

Panic Disorder

Panic attacks keep coming back, and the fear of the next one takes over your life.

THE STORY IN ONE SENTENCE

Panic attacks keep coming back, and the fear of the next one takes over your life.

“Panic Disorder is when your brain's alarm center fires for no real danger, over and over, and the dread of the next attack becomes its own prison.”

Normal anatomy — the body's job

In a healthy brain, the amygdala (the alarm center deep inside) watches for real threats, the prefrontal cortex (the front part that thinks things through) keeps the alarm from going off for small things, and GABA (the main calming signal) and serotonin (a messenger that steadies mood and keeps worry in check) keep the whole system balanced and smooth.

BODY'S JOB

The amygdala scans every moment for danger and decides whether to sound the alarm. The prefrontal cortex reads the situation, weighs whether the threat is real, and tells the amygdala to stand down if it is a false alarm. GABA acts like a gentle hand on the brake pedal, slowing down the alarm signals. Serotonin keeps mood steady and helps the prefrontal cortex do its job. Together, they let you feel appropriately alert without tipping into panic.

1. You hear a loud bang outside.
2. The amygdala (alarm center) picks up the sound and flags it as possible danger.
3. The prefrontal cortex (thinking brake) quickly checks: is this a gunshot or a car backfiring?
4. If it decides the threat is small, the prefrontal cortex sends calming signals down to the amygdala.
5. GABA (the brain's main calming chemical) floods the circuit, turning the alarm volume back down.
6. Serotonin keeps the mood steady so you do not spiral into worry.
7. You realize it was just a car, your heart slows, and you go back to what you were doing.

What breaks

The amygdala becomes hair-trigger sensitive and starts firing the alarm for no real danger—a crowded room, a flutter in your chest, even the memory of a past panic attack can set it off. At the same time, the prefrontal cortex (the part that should calm things down) gets worn out by chronic stress and loses its ability to pump the brakes. GABA (the calming signal) drops, and serotonin (the mood-and-worry steadier) runs low, so there is nothing left to turn the alarm off once it starts. The result: a full-blown panic attack triggered by nothing.

CLINICAL TERM

Panic Disorder involves amygdala hyperreactivity, prefrontal cortex hypofunction (reduced inhibitory control over the amygdala), and dysregulation of GABAergic (calming) and serotonergic (mood-stabilizing) neurotransmission. Chronic stress, prior trauma, and genetic vulnerability all lower the threshold for triggering the fear circuit, so benign internal sensations (palpitations, dizziness) or external cues (crowds, enclosed spaces) are misinterpreted as catastrophic threats, launching a sympathetic surge (adrenaline flood) that drives the cascade of panic symptoms.

How the body compensates

At first, your body and brain try to protect you by avoiding places or situations where panic happened before, and by staying on high alert to catch the next attack early. These workarounds feel like safety, but they actually make the disorder stronger and shrink your world.

1. {'label': 'Avoidance', 'mechanism': 'You start skipping places where you had a panic attack—buses, stores, meetings—hoping that staying away will keep you safe.', 'cost': 'Every time you avoid, your brain learns that those places truly are dangerous, so the fear grows and the list of off-limit places gets longer. This can become agoraphobia (fear of leaving home or being in situations where escape feels hard).'}
2. {'label': 'Hypervigilance (constant body scanning)', 'mechanism': 'You watch every heartbeat, every breath, every flutter in your chest, trying to catch a panic attack before it starts.', 'cost': 'The more you focus on your body, the more you notice normal sensations, and those sensations become new triggers. You end up creating the panic you were trying to prevent.'}

3. {'label': 'Safety behaviors', 'mechanism': 'You carry a phone, sit near exits, bring a trusted person, or use alcohol or benzodiazepines (medicines like Xanax or Ativan that calm panic fast) to feel safe.', 'cost': 'These behaviors teach your brain that you cannot handle panic on your own. If you rely on benzodiazepines too often, your body gets used to them (tolerance), you need higher doses, and stopping causes rebound anxiety or withdrawal. Alcohol dependence can grow the same way.'}
4. {'label': 'Misattribution of real medical problems', 'mechanism': 'Because panic attacks mimic heart attacks (chest pain, shortness of breath, sweating), emergency doctors may label real cardiac symptoms as 'just panic,' and true heart disease or arrhythmias can be missed.', 'cost': 'Delaying diagnosis of acute coronary syndrome, pulmonary embolism (a clot lodging in a lung artery), or arrhythmia can be life-threatening. Always rule out medical causes first, especially in patients with cardiac risk factors.'}

Domino effect

1. The amygdala (alarm center) becomes oversensitive—stress, trauma, or genes lower its threshold so that harmless things (a flutter in your chest, a memory of a past attack, a crowded room) are read as mortal danger. — The amygdala is wired to keep you alive by sounding the alarm fast. But chronic stress, childhood adversity, or a family history of anxiety can rewire it to fire too easily. Once it decides there is danger, it does not wait for the thinking part of your brain to agree—it acts instantly.
2. The prefrontal cortex (the front part that thinks things through and pumps the brakes) tries to calm the amygdala, but chronic stress and low serotonin wear it out, so it loses control. — The prefrontal cortex is supposed to check the amygdala's work and say 'false alarm, stand down.' But stress hormones like cortisol (the body's main stress hormone) damage prefrontal neurons over time, and low serotonin (the brain messenger that helps the prefrontal cortex do its job) weakens its grip on the reins. The amygdala takes over.
3. Once the amygdala sounds the alarm, it signals the brainstem and the adrenal glands (small glands on top of your kidneys) to flood the body with adrenaline (the emergency hormone that preps you to fight or run). — Adrenaline is the body's way of preparing for danger: it makes your heart race to pump blood to your muscles, speeds up your breathing to grab more oxygen, dumps sugar into your blood for quick energy, and triggers sweating to cool you down. All of this happens in seconds, and it feels terrifying when there is no real danger to fight or flee.

4. The panic attack peaks in about ten minutes—your heart pounds, your chest tightens, you cannot catch your breath, you sweat, the room spins, you feel detached from your body (derealization), and you are certain you are dying or losing your mind. — The adrenaline surge hits its highest level around ten minutes, then the liver and kidneys start breaking it down. As the adrenaline clears, the physical symptoms fade. But those ten minutes feel endless, and the terror of the experience burns into your memory.
5. After the attack, you are left shaken and terrified of the next one. You start watching your body for any sign of panic, and you avoid places or situations where an attack happened before. — The attack was so awful that your brain tags it as a major threat. Now the fear of having another panic attack becomes its own trigger. This is called anticipatory anxiety. The more you avoid, the more your brain believes those places are truly dangerous, and the list of feared situations grows.
6. Every panic attack strengthens the loop: a small body sensation (your heart skips a beat, you feel short of breath) triggers the memory of past panic, the amygdala fires, adrenaline floods, and a new panic attack begins—even though nothing dangerous is happening. — Your brain learns by repetition. Each panic attack teaches the amygdala that these body sensations are dangerous, so the threshold drops further. The cycle becomes self-sustaining: fear of panic → body sensations → more fear → full panic attack.
7. Over time, avoidance and hypervigilance shrink your world. You may stop going to work, riding buses, or leaving home. This is agoraphobia (fear of situations where escape feels hard or help might not be available). — The brain's job is to keep you safe, and if panic attacks keep happening in certain places, avoidance feels like the logical solution. But every time you avoid, you lose a piece of your freedom, and the disorder wins more territory.
8. Without treatment, Panic Disorder increases the risk of depression (because the constant fear and isolation wear you down), substance use (alcohol or benzodiazepines to numb the anxiety), and suicidal thoughts (because the suffering feels endless). — Living in constant fear is exhausting. The brain chemicals that are already low (serotonin, GABA) also regulate mood, so panic and depression often travel together. The shame and isolation make everything worse. Treatment—cognitive-behavioral therapy (CBT, which teaches you to face fear and rewrite the panic story) and medications (SSRIs like sertraline or escitalopram to raise serotonin, sometimes short-term benzodiazepines for severe panic)—can break the cycle and give you your life back.

Symptoms · what the patient feels, and why

- Sudden racing heart (palpitations): The amygdala (the brain's alarm center) fires a false danger signal, flooding the body with adrenaline (the emergency hormone), which makes the heart pound fast to pump more blood—even though there's no real threat.

- Chest pain or tightness: Adrenaline tightens the muscles around the ribs and chest wall, and fast breathing changes the carbon dioxide balance in the blood, creating a squeezing or aching feeling that can feel like a heart attack—but the heart itself is usually fine.
- Shortness of breath or feeling smothered: The body's breathing center in the brainstem reacts to the alarm signal by speeding up breaths (hyperventilation), making the person feel like they can't get enough air—even though oxygen levels are actually normal or even too high.
- Dizziness or feeling faint: Fast, shallow breathing blows off too much carbon dioxide, which narrows blood vessels in the brain slightly and shifts the blood's pH, causing lightheadedness—the person rarely actually faints, but the feeling is very real.
- Sweating or chills: Adrenaline activates the sweat glands to cool the body down (preparing for a physical fight or flight), and blood shifts away from the skin to the muscles, causing cold, clammy skin or sudden chills.
- Trembling or shaking: Adrenaline floods the muscles with energy and tenses them for quick action, but since there's no actual danger to run from or fight, the stored tension spills out as visible shaking or internal quivering.
- Feeling detached from yourself or reality (depersonalization or derealization): When the amygdala overwhelms the prefrontal cortex (the thinking and braking part of the brain), the brain can temporarily dampen sensory processing as a protective shutdown, making the world feel unreal or the person feel like they're watching themselves from outside.
- Fear of dying or losing control: The alarm signal hijacks rational thinking, so even though the person logically knows they're safe, the emotional brain screams that something catastrophic is happening right now—creating overwhelming terror that feels impossible to stop.
- Numbness or tingling (paresthesias), especially in hands or around the mouth: Hyperventilation drops carbon dioxide in the blood, which makes the blood slightly more alkaline (respiratory too little acid in the blood (alkalosis)), and this pH shift irritates nerve endings, causing pins-and-needles or numb sensations.
- Nausea or stomach upset: The fight-or-flight response shuts down digestion (the vagus nerve that calms the gut is overridden by adrenaline), so the stomach stops moving normally and can cramp or churn, causing queasiness.

Focused exam

- Heart rate 110–140 beats per minute during or right after a panic attack: Panic disorder switches on the body's alarm system fast, and the heart races as part of that alarm. But you **MUST** rule out a real heart problem first — chest pain plus a racing heart means you test the heart before you say it is panic. Never skip the heart workup.

- Normal electrocardiogram (ECG, the heart tracing), normal troponin (blood test for heart damage), and normal chest X-ray: When all the heart tests come back normal, panic disorder moves higher on the list. But never assume panic just because someone looks anxious or worried — real heart disease and panic can look alike at first.
- Patient says 'I thought I was dying' or 'I felt like I was losing my mind' DURING the attack, not before it started: In panic disorder, the body alarm fires first — heart pounds, breath gets short, chest tightens — and then the scary thought ('I'm dying') follows. If the scary thought comes first and then triggers the body response, that is generalized anxiety disorder instead. The order matters.
- Attack lasts 5 to 10 minutes, peaks fast (often under 3 minutes), then fades: Panic attacks are short bursts of intense alarm. The amygdala (the brain's danger alarm) fires hard and fast, then runs out of steam. If the anxiety builds slowly and lasts hours, that is a different brain circuit — not panic disorder.
- Patient avoids places where past attacks happened, such as the grocery store, the bus, or crowded rooms (called agoraphobia): Panic disorder can teach the hippocampus (the brain's map-maker) to mark certain places as dangerous. The person starts avoiding those places to prevent another attack, and life gets smaller. This is a sign the disorder is taking hold.
- Breathing is fast and shallow during the attack; blood carbon dioxide (CO₂) drops; patient feels dizzy, tingly, or unreal: The panic alarm makes you hyperventilate (breathe too fast), which blows off too much CO₂. Low CO₂ tightens blood vessels in the brain and makes you feel dizzy, unreal, or like your hands are tingling. This is not a lung or heart problem — it is the nervous system misfiring.
- Normal mental status between attacks — thinking is clear, no hallucinations, no severe sadness unless panic has gone on for months untreated: Panic disorder does not break your thinking or make you see or hear things that are not there. Between attacks, you feel okay. If the person is hearing voices, deeply depressed, or confused between attacks, look for a second condition on top of panic.

Diagnostics · every test answers a question

- Electrocardiogram (ECG or EKG, a tracing of the heart's electrical activity) → Is the heart rhythm normal, or is there a dangerous arrhythmia (irregular beat) or sign of blocked heart arteries causing the chest pain and racing heart?
- Troponin I or T (blood test that rises when heart muscle is damaged) → Is the heart muscle being damaged right now, like in a heart attack?
- Thyroid-stimulating hormone (TSH, a blood test that checks thyroid function) → Is the thyroid gland overactive and driving the racing heart, sweating, and anxiety?

- Complete blood count (CBC, counts red cells, white cells, and platelets) → Is the person anemic (low red blood cells), which can make the heart race to deliver enough oxygen?
- Basic metabolic panel (BMP, checks sodium, potassium, glucose, kidney function) → Are electrolytes or blood sugar out of balance, which can cause confusion, weakness, or a racing heart?
- Urine drug screen (tests for stimulants like cocaine, amphetamines, or other drugs) → Is the person using a stimulant drug that is causing the racing heart and panic-like symptoms?
- Chest X-ray (imaging of the lungs and heart) → Is there a lung problem (pneumothorax, pneumonia, or fluid) or heart enlargement causing shortness of breath and chest discomfort?

Treatment logic

- Selective serotonin reuptake inhibitor (SSRI) such as sertraline (Zoloft) 25 mg daily or paroxetine (Paxil) 10 mg daily, started low and increased slowly over 4 to 6 weeks to a target dose (sertraline 50–200 mg, paroxetine 20–60 mg) → SSRIs raise serotonin (a brain messenger that steadies mood, calms fear, and helps the prefrontal cortex — the thinking part of the brain — control the amygdala, the alarm center). Over weeks, this resets the alarm system so fewer triggers set off a panic attack. The amygdala stops firing so easily.
- Cognitive behavioral therapy (CBT) with interoceptive exposure: learning to trigger panic sensations on purpose (spinning to get dizzy, breathing through a straw to feel short of breath, running in place to make your heart race) in a safe setting, then sitting with those feelings without fear → Teaches the amygdala (alarm center) and hippocampus (memory and map center) that these body feelings are not dangerous and will not kill you. Each time you survive the feeling without disaster, the fear link weakens. Over 12 to 16 sessions, your brain learns: racing heart does not mean death.
- Short-term benzodiazepine (lorazepam 0.5–1 mg as needed, or clonazepam 0.25–0.5 mg as needed) for acute panic attacks only, used for 2 to 4 weeks while the SSRI is building up → Instantly calms the nervous system by boosting GABA (the brain's main calming messenger, like a brake pedal). Within 20 to 30 minutes, the panic spiral stops, the heart slows, and you can think clearly again. Helps you sleep and function while waiting for the SSRI to work.
- Remove or cut down caffeine (coffee, energy drinks, soda, pre-workout supplements) and fix sleep (7 to 9 hours per night, same bedtime and wake time every day, dark quiet room) → Caffeine blocks adenosine (a calming brain signal) and raises norepinephrine and cortisol (stress chemicals), which makes the amygdala more jumpy. Removing caffeine stops pouring fuel on an already-sensitive alarm system. Sleep lets the prefrontal cortex (the thinking brake) and hippocampus (memory) repair and strengthen the circuits that control fear.

- One complete medical workup (ECG, troponin, TSH, chest X-ray if symptoms suggest heart or lung disease), then clear reassurance from the doctor: 'Your heart is healthy. This is panic, not a heart attack.' → Removes doubt and fear that fuel the panic spiral. When your prefrontal cortex (thinking brain) knows the heart is safe, it can start to override the amygdala's false alarms. Each time you get reassurance, the link between 'racing heart' and 'I'm dying' weakens.
- Psychosocial support: stable housing, workplace or school accommodations (flexible schedule, quiet space during attacks), social connection (family, friends, support groups), and addressing trauma, job stress, or major life stressors → A safe, predictable life calms the hypothalamus (the brain's stress control center) and lowers cortisol (the main stress hormone). This gives the amygdala less fuel to misfire. Social connection activates oxytocin (a bonding and calming hormone) and helps the prefrontal cortex stay strong.

Medications

Sertraline (Zoloft), Paroxetine (Paxil), Fluoxetine (Prozac), Escitalopram (Lexapro) · SSRI — Selective Serotonin Reuptake Inhibitor

SSRIs turn up serotonin (a brain messenger that steadies mood and calms the alarm system) by stopping brain cells from quickly soaking it back up. With more serotonin around, the amygdala (the brain's alarm center) slowly learns to ring less often and less loudly, so panic attacks happen less and feel less scary over time.

1. Serotonin is released from one nerve cell into the synapse (the gap between cells).
2. Normally, a pump on the sending cell quickly sucks most of the serotonin back in, so the signal fades fast.
3. The SSRI blocks that pump, so serotonin stays in the gap longer and keeps sending its calming message.
4. Over 2 to 4 weeks, the extra serotonin teaches the amygdala to fire less wildly, and the prefrontal cortex gets better at calming false alarms.
5. Panic attacks become less frequent, less intense, and shorter; fear of another attack (anticipatory anxiety) also drops.

SAFETY WATCH

Nausea, loose stools, headache, or feeling jittery in the first 1 to 2 weeks (usually fades as your body adjusts). · Sexual side effects — lower desire, delayed climax, or trouble reaching orgasm — in about 30 to 40 out of 100 people. · Small rise in suicidal thoughts in the first few weeks in people under 25; watch mood closely and call your doctor if dark thoughts spike. · Do NOT stop suddenly — taper slowly under your doctor's plan to avoid dizziness, electric-shock feelings (brain zaps), or rebound anxiety. · Avoid mixing with other serotonin drugs (some migraine meds, St. John's wort, certain pain meds) because too much serotonin can cause confusion, high fever, and dangerous muscle stiffness (serotonin syndrome).

Venlafaxine (Effexor XR), Duloxetine (Cymbalta) · SNRI — Serotonin-Norepinephrine Reuptake Inhibitor

SNRIs block the pumps that suck both serotonin (a mood-steadying messenger) and norepinephrine (a focus and alertness messenger) back into nerve cells. Leaving both chemicals in the synapse longer calms the alarm system and helps the brain judge threats more clearly, so panic attacks happen less often and anticipatory anxiety drops.

1. Serotonin and norepinephrine are released into the synapse.
2. Normally, reuptake pumps on the sending cell quickly pull both messengers back in, ending the signal.
3. The SNRI blocks both pumps, so serotonin and norepinephrine stay in the gap longer.
4. Over 2 to 6 weeks, the extra messengers teach the amygdala to fire less often and help the prefrontal cortex recognize that racing heart or dizzy spells are not life-threatening.
5. Panic attacks become less frequent and less intense; worry about the next attack also fades.

SAFETY WATCH

Nausea, dry mouth, sweating, or feeling jittery in the first 1 to 2 weeks. · Rise in blood pressure at higher doses — check BP every few months. · Sexual side effects similar to SSRIs. · Increased suicidal thoughts possible in people under 25 in the first few weeks — monitor closely. · Do NOT stop cold turkey — taper slowly to avoid dizziness, brain zaps, nausea, and rebound anxiety. · Avoid mixing with other serotonin drugs to prevent serotonin syndrome.

Clonazepam (Klonopin), Lorazepam (Ativan), Alprazolam (Xanax) · Benzodiazepine

Benzodiazepines boost GABA (the brain's main calming signal) by making GABA receptors on nerve cells more sensitive. This slows down overactive fear circuits quickly, cutting a panic

attack short and easing intense anticipatory anxiety within 30 to 60 minutes. Because the brain adapts fast and dependence builds in weeks, these are used **ONLY** short-term (2 to 4 weeks) as a bridge while an SSRI or SNRI builds up, then tapered off.

1. GABA (the brain's calm-down messenger) is released and binds to GABA-A receptors on nerve cells.
2. The benzodiazepine locks onto a spot next to GABA on the same receptor and makes GABA's calming signal much stronger.
3. Nerve cells quiet down, slowing the fear loop in the amygdala and thalamus.
4. Within 30 to 60 minutes, the racing heart, shaking, and terror of a panic attack fade.
5. Because the calm is artificial and tolerance (needing more for the same effect) builds fast, the drug is tapered off as the SSRI or SNRI takes over.

SAFETY WATCH

Drowsiness, slowed thinking, clumsiness — do NOT drive or operate machinery. · Risk of physical dependence (your brain needs the drug to feel normal) within 2 to 4 weeks of daily use. · Withdrawal if stopped suddenly — rebound anxiety, shaking, sweating, confusion, and in severe cases seizures. · Memory problems — trouble forming new memories while the drug is active. · Breathing slows down — dangerous if combined with alcohol, opioids, or sleep meds; can cause overdose and death. · NEVER stop on your own — taper very slowly under close medical supervision. · Not safe in pregnancy — can cause birth defects and withdrawal in the newborn.

Pregabalin (Lyrica) · Anticonvulsant (used off-label for anxiety)

Pregabalin calms overexcited nerve cells by blocking calcium channels (the gates that let calcium rush in and trigger a nerve to fire). Slowing down these gates in fear circuits reduces the flood of alarm signals, so panic attacks happen less often and background anxiety drops. It is an alternative when SSRIs or SNRIs do not work or cause bad side effects.

1. Calcium normally rushes into nerve cells through voltage-gated channels when the cell fires.
2. That calcium surge triggers the release of excitatory messengers (like glutamate) that keep the alarm loop spinning.
3. Pregabalin binds to a subunit of the calcium channel and blocks some of the calcium from entering.
4. With less calcium, nerve cells release fewer excitatory messengers, so the fear circuit quiets down.
5. Over 1 to 2 weeks, panic attacks become less frequent and anticipatory anxiety eases.

SAFETY WATCH

Dizziness, drowsiness, trouble with balance — avoid driving until you know how it affects you. · Weight gain (about 5 to 10 pounds on average) from increased appetite. · Swelling in hands, feet, or legs (peripheral swelling (edema)). · Can cause dependence if used long-term at high doses; taper slowly when stopping. · Rarely, worsening depression or suicidal thoughts — watch mood closely. · Not safe in pregnancy unless benefit clearly outweighs risk — can harm the developing baby.

Buspirone (BuSpar) · Azapirone anxiolytic

Buspirone gently tweaks serotonin signaling by acting as a partial agonist at 5-HT_{1A} receptors (a type of serotonin docking site). This steadies the brain's mood and anxiety circuits without the sedation or dependence risk of benzodiazepines. It is an alternative when SSRIs or SNRIs are not tolerated, though it works better for general worry than for stopping full-blown panic attacks.

1. Buspirone binds to 5-HT_{1A} receptors and acts as a partial agonist — it turns the receptor on partway, not fully.
2. In areas where serotonin activity is too high, buspirone calms it down; where it is too low, buspirone nudges it up.
3. Over 2 to 4 weeks, this balancing act steadies background anxiety and reduces anticipatory worry.
4. Unlike benzodiazepines, buspirone does not cause sedation or quick tolerance.

SAFETY WATCH

Dizziness, headache, nausea, or nervousness in the first week (usually mild and fades). · Takes 2 to 4 weeks to feel benefit — you must take it every day, not as needed. · Generally very safe with low risk of serious side effects. · Can be used long-term without dependence risk. · Safe to stop without tapering, though your doctor may still reduce the dose slowly for comfort.

Red flags

- Chest pain with new shortness of breath, arm pain, jaw pain, or sweating (could be a real heart attack, not panic—get emergency help)
- Attack happens only during physical effort or always in the same specific situation (may point to a heart or lung problem, not pure panic)
- New confusion, slurred speech, one-sided weakness, or severe headache during an attack (could be stroke or another brain emergency)

- Symptoms that don't peak within 10 minutes or last many hours without relief (classic panic attacks surge fast and fade within 20–30 minutes; longer episodes suggest another cause)
- First panic-like episode ever in someone over age 45 with heart disease risk factors (higher chance it's cardiac, not psychiatric)

Nursing priorities

1. Rule out acute cardiac or respiratory emergency by checking vital signs, oxygen saturation, and 12-lead electrocardiogram (ECG, a heart tracing) if the patient has chest pain, shortness of breath, or arm or jaw pain. — Panic attacks mimic heart attacks perfectly; missing acute coronary syndrome (blocked heart artery) or pulmonary embolism (a clot lodging in a lung artery) (blood clot in the lung) can be fatal, so safety screening comes first.
2. Stay with the patient and speak in a calm, steady voice; remind them that the attack will pass and they are not dying or going crazy. — During a panic attack, the amygdala (the brain's fear center) floods the body with adrenaline (a stress hormone), making the patient feel they are in mortal danger; reassurance helps the prefrontal cortex (thinking brain) regain control and lowers adrenaline release.
3. Coach slow diaphragmatic breathing by placing one hand on the patient's belly and asking them to breathe in through the nose for four counts and out through the mouth for six counts. — Panic causes hyperventilation (breathing too fast), which lowers carbon dioxide in the blood and triggers dizziness and tingling; slow belly breathing restores normal carbon dioxide and calms the sympathetic nervous system (fight-or-flight response).
4. Ask the patient to name five things they see, four things they can touch, three things they hear, two things they smell, and one thing they taste. — This grounding technique (5-4-3-2-1 method) shifts attention away from internal panic sensations to the external environment, interrupting the fear loop in the amygdala and reducing symptom intensity.
5. Document the time the attack started, peak symptoms, duration, and any triggers the patient identifies, then share this log with the provider. — Tracking attack patterns helps the provider confirm the diagnosis of panic disorder (recurrent unexpected attacks), spot triggers, and measure treatment response when medication or therapy begins.
6. Screen for suicidal thoughts by asking directly, 'Have you thought about hurting yourself or wished you were dead because of these attacks?' — Panic disorder doubles the risk of suicide attempts because repeated attacks cause severe distress and hopelessness; early detection allows psychiatric referral and safety planning before a crisis.
7. Teach the patient that panic attacks cannot cause heart attacks, stop the heart, or make them lose control or go insane. — Catastrophic misinterpretation (believing panic sensations mean something terrible is happening) fuels the fear-adrenaline cycle; accurate education breaks this cycle and reduces future attack frequency.

8. Refer to a therapist trained in cognitive behavioral therapy (CBT) with interoceptive exposure before the patient leaves, and give printed information about local CBT providers or teletherapy options. — CBT with interoceptive exposure (deliberately triggering panic sensations in a safe setting) retrains the brain to stop fearing the body's normal stress response; combining CBT with medication produces better long-term results than medication alone.

Sources

- DSM-5-TR (American Psychiatric Association, 2022)
- APA Practice Guideline for the Treatment of Patients with Panic Disorder, 2nd Edition
- Cochrane review: Psychotherapy for panic disorder with or without agoraphobia
- UpToDate: Panic disorder in adults—Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis

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