

What Is Panic Disorder?

A full-content, evidence-contextualized companion to the supplied Psychology Tools handout.

Panic can feel terrifying. This resource explains themes in the supplied handout; it is information, not a diagnosis. Keep what fits, pause or return later if reading increases distress, and discuss your own symptoms with a qualified clinician.

1 EXPERIENCES THE SOURCE LINKS WITH PANIC DISORDER — descriptions, not a self-test

- 1 **Recurrent panic attacks**, where you fear that you will lose control or die.
- 2 **Avoiding things** that you worry might cause a panic attack.
- 3 **Worrying about more attacks**, and avoiding things you think might cause them.
- 4 Being **constantly on the lookout** for signs of danger.

SOURCE IDEA · LIGHTLY EDITED

A panic attack

The supplied handout describes a panic attack as a sudden surge of intense fear accompanied by strong body feelings and catastrophic thoughts. It says attacks feel terrifying but are not dangerous; people who worry about panic and take steps to prevent more attacks are said to suffer from panic disorder.

Evidence context: An isolated attack does not establish panic disorder. Diagnosis considers recurrent *unexpected* attacks, lasting concern or behavior change, and possible medical, substance-related, and other mental-health explanations.[1][4]

About the source's prevalence statement. The source says that “between 1 and 3 people out of every 100” experience panic disorder every year, and many more people have a panic attack at least once. Estimates vary by population, period, and diagnostic method. For context, NIMH reports a 2.7% past-year estimate for U.S. adults from an older national survey; it is not a personal prediction.[5]

2 A PANIC ATTACK IS NOT THE SAME AS PANIC DISORDER

Panic attack

An abrupt wave of intense fear or discomfort. It can involve strong physical and cognitive symptoms, including sensations that may feel alarming. One or occasional attacks can occur without panic disorder.[1]

Panic disorder

A clinician may consider this when **unexpected attacks recur** and at least one attack is followed by **one month or more** of worry about further attacks or their meaning, and/or behavior changes meant to avoid them. Assessment also considers other explanations.[1][4]

Why assessment matters

Symptoms during panic can be intensely physical. A provider can ask about timing, frequency, impact, medications or substances, and physical conditions that can overlap with panic symptoms.[1][3][4]

A provider may ask:

- When did symptoms begin, how often do they occur, and what is their impact?
- Are attacks unexpected, and what worry or behavior changes follow?
- Could a physical condition, medication, substance, or another concern need attention?

New, severe, unfamiliar, or different symptoms deserve medical attention rather than an automatic assumption that they are panic.

Optional note for a future conversation

One pattern I want to describe to a clinician, in my own words:

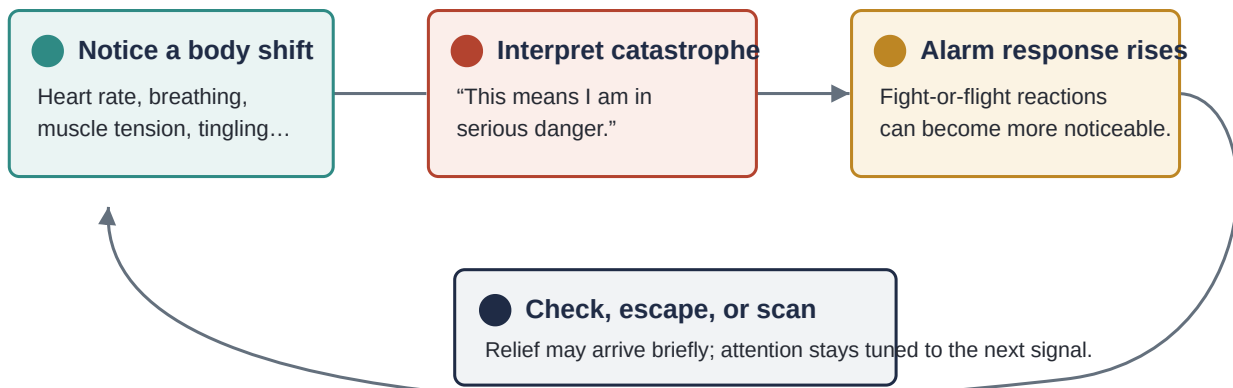
The core of panic: what the body is doing

The source's "false alarm" explanation, retained with medical-safety and evidence context.

The source's explanation: Your body changes all day to help you live your life. As you move around, your heart beats faster or slower, breathing speeds up or slows down, and muscles contract or relax. Much of the time these changes are outside awareness. The source says people who panic tend to interpret harmless body sensations as signs of impending catastrophe.

Use this as a model, not a verdict. "False alarm" is a metaphor used by some researchers to describe survival responses that may be active too often or strongly. It is not proof that a particular symptom is harmless or that a person has panic disorder.[1]

3 ONE COMMON CBT MAP — people's experiences and explanations vary



A possible loop: protective actions and monitoring can make sensations easier to detect, which may restart the alarm.

Source relationship retained: sensations interpreted as catastrophe can activate fight or flight; those reactions may be read as more danger, keeping a vicious cycle going. This is a common CBT formulation, not a universal cause or a substitute for assessment.[1][4]

Body shifts

Heart rate, breathing, and muscle tension can change during ordinary activity and stress.

Meaning added

The source emphasizes a feared interpretation: a body cue is read as an impending catastrophe.

Alarm reactions

Raised heartbeat, quicker breathing, and tense muscles can feel like further danger.

Attention & protection

Checking, escape, avoidance, and scanning may briefly reassure while keeping the next signal highly visible.

4 EXAMPLES FROM THE SOURCE — thoughts can feel compelling without being proof

"I'm worried this feeling in my chest means I'm having a heart attack."

CHEST SENSATION

"This tightness in my throat means I'm going to choke."

THROAT TIGHTNESS

"If I don't get out of here, I'm going to lose control."

URGENCY TO ESCAPE

Medical-safety context. Panic attacks are not generally life-threatening, but chest pain, breathing trouble, fainting, and other physical symptoms can overlap with medical conditions. Do not use this model to dismiss new, severe, unfamiliar, or different symptoms; seek urgent medical assessment when appropriate.[1][3][4]

Why panic can persist and get stuck

Three connected processes described in the supplied handout, with the original examples retained.

1 · SOURCE CONCEPT

Misinterpretation of body sensations

The source says that interpreting body sensations as a sign of catastrophe activates the **fight-or-flight system**.

Common fight-or-flight reactions named in the source:

- Raised heartbeat
- Quicker breathing
- Tense muscles

It adds that people with panic tend to misinterpret these reactions as further signs of danger, which keeps the vicious cycle going.

Editorial context: body changes have many causes. The clinical question is not simply whether to “think positive,” but whether symptoms need assessment and what meaning the mind has attached to them.

2 · SOURCE CONCEPT

Avoidance and safety behaviors

The source describes actions intended to prevent the worst from happening, including:

- Carrying medication “just in case”
- Looking for exits in case a quick getaway is needed
- Avoiding exercise or coffee to avoid increasing heart rate

It says these can feel reassuring in the short term while preventing learning that panic symptoms may be a “false alarm” from the fight-or-flight system.

Editorial context: these are examples, not instructions to stop medication, eliminate caffeine, or avoid/undertake exercise. Changes involving medicine or physical symptoms belong in a conversation with a clinician.

3 · SOURCE CONCEPT

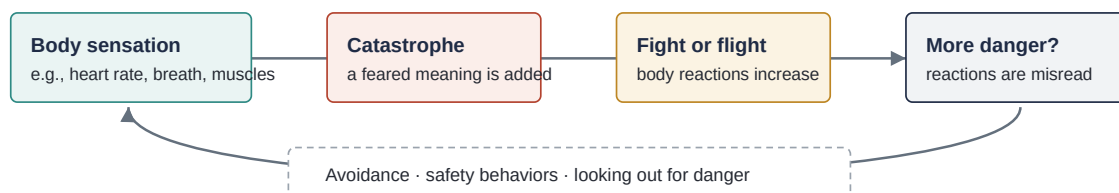
Being on the lookout for signs of danger

The source compares this to hearing that an escaped tiger is in your neighborhood: you would probably keep a lookout when you left home. In the same way, it says a person may stay alert for body sensations they think are dangerous.

Its point is that looking out makes it easier to notice. Noticing and worrying about harmless body sensations can then trigger another “false alarm” and panic.

Editorial context: monitoring can be an understandable attempt to feel prepared. In a CBT model, it may sometimes amplify attention to sensations; it is not a character flaw and may not fit every person.

4 THE SOURCE'S PROPOSED RELATIONSHIPS — a visual summary, not a diagnostic chain



The source proposes that these protective responses can bring short-term reassurance while keeping sensations and feared meanings especially visible. This relationship is a common CBT formulation and may not explain every person's panic.

How the three source concepts connect

A sensation may be interpreted as catastrophe. Fight-or-flight changes can then feel like further evidence of danger. Leaving, checking, carrying something for reassurance, or scanning for symptoms can reduce distress briefly; the source proposes that these responses can also keep the next alarm easier to trigger or notice. This is a formulation to explore with a clinician, not a rule about what “causes” all panic.

Optional reflection

If useful, name one pattern—not a personal failure—you would like to understand better.

Choice and pacing: You do not need to test yourself by facing a feared situation alone or suddenly dropping a coping strategy. Exposure-based work, when appropriate, is planned and individualized with a qualified clinician.[1][2]

Treatment for panic disorder

The source's treatment content, retained and updated with evidence limits and collaborative-care context.

The source names cognitive behavioral therapy (CBT). It says CBT can help a person learn how the body reacts to stress, examine whether body sensations are really dangerous or not, and confront situations they have been avoiding. Current sources describe CBT as a well-studied treatment option; it may include work with thoughts, behavior, and reactions to feared sensations or situations, including exposure when appropriate.[1][2][4]

PSYCHOTHERAPY

CBT and planned practice

CBT is commonly used for panic disorder. Exposure is a CBT method that may involve gradual, planned contact with feared sensations, situations, or beliefs so that learning can occur. It is not a direction to force yourself through an unsafe situation or attempt an exercise without appropriate assessment and support.[1][2]

Evidence limit: The source's fixed claim that about 80% of people who complete CBT are "panic-free" at the end of treatment is preserved below as a source claim, but should not be read as a guaranteed outcome. Research supports CBT, while outcome estimates vary across studies, people, formats, comparators, and follow-up periods.[6][7]

MEDICATION · SOURCE DETAIL RETAINED

Medication is a clinical decision

The source says that if a person with panic disorder chooses drug treatment, medical guidelines suggest a **selective serotonin reuptake inhibitor (SSRI)** or **tricyclic antidepressants (TCAs)**. It also says benzodiazepines are associated with poorer long-term outcome and should not be prescribed for treatment of panic disorder.

- NICE likewise states that antidepressants are the pharmacologic option with evidence for longer-term management and names SSRIs and TCAs; it advises against benzodiazepines for panic disorder because of less favorable long-term outcomes.[2]
- Current U.S. summaries also mention SSRIs/SNRIs and describe medication choice, risks, and duration as individualized decisions with a prescriber.[1][4]

Source outcome claim, clearly bounded

What the 2022 source said: CBT is "extremely effective" and "about 80%" of people completing a CBT course are "panic-free" at its end. This handout retains that claim as an attributed source statement, not as a promise. A 2023 network meta-analysis of 74 trials (6,699 participants) found guided self-help, individual, and group CBT superior to treatment as usual, with low-to-moderate confidence and no high-confidence comparison.[6]

Care is collaborative

Psychotherapy, medication, or both may be considered in light of preferences, medical situation, access, co-occurring conditions, and professional assessment. Do not start, stop, or alter medication based on a handout. If panic or avoidance disrupts daily life, a health or mental-health professional can help consider next steps.[1][2][3]

Questions or information to bring forward

Use only what is useful. Specific details can help a clinician understand timing, symptoms, impact, current medicines/substances, and what you have tried.

What do I want a clinician or prescriber to know about my attacks, worry, avoidance, or physical symptoms?

A small support step

Choose a manageable next step, such as asking for an appointment, bringing this resource to therapy, or writing down a question. This is not a test of willpower.

The support question or next step I want to take:

Source and rights notice: Content themes and the source's prevalence, CBT-outcome, symptom-model, safety-behavior, and treatment statements are from the supplied *What Is Panic Disorder?* handout. **Copyright © 2022 Psychology Tools Limited. All rights reserved.** This original companion layout and editorial framing do not reproduce source artwork or its distinctive layout. Evidence-context references: [1] NIMH (2025); [2] NICE CG113; [3] MedlinePlus (2024); [4] DeGeorge et al. (2022); [5] NIMH statistics; [6] Papola et al. (2023); [7] Cochrane (2016). Full citations and limits are in the accompanying research record.