether the formulation predicted the course, whether the agreed action was feasible, and whether new medical, functional, or safety information requires revision.

A structured assessment map (author-developed narrative synthesis; nonvalidated)

Domain	Questions to test
Episode	What started first; how quickly did it peak; what ended it?
Prediction	What did the person think would happen in the next minute or hour?
Between attacks	Is there anticipatory anxiety, monitoring, or behavior change?
Function	Which roles or places are restricted, and what effort keeps others going?
Differential	Medical symptoms, substances, medication changes, mood, trauma, obsessions?
Risk	Self-harm, severe hopelessness, intoxication, safeguarding, inability to care?
Resources	Who helps, what remains possible, and what prior coping was effective?

F. SAFETY AND URGENCY

Most panic attacks are not medically dangerous, but that generalization cannot decide whether a particular first or atypical episode is benign. Urgency is determined by the whole presentation. Severe anxiety can also coexist with suicidal thinking, substance withdrawal, domestic danger, or medical illness, so reassurance should follow rather than replace assessment.

Urgent and safeguarding considerations (author-developed safety summary; not a substitute for individual assessment)

- Seek urgent or emergency assessment for severe chest pain, collapse, marked breathing difficulty, a new focal neurological sign, delirium, catatonia, marked behavioral change, severe medical symptoms, a rapidly deteriorating mental state, or other features suggesting an acute medical condition.
- Review abrupt medication changes, intoxication, and withdrawal, especially alcohol, sedatives, and stimulants.
- Do not use unsupervised exposure to situations that are genuinely unsafe or medically contraindicated.
- Ask directly about suicidal thoughts, self-harm, violence, exploitation, inability to care for basic needs, severe intoxication or withdrawal, and safeguarding concerns when clinically indicated.
- This narrative review cannot determine an individual's diagnosis, fitness for work, medication plan, or level of care; those decisions require an appropriately qualified clinician with access to the person and relevant records.

XI. LIMITATIONS AND RESEARCH NEEDS

Terms such as proportionality and impairment require judgment and can be distorted by cultural assumptions, inaccessible services, or social adversity. Trials often exclude complex comorbidity, and symptom scales may not represent episodic panic or concealed avoidance. Neurobiological models explain components of alarm but cannot infer personal meaning from a scan or circuit label. This review does not compare every psychotherapy or medication and cannot replace a medical evaluation.

Panic research supports group-level models of bodily alarm, catastrophic prediction, avoidance, and treatment response, but it cannot decide what one episode means. Episodic symptoms and concealed safety behavior are easily missed by broad scales, while medical and social context can alter both presentation and access to care. The review therefore supports a testable formulation rather than a hidden-cause claim. Future studies should pair symptoms with life-space restriction, adverse effects, and outcomes chosen with patients.

XII. CONCLUSION

Normal stress crosses a clinically important line not at one intensity value, but when alarm becomes persistent, recurrent, inflexible, disproportionate to available information, or costly to functioning. Panic attacks should be described before they are classified. A sound assessment validates the event, checks medical and substance explanations, identifies anticipatory anxiety and avoidance, and tests the meaning assigned to bodily cues. Professional help is reasonable before a formal

disorder is certain, particularly when episodes recur, the safe zone is shrinking, or the person cannot recover. Treatment aims to expand informed choice, so that the patient can respond to real danger without organizing daily life around predictions that have not been adequately tested.

XIII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). CFT is discussed as a formulation perspective and not as a substitute for established diagnostic assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

XIV. REFERENCES

- Carpenter, J. K., Andrews, L. A., Witcraft, S. M., Powers, M. B., Smits, J. A. J., & Hofmann, S. G. (2018). Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depression and Anxiety*, 35(6), 502–514. doi:10.1002/da.22728
- Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24(4), 385–396. doi:10.2307/2136404
- Craske, M. G., Stein, M. B., Eley, T. C., Milad, M. R., Holmes, A., Rapee, R. M., & Wittchen, H. U. (2017). Anxiety disorders. *Nature Reviews Disease Primers*, 3(1), 17024. doi:10.1038/nrdp.2017.24
- Firth, J., Marx, W., Dash, S., Carney, R., Teasdale, S. B., Solmi, M., et al. (2019). The Effects of Dietary Improvement on Symptoms of Depression and Anxiety: A Meta-Analysis of Randomized Controlled Trials. *Psychosomatic Medicine*, 81(3), 265–280. doi:10.1097/PSY.0000000000000673
- Freeman, D., Sheaves, B., Goodwin, G. M., Yu, L. M., Nickless, A., Harrison, P. J., et al. (2017). The effects of improving sleep on mental health (OASIS): a randomised controlled trial with mediation analysis. *The Lancet Psychiatry*, 4(10), 749–758. doi:10.1016/S2215-0366(17)30328-0
- Gordon, B. R., McDowell, C. P., Hallgren, M., Meyer, J. D., Lyons, M., & Herring, M. P. (2018). Association of Efficacy of Resistance Exercise Training With Depressive Symptoms: Meta-analysis and Meta-regression Analysis of Randomized Clinical Trials. *JAMA Psychiatry*, 75(6), 566–576. doi:10.1001/jamapsychiatry.2018.0572
- Grupe, D. W., & Nitschke, J. B. (2013). Uncertainty and anticipation in anxiety: an integrated neurobiological and psychological perspective. *Nature Reviews Neuroscience*, 14(7), 488–501. doi:10.1038/nrn3524
- Haverkamp, C. J. (2012). A case of severe anxiety. *J Psychiatry Psychotherapy Communication*, 1(2), 35–40.
- Haverkamp, C. J. (2017a). Communication-Focused Therapy (CFT) for anxiety and panic attacks. *J Psychiatry Psychotherapy Communication*, 6(4), 91–95.
- Haverkamp, C. J. (2017b). Treatment-resistant anxiety. *J Psychiatry Psychotherapy Communication*, 6(3), 61–67.
- Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 78(2), 169–83. doi:10.1037/a0018555
- LeDoux, J. E., & Pine, D. S. (2016). Using Neuroscience to Help Understand Fear and Anxiety: A Two-System Framework. *The American Journal of Psychiatry*, 173(11), 1083–1093. doi:10.1176/appi.ajp.2016.16030353
- MacBeth, A., & Gumley, A. (2012). Exploring compassion: a meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review*, 32(6), 545–52. doi:10.1016/j.cpr.2012.06.003
- Malhi, G. S., & Mann, J. J. (2018). Depression. *The Lancet*, 392(10161), 2299–2312. doi:10.1016/S0140-6736(18)31948-2
- McEwen, B. S. (2007). Physiology and neurobiology of stress and adaptation: central role of the brain. *Physiological Reviews*, 87(3), 873–904. doi:10.1152/physrev.00041.2006
- National Institute for Health and Care Excellence. (2011). Generalised anxiety disorder and panic disorder in adults: Management (Clinical guideline CG113). <https://www.nice.org.uk/guidance/cg113>

Haverkamp, C. J. (2022). Anxiety and Panic: When Does Normal Stress Cross the Line into a Disorder? *J Psychiatry Psychotherapy Communication*, 2022 Mar 31;11(1):1-10

- Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2(2), 85–101. doi:10.1080/15298860309032
- Penninx, B. W. J. H., Pine, D. S., Holmes, E. A., & Reif, A. (2021). Anxiety disorders. *The Lancet*, 397(10277), 914–927. doi:10.1016/S0140-6736(21)00359-7
- Schuch, F. B., Vancampfort, D., Firth, J., Rosenbaum, S., Ward, P. B., Silva, E. S., et al. (2018). Physical Activity and Incident Depression: A Meta-Analysis of Prospective Cohort Studies. *The American Journal of Psychiatry*, 175(7), 631–648. doi:10.1176/appi.ajp.2018.17111194
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166(10), 1092–7. doi:10.1001/archinte.166.10.1092
- Trauer, J. M., Qian, M. Y., Doyle, J. S., Rajaratnam, S. M. W., & Cunnington, D. (2015). Cognitive Behavioral Therapy for Chronic Insomnia: A Systematic Review and Meta-analysis. *Annals of internal medicine*, 163(3), 191–204. doi:10.7326/M14-2841