THE WETC PSYCHOLOGY NEWSLETTER

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Panic Attacks and Panic Disorders

"In order to diagnose a Panic Disorder correctly the person must have Panic Attacks and there must be evidence that the individual has a persistent concern about having additional attacks as well as worries about the consequences of the attacks, or the individual must present with a significant behavioral change as a result of the attacks."

Panic Attacks

Patients who present for psychological evaluations and/or treatment in a medical-legal context often have complaints of Panic Attacks. While Panic Attacks are not in themselves DSM-IV-TR psychological disorders, they may occur in a variety of Anxiety Disorders such as Panic Disorders, Phobias and Posttraumatic Stress Disorder.

The DSM-IV-TR delineates three different types of Panic Attacks according to the context in which they occur. First, unexpected or "uncued" Panic Attacks are not associated with anything in the patient's environment but are said to occur "out of the blue." Second, situationally bound Panic Attacks are "cued" and almost invariably occur when the individual is either presented with some environmental event or anticipates the occurrence of that event. Third, situationally predisposed Panic Attacks are likely to occur when the individual is presented with some environmental event but they are not invariably associated with that event and do not necessarily occur immediately on being presented with that event.

According to the DSM-IV-TR, a Panic Attack is defined as a discrete period of intense fear or discomfort in which four or more of 13 signs and/or symptoms occur that develop abruptly and usually reach a rapidly developed peak within ten minutes. Individuals who experience Panic Attacks describe the experience as intense and accompanied by such thoughts as imminent death, heart attack or stroke, or "going crazy." The 13 signs and/or symptoms are given below.

A. Palpitations, or an abnormally rapid or a pounding heartbeat
B. Sweating
C. Trembling and/or shaking
D. A sensation of shortness of breath and/or smothering.
E. Feelings of choking
F. Chest pain or discomfort
G. Nausea and/or abdominal distress
H. Feelings of dizziness, unsteadiness, lightheadedness and/or faintness
I. Derealization, which is a feeling of unreality and/or depersonalization, which is a feeling of being detached from oneself
J. A fear of losing control and/or going crazy
K. A fear of dying
L. Numbness and/or tingling sensations
M. Chills and/or hot flushes

Panic Disorders

There are two types of Panic Disorders: Panic Disorder With Agoraphobia (300.21) and Panic Disorder Without Agoraphobia (300.01).

A Panic Disorder With Agoraphobia (300.21) is diagnosed correctly when the individual presents with recurrent and unexpected Panic Attacks. There must also be at least one month of either persistent concern about having additional attacks, worry about the implications of the attacks or their consequences, or a significant change in behavior related to the attacks. In addition, the individual must present with signs and/or symptoms of Agoraphobia, which is anxiety or fear about being in places or situations from which escape might be difficult or embarrassing and/or in which assistance might not be available in the event of the occurrence of a Panic Attack or panic-like signs and/or symptoms such as having a sudden attack of dizziness or diarrhea. The anxiety or fear that is characteristic of Agoraphobia is what typically leads the individual to a pervasive avoidance of a variety of situations such as being home alone, leaving home alone,

being in a crowd, or taking public transportation. The DSM-IV-TR criteria for Agoraphobia are given below.

A. Anxiety about being in situations and/or places from which escape may be difficult and/or embarrassing, or in which help might not be available in the event of the occurrence of either a Panic Attack or panic-like signs and/or symptoms. Consequently, the individual avoids those situations and/or places such as being home alone or leaving home alone, crowds and taking public transportation.
B. The individual avoids situations and/or places or endures them with marked distress and/or requires the presence of a companion.
C. The signs and/or symptoms listed in Criteria A and B are not better accounted for by another disorder, for example, a Social Phobia or a Posttraumatic Stress Disorder.

As you might expect, a Panic Disorder Without Agoraphobia (300.01) is diagnosed correctly when the individual presents with recurrent and unexpected Panic Attacks but no Agoraphobia. There must also be at least one month of either persistent concern about having additional attacks, worry about the implications of the attacks or their consequences, or a significant change in behavior related to the attacks.

Diagnostic Problems

The principal diagnostic problem confronting a psychologist or a psychiatrist who is examining a patient who reports symptoms of a Panic Attack is the elimination of general medical conditions and/or drug and medication effects that can produce Panic Attacks and/or panic-like symptoms. In many cases it will be possible to eliminate some of the causes by obtaining a thorough and complete history and a careful reading of the medical records. However, at other times it may be necessary to obtain a comprehensive internal medicine examination to eliminate many of the physical possibilities. Consider, for example, that Panic Attacks can be caused by:

Hyperthyroidism – an excess of thyroid hormones or what is said to be an overactive thyroid gland

Hyperparathyroidism - an excess of parathyroid hormones or what is said to be an overactive parathyroid gland

Pheochromocytoma - a neuroendocrine tumor of the medulla of the adrenal glands that causes a secretion of excessive amounts of catecholamines

Vestibular dysfunctions - dysfunctions of the inner ear, such as labyrinthitis, an inflammation of the inner ear usually caused by a virus, a bacteria, a head injury, an allergy or a reaction to a medication

Seizure Disorders – abnormal brain functions that are the direct result of neurobiological factors that mimic the signs of a Panic Attack

Cardiac conditions – problems such as heart arrhythmias and supraventricular tachycardia

Medications – Ritalin, some antibiotics, withdrawal from CNS depressants and SSRIs

Drugs of Abuse – cocaine, caffeine, amphetamines and alcohol

In summary, a Panic Attack is not a psychological disorder but a sign and/or a symptom of a variety of Anxiety Disorders, including Panic Disorders. Panic Attacks are diagnosed correctly when the individual presents with at least four of the 13 symptoms described in the DSM-IV-TR. In order to diagnose a Panic Disorder correctly the person must have Panic Attacks and there must be evidence that the individual has a persistent concern about having additional attacks as well as worries about the consequences of the attacks, or the individual must present with a significant behavioral change as a result of the attacks. As with all other DSM-IV-TR diagnoses, if the doctor does not present sufficient hard data to support their diagnosis then their report is substantially flawed and incapable of supporting any conclusions about a psychiatric injury, a psychiatric disability or a need for psychological and/or psychiatric care.

This is the thirty-first of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters listed on the next page, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.

February, 2009 – Litigation Problems With The GAF

March, 2009 – Common Flaws In Psych Reports

April, 2009 – The Minnesota Multiphasic Personality Inventory (MMPI)

May, 2009 – Apportioning Psychiatric Disability In Workers' Compensation cases And Assessing Aggravation In Personal Injury Cases

June, 2009 - Subjectively Interpreted Projective Psychological Tests

July, 2009 - Sleep Disorders And Psychiatric Injuries

August, 2009 - Posttraumatic Stress Disorder

September, 2009 - Compulsive Computer Use Disorder

October, 2009 - Major Depressive Disorder

November, 2009 - The Millon Tests

December, 2009 - Psychological Factors Affecting Medical Condition

January, 2010 - Pain Disorders

February, 2010 - Common flaws in psych reports #2

March, 2010 - Drugs: Use, Abuse and Dependence

April, 2010 - Common Flaws In Psych Reports #3

May, 2010 - "Impossible" MMPI-2 scores and their consequences for litigation

June, 2010 - Adjustment Disorders

July, 2010 - Bipolar Disorders

August, 2010 - Mental Status Examination

September, 2010 - Symptoms, Signs and the GAF: A Potential Litigation Problem

October, 2010 - What vs. Why: Determining Causality in Psych Cases

November, 2010 - Tightrope Walking and the GAF

December, 2010 - Apportioning Psychiatric Injuries: A More Complete View

January, 2011 - Personality Disorders

February, 2011 - Apportioning Psychiatric Disability With Multiple Orthopedic Injuries

March, 2011 - How To Cx a Shrink

April, 2011 - The Mental Status Examination - Revisited

May, 2011 - Dysthymic Disorder

June, 2011 - The Credibility of Psychological Diagnoses

July, 2011 – Physical and Psychiatric Injuries: A Tale of Three Patients