



Comorbid panic attacks among individuals with posttraumatic stress disorder: Associations with traumatic event exposure history, symptoms, and impairment

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ABSTRACT

Little is known about the prevalence of panic attacks in PTSD and their influence on symptom severity and disability. Utilizing the National Comorbidity Survey–Replication data, respondents meeting DSM-IV criteria for past year PTSD ($n = 203$) with and without comorbid panic attacks were compared across various dimensions. Past year panic attacks were found among 35% of the sample and were associated with greater PTSD-related disability and less time spent at work. Panic attacks were also associated with greater prevalence of comorbid depression, substance abuse/dependence, medically unexplained chronic pain, number of anxiety disorders and lifetime traumatic events, PTSD reexperiencing and avoidance/numbing symptoms, and treatment-seeking related to traumatic stress reactions. Multivariate analyses revealed that panic attacks were one of the only unique predictors of severe PTSD-related disability. Overall, findings suggest that panic attacks are common among individuals with PTSD; therapeutic strategies targeting panic in this population may be of significant benefit.

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Over the past several years, significant progress has been made in psychological treatments for posttraumatic stress disorder (PTSD). However, a significant portion of individuals who undergo traumatic event-focused therapies remains symptomatic following treatment. For example, approximately half of treatment completers retained their PTSD diagnosis in a recent clinical trial comparing two well-established therapies (Resick, Nishith, Weaver, Astin, & Feuer, 2002). Recently, investigators have turned their attention to comorbid panic attacks and panicogenic processes in PTSD. For example, Falsetti, Resnick, and Davis (2005) and Falsetti, Resnick, and Davis (2008) have presented preliminary evidence for efficacy of a treatment designed specifically for individuals with PTSD and comorbid panic that combines elements of cognitive processing therapy (Resick & Schnicke, 1993) and panic control treatment (Barlow & Craske, 1994). Hinton et al. (2005a) have presented data demonstrating efficacy of culturally adapted cognitive-behavioral therapy for Vietnamese refugees with PTSD and comorbid neck-focused and orthostatic-cued panic attacks. In addition, Wald and Taylor (2005, 2007) have conducted pilot work to test the effectiveness of interoceptive exposure, a key psychological treatment component for panic disorder, in combi-

nation with trauma-focused exposure therapy among individuals with PTSD. These developments continue to advance understanding of how to treat comorbid panic and PTSD. However, relatively little work has examined what types of additional problems panic attacks may mark among people with PTSD.

A comprehensive account of the relationship between panic and PTSD was recently proposed by Hinton et al. (2005a) and Hinton, Hofmann, Pitman, Pollack, and Barlow (2008). According to their model, panic attacks may be triggered when certain sensations (e.g., neck tension) activate: trauma memory networks, catastrophic cognitions, metaphoric associations that may be culture-specific (e.g., negative connotations of dizziness found among Cambodian refugees), or interoceptive conditioning that has occurred in relation to specific fear sensations. If activation of any of these four networks results in escalating anxiety, a panic attack is a likely result. They also argue that such panic attacks will worsen PTSD severity through activation of traumatic event-related fear networks and increasing arousal.

Empirical work has supported models of panic and PTSD comorbidity. Among rape victims, 90% of the sample reported four or more panic attack symptoms within 72 h of the assault (Resnick, Falsetti, Kilpatrick, & Foy, 1994). Panic attacks during exposure to a traumatic event have also been linked to acute stress reactions (Bryant & Panasetis, 2001) and PTSD (Galea et al., 2002). History of traumatic suffocation is reported to be more common among individuals with panic disorder and to be linked with respiratory concerns (Bouwer & Stein, 1997). In a treatment study, changes in

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panic attack symptom severity were found to partially mediate changes in PTSD symptoms (Hinton et al., 2008). In addition, there are now several studies linking heightened anxiety sensitivity and fearful reactivity to bodily arousal, core features of panic disorder, to PTSD (Fedoroff, Taylor, Asmundson, & Koch, 2000; Feldner, Vujanovic, Gibson, & Zvolensky, 2008a; Feldner, Zvolensky, Schmidt, & Smith, 2008b; Leen-Feldner, Feldner, Reardon, Babson, & Dixon, 2008; Taylor, 2003; Taylor, Koch, & McNally, 1992).

Studies also have examined prevalence of comorbid panic spectrum problems (including panic attacks and panic disorder) among individuals with PTSD. Nationally representative samples suggest lifetime prevalence of both panic attacks and panic disorder is elevated among people with compared to without PTSD. Specifically, panic disorder estimates range from 7.3% to 18.6% among men and 12.6–17.5% among women (Feldner et al., 2009; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Estimates of lifetime prevalence of panic attacks suggest people with PTSD are significantly more likely to endorse a positive lifetime history of panic attacks, even after accounting for variance associated with sex, education level, socioeconomic status, race, and diagnoses of drug, alcohol, and nicotine dependence; approximately 53% of men and 62% of women with PTSD, compared to 23% of men and 28% of women without PTSD, endorsed a lifetime history of panic attacks (Feldner et al., 2009). In an investigation of 62 treatment-seeking crime victims (most of whom met criteria for PTSD), 69% reported current panic attacks (Falsetti & Resnick, 1997). No significant gender differences or differences in traumatic event history were found among those with versus without panic attacks, though these comparisons were likely underpowered. In a separate investigation of a community sample, researchers found that 18.2% of those with current PTSD reported panic attacks compared to 1.1% of those without current PTSD (Falsetti, Resnick, Dansky, Lydiard, & Kilpatrick, 1995). Lastly, in a survey of treatment-seeking Cambodian refugees, 80% of those with current PTSD reported orthostatic panic attacks, while only 8% of those without PTSD reported such attacks (Hinton, Pollack, Pich, Fama, & Barlow, 2005b).

Research suggests panic attacks could contribute significantly to symptom severity and disability among people with PTSD. In a large epidemiological study, panic attacks were associated with impairment in perceived physical and emotional health, greater health care utilization, psychoactive drug use, and occupational and financial functioning (Klerman, Weissman, Ouellette, Johnson, & Greenwald, 1991). Moreover, these associations were not accounted for by psychiatric comorbidity, including comorbid panic disorder. An additional study found that non-clinical panickers reported more family, work, and social disability than non-panickers (Katon et al., 1995). Such findings raise the possibility that comorbid panic could increase the substantial rates of comorbidity (Kessler et al., 1995) and severe impairment found among those with PTSD (Rapaport, Clary, Fayyad, & Endicott, 2005).

There remains surprisingly little research on the prevalence and consequences of panic attacks among individuals with PTSD. Such research would speak to the importance of panic attacks in this disorder and the potential utility of panic-focused strategies for improving treatment outcome. Data on treatment-seeking, in particular, may also help indicate likelihood of encountering individuals with PTSD with comorbid panic attacks in a clinical setting. Studies on this topic have been rather limited in scope and have been confined mostly to relatively small samples and populations from a narrow demographic. To our knowledge, no published research has compared individuals with PTSD with and without panic attacks in terms of symptom profiles, disability, or treatment-seeking. Accordingly, the goal of the current study was to examine prevalence of comorbid panic attacks among indi-

viduals with PTSD in the National Comorbidity Survey-Replication (NCS-R; Kessler et al., 2004), a large, nationally representative survey of adults living in the U.S. Individuals with PTSD with and without comorbid panic attacks were compared across various dimensions, including traumatic event history, disability, psychiatric comorbidity, chronic pain, and treatment-seeking. It was hypothesized that presence of comorbid panic attacks would be associated with greater symptom severity and disability among individuals with PTSD. In addition, given that previous research found no differences in trauma history between trauma victims with and without panic (Falsetti & Resnick, 1997), comparisons of trauma histories between these groups were considered exploratory in nature.

1. Method

1.1. Sample

The NCS-R is composed of a representative sample of English-speaking adults from the contiguous United States. Participants were interviewed in-person at their place of residence between February 2001 and April 2003. A detailed description of the methodology, weighting, and sampling procedures used in the NCS-R has been provided by Kessler, Berglund, Demler, Jin, and Walters (2005).

All respondents completed Part I of the interview ($N = 9282$) which contained a section covering each of the core mental health disorders. Part II included sections on disorders of secondary importance as well as risk factors, consequences, services, and other correlates of mental health disorders. In an effort to reduce respondent burden, Part II was completed only by those who met criteria for a lifetime core diagnosis as well as a probability subsample of those who did not meet criteria. The current investigation was based on data from a subsample of individuals ($N = 5692$) who reported psychiatric history. Specifically, participants from Part II of the NCS-R were included as only the subset of participants who completed this part of the survey completed measures of PTSD. The sample was 53% female with an average age of 45.01 ($SD = 17.9$). The racial and ethnic representation of the study participants was 72.8% Caucasian, 11.7% African-American, 11.1% Hispanic, and 4.4% from other ethnicities.

1.2. Procedure

Based on the 2000 U.S. Census, a stratified, multistage probability sample was created. Respondents received a letter describing the survey and their potential participation several days before in-person contact was made. Interviews were conducted face-to-face by professional interviewers who had obtained extensive training and were closely supervised by the Institute for Social Research. Consent procedures were approved by the Human Subject Research Committees at Harvard Medical School and the University of Michigan. Respondents received \$50 for completing the interview. The overall response rate was 70.9%. Part I was weighted to adjust for discrepancies between the sample and the U.S. Census in terms of geographic and sociodemographic variables. Additional weighting of Part II was conducted to adjust for differential probability of selection from Part I (Kessler et al., 2004).

1.3. Measures

1.3.1. Demographic

The interview included an extensive demographic section that assessed sex, age, education, marital status, and other demographic variables.

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