



A comparison of the nature and correlates of panic attacks in the context of Panic Disorder and Social Anxiety Disorder



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ABSTRACT

Panic attacks occurring outside of Panic Disorder are not well-understood despite their inclusion as a diagnostic specifier in the Diagnostic and Statistical Manual for Mental Disorders (DSM-5). This study compares panic attacks in the context of Panic Disorder compared to social anxiety in terms of their symptom frequency, severity, and clinical correlates. Method: Participants ($n=404$) were interviewed using the Anxiety Disorders Interview Schedule (ADIS-IV-L; Brown et al., 1994), from which we analyzed interviewer ratings of panic attacks and panic attack symptoms, as well as other demographic and clinical characteristics. Results: Panic attacks in the context of Panic Disorder were characterized by a greater number and severity of symptoms compared to panic attacks in the context of Social Anxiety Disorder, and were associated with a history of traumatization, inpatient psychiatric treatment, and benzodiazepine use. Social anxiety panic attacks were associated with reduced physical health concerns. Cognitive panic attack symptoms were more prevalent in Panic Disorder and were associated with a variety of poor clinical correlates. Conclusions: Panic attacks in the context of Panic Disorder are more severe than those in social anxiety, and this may be driven by cognitive disturbances during those attacks.

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1. Introduction: the nature and correlates of panic attacks occurring in the context of Panic Disorder and Social Anxiety Disorder

According to DSM-5 diagnostic criteria (American Psychiatric Association, 2013; APA), panic attacks are episodes of intense fear or terror with rapid onset of at least four physiological (e.g., heart racing, difficulty breathing, nausea) or cognitive (e.g., fear of going crazy, fear of dying, fear of losing control) symptoms. Although panic attacks are most commonly associated with Panic Disorder, they are a ubiquitous phenomenon (Barlow, 1988) and occur across an array of disorders including other anxiety disorders, as well as mood, substance use, psychotic spectrum, and personality disorders. For a number of disorders, the presence of panic attacks indicates increased symptom severity, higher rates of comorbidity and suicidality, and poorer treatment response (American Psychiatric Association, 2013). For this reason, panic attacks are recognized as a diagnostic specifier in DSM-5 (e.g., Social Anxiety Disorder, Panic Attack Specifier, or Major Depressive Disorder,

Panic Attack Specifier) when a comorbid Panic Disorder diagnosis is not warranted.

Despite the wealth of literature that the presence of panic attacks in DSM-5 disorders outside of PD are clinically informative, little is known about the extent to which they resemble or differ from those that characterize PD, as the vast majority of research on panic attacks has been conducted with PD patients. The current study aims to compare the nature and correlates of panic attacks that occur within the context of PD with those within the context of Social Anxiety Disorder (SAD), a prevalent anxiety disorder that can occur with or without the presence of panic attacks.

One key difference between panic attacks occurring within the context of PD and those occurring within SAD is whether they are unexpected or expected in nature (Barlow et al., 1994; Craske et al., 2010; Rachman et al., 1987). Unexpected panic attacks, or attacks for which there is no obvious trigger or cue, are an essential element of PD. Such attacks are characterized by perceived lack of prediction and control, which is theorized to contribute to the high levels of overall anxious apprehension found in PD (Barlow, 1988; Craske, 1991; Craske et al., 1995). Expected panic attacks, for which there is an obvious trigger or cue, include the panic attacks that reliably occur in response to phobic stimuli (e.g., public speaking for the person with SAD).

The limited data that does exist regarding the symptom

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characteristics of expected and unexpected panic attacks is mixed. Across the anxiety disorders, one study reported that unexpected attacks in the context of PD were associated with higher symptom frequency, but few intensity differences, compared to expected attacks in other anxiety disorders (Barlow et al., 1985). Compared to SAD panic attacks in particular, PD panic attacks were characterized by more severe dizziness, fears of losing control, fears of going crazy, and dysregulated breathing (Barlow et al., 1985; Rapee et al., 1992). However, when comparing unexpected to expected attacks across all anxiety disorders, no symptom severity differences were found after accounting for symptom frequency (Barlow et al., 1985). Expected attacks in SAD are associated with increased severity of the disorder even after controlling for the presence of PD (Jack et al., 1999), but this study did not have a PD alone comparison group. Should further investigation reveal reliable differences between expected panic attacks within SAD and unexpected panic attacks within PD, then the diagnostic specification of panic attack may be improved by distinguishing between them.

Research on the clinical correlates of panic attacks is widespread, although the majority of studies do not distinguish between expected and unexpected panic attacks. Such research has found that the presence of panic attacks in general confer risk for the later development of an anxiety disorder as well as an array of other psychological disorders (Batelaan et al., 2012; Goodwin et al., 2004a; Goodwin and Gotlib, 2004b; Goodwin et al., 2004c; Wilson and Hayward, 2005) and are associated with greater severity of these disorders (Goodwin et al., 2004c). In addition, a large body of research has found a link between panic attacks and poor outcomes across a variety of psychological health and quality of life variables such as suicidality (even after controlling for depression and borderline personality disorder), physical health, use of medications, and inpatient treatment (Batelaan et al., 2012; Brown et al., 2010; Klerman et al., 1991). In addition to exploring differences in the nature of panic attacks, this study aims to investigate whether the clinical correlates of panic attacks occurring in PD differ from those occurring in SAD. Should clinical correlates between the two types of panic attacks differ, this would provide further justification for a diagnostic specification that distinguishes between expected and unexpected panic attacks.

The current study compared unexpected panic attacks in the context of PD and expected panic attacks in the context of SAD to provide a better understanding of panic attacks occurring outside of the context of Panic Disorder. First, similarities and differences in symptom presentation and intensity were explored. We hypothesized that unexpected attacks would be characterized by greater frequency of individual panic attack symptoms and more intense cognitive dysregulation than expected attacks based on the prior literature (Barlow et al., 1985; Rapee et al., 1992). Second, panic symptom frequency or severity was predicted by type of panic attack (i.e., unexpected panic attack in PD vs expected panic attack in SAD). We hypothesized that severity and frequency of panic attack symptoms would be differentially predicted by panic attack type, with greater frequency and severity of symptoms in unexpected (i.e., PD) versus expected (i.e. SAD) panic attacks. Thirdly, panic attack symptoms were analyzed along a linear dimension that was calculated to capitalize on categorization of expected and unexpected attacks based on symptom severity. These analyses were exploratory in nature and no specific hypotheses were made. Then, panic symptom severity was used to predict panic attack type, and we hypothesized that greater symptom severity would classify participants into PD versus SAD attacks. Next, severity of panic attacks (calculated by summing the severity scores for each of the 14 panic attack symptoms) within the context of each disorder was analyzed in relation to a variety of important clinical outcomes, including suicidality and medication use. Given that unexpected panic attacks are associated with

higher anxiety than expected panic attacks, we hypothesized that panic attacks in PD would have stronger associations with adverse clinical indicators, such as suicidality and history of inpatient and outpatient treatment, than expected panic attacks in the context of SAD. Finally, in order to determine whether the presence of panic attacks within SAD conferred greater risk of disorder severity and clinical correlates, SAD participants with and without panic attacks were compared in terms of severity of diagnosis and clinical correlates. Based on the prior literature demonstrating that expected panic attacks were less severe than unexpected attacks, we hypothesized that the presence of panic attacks would not confer greater risk in these analyses.

2. Method

2.1. Participants

Participants ($n=556$) were recruited throughout the Los Angeles, CA area between 1993 and 2013 for enrollment in various treatment studies in the Anxiety Disorders Research Center at the University of California, Los Angeles. A subsample of 404 participants (73%) reported experiencing panic attacks and was thus included in the present study. The participants with panic attacks averaged 34.4 years old ($SD=9.7$, range=18–62), and were predominantly Caucasian (67%; 11.4% Latino/Hispanic; 7% Asian; 14.6% other). The sample contained slightly more females (52.7%) than males (47.3%). There were no differences by principal panic type in age ($F(1,105)=0.02$, $p=0.88$), but there were differences in ethnicity ($\chi^2=37.2$, $p<0.001$, with the SAD group (54% Caucasian) more diverse than the PD group (75% Caucasian) and gender ($\chi^2=5.49$, $p<0.05$), with the SAD group having more males (56%) than females, and the PD group having more females than males (56%). Therefore, these demographic variables were used as covariates whenever possible. Differences based on analyses with the covariates are reported. Diagnoses represented in the sample include PD ($n=297$), SAD ($n=225$), specific phobia, ($n=196$), major depression ($n=140$), and generalized anxiety disorder ($n=193$), among others.

2.2. Measures

Anxiety Disorders Interview Schedule (ADIS-IV-L; Brown et al., 1994). All participants were administered the ADIS-IV-L to determine eligibility to participate in the studies. The ADIS-IV-L is a highly reliable and valid semi-structured interview that assesses the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) symptoms of anxiety, mood, substance use disorders, and psychosis (Brown et al., 2001). The interview also assesses demographic information, medical history, and relevant psychosocial variables. Each disorder assigned by the interviewer is given a clinician severity rating (CSR), using a scale from 0 (not at all) to 8 (very severe) to represent severity of symptoms, distress and impairment (with 3 representing probable/subthreshold and 4 representing clinical case). A CSR of 4 or greater indicates a clinically significant presentation of the disorder. The ADIS-IV-L was administered by either doctoral-level graduate students or highly-trained bachelor-level research assistants, all of whom demonstrated reliability over three consecutive interviews before being certified as interviewers, and were subsequently supervised by licensed clinical psychologists. All of the interviews were audio-recorded and a total of 78 were reviewed to establish inter-rater reliability across the included studies. On principal diagnoses, inter-rater reliability was excellent (kappa range=0.93–1.00) whereas ratings were moderately reliable for secondary diagnoses (kappa range=0.52–1.00).

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