

Peritraumatic panic attacks and health outcomes two years after psychological trauma: Implications for intervention and research

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Abstract

Several studies have suggested that experiencing a peritraumatic panic attack (PPA) during a traumatic event predicts future mental health status. Some investigators have suggested that this finding has psychotherapeutic significance. We assessed the hypothesis that PPA was *not* related to longer-term health status after event exposure, once background confounders were controlled. In our study we assessed exposure to the World Trade Center disaster (WTCD) and other negative life events, demographic factors, social support, self-esteem, and panic attack onset in predicting health outcome among 1681 New York City residents 2 years after the attack. Initial bivariate results indicated that a PPA was related to a number of adverse outcomes 2 years after the WTCD, including posttraumatic stress disorder, depression, poor physical health, anxiety, binge drinking, and mental health treatment seeking. However, when multivariate (MV) models were estimated adjusting for potential confounders, most of these associations were either non-significant or substantially reduced. Contrary to previous predictions, these MV models revealed that recent negative life events and current self-esteem at follow-up were the best predictors of health outcomes, not PPA. Although post-trauma interventions may target individuals who experienced PPA after traumatic exposures, reducing the long-term health consequences following such exposures based on PPA alone may be problematic. Modifications of psychopathology constructs based on the reported correlation between PPA and post-trauma outcomes may be premature.

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1. Introduction

Research has suggested that having a history of panic attacks is a good indicator of having other psychiatric disorders, including posttraumatic stress disorder (PTSD), depression, attention deficit, substance abuse, as well as other mental health disorders (Reed and Wittchen, 1998; Goodwin and Hamilton, 2002; Goodwin et al., 2004; Baillie and Rapee, 2005; Goodwin

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et al., 2005). Current research suggests that as many as 24% of adults have had a panic attack in their lifetimes (Kessler et al., 2006). Reported risk factors for this condition include race/ethnicity, gender, socioeconomic status, history of childhood abuse, as well as genetic factors (Goodwin and Hamilton, 2002; Kessler et al., 2006; Safren et al., 2002). Recently it has been suggested that “peritraumatic” panic attacks (PPAs), that is, those occurring in close temporal proximity to traumatic exposures (Boscarino et al., 2002; Ahern et al., 2004), have prognostic and clinical value related to future mental health status (Bryant and Panasetis, 2001; Lawyer et al., 2006; Person et al., 2006; Pfefferbaum et al., 2006). If so, then this finding may have significant therapeutic and public health implications. For example, it has been reported that brief work-site mental health interventions after the World Trade Center disaster (WTC/D) were highly effective for workers up to 2 years after the attack (Boscarino et al., 2006a). If this can be confirmed in other studies, then it might be important to focus interventions among those who experienced PPAs following mass-casualty events, where treatment resources could be limited (Foa et al., 2005; Boscarino et al., 2006d).

A significant limitation of past PPA research, however, was that investigators have either assessed post-event outcomes on a short-term basis (e.g., a year or less) (Boscarino et al., 2002) or only evaluated one or two health outcomes of interest (Pfefferbaum et al., 2006). In addition, many previous studies have not controlled for key pre-exposure and post-exposure variables that could have affected mental health status (Fikretoglu et al., 2007). Consequently, the PPA findings reported to date may be limited. If this were correct, PPA may be a poor measure for future health outcomes and of limited clinical value post-exposure. This is important because there has been speculation about the psychotherapeutic implications of this reported association (Lawyer et al., 2006; Pfefferbaum et al., 2006).

To better assess the prognostic value of PPA, we examined a battery of mental health outcomes possibly correlated with PPAs, including PTSD, depression, anxiety, functional health status, alcohol use, and mental health service utilization among New York City (NYC) adults 2 years after the WTC/D. Past research has suggested that exposure to community-wide disasters was often associated with the onset of panic attacks, as well as depression, PTSD and other adverse mental health outcomes (Adams et al., 2002; Galea et al., 2002; Boscarino et al., 2004a,b). However, as suggested, the value of PPA in predicting such outcomes over the long term, independent of other common risk factors, is unknown.

The WTC/D represented one of the most destructive community disasters in US history (Galea et al., 2002; Boscarino et al., 2004a). Since past research suggested that the WTC/D had the elements that could result in long-term health problems, including major loss of life, extensive property damage, ongoing financial problems, and a disaster caused by human intent (Rubonis and Bickman, 1991; Norris et al., 2002), one would expect persistent adverse health outcomes following this event. Earlier studies following the Oklahoma City bombing suggested that persons directly exposed to the blast were more likely to report PTSD symptoms 6 months post-disaster (North et al., 1999). Similarly, studies following the WTC/D reported that 7.5% of adults living near the WTC on September 11th met criteria for PTSD and 9.7% met criteria of major depression (Galea et al., 2002). Other studies reported similar results (Boscarino et al., 2004a; Boscarino et al., 2004b).

In the current study, as discussed below, we used a general hierarchical model that examined the significance of PPA in predicting longer-term health outcomes after the WTC/D that was used in previous studies (Adams and Boscarino, 2005b; Boscarino et al., 2006c). Another study suggested that while the WTC/D had a major impact on mental health status among NYC workers 1 year after this event, 2 years after the attack these effects had dissipated (Boscarino et al., 2006c). Consequently, and inconsistent with previous reports (Bryant and Panasetis, 2001; Lawyer et al., 2006; Person et al., 2006; Pfefferbaum et al., 2006), we hypothesized that experiencing a PPA during or shortly after the WTC/D would *not* be predictive of longer-term health outcomes, once pre-disaster mental health status and other risk factors were controlled. In this way, we sought to evaluate the longer-term health outcomes associated with PPA, unconfounded by potential pre- and post-morbid disaster factors. If our hypothesis was correct, we note that this would not necessarily diminish the prognostic value of PPA, per se, but rather refocus the clinical implications of this correlation. For example, it would suggest that speculation related to intrapsychic and clinical implications of such an association, such as focusing interventions on perceived fears or psychosomatic symptoms (Bryant and Panasetis, 2001; Nixon and Bryant, 2003), might be premature at this time.

2. Data and methods

2.1. Study participants

The data for our present study come from a prospective cohort study of adults who were living in NYC

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