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The phenomenology of the first panic attack in clinical and community-based samples

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ABSTRACT

The purpose of the study was to contrast first panic attacks (PAs) of patients with panic disorder (PD) with vs. without agoraphobia and to explore differences between first PAs leading to the development of PD and those that remain isolated. Data were drawn from a community survey ($N = 2260$ including 88 isolated PAs and 75 PD cases). An additional sample of 234 PD patients was recruited in a clinical setting. A standardized interview assessed the symptoms of the first PA, context of its occurrence and subsequent coping attempts. Persons who developed PD reported more severe first PAs, more medical service utilization and exposure-limiting coping attempts than those with isolated PAs. The context of the first PA did not differ between PD and isolated PAs. PD with agoraphobia was specifically associated with greater symptom severity and occurrence of first attacks in public. Future research should validate these findings using a longitudinal approach.

1. Introduction

Panic attacks are described as an abrupt surge of intense fear or impending doom, a paroxysmal increase in strong autonomic arousal and an overwhelming urge to escape the situation (Barlow, 2002; Richter et al., 2012). According to current diagnostic criteria (DSM-5; American Psychiatric Association, 2013) panic attacks are defined by symptom reports, i.e., persons have to report at least four or more of a list of 13 symptoms, including somatic symptoms such as heart palpitations, chest pain, sensations of shortness of breath, as well as cognitive symptoms such as fear of dying or fear of losing control or going crazy (Craske, Kircanski, Epstein, Wittchen, & Pine, 2010). Moreover, symptoms of a panic attack have to reach their peak intensity within minutes (crescendo criterion).

Panic attacks can be elicited by innocuous objects or situations. They are then diagnosed as cued attacks in the context of specific phobias or agoraphobia and further classified according to the situations that are feared or avoided (e.g., specific phobias animal type). Panic attacks may also appear "out of the blue", i.e., unexpectedly for the individual without any explicit perceivable situational trigger. If at least one of such recurrent unexpected panic attacks has been followed by one month of persistent concern or worry about having additional attacks or about their consequences or significant maladaptive changes in behavior because of the attacks, the criteria for a diagnosis of panic disorder are met (see Craske et al., 2010). When individuals report panic

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attacks that are not associated with such concerns or changes in behavior such attacks are called isolated (Kessler et al., 2006) or non-clinical panic attacks (Norton, Cox, & Malan, 1992).

Large epidemiological studies (Eaton, Kessler, Wittchen, & Magee, 1994; Eaton et al., 1989; Kessler et al., 2006) investigating the prevalence of sudden experiences of unexplained fear found that up to 15.6% of the general population report fearful spells (sudden experiences of unexplained fear, Eaton et al., 1994) with 7% fulfilling all criteria of a full-blown panic attack (presence of four or more symptoms and a crescendo). However, only 3.5–3.7% of the respondents fulfill the diagnostic criteria of a panic disorder (Eaton et al., 1994, 1989; Kessler et al., 2006). Although the overall prevalence rates of fearful spells (13.1%), panic attacks (4.3%) and panic disorder (1.6%) are lower for adolescents and young adults, the proportion within this hierarchical pattern is comparable (see findings from the Early Developmental Stages of Psychopathology (EDSP) study, Reed & Wittchen, 1998). Given this epidemiological evidence it is surprising that there are only very few studies that investigated the phenomenology and the circumstances of those panic attacks that set the stage for the development of a panic disorder, contrasting them to those attacks that remain isolated or non-clinical.

The few studies that investigated the phenomenology and the circumstances of the first panic attacks did not investigate larger community based samples but rather collected data from patient samples. Patients with panic disorder can typically recall the first panic attack that marked the beginning of the development of the disorder very vividly (Amering, Katschnig et al., 1997; Lelliott, Marks, McNamee, & Tobena, 1989). Lelliot et al. (1989) as well as Amering, Berger, Dantendorfer, Windhaber, and Katschnig (1997) used a semi-structured interview to characterize the circumstances of the first panic attack in a group of 57 and 90 patients with panic disorder. The main results of these studies revealed that first panic attacks typically occurred during the daytime from 6 AM to 6 PM (76% in Lelliott et al., 1989 and 63% in Amering et al., 1997, respectively) and outside home (92% and 75%, respectively). At time of their first panic attack 55% (Lelliott et al., 1989) and 67% (Amering et al., 1997), respectively, of the patients had been accompanied. Most patients (71% in Lelliott et al., 1989 and 68% in Amering et al., 1997, respectively) fled from the situation the attack occurred in and one third of the patients sought medical advice about the first panic attack. Craske and coworkers (Craske, Miller, Rotunda, & Barlow, 1990) analyzed the reports of the first panic attack in a group of 162 patients using the data from the Anxiety Disorder Interview Schedule-Revised (ADIS-R; Di Nardo & Barlow, 1988). First panic attacks were reported to have occurred outside home in 66% of the cases. 63% of patients had been in company during the first attack. More recently, Hara et al. (2012) investigated the first panic attack in a large group of 830 patients with panic disorder using a questionnaire administered during the patients initial visit at the outpatient clinic. Similarly to previous studies, 63% of patients reported that their first panic attack occurred away from home. First panic attack symptoms reported most frequently were palpitations, smothering, fear of dying, feeling dizzy, going crazy, trembling, and sweating.

These clinical studies also revealed that first panic attacks of panic disorder patients with comorbid agoraphobia systematically differed from those first attacks reported by patients without comorbid agoraphobia: the presence of agoraphobia was associated with a more frequent occurrence of the first attack in public as opposed to in a home setting (Amering, Katschnig et al., 1997; Hara et al., 2012). Whether symptoms of or the behavioral responses to the first panic attack systematically differ between patients with vs. without comorbid agoraphobia has not been analyzed yet. The present study was therefore designed to complement the present database with a more detailed characterization of the first panic attack of patients with panic disorder with and without comorbid agoraphobia, including an elaborate description of the symptoms of the first panic attack, the circumstances during which it occurred, as well as the behavioral responses that followed the first attack.

Although, there is a large body of literature on increased risk for mental disorders for persons with isolated panic attacks (Kessler et al., 2006; Pané-Farré et al., 2013) descriptions of the phenomenology and circumstances of such isolated panic attacks are sparse. Using the revised panic attack questionnaire, Norton, Zvolensky, Bonn-Miller, Cox, and Norton (2008) assessed isolated panic attacks in a student population ($N = 21$) and reported symptom patterns that were strikingly comparable to the first attacks of panic disorder patients: 57% of the student respondents reported to try to get out of the situation to cope with the panic attacks. Moreover, 24% reported to seek medical attention in response to their panic. Analyzing data ($N = 335$) from the NCS, Vickers and McNally (2005) provided a description of the symptom pattern of the worst isolated panic attack persons had experienced. The main difference between first panic attacks that remain isolated and those that lead to a panic disorder was that panic disorder patients more often reported fear of dying as a symptom of their first panic attack.

Although the studies described above give a first valuable insight into the circumstances and phenomenology of the first panic attacks that remain isolated, they do not allow a direct comparison of isolated attacks vs. panic attacks that lead to the development of panic disorder. Therefore, with the aim to provide such a direct comparison of key features of panic attacks that lead to a panic disorder and those that remain isolated, we assessed both, first attacks in persons with panic disorder and persons with isolated panic attacks in a large community based study using the same diagnostic instruments. Moreover, the recruitment of panic patients from a community sample allows to test whether findings from the clinical studies regarding differences between first panic attacks of panic disorder patients with vs. without agoraphobia can be validated in an independently recruited study sample.

An additional objective of the current study was to investigate the role of agoraphobic avoidance and its temporal relationship to the first panic attack and/or panic disorder. After years of controversial debates whether agoraphobia exists independently from panic disorder, agoraphobia can be diagnosed irrespective of the presence of panic disorder according to the current diagnostic criteria of DSM-5 (American Psychiatric Association, 2013). This is in line with epidemiological studies that find a quite substantial amount of individuals (25%) who meet the even stricter ICD-10 criteria of agoraphobia without reporting full-blown panic attacks or meeting the criteria of panic disorder (Kessler, Chiu, Demler, & Walters, 2005; Wittchen, Gloster, Beesdo-Baum, Fava, & Craske, 2010). In contrast, clinical studies rarely find any patients with agoraphobia who do not report a precipitating history of panic (Craske et al., 1990). We used a standardized diagnostic interview in the clinical as well as in the community based sample to assess whether agoraphobic avoidance occurred prior to, at time of, or following the first panic attack. Moreover, we wanted to assess whether the phenomenology and the circumstances of the first panic attacks were comparable or differed between the individuals of the community sample and the patients.

2. Methods

2.1. Samples

The clinical sample consisted of $N = 234$ patients (154 females) diagnosed with panic disorder with ($n = 183$) or without ($n = 51$) agoraphobia. Patients were recruited from the second phase of