

Panic Disorder

A plain-English guide for you and your family

WHAT IS HAPPENING

In a healthy brain, the amygdala (your alarm center deep inside) watches for danger while the prefrontal cortex (the front part that thinks things through and pumps the brakes) keeps the alarm from going off too easily. GABA (the brain's main calming signal) and serotonin (a messenger that steadies mood and keeps worry in check) work together to keep this balance smooth. In Panic Disorder, that balance tips: the amygdala becomes oversensitive and fires as if a lion is charging even when you are sitting in a quiet room, and the prefrontal cortex loses its grip on the reins. The result is a panic attack—your heart races, your chest tightens, you cannot catch your breath, you sweat, the room spins, and you feel certain you are dying or losing your mind. The attack peaks in about ten minutes, then fades, leaving you shaken. But the disorder is more than the attacks themselves: it is the constant worry about when the next one will strike, the avoiding of places or situations where an attack might happen, and the creeping sense that your own body has turned traitor. Over time, this fear can shrink your world—you may stop going to work, riding buses, or even leaving home. The biology is real (low serotonin and GABA, an overactive amygdala, a weakened prefrontal brake), but stress, trauma, and loneliness turn the volume way up, while therapy, medication, support, and gradual facing of feared places turn it back down. Treat the brain and the life around it, or the loop just spins.

What you might feel

- Sudden racing heart (palpitations)
- Chest pain or tightness
- Shortness of breath or feeling smothered
- Dizziness or feeling faint
- Sweating or chills
- Trembling or shaking
- Feeling detached from yourself or reality (depersonalization or derealization)
- Fear of dying or losing control
- Numbness or tingling (paresthesias), especially in hands or around the mouth

- Nausea or stomach upset

Call the doctor right away if...

- 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)

What the care team will do

- 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.
- 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.
- 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.
- 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.
- Document the time the attack started, peak symptoms, duration, and any triggers the patient identifies, then share this log with the provider.
- Screen for suicidal thoughts by asking directly, 'Have you thought about hurting yourself or wished you were dead because of these attacks?'
- Teach the patient that panic attacks cannot cause heart attacks, stop the heart, or make them lose control or go insane.
- 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.

Medicines you may be given — and why

Sertraline (Zoloft), Paroxetine (Paxil), Fluoxetine (Prozac), Escitalopram (Lexapro)

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.

Venlafaxine (Effexor XR), Duloxetine (Cymbalta)

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.

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

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.

Pregabalin (Lyrica)

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.

Buspirone (BuSpar)

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.

Where this information comes from

- 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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