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BMHP6029

Psychopathological Classifications and Provisions Component

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Acknowledgement of the use of AI tools

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ANXIETY PANIC DISORDER 6B01

INTRODUCTION

Panic disorder affects millions of people worldwide and can be profoundly disabling, yet it is highly treatable when recognised early.

Panic disorder, a subset of anxiety disorders affecting 4.4% of people globally (WHO, 2025), occurs in 1–1.7% of UK adults (NHS England Digital, 2025). It involves recurrent, unexpected panic attacks with sudden physical symptoms such as palpitations and breathlessness, alongside persistent fear of recurrence (WHO, 2025), often severely impairing daily functioning and quality of life.

CAUSES

Biological Factors

- Tends to run in families; risk rises with an affected close relative (Johns Hopkins Medicine, 2021; NHS, 2023)
- Linked to neurotransmitter imbalances affecting mood and stress (NHS, 2023)
- May reflect an overactive fight-or-flight response, triggering false alarms (Johns Hopkins Medicine, 2021)
- Often co-occurs with generalised anxiety disorder and agoraphobia (Pizzolla et al., 2026)

Environmental and Life Stressors

- Severe adverse experiences—bereavement, accidents, childhood abuse or early trauma—raise risk (NHS, 2023; Kim et al., 2026)
- Caffeine, poor sleep and substance use can worsen stress symptoms (NHS Inform, 2024)

SYMPTOMS

- **Panic attacks** bring on a racing heart, breathlessness or a choking sensation, fear of dying or losing control, dizziness or faintness, and numb fingers (NHS, 2023).
- **Panic disorder** itself has three core features: sudden attacks that start and peak rapidly with no clear trigger; ongoing worry about future attacks or what they mean for one's health; and avoidance, where daily routines or places are changed to try to prevent attacks (Mental Health UK, n.d.).

DIAGNOSIS

DIAGNOSTIC CRITERIA

Unexpected Attacks

(Cackovic, Nazir and Marwaha, 2023).

Persistent Worry

(AAFP, 2022).

Behavioural Changes

(AAFP, 2022).

CLINICAL EVALUATION

Medical Exclusion

(Cackovic et al, 2023).

Structured Assessment

(AAFP, 2022).

Comorbidity and Differential

Diagnosis (Melaragno, 2021).

HISTORICAL PERSPECTIVES AND TREATMENTS

Ancient Greece

Humoral imbalance

diet, lifestyle, philosophy (Stoic/Epicurean)
(Sideris et al., 2026)

Middle Ages

Moral/theological distress

spiritual discipline, herbal remedies
(Sideris et al., 2026)

19th Century

Neurasthenia, hysteria

rest, environmental change
(Sideris et al., 2026)

Early 20th Century

Freud: unconscious conflict

psychoanalysis

(Sideris et al., 2026)

1980 (DSM-III)

Panic disorder recognised

benzodiazepines, TCAs

(Cackovic, Nazir and Marwaha, 2023; Sideris et al., 2026)

Present

Evidence-based diagnosis

SSRIs/SNRIs + CBT

(DeGeorge, Grover and Streeter, 2022)



CONTEMPORARY CARE

Assessment

- ICD-11 diagnostic criteria
- Risk assessment
- Differential diagnosis



Treatment

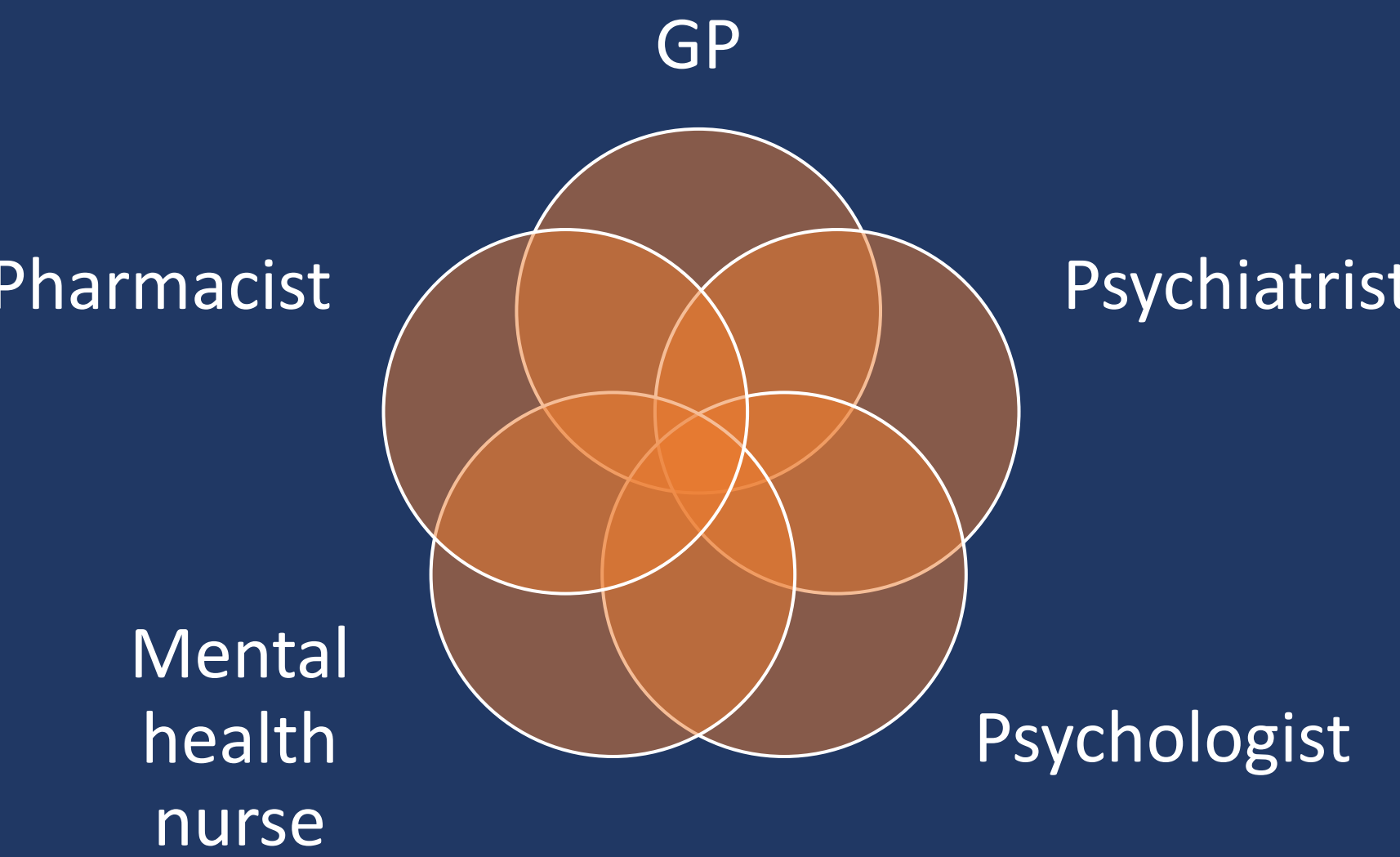
➤ Psychological

- CBT (first-line)
- Exposure therapy
- Psychoeducation
- Mindfulness

• Medication

- SSRIs
- SNRIs
- Short-term benzodiazepines

Multidisciplinary Care:



Recovery

Early intervention

Relapse prevention

Self-management

Family support

CRITICAL EVALUATION

STRENGTHS

- ✓ **Effective CBT** — first-line treatment, non-inferior across in-person, remote, and digital formats (*Papola et al., 2023*)
- ✓ **NICE evidence-based guidance** — stepped-care model matching treatment intensity to severity (*NICE, 2020*)
- ✓ **Improved diagnosis** — validated tools like the GAD-7 support earlier, more consistent identification (*DeGeorge, Grover and Streeter, 2022*)
- ✓ **Community treatment** — care shifted from institutional settings to primary care and outpatient pathways (*NICE, 2020*)

CHALLENGES

- | | |
|-------------------------|---------------------|
| Waiting lists | Health inequalities |
| Limited access to CBT | Stigma |
| Medication side effects | |

RECOMMENDATIONS

Future Directions

Digital CBT — comparable efficacy to face-to-face delivery, expanding capacity beyond therapist availability (*Papola et al., 2023*)

Telehealth — reduces geographic and time barriers, particularly for underserved populations (*Papola et al., 2023*)

Personalised care — treatment matched to individual response and comorbidity profile (*DeGeorge, Grover and Streeter, 2022*)

Trauma-informed practice — care that accounts for underlying trauma history to reduce re-traumatisation and improve engagement

CONCLUSION

Modern management of panic disorder has moved from institutional care to person-centred, evidence-based practice. Despite highly effective treatments, inequalities in access and long waiting times remain significant barriers to recovery.

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